AMEDD Guidance:
Core Provider Teaching for AHLTA

Note: This material, along with the associated How To information, is designed to facilitate transition to AHLTA use and includes time saving tips and tricks for documenting in AHLTA. It is intended to augment the standard over-the-shoulder training and classroom training. The provider should recognize that NOT ALL medication, consults, labs, and radiographic procedure are available in the training database. However, the practice of trying to reproduce one of your previous handwritten notes into AHLTA can be very beneficial in training/learning the outcome of efficiently producing effective clinical documentation.

V8 – 05 September 2006

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Change History			
Version	Section	Content of Change/Addition	Page Number
8.0	How To	Added information to “Cleaning up the Problem List”.	57
4.0	All	Incorporated AMEDD AHLTA OTSG MC Consultants: Efficiency Tips v.1 May 2006 PowerPoint into document	
4.0	All	Changed CHCS II text to AHLTA	
4.0	Title Page Note	Note has been modified to state that time saving tips and tricks have been included into the document	1
1.0		Document Created	

Introduction

Often, the users who have the most difficult time adjusting to AHLTA are providers. This occurs for several reasons. One is that providers have more areas of concern and more complex documentation that must be done. The written portion of a clinical note in AHLTA also seems vastly different from documentation done by hand or dictation. Finally, AHLTA can do a vast assortment of things and there is no way to teach (or learn) everything in eight hours of class time. More instruction is not the answer. The solution is to teach (learn) the skills that the provider needs to function effectively and efficiently at initial training. Skills can continue to grow and develop over time. This is true learning, not just exposure to the application.

Although AHLTA has many functions, this paper will guide you through acquiring the basic skills needing to practice effective and efficient outpatient medicine using AHLTA. The AMEDD provides sustainment training for ongoing support of learning. The goal is to become proficient with the application within 2 weeks.

The following areas will be covered and 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 provider has gone through the self-paced (guided) tutorial on AHLTA prior to training and brings at least 3 notes that they have recently written to use as clinical examples for practice.

1. Customizing the Provider Desktop
    - A. How to customize the Desktop for clinic speed
    - B. Customizing Physician Shortcuts
2. Health History Module
    - A. How to configure
    - B. How to use
        - 1) Reviewing patient information
            - a. Test results – labs, rads, and x-ray
            - b. Medication
            - c. Previous visits.
            - d. Allergies
            - e. Searching for information by diagnosis from the Problem List
        - 2) Moving information into note
3. User Defined Settings
    - A. AutoCites
    - B. Other User Settings
    - C. Problems List Use
4. Encounter Documentation
    - A. A/P Module
    - B. Physical Exam
    - C. ROS
    - D. HPI and History review
    - E. Disposition

5. AIM form loading and Use
6. Default Template
   A. DxPrompt
7. Coding Information
   A. SOAP to Coding
8. Team Documentation
   A. Recommended Clinic Workflow
   B. Recommended Provider Encounter Workflow
9. Copy Forward and Previous encounters
10. Telephone consults
11. Consult log
12. Flowsheets
13. Use of Word documents
14. Adding, Deleting, and removing items from the Problem List module.

Only after the above has been mastered should the provider venture into template-building and other available functions within the application.

Customizing the Provider Desktop

AHLTA has many ways to do the same thing. Consider having only the things you need on the desktop and using "Go" to access other items.

AHLTA speed can be increased by:

- Setting personal preferences for clinic "speed"
- Customizing the physicians personal view
- Limiting extraneous mouse movements and clicks

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. It also allows you to pull up detailed patient information. It is customizable to your preferences.

1. Set up and configuration – See HOW-TO
2. Health History Module areas
   A. Problem List – Lists all the patient's recorded diagnoses. This area is updated automatically when you enter any new diagnosis. By clicking on this area you can drill into the patient's problem list to see all 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.
   B. Medication
   C. Laboratory
   D. X-rays
   E. Allergies

F. Previous encounters to include items placed into the comment field at the time of diagnosis that are viewable from the Problem List.
G. Vital signs – Review a historical record of the patient’s vital signs.

3. Moving test result information into your note
   A. Open the test result
   B. Highlight the area
   C. Right-click, then select either
      1) Copy – places the selection on the clipboard; it can then be Pasted into the note
      2) Copy To Note – copies the details directly into the S/O portion of the current patient encounter summary. Note you must have an encounter 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.
4. Practice Recommendation
   A. Open Health History Module, at the beginning of the encounter, as you enter the exam room after greeting the patient (or in the hallway if on a wireless connection). The Health History module loads patient data in the background.
   B. The module will take a few seconds to load but this is comparable to looking at all the individual areas of CHCS I (Legacy). You can work on something else while the patient data is loading.
   C. Review the information after your initial talk with the patient. It will often show other encounters and results that may have been ordered on the patient that you were unaware of.
   D. When you return to the module it will open much faster (for example, the Rads and Labs modules will load faster on the PC in use).

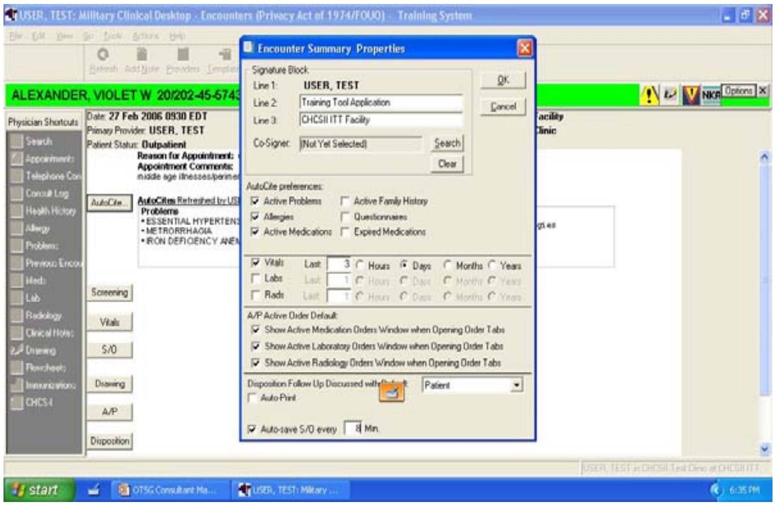
User Defined Settings

AutoCites

Setting the AutoCite preferences:

1. Only select the following AutoCites:
   - Active Problems
   - Allergies
   - Active Medications

By selecting only these three preferences, A/P loading is sped up. Having additional information selected in the AutoCites slows the system and makes you legally liable for any AutoCite results.



2. Close the patient record when not in use.
3. Set the Auto-save S/O at eight minutes. This will save data if event occurs and more frequent saves slows the system.
4. Deselect the Auto-Print checkbox.
5. Select your Lab/Rad settings.

Other User Settings

Medications module

- The filter used for medication display will impact view and AutoCite.
  - o Options: Set the medications filter to Outpatient Current/ All Inpatient/ All Current

If Using Health History Module:

- Set Labs filter to All
- Set Meds filter to All

If NOT using the Health History Module:

- Set Labs filter to N-days
- Set Rads filter to N number or days

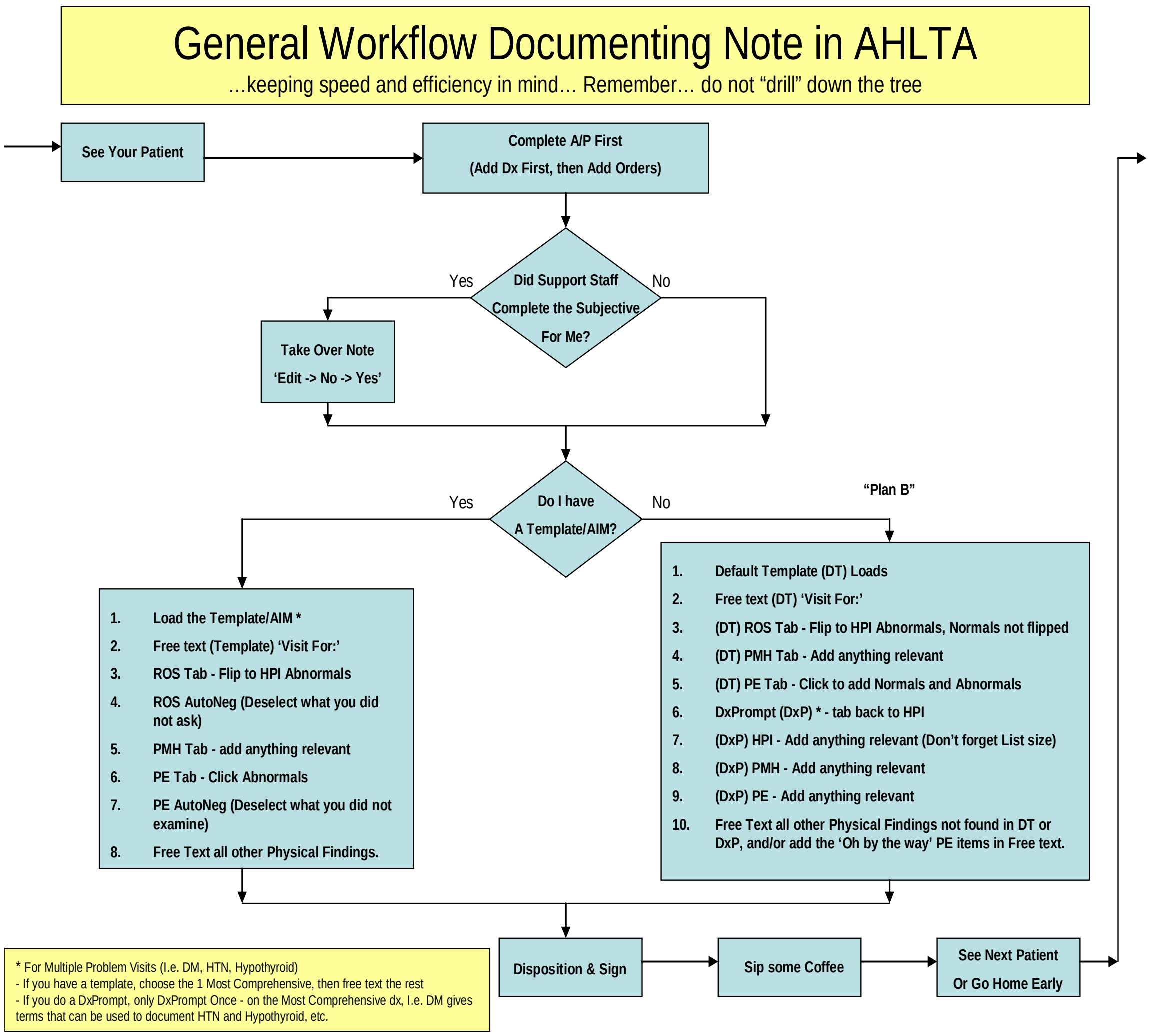
Remember, the larger the date range, the slower the system.

Problem List Use

The entire health team has the responsibility to update and maintain the Problems list.
Eliminate inactive or repetitive terms.
Use a patient's previous diagnoses to enter the diagnosis on new appointments or to change it.
If Problems, Surgeries and FamHx is updated once, this decreases work by ALL.

Encounter Documentation

Note writing should be learned in the following sequence. An understanding of the functions is critical to the next step of learning. Providers also have more of a tendency to read the A/P of previous notes more than any other section of the note. The A/P is usually the key area where medical diagnosis, decision-making, and plan of care are conveyed for later follow-up. The diagram below demonstrates generally how navigation through the modules should take place to be most efficient when documenting in AHLTA.



A/P Module – Complete A/P First

It is recommended to complete the A/P first, ideally in the room with the patient. The general workflow is this:

- Enter room greet patient, open appointment, read screening entry and click HHM (note: if you have a wireless tablet this can be done before entering the room.)
- Take history and do exam (Most people will not write note while taking history)
- Complete A/P with patient in room (This limits the time of opening and closing the A/P module)
- Diagnosis, orders, and Instructions reviewed with patient – Pt Leaves

After opening an encounter in the A/P module, use of the module is very intuitive.

1. Entering a diagnosis –
   A. Try to add the diagnoses first before ordering (saves time) – any orders placed, procedures, consults ordered will auto-associate to that diagnosis
   B. If the patient has been seen within AHLTA in the past, their previous diagnoses are present under the problem list. Double-clicking on these is the quickest way to add those diagnoses discussed during the visit to the present note.
   C. If the patient has not been seen before or if this is a new problem, the diagnosis can be entered by using either the Default Template List, Clinic / Personal Favorites, or searching by medical terms.
      1) Default Template (One time initial investment) – This list should be populated with your Most Common (not everything) and Hard-To-Find Diagnoses. Try to keep the list short for speed. Can ask your trainer to help set this up and customize to match what you see.
      2) Clinic Favorites – This area should be preloaded with source data from your clinic's past ADM data and other diagnoses that the clinic agrees are common. The list should not exceed 15-20 items or it becomes cumbersome to use.
      3) 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.
      4) Search – The search function is much more robust than was present in CHCS Legacy. 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.
2. Ordering Labs, Rads, Meds and Consults
   A. The use of these functions is very similar to previous ordering.
   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 Legacy.
   D. Default Template (One time initial investment) - Adding Orders (especially all your common Labs) to the Default Template makes them show up in the Order Sets tab which eliminates the need to search repeatedly on common labs.

E. Remember to use ‘CTRL C’ when ordering Consults and X-Rays (saves time) – When you enter the reason for a consult or X-Ray, prior to submitting, remember to highlight the text, then press ‘CTRL C’. You may be able to re-use this information in the ‘Subjective’ portion of your note (in the ‘Visit For:’ free text area). Note: To paste that text, press ‘CTRL V’, then edit the text, as appropriate.

3. Associating Procedures with Diagnosis
   A. If the diagnosis is picked first, then adding procedures automatically associates the procedure to the diagnosis – saving time.
   B. 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).
   C. These items can be associated with a diagnosis by the nursing or technical support staff in the clinic when the procedure is performed, and will thus be included when you sign the note after the encounter is completed.
   D. 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.
4. Use of the COMMENT box under the diagnosis.
   A. The comment box might be more appropriately simply labeled the “PLAN” box. It is an area where free text (typing) should be used. In this box you can list a follow-up plan, differential diagnosis, 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. In the comment box you do not need to include your medication plan, labs ordered, consultation plan, or medication ordered, as they are all included in the documentation as you order them.
   C. Note: The communication in the comment box will appear in the comment box on the Problem List. This gives you or other providers a source of quick information when looking at the Problem List.
5. Learning and Exercise
   A. 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.
   B. Using the previous notes that you have written, start trying only to write an equivalent A/P documentation in AHLTA. Once you can do this, a big part of your documentation is complete.
6. Practice Tip
   A. Most providers have found it more efficient (and natural) to complete the A/P while the patient is in the exam room with them. Most do not complete the S/O while the patient is in the room. It also tends to slow down the turnover of the room and distract from the provider/patient interaction. This is multiplied if you work out of one exam room.
   B. The A/P is reviewed with the patients so they can see and hear the plan. The orders are also submitted.
   C. You can now close the note, come back and complete it later.
   D. After two to four patients, you can complete the S/O in a group. Providers often make quick jots on the paper SF600 used for patient queuing to remind

themselves of key information to capture in the note. After a while you will find that the completed A/P provides a tremendous reminder if needed.

S/O Module (Highly recommended to be familiar with all 3 methods)

Documenting the S/O portion of the note is challenging initially (even later) when you don't have a systematic plan. Documented here is the secret to your success in documenting the right information with speed, efficiency and legibility, in mind. Please read and understand this entire S/O Module Section.

There are 3 general ways to document the S/O portion of the note after the A/P section is done.

1. AIM Forms – for use with Well Visits, Disease Specific AIM forms, and General AIM Forms. These are pre-made, maintained centrally by AMEDD
2. Disease Specific Visit Templates – can be created by you to match exactly what you do (advanced skill, not needed up front).
3. Default Template / DxPrompt / Free Text – aka "Plan B". Everyone should have a Default Template initially before starting to see your first patient (One time investment). An AIM form can be part of your default encounter template. If it is not possible initially, make it a higher priority to get it set soon after starting to see patients (increases efficiency when documenting when you don't have a template).

Each also has a generally recommended <u>very specific tab order</u> for navigating to speed documentation and improve legibility of the note.

Before we begin, there are several <u>keys</u> to remember:

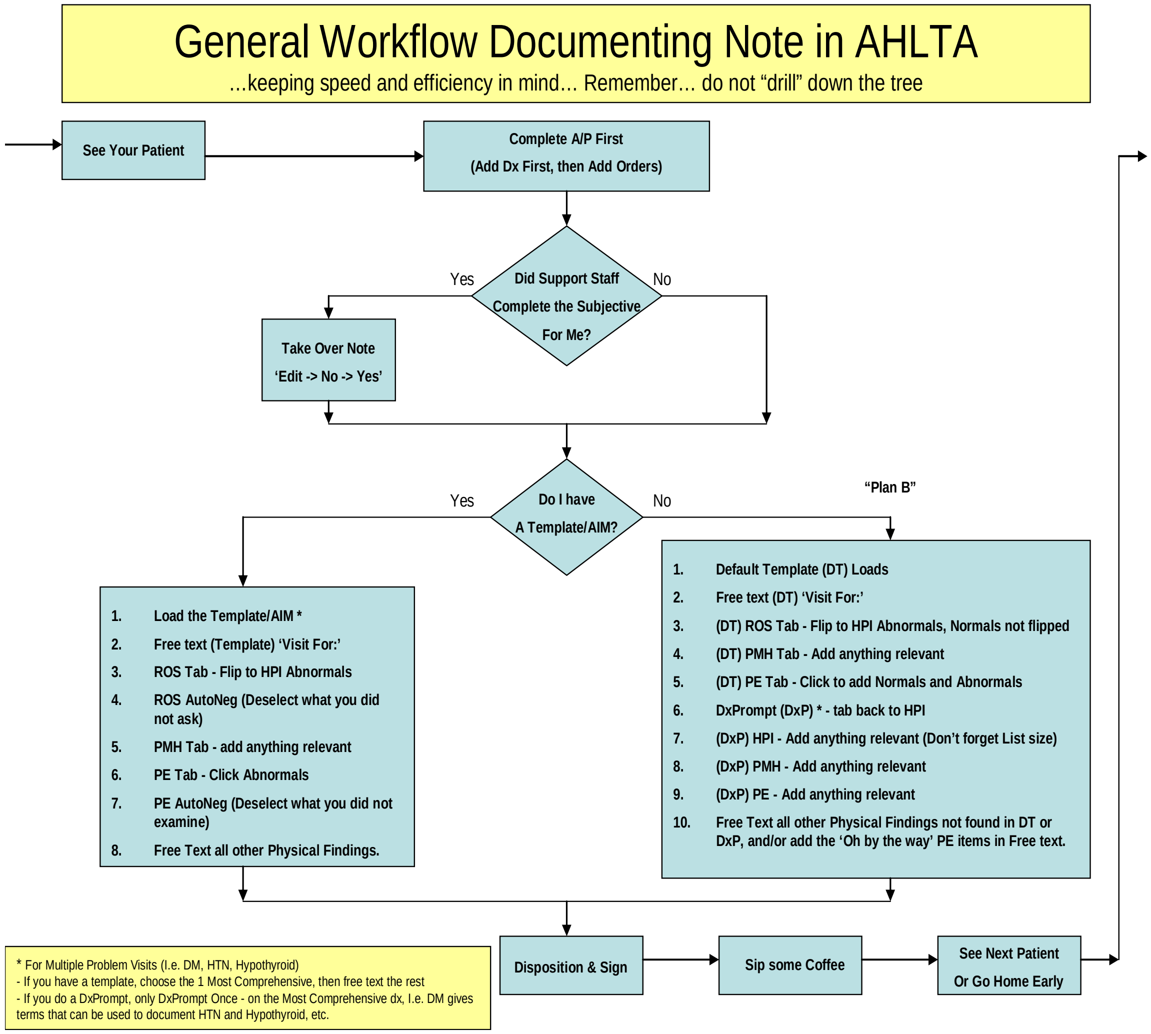
1. Do <u>not</u> fight the system (clear the mind of frustration) – the steps outlined in this section will give you the strategy you need to complete your note with ease.
2. You <u>should</u> have a Default Template set up (Initial one-time investment) – this saves time by allowing you to have commonly used Medcin terms available to you in a list (Your Most Commonly used Symptoms, PMH/FHx, Soc Hx, Sx Hx, PE findings, and tests - for documenting 'Wet Reads'). You could also use the AIM for your specialty as part of the encounter template.
3. If you set an AIM form as your Default (s/o section), remember there will be a slight pause when navigating to the S/O Module every time, as this template loads.
4. If you set a List Template as your Default (s/o section), you can customize it with all your <u>most commonly used</u> Medcin terms in how you practice (saves time), and there is no pause when navigating to S/O. Some prefer this. (Your local AHLTA Specialist can help you set this up and customize the list to match your practice).
5. Use the DxPrompt (big return on 'search' investment) – brings back relevant Medcin Terms in each of the tabs (HPI, PMH, ROS, PE, Tests) that you can use for a particular 'working diagnosis'. <u>For example:</u> CC is Chest Pain -> DxPrompt

on Acute MI to give you relevant Medcin terms to document either positive or neg.

6. Generally <u>avoid</u> excessive use (if at all), the Find Term button (poor return on 'search' investment time) – This brings back only 1 term you can generally use.
7. <u>Avoid drilling</u> from the main Medcin Tree (wastes time) – instead use DxPrompt, add what you can, and free text the rest. Drilling can take place once, when you are building your default template, not
8. <u>Avoid drilling more than one level</u> in the Medcin Tree (wastes time) – usually brings back 'Laterality' i.e. Left or Right, but is usually is faster to pick a higher level term and free text. This is appropriate use of free text and rarely will negative impact coding. You decide which is faster/better for you.
9. Generally <u>avoid using Level 1 Medcin Terms</u> or attaching free text to them (i.e. highest level terms on the Medcin hierarchy, i.e. Head, Neck, etc). This gives no automated coding credit in the system's calculator. This should be absolutely avoided when documenting a physical exam.
10. <u>Well Visits</u> - you should have Well Visit Templates (saves time) – if you do well visits, i.e. Pap Smears, Annual Physical Exams, Well Child Exams, Flight Physicals - these are best done with an equivalent Template Type and should be in your favorites list.
11. <u>Procedures</u> - are faster with a Procedure Template (saves time) – if you do procedures, i.e. skin biopsies, toenail removals – the AMEDD General AIM Form has a procedure Tab that works very well for procedures. This template should be in your favorites list. Additionally, you can save a free text procedure note into a template for re-use of common lengthy worded procedural text.
12. Add only a few disease specific templates for <u>the most common</u> diseases you see, especially when first starting to use the system. More can be added later, if needed.
13. <u>Too many templates</u> may actually slow you down, as it adds clutter, and increases difficultly finding the one you need quickly. It is not possible or efficient to have a template for every diagnosis there is, unless the scope of your practice is relatively focused. Having a Default Template with the DxPrompt (example below) should be reserved for everything else you see.
14. <u>Initially</u>, it is best practice to use the Default Template / DxPrompt in your arsenal for things you see that 1) are <u>not</u> Well Physicals, 2) you don't have a disease specific template/AIM Form to use, and 3) handles the 'Oh by the ways'.
15. <u>Team Documentation</u> - If you can get your support staff to enter the history portion, this will save you time (see the Team Documentation section). But, if this is not available, it is still easily done with the strategy outlined below.

These will be discussed below. It is important to understand each; as they represent 3 general scenarios one experiences when documenting visits in AHTLA. Each also has a generally recommended <u>very specific tab order</u> for navigating to speed documentation and improve legibility of the note.

The diagram below describes the general workflow to follow to manage your documentation while managing your patients through the day. It is generally the optimal way to document most efficiently, although your practice may prove otherwise.



AIM Form

Physical Exam (PE Tab)

In an AMEDD AIM form the PE tab can be seen along the top. In a template the PE tab is along the left side.

1. Document review of vitals signs – This is required for the computer to know that you reviewed them.
2. Physical exam finding should be documented by checking the most specific term that you can find and then adding specificity with free text (typing). AIM forms preposition the most common exam findings on the form for you to use. If you use a template this can also occur. You can request addition to the AIM form for your specialty by using the "?" mark button on the last tab.

3. The physical exam should never be documented by just typing free text after the organ system heading.
4. Practice – Using your previous written encounter notes, try to document the same physical exam finding using an AIM form, a template, or just the physical exam tab. Sometimes using the entire tab works well if you will see the patient multiple times. On follow-up, the copy forward function will permit the re-use of the information and allow you to follow serial exam findings.

Review of System (ROS Tab)
The ROS is where pertinent positive and negatives should be documented. It is also the area that your assessment of other areas of patient health should be documented.

1. AIM forms and templates position the most common specific ROS items for each area.
2. ROS is an area that you can simply type the ROS finding under an organ system header if you choice. Coding rules are different for ROS than PE.
3. Practice as above.
4. Note: Many providers have a practice of writing all the patient information after the HPI or problem. Information about the problem, ROS data, and previous history is all listed in stream of consciousness. The computer application takes this information into specific areas of the note. The automatic coder also looks for elements in each of these areas.

History of Present Illness and Past Medical and Family History Review (HPI / PMH)
These areas are on the first part of each AIM form. They are on separate tabs in templates. Please be aware that when using the entire template the HPI and ROS system are exactly the same.

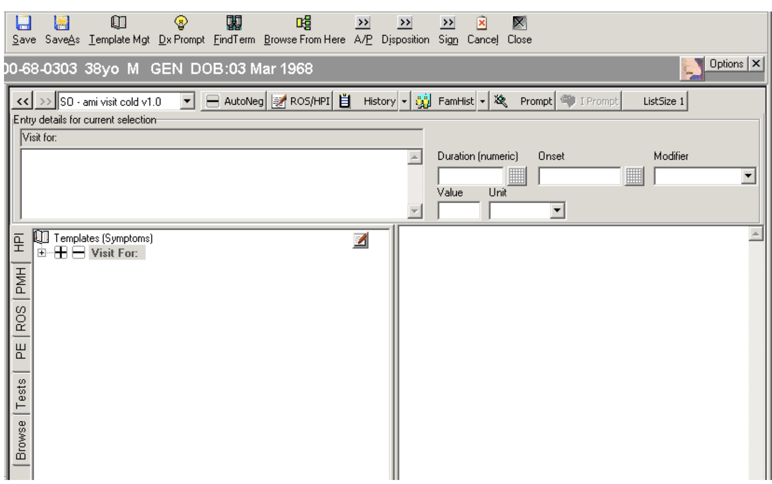
1. **HPI**
   A. On an AIM form, common reasons for visits are listed. Just check one and add specific detail. This is an area that will again require some free text. On templates the HPI can also have free text added.
   B. Free text and a narrative usually in the patient words should be entered here. This is an area that staff support will greatly speed the day. Facts/data will be added from the ROS information.
   C. Practice again as above
2. **PMH**
   A. AIM Forms – Each AIM form has specific information on the form to facilitate documenting that PMH was reviewed and updated on the patient's problem list. By entering data to include past surgeries, family history and patient problems on the problem list module, the items can be listed once and then used by all. Note: Remember that you can remove items from the problem list by making them inactive (resolved), or delete. Other military and service specific items are also propositioned for speed for speed of us.
   B. AIM forms also contain boxes so you can indicate that you reviewed other items completed in their respective modules (current medication, and allergies).

C. Templates can be customized to allow documentation of information to similar detail.
D. Practice again as above.
E. Note: Depending on how your clinic support staff works, the nursing/technical staff can load an AIM form or Template during the screening process. The support staff can also begin documenting whatever portion of the HPI/PMH/ROS that the team decides. When you open the S/O portion of the note you can select to edit what has been written or start a new note. It is recommended that, if the clinic decides on a set AIM form or forms, you should select "edit" and then open the same AIM form. This way ALL areas that were previously documented can be seen by the provider, who can edit what was written or expand on the information. Please be aware that a nursing note initiated with an AIM view will appear as a template when you select edit note, and you will have to select the AIM form, but once done, the information will be presented in the context of the AIM form itself.

Disease Specific Visit Template (List View, Not AIM Form)

Disease specific visit templates can be constructed by you (advanced skill), but is not required to know before using AHLTA. It is not even required to have before seeing your first patient (see Default Template / DxPrompt below). If you have a Disease specific visit template, this is how you use it.

1. After you load the template, the system returns you to the S/O module on the HPI tab. You are ready to document the S/O portion of the simulated patient visit.



Loaded S/O Template

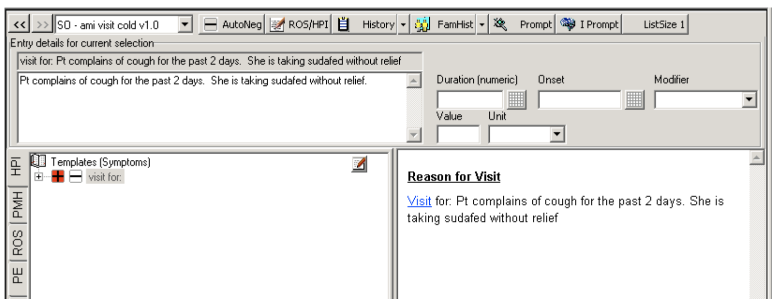
Step 1: History of Present Illness

The HPI tab displays a blank 'Visit For' MEDCIN Term. You need to enter free text for the patient's reason for visit to include the chief complaint and any free text history needed to document why the patient is here and how the patient is doing currently. This is where the 'Story' goes, so that it reads well, and you know why the patient is here.

1. Click the (+) next to 'Visit For'

2. Place the cursor in the Free Text Box above and type "pt complains of a cough, mainly at night, for the past 2 days..."

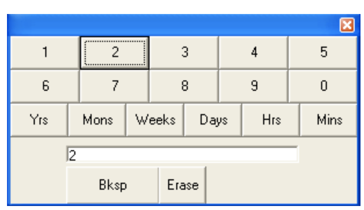
3. Press 'Enter' on the keyboard (Very Important: Failure to press 'Enter, can result in Lost Free Text. You have now been warned).

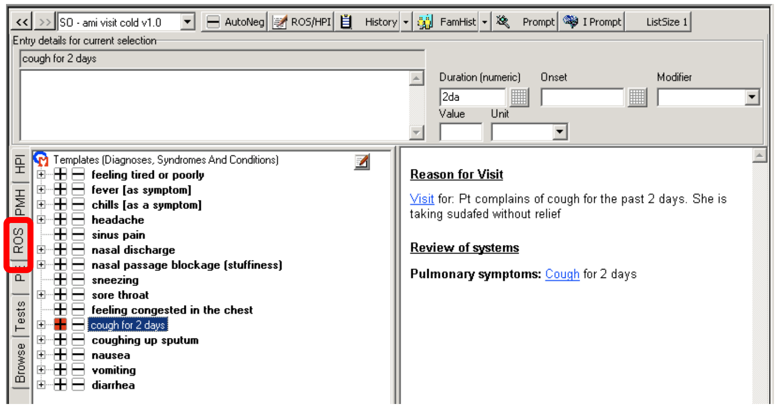


HPI Tab with Free Text added to 'Visit For:' term

Step 2: Documenting Bulleted HPI Symptoms from Disease Specific Visit Template

1. Click on ROS tab - click on Cough, then on the Duration Grid 

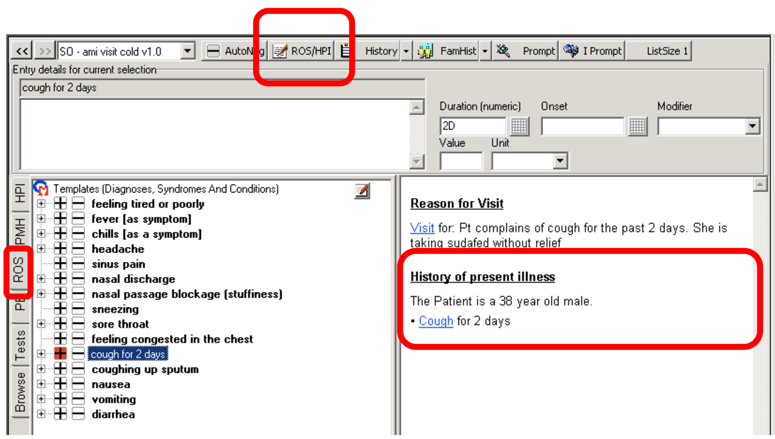
2. Click '2' and Click 'Days' 



ROS Tab: Cough for 2 days documented

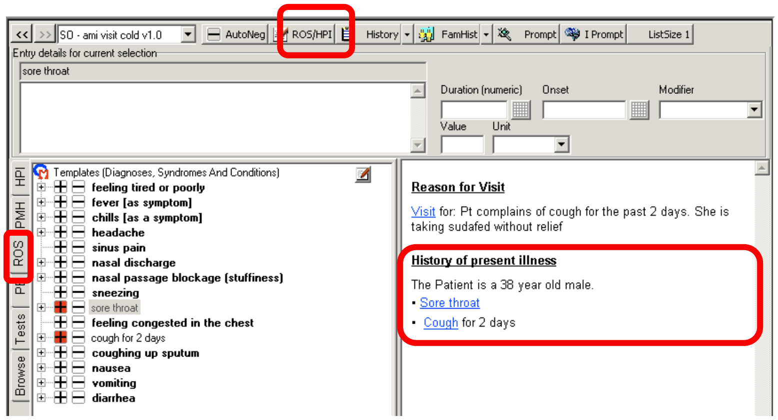
3. Then click the 'ROS/HPI' button  to flip the term up to the HPI section.

4. This puts the positive symptom (or abnormal term) in the HPI section of the note – PEARL: Put abnormal terms in HPI, and everything in ROS should be normal (makes for an easier reading note).



Note showing Positive symptom, Cough, in the HPI section of the note using 'ROS/HPI' button

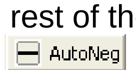
5. Repeat this for 'Sore Throat' [i.e. select (+) next to sore throat, then click the <u>ROS/HPI button</u> to flip this abnormal symptom up to the HPI section].

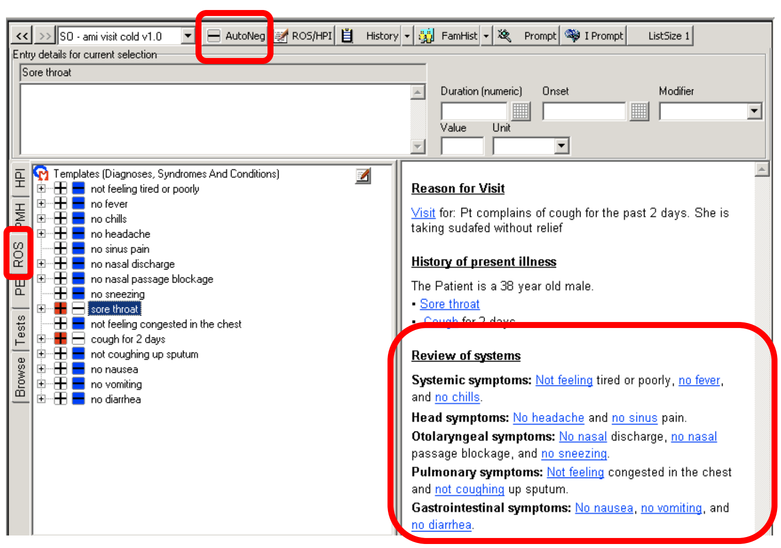


Note showing Positive symptoms, (Sore Throat and Cough) in the HPI section of the note using 'ROS/HPI' button

Step 3 Documenting ROS from Disease Specific Visit Template

The patient denies the rest of the symptoms listed on the template.

1. To document the rest of the normal (or denies) ROS findings, then click the <u>'Autoneg' </u>button 



Completed HPI and all Negative Symptoms are in ROS section of the note

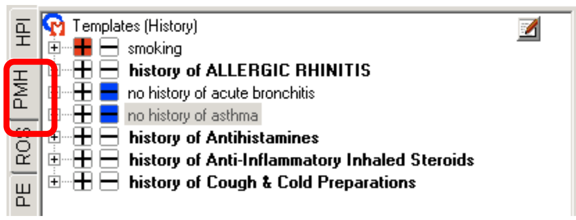
2. It is important to remember, <u>if you did not ask the patient all the symptoms, de-select the items you did not ask</u> by clicking on the (-) [blue] box next to the term. This takes it off the note

Step 4: Documenting PMH from Disease Specific Visit Template

To document the <u>PMH:</u>

1. Click the PMH tab and click (+) next to 'smoking', click (-) next to history of Acute Bronchitis, click (-) next to history of Asthma.

2. Remember that it is best to put all positive personal medical and surgical history on the problem list. This is also true of the patient family history and allergies along with medication review. This will save time for all in the future as only changes to the history are added.



Documenting PMH

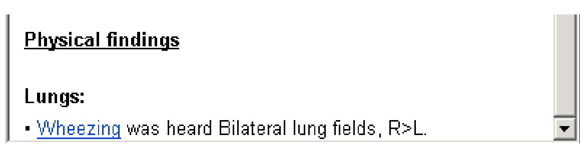
Step 5: Documenting the PE

Functionally, the PE findings are well suited for using Autoneg**,** using a disease specific template, as in general; there are fewer abnormal findings than normal findings on exam. Note: For maximal efficiency, this works best if you authored the template, so that it matches exactly what you do; but this is not always possible, is an advanced feature, and is not necessary.

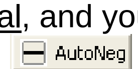
It is important to document the abnormal findings first, then click Autoneg to automatically document the remaining findings as normal. In the PE, you find wheezing on auscultation; your other PE findings are normal.

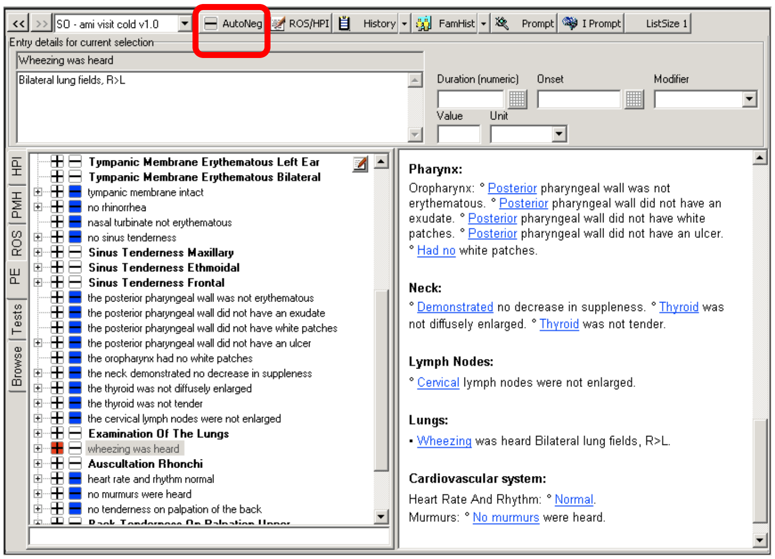
To document the PE:

1. Click the PE tab, and scroll down to 'Auscultation Wheezing', click (+) and in the Free Text box, type "Bilateral lung fields, R>L", then hit 'ENTER' on the keyboard.



Showing only Abnormal PE finding, Wheezing with attached free text added to the note first

2. Then, if everything else was normal, and you did the exam listed on the template, you can click the 'Autoneg' button.  to quickly document that everything else was normal.

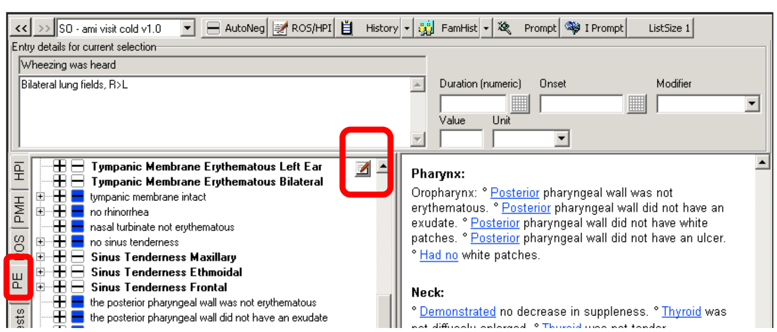


Note view after 'Autoneg' used

Again, it is very important to remember, <u>if you did not examine items in the physical exam portion of the template, de-select the items you did not examine</u> by clicking on the (-) [blue] box next to the term. This takes it off the note.

Step 6: Free Text all other Physical Findings

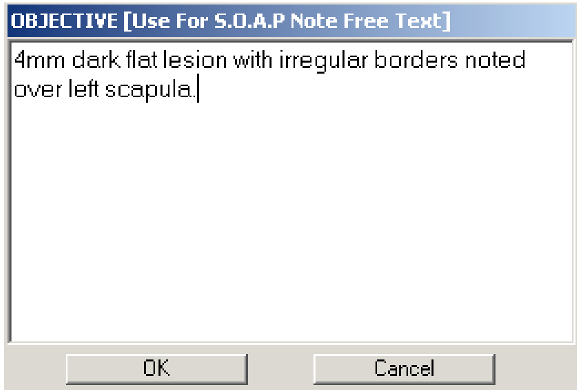
You have just finished documenting PE items from the disease specific visit template. All other physical exam findings are best done with Free Text, so extra time is not spent trying to find the exact MEDCIN finding. To do this, from the PE Tab, press the small notepad icon in the list window  As you use the system more you will slowly add the specific terms that you regularly use to your default or disease specific template.



Free text 'Objective' Note Pad button

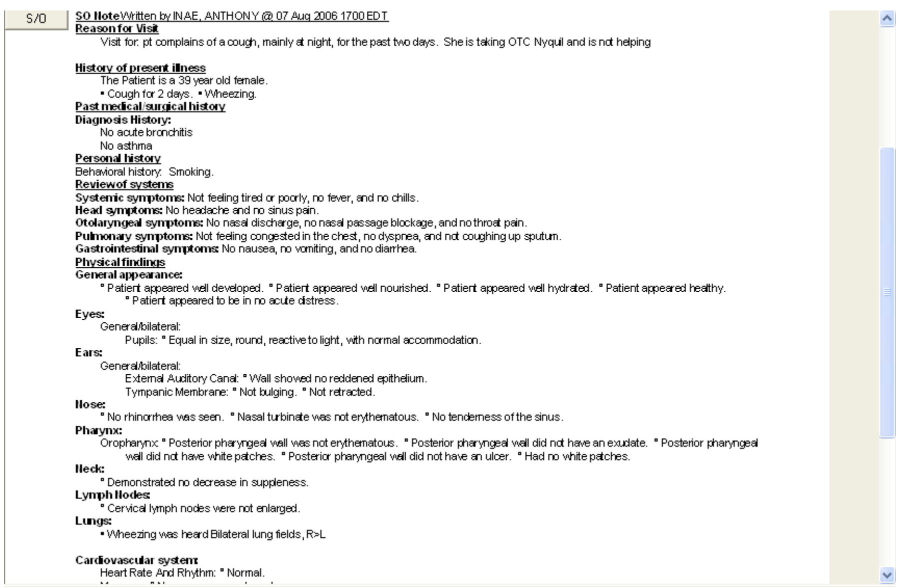
1. Free text any other physical findings you want to add into the note, and then click 'Save and Close'. This way, <u>extra time is not spent trying to find the exact MEDCIN finding</u>. If time permits, one can either search for 'Nevus' using the 'Find Term' icon, or 'Dx Prompt' on 'Compound Nevus', etc. Dx Prompt will be explained in a later section.

2. But in this example, we will free text the "other" physical findings that are not in your disease specific visit template.



Free text all other physical findings here

3. You can now complete the Disposition, and then sign. But, to view the entire note, close the S/O module by clicking 'Close'.



Completed S/O section of the note, done with Disease Specific Visit Template

Default Template + Dx Prompt

In this section, we will be documenting a visit without the use of a disease specific visit template, i.e. when the condition you are documenting is not seen often enough to warrant having a disease specific template; or you want to use one, but don't have time to find one at this time. Remember, this is to be used if you <u>do not</u> have a particular template you typically use for a particular disease process. <u>This is “Plan B”.</u> This will help get you home sooner, than later.

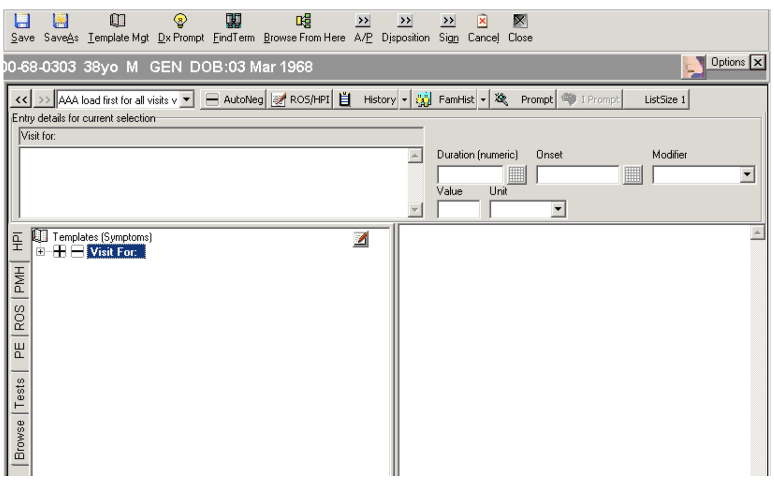
Remember, *do not fight the system!* If the term you are looking for is not displayed in the DxPrompt (and increasing the List Size to 3 doesn’t show it either), just relax and free text it.

This method is simple: 1) <u>Exhaust full use of the Default Template</u> (adding in from each of the tabs), then 2) <u>DxPrompt</u> (adding in from each of the tabs again), then 3) <u>Free Text the rest</u>, in that order.

For setting the default, and tailoring it to your practice,   please see documentation in the Setting the Default Encounter Template section of this guide and/or ask your local AHLTA specialist.

Using the Default Template

When you enter the S/O module, the Default Encounter Template will load. The system is on the HPI tab. You are ready to document the S/O portion of the simulated patient visit.



View of S/O with Default Encounter Template loaded

Step 1: Documenting ‘Visit For’ <u>Free Text</u> using Default Template

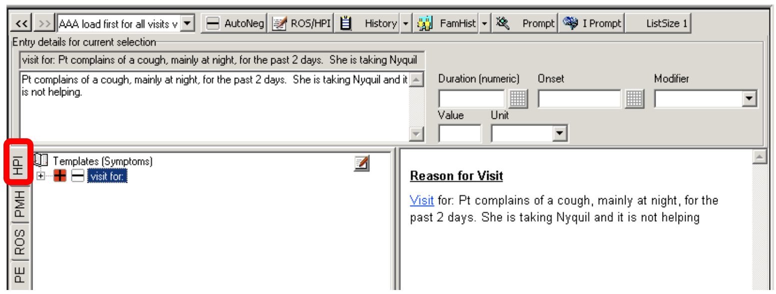
The scenario is the same as the prior example where we documented the patient's visit with a disease specific Visit Template. The patient's reason for visit and the story behind her present symptoms is entered using the 'Visit For' term with anchored free text. This information is documented on the HPI tab.

The patient complains of a cough, mainly at night, for the past two days. She is taking OTC Nyquil and is not helping.

1. Click the (+) next to 'Visit For'

2. Place the cursor in the Free Text Box above and type "Pt complains of a cough, mainly at night, for the past 2 days. She is taking Nyquil and it is not helping."

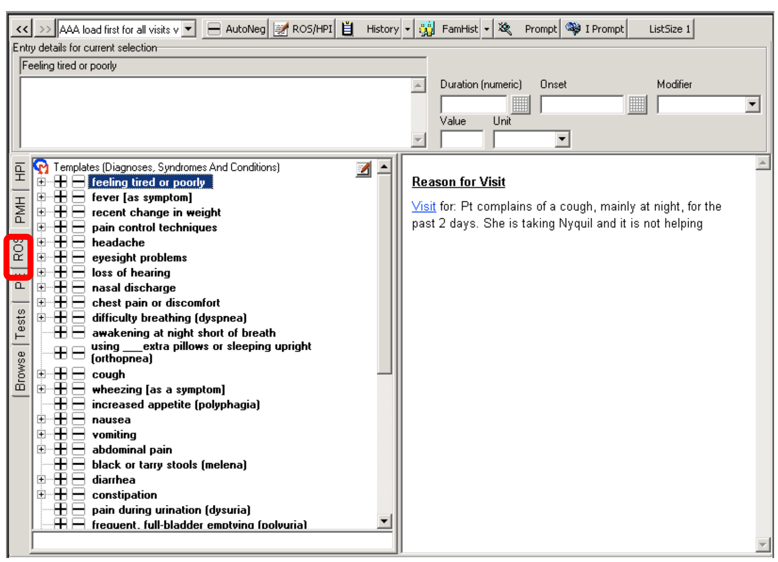
3. Press 'Enter' on the keyboard.

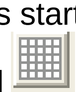


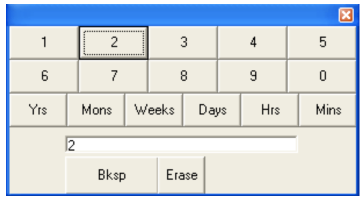
HPI Tab with Free Text added to 'Visit For:' term

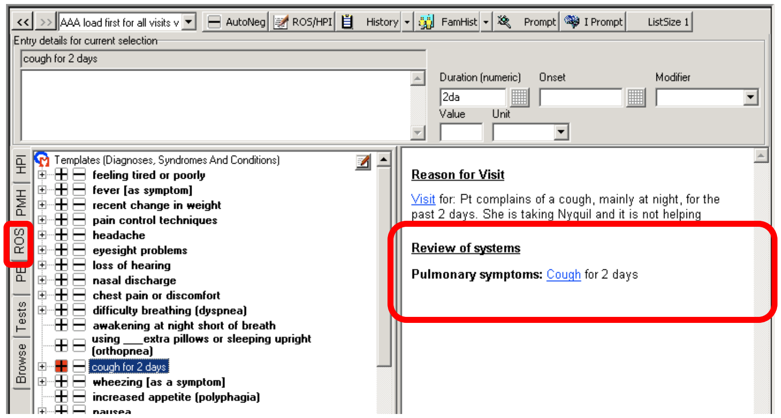
Step 2: Documenting Bulleted HPI Symptoms from Default Template using ROS/HPI button

1. Click on ROS tab. The system will display the symptoms listed from the Default Template. Each user has the ability to customize this list of commonly used symptoms.

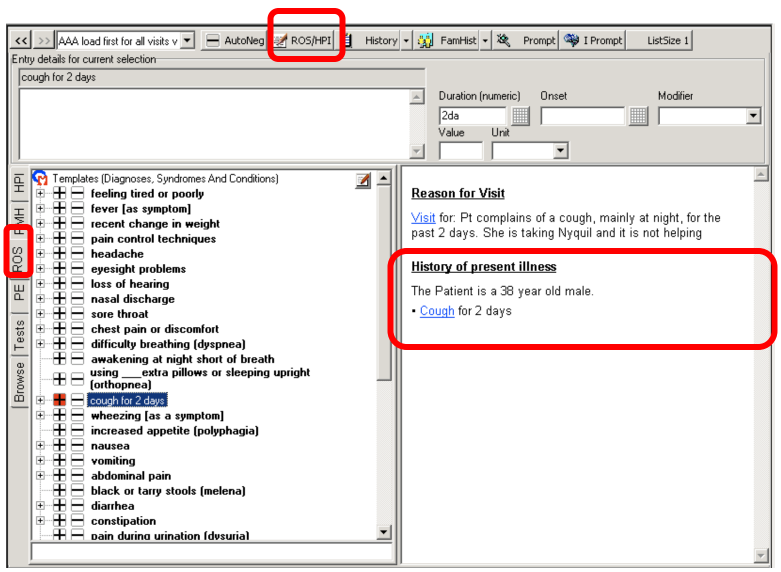


2. Cough is a symptom that is in this starter Default Encounter Template. Click on Cough, then on the Duration Grid 

3. Click '2' and Click 'Days' 

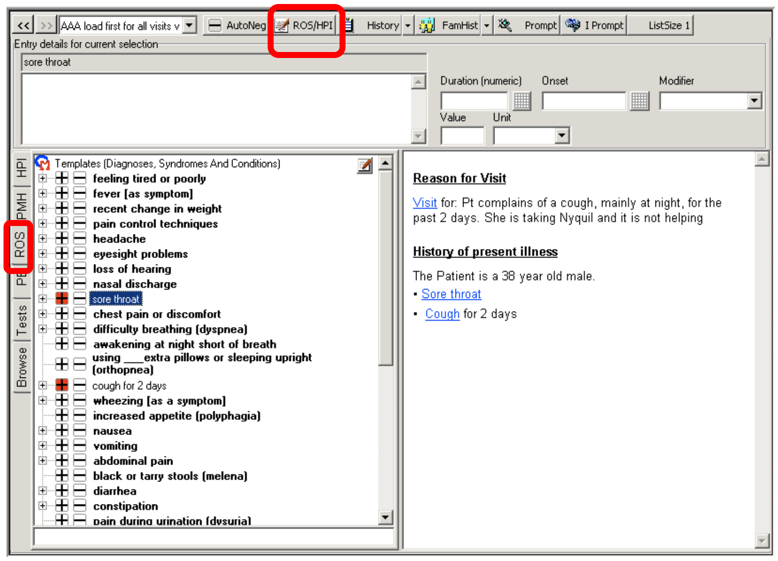


4. Then click the 'ROS/HPI' button  places that symptom (or abnormal finding) in the HPI section of the note.



Note showing Positive symptom, Cough, in the HPI section of the note using 'ROS/HPI' button

5. Repeat this for 'sore throat' [i.e. select (+) next to sore throat, then click the ROS/HPI button to flip this positive symptom up to the HPI section].

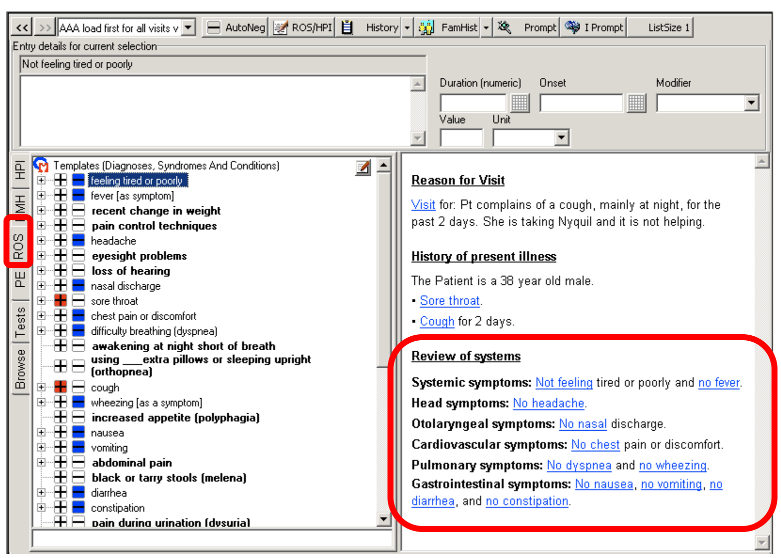


Note showing Abnormal symptoms (Sore throat, Cough), in the HPI section of the note using 'ROS/HPI' button between each

Step 3: Documenting ROS from Default Template

The patient is not feeling tired or poorly, no fever, no chills, and no headache, and so on

1. Click (-) next to the symptoms that are pertinent negatives. i.e. click (-) for 'Feeling tired or poorly', 'fever', 'headache', 'nasal discharge', 'chest pain or discomfort', etc. These items automatically go into the ROS section of your note.



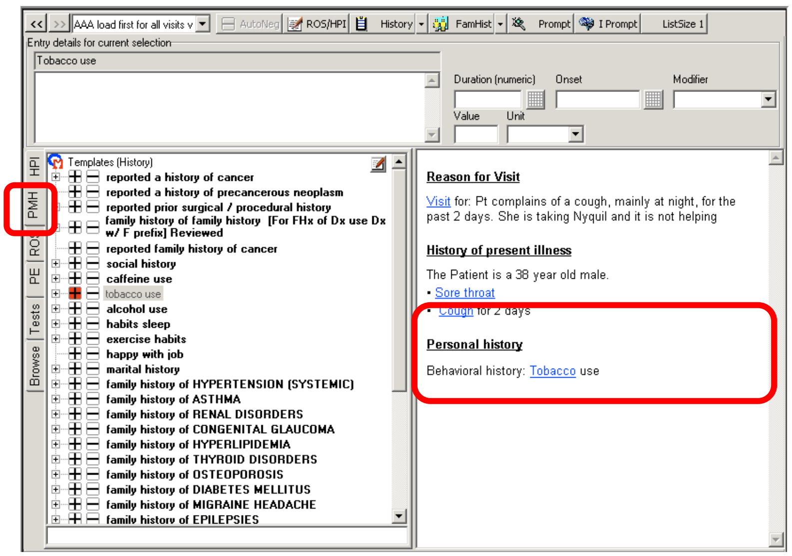
Note showing negative symptoms added to ROS using the Default Encounter Template

3. Never use Autoneg with the Default Template. The Default Template contains symptoms that could be used for many common disease processes. The

purpose of having a default template is to be able to add your commonly used symptoms to your note quickly. It would be inappropriate to use Autoneg.

Step 4: Documenting PMH from Default Template

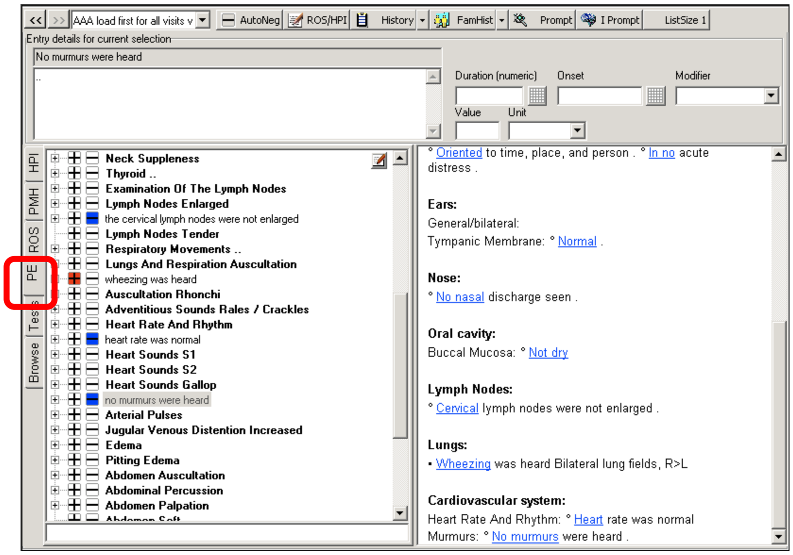
1. Next, click the PMH tab and scroll down. Click (+) next to 'tobacco use'. You will be adding No History of Bronchitis and No History of Asthma later. For efficiency in documenting, avoid the urge to try to document it here and now, unless those history items are on your Default Template. We will be returning to this tab again. This part is not the way we were trained to think, but is the most efficient way to document in AHLTA given this scenario. Basically, add what you can from this tab, the things you may be able to use from your default.



Note showing Tobacco use added to the PMH section of the note using the Default Encounter Template

Step 5: Documenting the PE from your Default Template

1. Click the PE tab, add items that you have examined, such as, (+) General Appearance - Oriented To Time, Place And Person', 'General Appearance - In No Acute Distress', (-) Tympanic Membranes, (-) Nasal Discharge, (-) Buccal Mucosa, (-) Cervical Lymph Nodes Enlarged and (+) next to 'Auscultation Wheezing', and in the Free Text box, type "Bilateral lung fields, R>L", then <u>hit 'ENTER' on the keyboard</u>. Click (-) Heart Rate And Rhythm, and (-) Murmurs.



Adding normal and abnormal findings to the PE section of the note using the Default Encounter Template

2. Do not click 'Autoneg' on this Default Template. It would be inappropriate.

Step 6: Dx Prompt

With the PE from the Default Encounter Template completed, you are ready to use the DxPrompt to add in 'disease specific symptoms, past history, and physical findings' into your note. This is your second pass through the tabs. Again, not how we were trained to think as clinicians, but the best way to do it in AHTLA.

The DxPrompt feature is not a template, but will return a list of related symptoms, history, and physical findings to diseases you search.

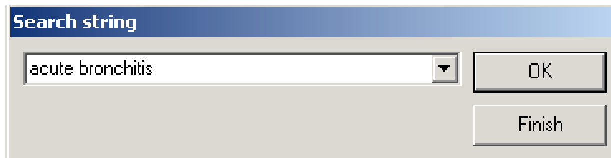
The DxPrompt button is on the Action Bar (4th icon from the left).

There are 3 levels of weighted associations (brings back longer list of associations), and the user can toggle through them using the List Size button on the Tool bar (right most button). You can toggle to List Size 3 and back to 1 by repeatedly pressing the button.

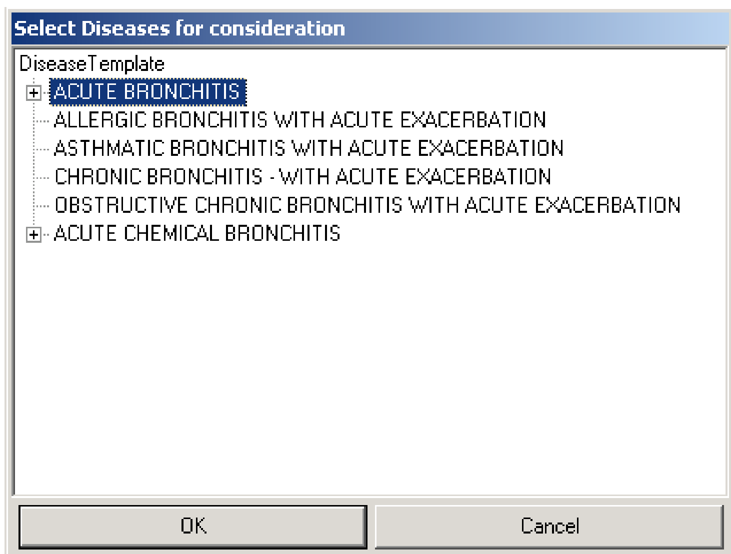
In contrast to using a disease specific visit template, and you are using the Default Encounter Template, Autoneg should not be used. Autoneg should also not be used on when using DxPrompt, as well, as you will see, the system may return terms that seem irrelevant or obscure. Do not take this personally, just ignore that strangeness, and move on. Back to our example.

1. Click on the Dx Prompt button on the Action Bar .

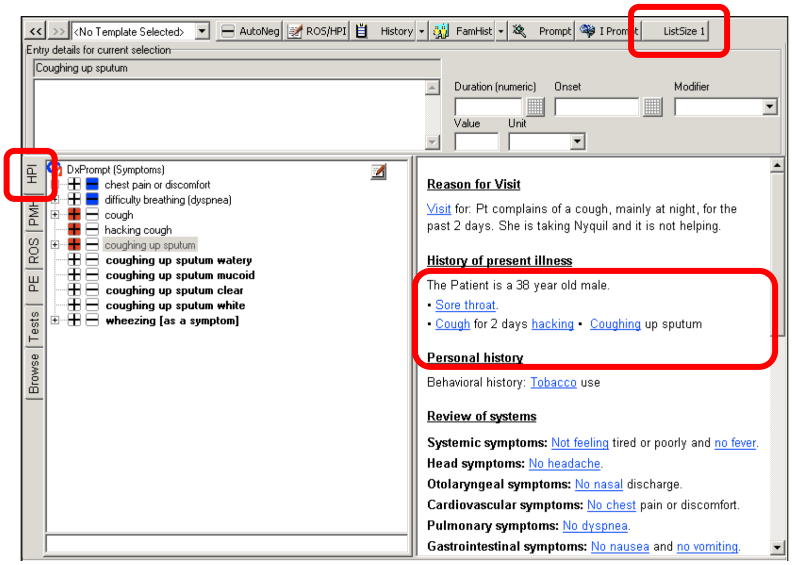
2. Type 'Acute Bronchitis' (or whatever your working diagnosis is) in the Search String, then press 'OK'



3. Select 'Acute Bronchitis', then press 'OK'

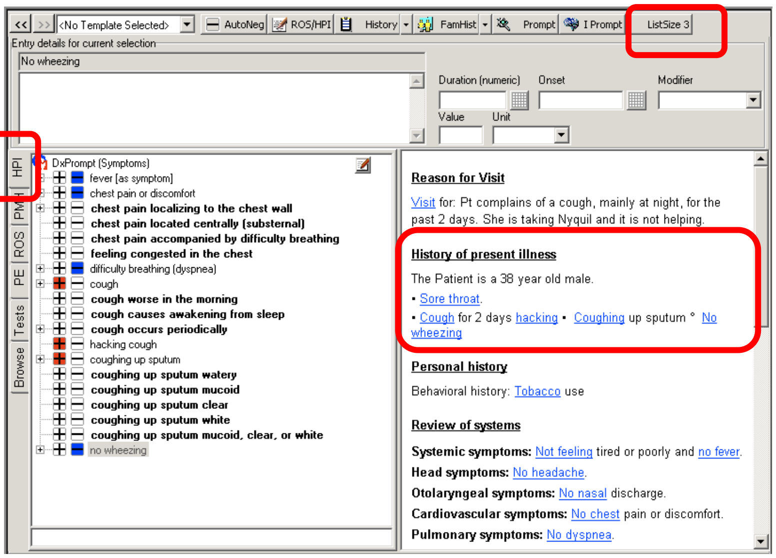


4. Click the HPI Tab and add anything else you want to add into the note, i.e. (+) a hacking cough and (+) coughing up sputum



Adding to HPI items from the DxPrompt, as needed

5. Click the List Size Button  and notice more symptoms are displayed to choose from. It toggles to List Size 3, then repeats to List Size 1. While on List Size 3, add in (-) feeling congested in the chest and the patient did state No wheezing, so press (-) next to wheezing. List size 1 is generally a good place to keep this, so the list is not overwhelming at first.

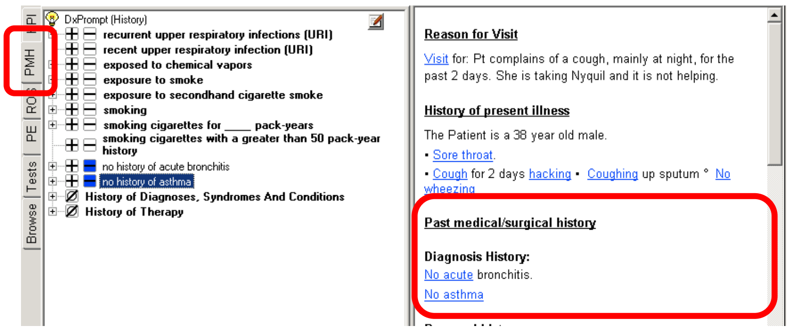


Increasing the List Size to return more related DxPrompt symptoms/findings

6. Also note, we are now placing some normal findings in the HPI section, and we stated earlier "generally abnormal symptoms in HPI and Normal symptoms in ROS. At this point in your documentation, for speed, go ahead and add them here. It will not clutter the HPI much with a few normal findings. Also reserve

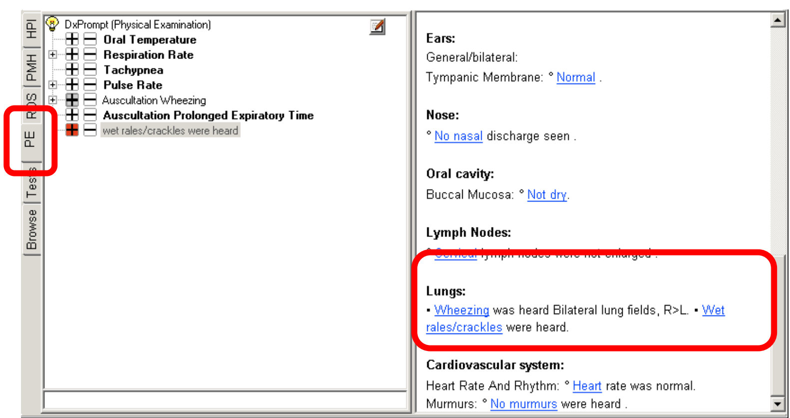
putting Normal Findings in the HPI section, to show 'Pertinent Normal' symptoms.

7. Click the PMH Tab, and add (-) history of Acute Bronchitis, and (-) history of Asthma



Adding to PMH items from the DxPrompt, as needed

8. Click the PE tab, and add (-) Rales / Crackles Wet



Adding to PE items from the DxPrompt, as needed

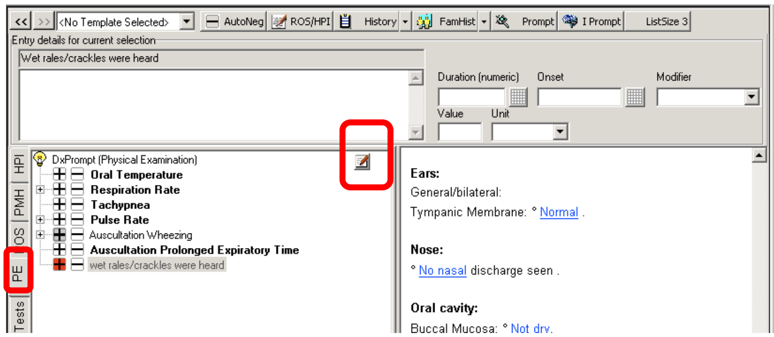
Step 7: Free Text all other Physical Findings

With the PE from the DxPrompt completed, you might find that there are still Physical Findings that need to be documented. There are several ways to do this. For increased efficiency, use the 'Free Text' notepad feature to add the physical findings that were not on your Default Template or in the DxPrompt. This is also good for those multi-problem visits, as it is not recommended to do multiple DxPrompts due to the increased time it takes to document. This practice will slow you down.

<u>What is recommended is to choose the DxPrompt that is most comprehensive as to the patient's reason for visit, and then free text the rest of the exam</u>. For example, if your patient is a Diabetic, Hypertensive, and Hypothyroid, most can be documented from the Default Template alone with free text, but you could DxPrompt once, on Diabetes. This

will give you terms to document the foot exam, and other symptoms, i.e. fatigue, etc can be used to document the HTN and Hypothyroid components… then free text the rest!

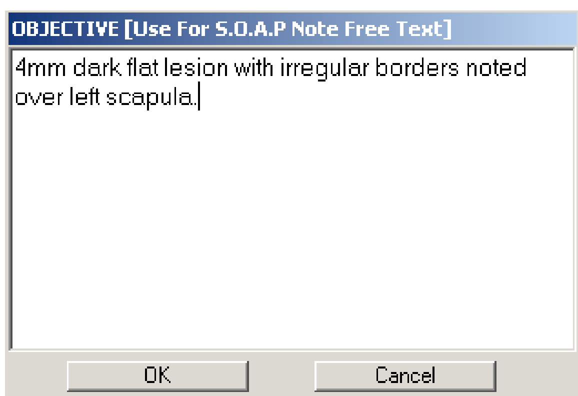
You have just finished documenting PE items from the DxPrompt. All other physical exam findings are best done with Free Text, so extra time is not spent trying to find the exact MEDCIN finding. To do this, from the PE Tab, press the small notepad icon in the list window 



Free text 'Objective' Note Pad button

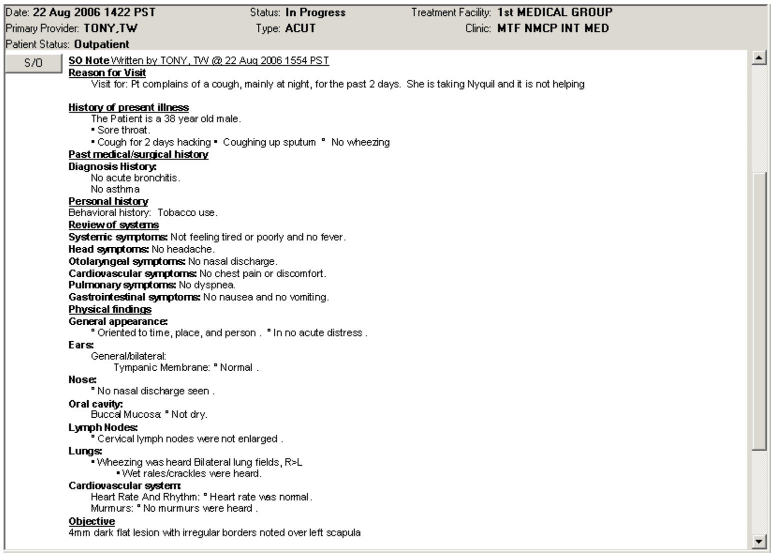
4. Free text any other physical findings you want to add into the note, and then click 'Save and Close'. If time permits, one can either search for 'Nevus' using the 'Find Term' icon, or 'DxPrompt' on 'Compound Nevus', etc. DxPrompt will be explained in a later section.

5. But in this example, we will free text the "other" physical findings that are not in your disease specific visit template.



Free text all other physical findings here

6. You can now complete the Disposition, and then sign. But, to view the entire note, close the S/O module by clicking 'Close'.



View of the completed S/O Note using Default Template + DxPrompt + Free text

7. This method, when mastered, is very quick to document any condition that you don't necessarily have a template to use. It is also a great tool to use with your default AIM form which may not cover in detail every disease/condition. This also eliminates the need to drill down the Medcin tree. This method also makes for an easier reading note, with all abnormal symptoms in HPI, and only Normal findings in ROS. The analogy here is like painting a picture. You paint all the blues first, then the reds, etc. Only make 2 passes (once with the Default Template, and once with the DxPrompt) through the HPI->PE tabs, and then free text the rest, then your note is done! The system will place the terms in the appropriate sections of the note, allowing you to document in this way.

Disposition Tab

The disposition tab allows you to document discharge status and follow-up instructions for the patient. It also allows you to insure that the correct type of encounter was documented, which can have an impact on coding

1. Discharge Status – This is a pick list just like the old bubble sheets or ADM.
2. Follow-up instruction – You can indicate the time & clinic for the next follow-up. This section will eventually be integrated into the new enterprise appointment module and will be able to book follow-ups.
3. Location of Service – The type of service will default to outpatient visit. This should be accepted unless one of the following conditions exists:
   A. This is an IBWA visit
   B. This is an Inpatient consultation (and hence an IBWA visit)
4. Service Type – This will default to general outpatient visit. It may need to be changed in these common situations:

A. PrevMed Eval – This would be used for an annual physical, well child visit, or annual well woman exam.
B. Consult visit – This would be selected for any initial consultation visit.
C. Other Service (99499) – This should be selected for all visits by optometry, physical therapy, occupational therapy, social work services, etc. This will default the E/M code for the visit to a 99499. This is a military placeholder as these areas bill by service rendered. If you are unsure if this is the correct option for you, check with your local coding staff.

5. Coding
   A. The E/M code for the visit will be initially calculated for you once you have completed your S/O note. If the report is listed as insufficient information for coding then you will need to either override the coding or have your coders review the note after you have signed it. The coder will document the code in ADM, which is the ARMY gold standard for any coding report.
   B. Documentation by time – If greater than 50% of your time was spent counseling the patient or coordinating care, you can check the appropriate button and enter the total time for the visit. Based upon the service type, the visit will be initially coded. This should be only rarely used by most providers as the content of documentation is the preferred means of determining the code for the MHS.
   C. Changing a recommended code – If you understand coding for your specialty and feel AHLTA has over- or under-coded the note, you can change the code.

AIM Form loading, use and feedback

See How To.

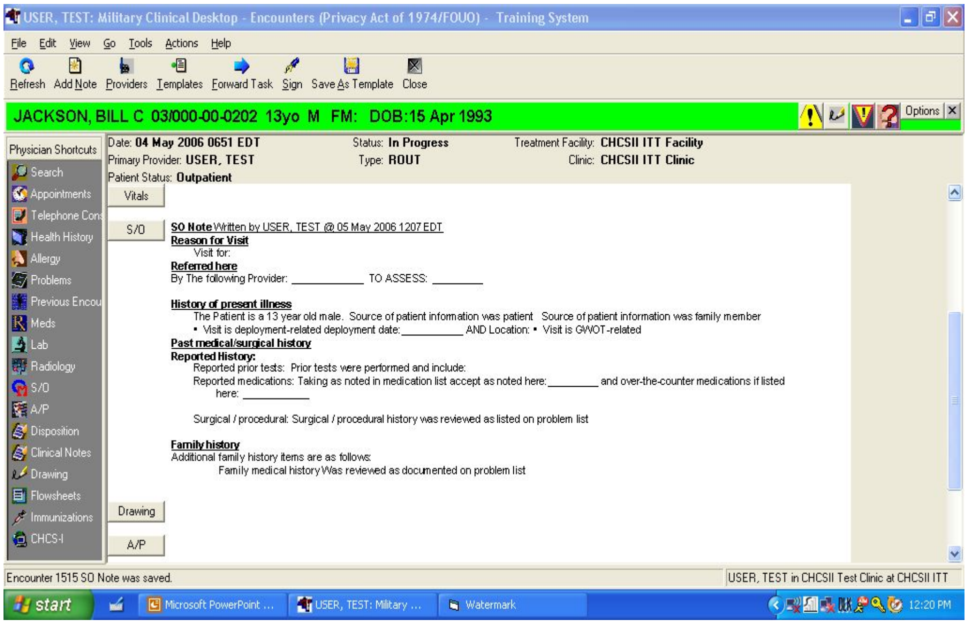
Default Templates

The default template gives the provider the ability to add diagnoses, access favorite acute medications and favorite tests without having to perform a search. The default template can be used in conjunction with other “templates.” The default template can be augmented with the clinic favorites and in the A/P module, the provider can use the Patient List as an initial way to find a diagnosis and enter it into the note.

The default HPI should include only terms.

- Visit For
  - Free text the story
  - Note: You will add Pos ROS to the HPI when writing the note.
- Consult
  - Referred Here: You type in reason and provider name
- Deployment Related
- GWOT Related
- Information Source

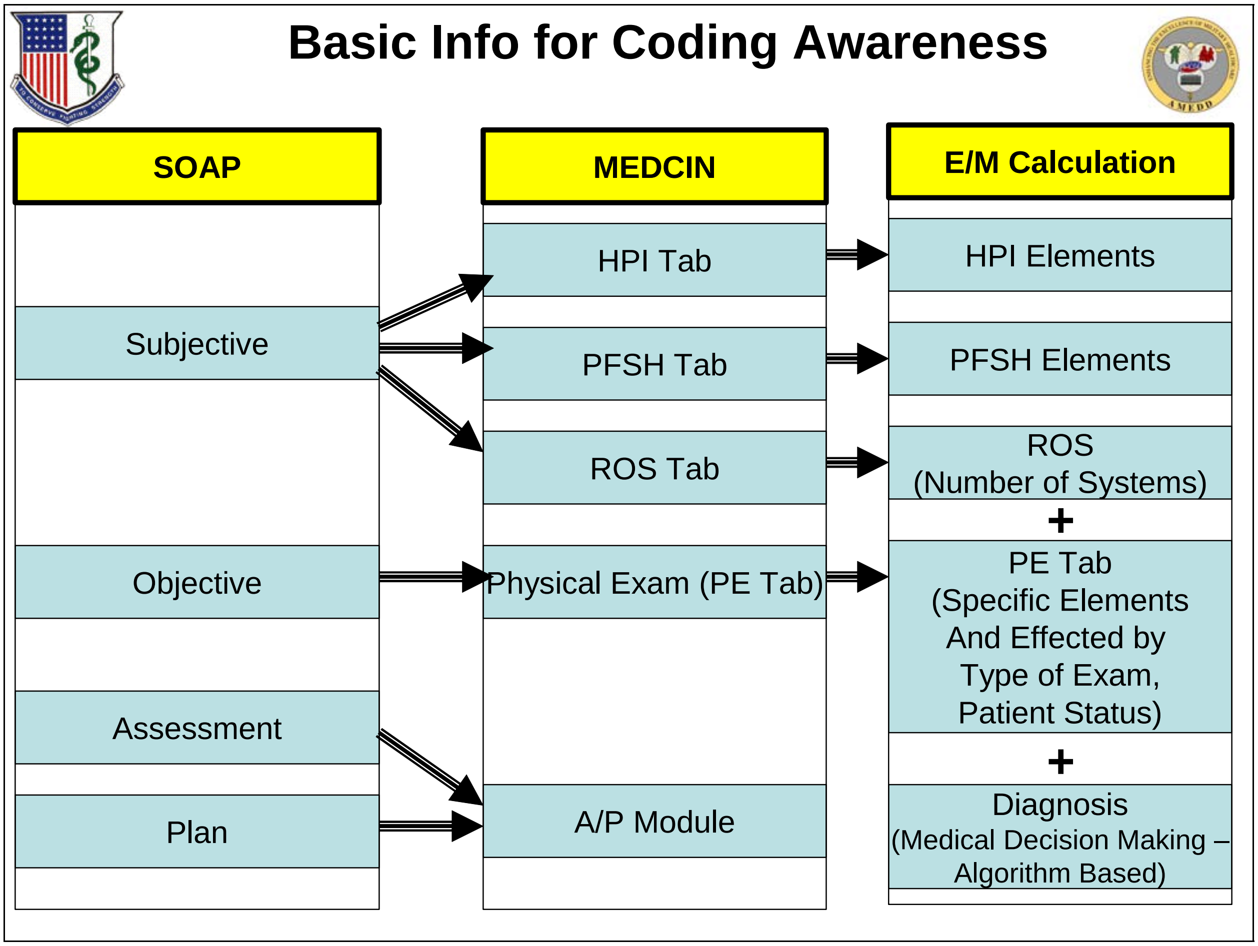
The note should look like the image below.



DxPrompt

- Only accessible in template mode (not from AIM form)
- Click ICON and type in diagnosis
- MEDCIN will give you common terms for that diagnosis in each area of the note. It will show you what has already been clicked
- Considering using when diagnosis is not covered by your personal default template

Coding Information



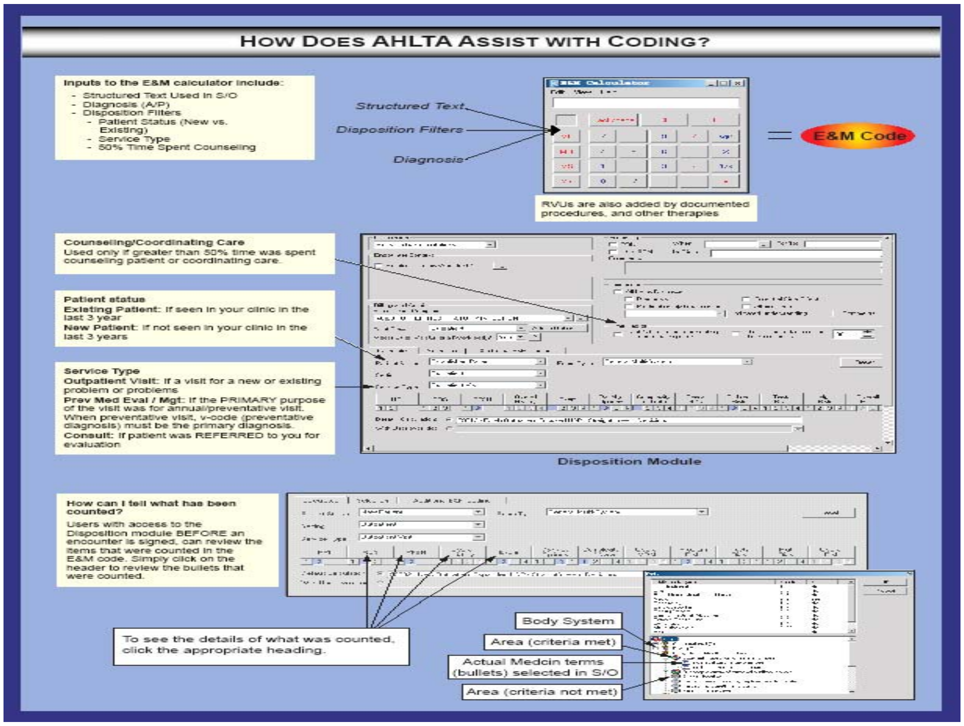
SOAP to Coding

More clicks do not mean a higher E&M Code
Where the information is placed is important
Many items roll up under a higher term
Create ROS and HPI of Terms YOU use that are specific as you feel comfortable
Using these terms:

- Free text specificity clarity
- Save usual text (must be in an encounter and use "Save As Template" or Previous Encounter with Save As Encounter Template

Word file use on your desktop to "copy and paste" common instructions/information
Free text in HPI to tell story and in A/P comments
Place pertinent positives in ROS into HPI (use Flip button)

Coding Facts You Have to Know



Team Documentation

Many users complain about the “speed” of documentation with AHLTA and its ability for multiple people to enter information into the note.

- **Speed:** The time it takes to complete the entire healthcare encounter from check-in to a completed note.
- **Training:** Usually focuses on capabilities of the system, NOT how AHLTA can improve healthcare delivery and your workday.
- **Solution:** The best way to improve speed and effectiveness is to understand how AHLTA assists in the process of care.

There are several workflows/options using AHLTA. The provider is not the only one who can write on or add to the patient’s note.

Select option(s) based upon Outcome Desired for the documentation.

Scenario 1

Multiple entries during a single encounter where separate time/date stamps are needed.

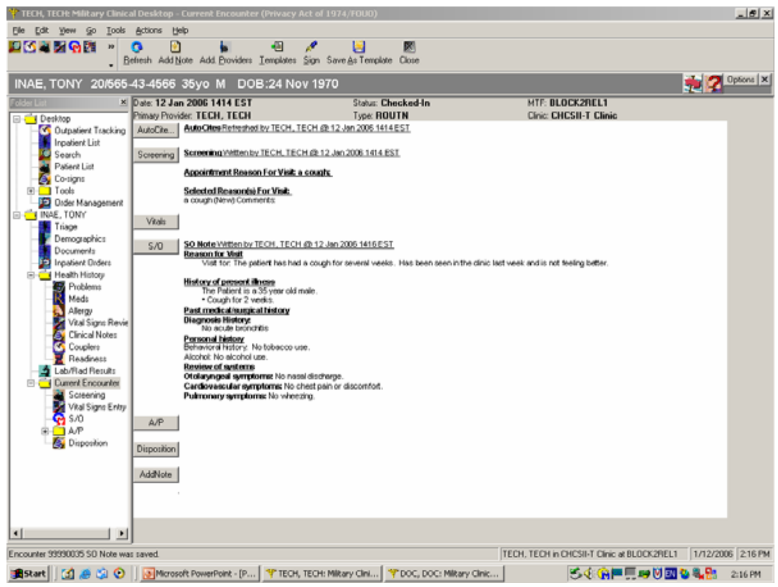
- Nurse/Tech writes initial note or enters serial notes.
- Provider writes ADDITIONAL note(s) that show up below the Nurse/tech's note.
- All entries into the encounter stored in chronologic order.

Use Cases:

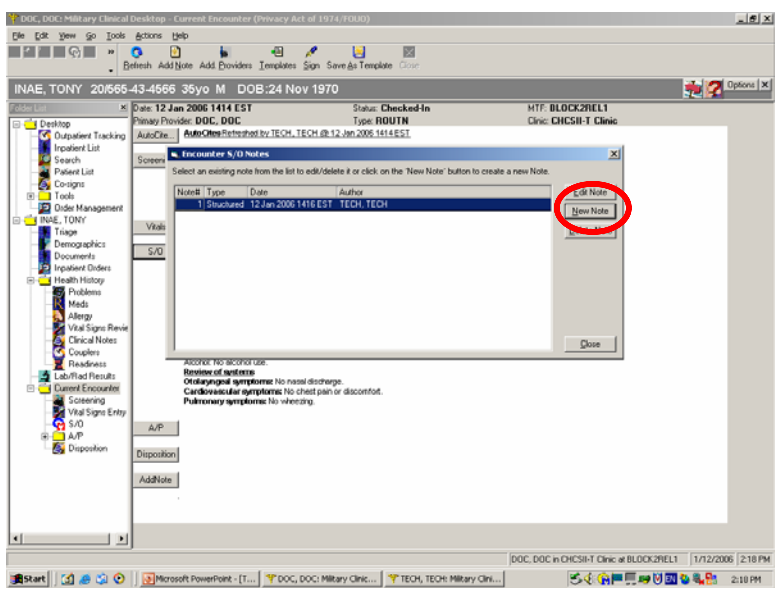
- Note started by Triage Nurse in Emergency Department
- Documentation of Serial exams
- Nursing documentation of intervention (IV fluids, nebulizer treatment, medication during the visit)
- Transition of care between provider (i.e. Change of shift)

Here is the technician's note. Subjective information is collected for the provider, or it could be someone doing triage.

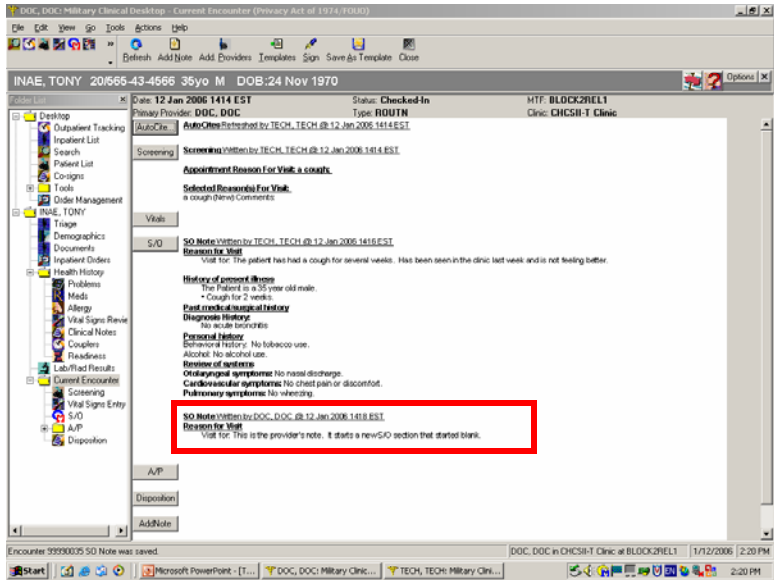
Please note that what the tech/nurse enters here will be discussed later; however, there are a number of options depending on the clinical need. A default template, designated clinic template, specific AIM form. The team needs to understand and agree on the work process.



The provider or second person clicks the S/O Button, and this is the window presented. If the provider wants to just add an additional entry to the note, then the provider should click, 'New Note'.



Note the technician's note is intact above the doctor's note. The provider's or second person's entry has a new signature and time/date stamp.



Scenario 2

Provider wants to start with the data/information that the Tech/Nurse has gathered.

- Tech/Nurse documents initial data and an initial note is generated
- Provider takes over the tech/nurses note
- Provider edits note
- The tech/nursing note shows up at the bottom of the page (for auditing purposes).

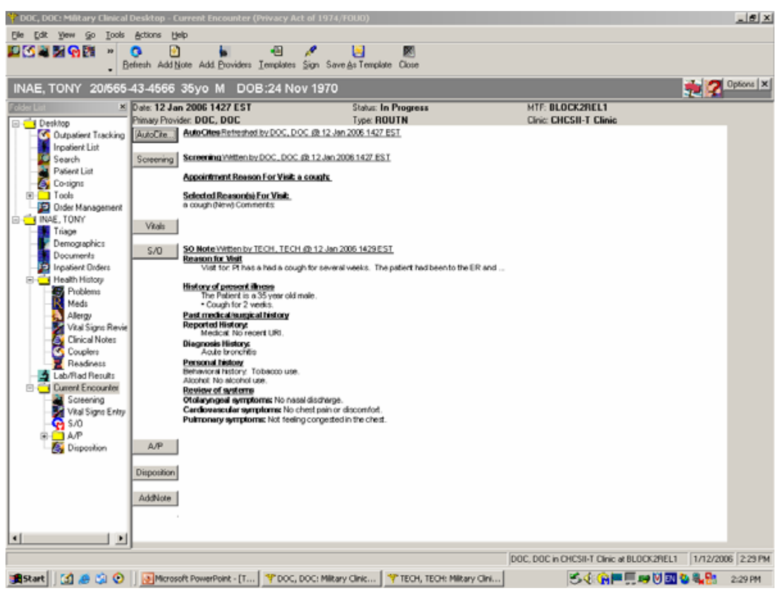
Provider assumes responsible for the encounter and completes the encounter with a single time data stamp. This makes a more legible note for the next person to read.

Use Case:

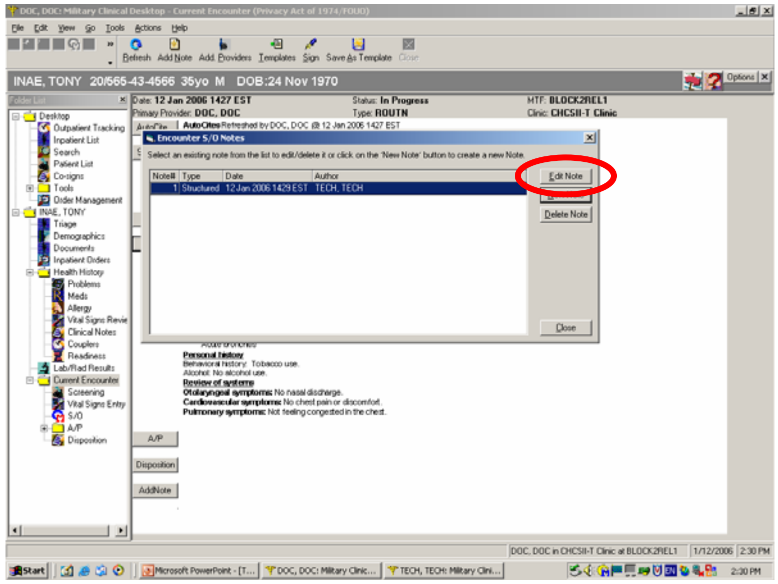
- Typical Office Visit (at least the start of one).

Here is the technician's note. Subjective information is collected from the patient as agreed by the healthcare team.

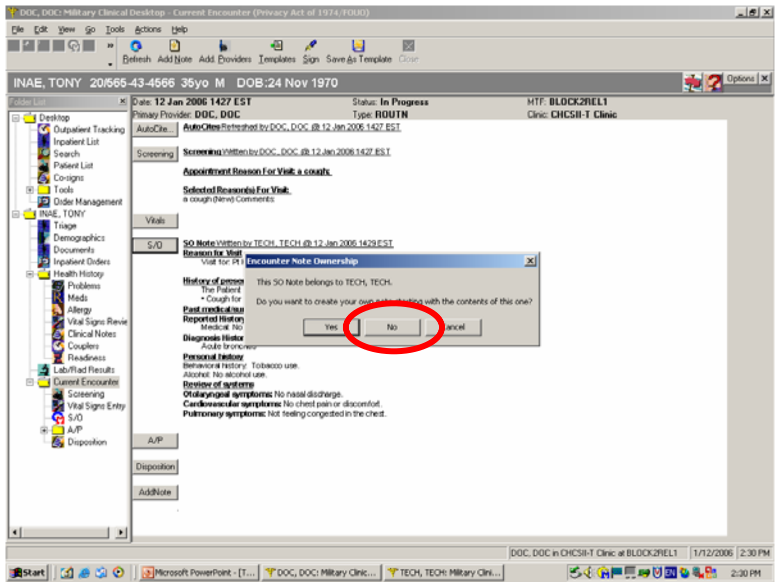
The Tech/Nurse uses screening template or AIM form. Specific items are checked/documented. Use Prompt button for additional questions, if desired.



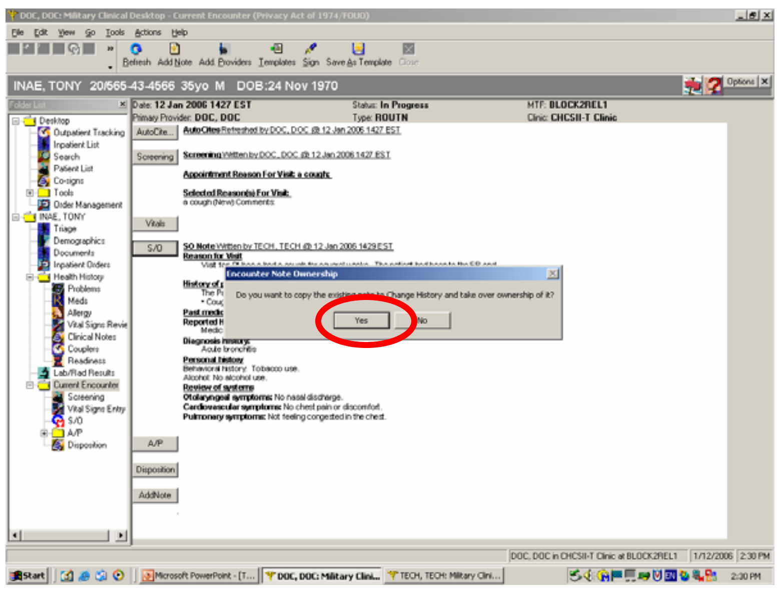
The provider clicks the S/O Button, and this is the window presented. Provider click’s Edit Note.



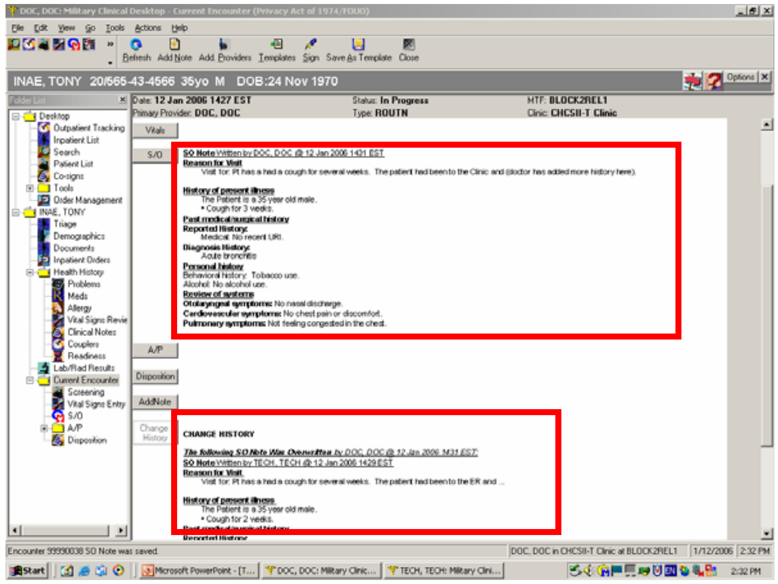
Try hard to avoid reading this pop-up (as it is very confusing),
Just click ‘No’.
You will get another pop-up.



Provider clicks ‘Yes’ now.



Provider completes S/O portion of note with his/her default encounter template or AIM form.
The result of this is just 1 S/O note, the provider's note, and the information entered by the nurse/technician's is moved to the change history.

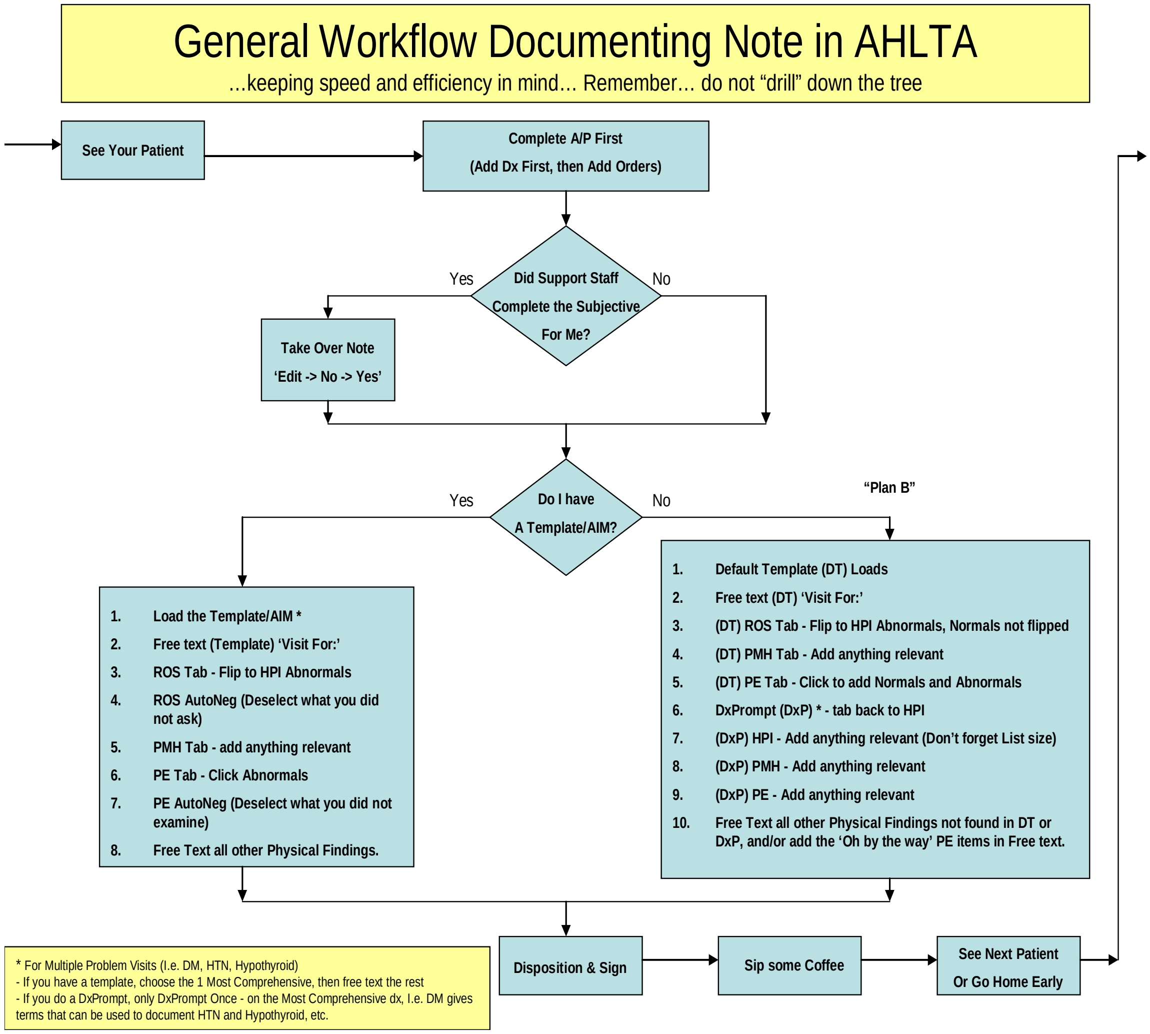


Recommended Clinic Workflow

- Set User Preferences/Defaults
- Establish clinic favorite list
- Establish SOP or agreement on what screeners will document.
- Screener should limit or not use the free text comment box in screening tab. Information should be placed in note for use by provider.
- Use Team documentation. (The extra time spent screening with some of the note written will speed not slow the clinic)
- Everyone add to CPTs as appropriate.
- Check 99211 visits in against provider, nursing staff compete documentation and provider ONLY reviews and sign. Note: Check with coders to see what visits are a 99211 in your clinic and do not require the provider to see.

Recommended Provider Encounter Workflow

- Before Clinic (one time investment)
- Set User Preferences/Defaults
- Establish clinic favorites DX and CPT (only the most common)
- Create personal default template (can be clinic or MTF specific)
- Team Documentation – Same Template or Clinic
- Enter room greet pt, open appointment, read screening entry and click HHM
- Take history and do exam (Most people will not write note while taking history)
- Complete A/P with patient in room (limit A/P jumps)
- Dx, orders, and Instructions reviewed with patient – Pt Leaves
- EDIT-No-Yes to take over screening note THEN write note with default template
- Augment default template with DxPrompt (if needed) to complete note
- Remember to put positive ROS into HPI (using flip button)
- Disposition and Sign with a cup of coffee


General Workflow Documenting Note in AHLTA
…keeping speed and efficiency in mind… Remember… do not "drill" down the tree
See Your Patient
Complete A/P First
(Add Dx First, then Add Orders)
Did Support Staff Complete the Subjective For Me?
Yes
No
Take Over Note
'Edit -> No -> Yes'
Do I have A Template/AIM?
Yes
No
"Plan B"
1. Load the Template/AIM *
2. Free text (Template) 'Visit For:'
3. ROS Tab - Flip to HPI Abnormals
4. ROS AutoNeg (Deselect what you did not ask)
5. PMH Tab - add anything relevant
6. PE Tab - Click Abnormals
7. PE AutoNeg (Deselect what you did not examine)
8. Free Text all other Physical Findings.
1. Default Template (DT) Loads
2. Free text (DT) 'Visit For:'
3. (DT) ROS Tab - Flip to HPI Abnormals, Normals not flipped
4. (DT) PMH Tab - Add anything relevant
5. (DT) PE Tab - Click to add Normals and Abnormals
6. DxPrompt (DxP) * - tab back to HPI
7. (DxP) HPI - Add anything relevant (Don't forget List size)
8. (DxP) PMH - Add anything relevant
9. (DxP) PE - Add anything relevant
10. Free Text all other Physical Findings not found in DT or DxP, and/or add the 'Oh by the way' PE items in Free text.
* For Multiple Problem Visits (I.e. DM, HTN, Hypothyroid)
- If you have a template, choose the 1 Most Comprehensive, then free text the rest
- If you do a DxPrompt, only DxPrompt Once - on the Most Comprehensive dx, I.e. DM gives terms that can be used to document HTN and Hypothyroid, etc.
Disposition & Sign
Sip some Coffee
See Next Patient
Or Go Home Early

Copy Forward

The copy forward function allows you to bring a previously-completed encounter into a template. Copy forward can be done by right-clicking on a previous encounter and clicking on “copy forward”. (See How to).

Note that the copy forward template will look like a template view even if the note was recorded using an AIM form. The findings that were previously checked, including most of the free text that was entered, will be in the note. The items that were selected will appear with a yellow box. They must be selected with either AUTOENTER to select all or individually to become part of the new note. If you are using an AIM form, you can overlay a new identical AIM over the copy forward template once the items that you wish to recheck have been checked.

Notes:

1. Copy forward is particularly useful for post op checks, cancer follow-up visits, ear rechecks or other conditions where the patient is seen repetitively or serially when similar issues are addressed.
2. You can use copy forward on a previous encounter that was written by another provider. This may be valuable when doing a consult. Copy forward will bring forward the previously recorded reason for visit and exam finding. This information will ONLY be included in your current note IF you select them. You can edit items just as above. You can also use a different specialty-specific AIM form or template with the copy forward note. Be mindful that when using copy forward, similar to “auto-negative”, you are stating that you did review these items; by signing the note you acknowledge the validity of the content and are responsible for it.

Telephone Module

See How To

Notes:

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. This will change in July 2005 when the entire module is redone. This change will allow TCONs to be passed between any nursing staff and providers, similar to what is currently available in CHCS Legacy.
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.
3. Most telephone consults will truly meet workload count requirements as they require a diagnosis, and you will likely document some assessment if you talked to the patient.

Consult Log

See How To.

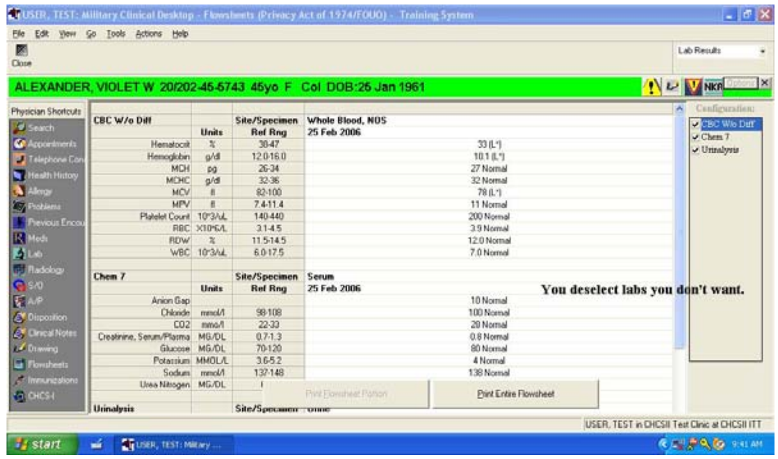
This is an effective means of keeping aware of the consults on your patients. It makes those annoying CHCS I (Legacy) emails about the patient’s consult status become useful. Once the consult is complete, double-clicking on it will take you to the completed note if it was done in AHLTA. If the result was scanned into the system in Clinical Notes, then you will move to this section in the Health History to locate the appropriate visit.

Flow Sheets

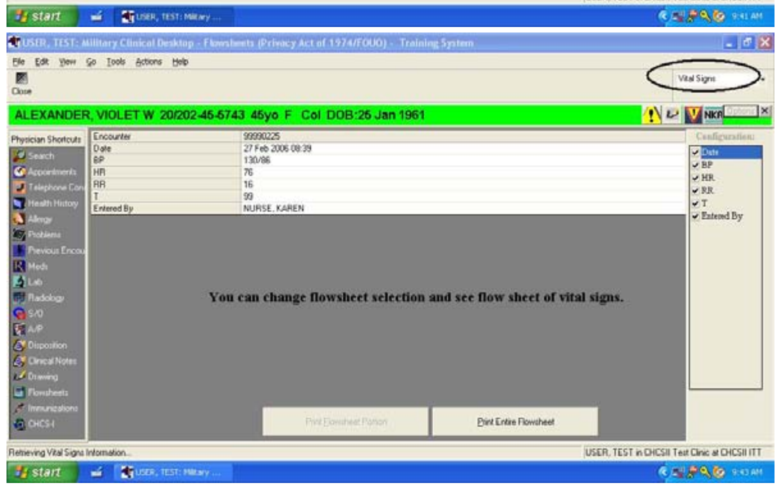
Flow sheets can be used to review all current labs.

Micro labs, UA, etc., tend to fill the screen and should be taken off.

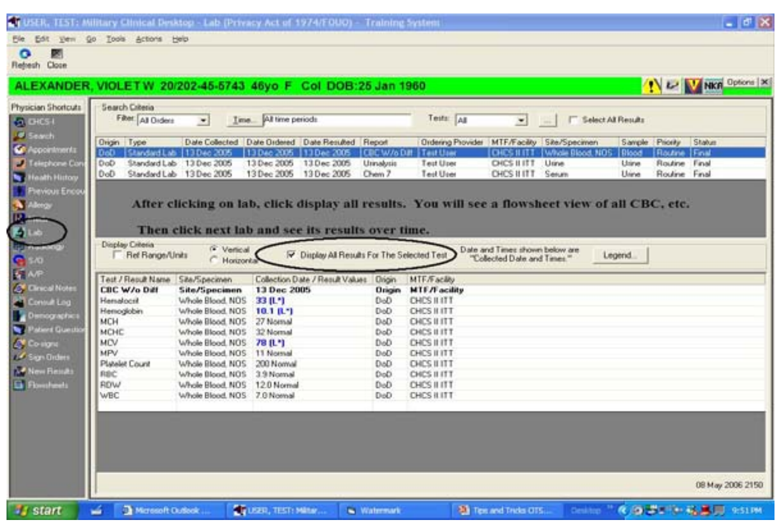
Micro labs are best viewed in the Lab module.



You can change the Flowsheets filter to ‘Vital Signs’ to review a patient’s vitals.



In the Lab module, using Select All will display the lab flow sheet in the lab module.



Use of Word Documents

If you use the same PC, you can save common word documents.

- Education Material
- Counseling Material
- Treatment Plans/ Recommendations
- Other

Simply cut and past as appropriate into the record (AddNote or other).
Used a lot by Behavioral Health, also beneficial for PT/OT, and certain subspecialties.

A Final Note

Now that you have worked through the self-paced tutorial, experimented with reproducing previously-written notes with the AHLTA training database, and possibly completed training, you should have the basis to begin AHLTA use effectively. This was true of CHCS I (Legacy) where you had to learn the three-letter language for entry and other shortcuts that were often not immediately intuitive. As with any new change, it will take time to become proficient and learn all the capabilities of AHLTA, an application that is constantly being improved through user feedback and enhanced with evolving features. The more consistent users are now, the more helpful and faster the features will be.

Top Reasons EUD Performance Issues: That the MTF Can Control

1. User settings (see below)
2. Number of clinics where the user is mapped (see below)
3. Spyware/other non-work related software
4. Incorrect version of AHLTA
5. Extraneous running software (Music, email, etc)
6. User perception (workflow)
7. Network issues

Expanded Top Reasons for EUD Performance Issues

1. User settings
   - AutoCites (Extensive Auto-cites will slow system)
   - Appointment Search Criteria
     - Allows the user to return all un-signed encounters for all Clinics they are mapped to as well as selecting all Providers in that Clinic
       - User configurable
       - Users requiring extensive encounter lists will operate slower
2. Number of clinics the which the user is mapped
   - Database call to “get Clinic data” is used throughout AHLTA
     - The “get Clinic data” call retrieves:
       - Appointment Data Types for each Clinic
       - Clinic Information for each Clinic
       - Amount of and users in each Clinic
       - Amount of templates assigned to each Clinic (only for the Template Management Module)

- User mapped to more clinics then required will slow system

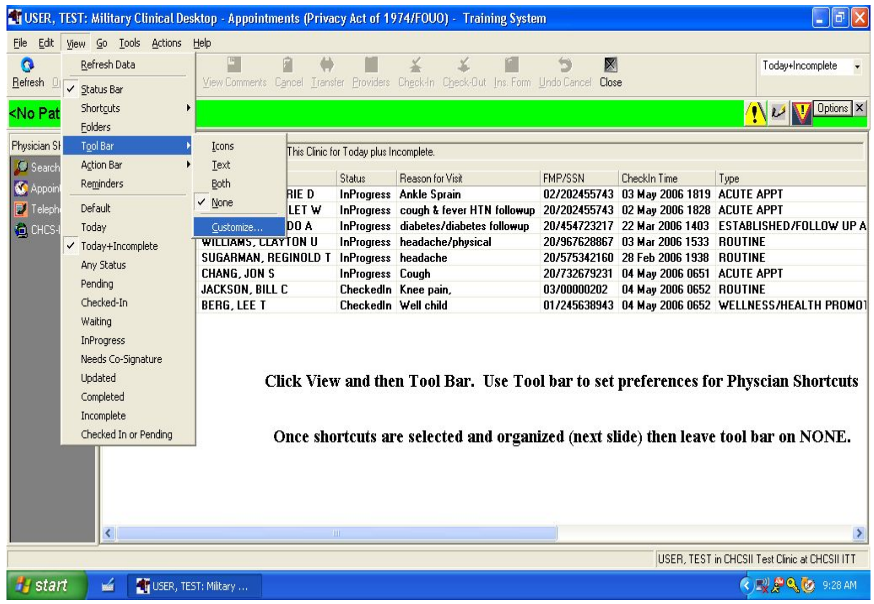
Top Items to Correct to Improve EUD Performance

- Spyware
    - What is in your Internet files
    - Have you deleted your cookies
- Incorrect version of AHLTA
    - AHLTA Client Software not in sync with CDR (Database) indexes
- Extraneous running software
    - Streaming music/Instant Messaging
- User perception
    - Users are not aware of what takes place in the background when they use a function in AHLTA
        - For example: Going between the S/O and A/P modules
            - The system saves the S/O data, updates and saves the Encounter, updates and Saves the Appointment, then opens the A/P module, updates the Appointment, updates the Encounter, retrieves A/P data

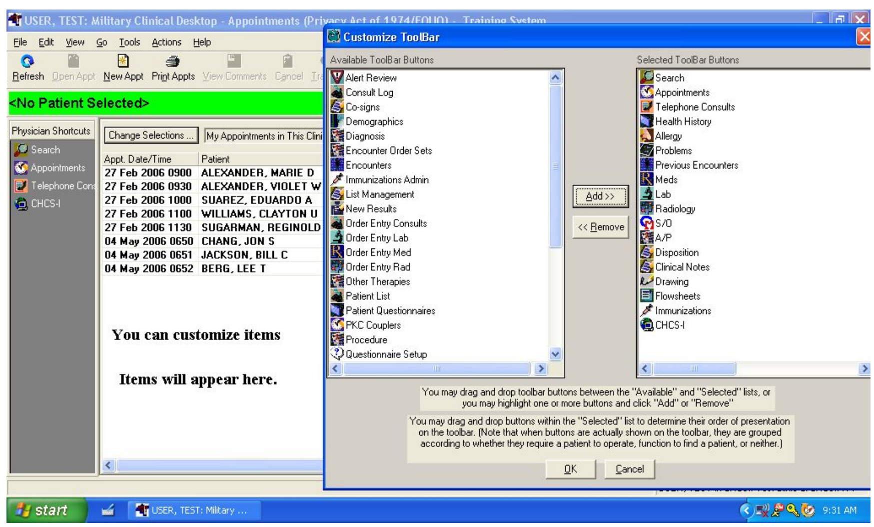
How To’s

Customizing the Desktop

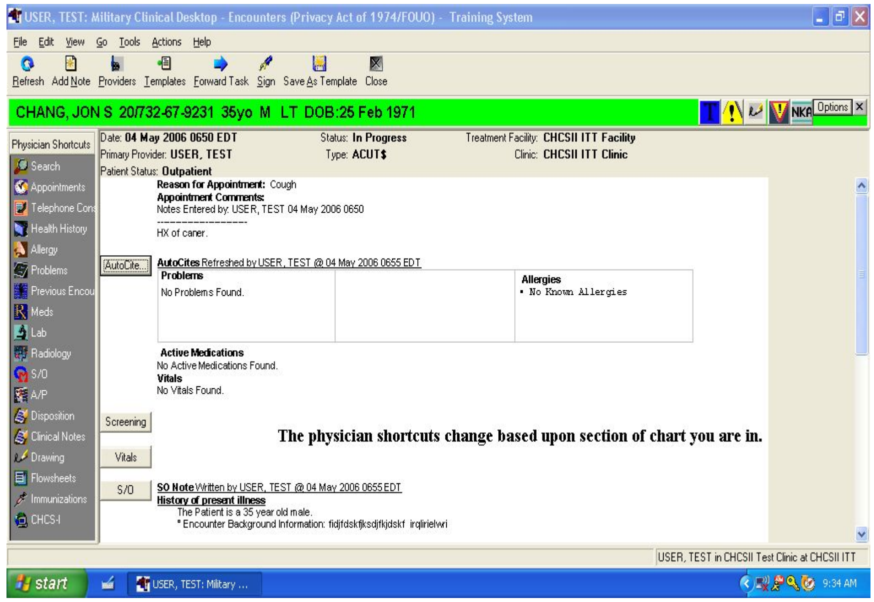
AHLTA has many ways to do the same thing. By customizing the desktop, user’s can improve their performance. Customizing the desktop will help “speed” the encounter process and minimize extraneous mouse movements and clicks. Use the View>Tool Bar menu to set the Physician shortcuts. Once the shortcuts are selected and organized, set the Tool Bar to None.



To set Physician Shortcuts: Click View on the Menu Bar and select Customize. The Customize ToolBar window opens. When setting the Physician shortcuts, place them in the sequence that you want to use them.

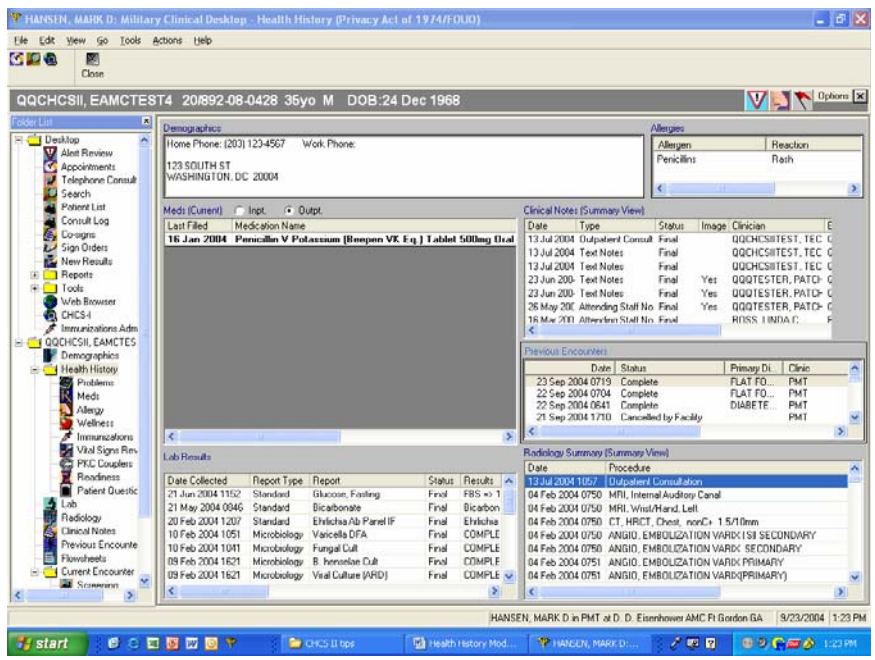


After the shortcuts have been set, set the View>Tool Bar to None. Please note that the Physician Shortcuts change based upon the section of the chart you are in.

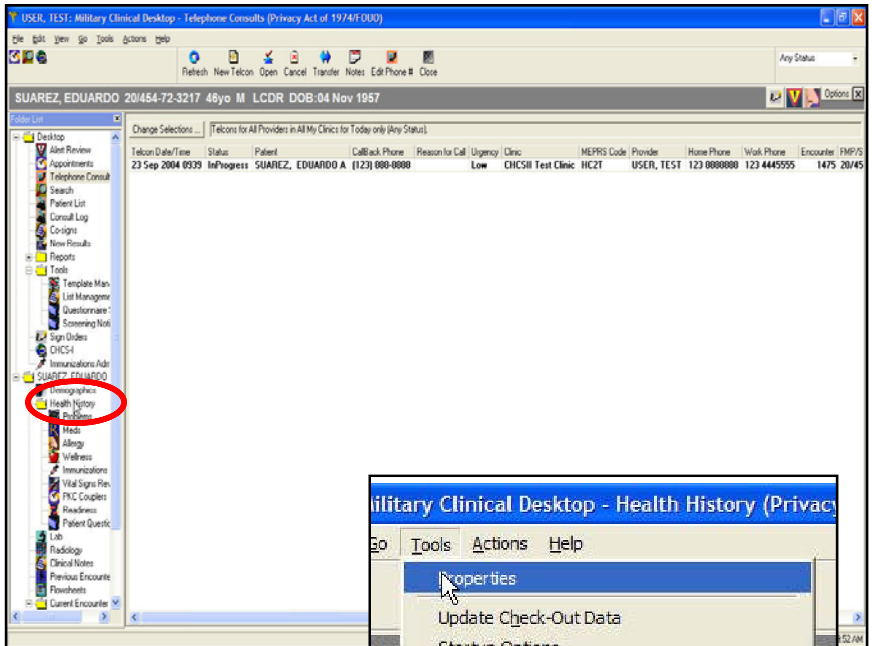


Health History Module

The Health History module will allow the user to display a customizable screen that can have various areas of the patient's health record. This module is better than IDCB because it is integrated into the FULL electronic record. This module can provide a quick look into multiple areas of the patient's record at one time. In addition, it can provide easy access into those modules.

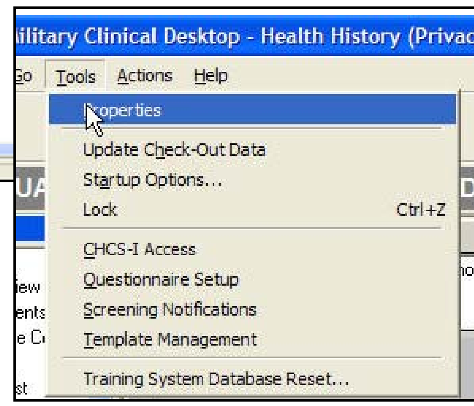


When you enter the Health History module, you will need to perform initial setup. This screen can be customized with whatever is needed.

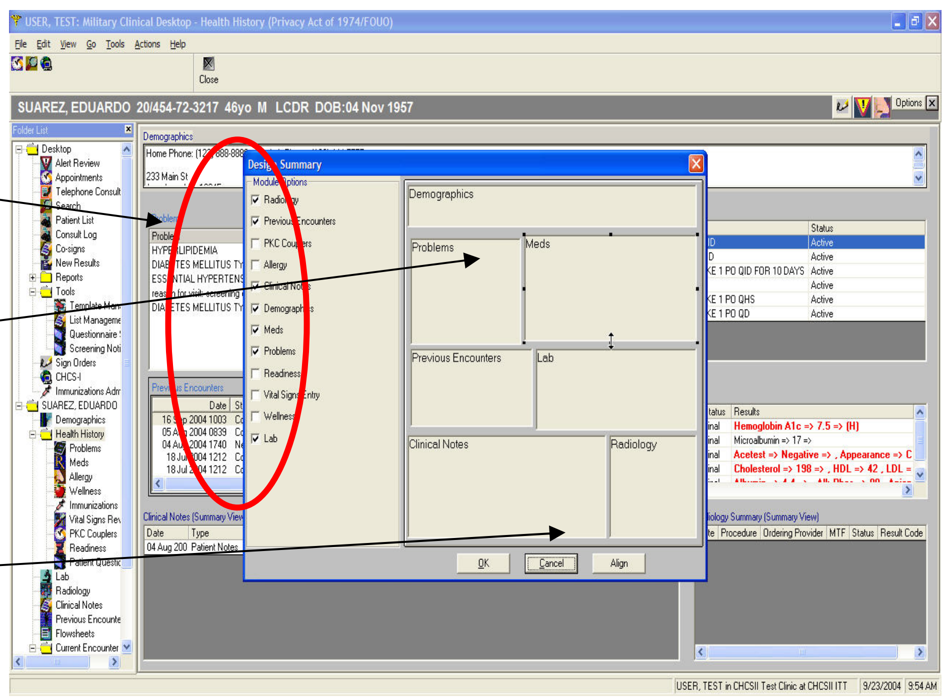


To setup:

Go to Health History item on left side of screen.



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.



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.

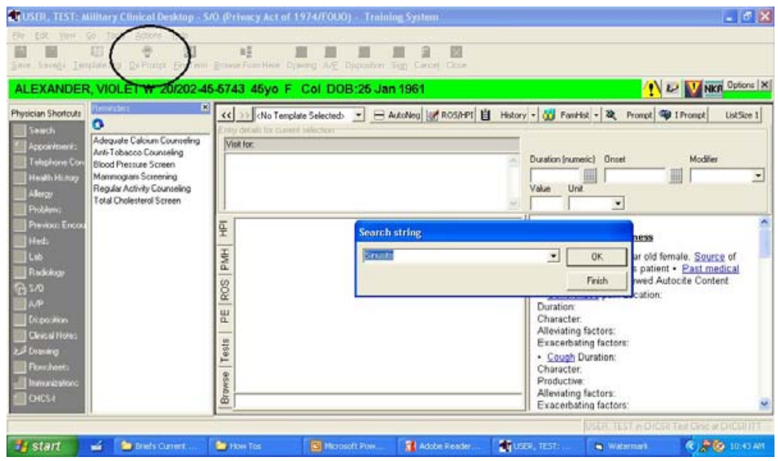
If you find you don't need a module, follow the same above steps to reconfigure as needed.

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.

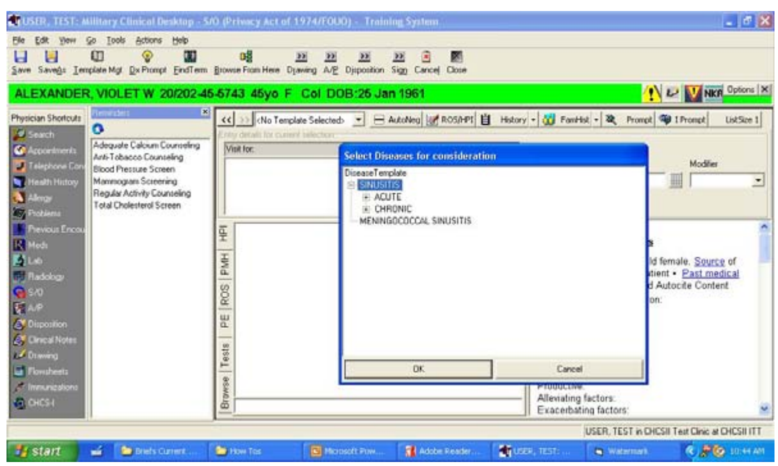
DxPrompt

To use DxPrompt:

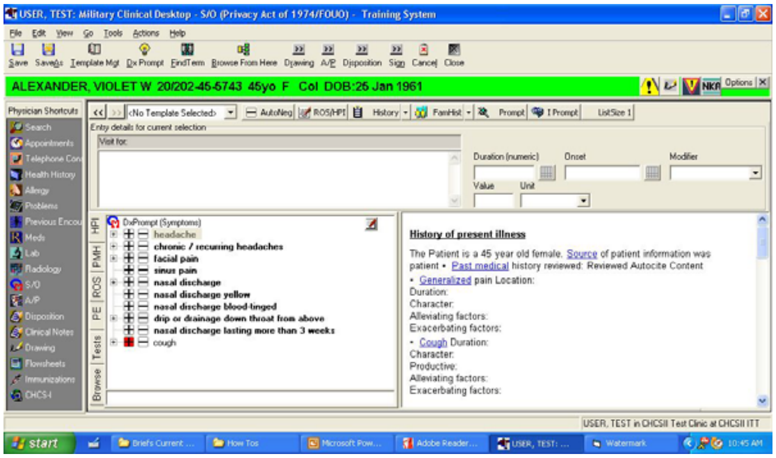
Click the DxPrompt button on the Action Bar. The Search String window opens. Type the diagnosis you would like to search for in the search field and click OK.



The search results populate the Select Disease for Consideration window. Highlight the appropriate diagnosis and click OK.



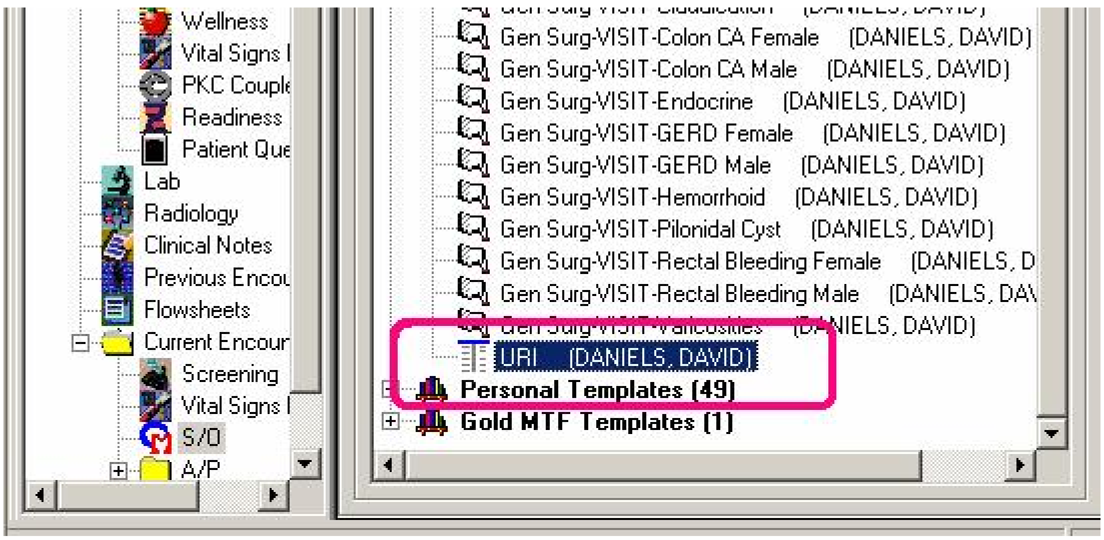
The tabs of the S/O module populate with terms related to the diagnosis.



Find, Load and Use AIM Forms

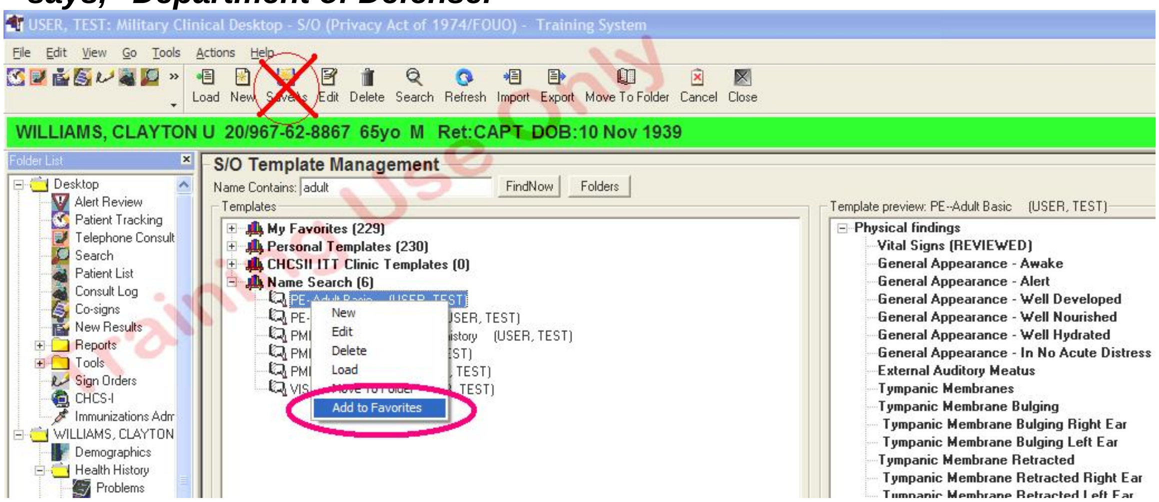
<u>Finding and Loading AIM Forms *(see current list of AIM on AKO site)*</u>

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 toolbar, as noted below:

7. 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.”***



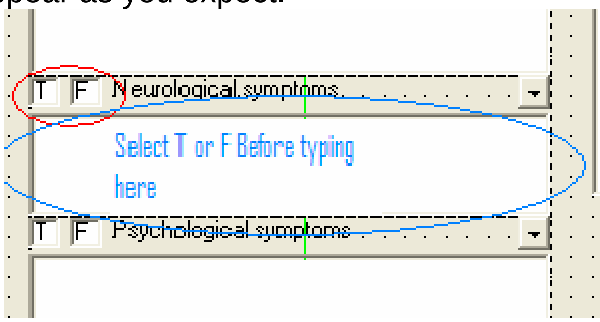
8. AMEDD Standard AIM templates will have either an Owner of the Department of Defense, or the local MTF. Ones with individual user names as owners are copies that were saved **incorrectly** as described in #7.

<u>NOVEL Uses and Behaviors of AIM forms</u>

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 provider or clinic can be started during vital signs entry.
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 ?

CURRENT Available AIM Forms
See AHLTA AKO website

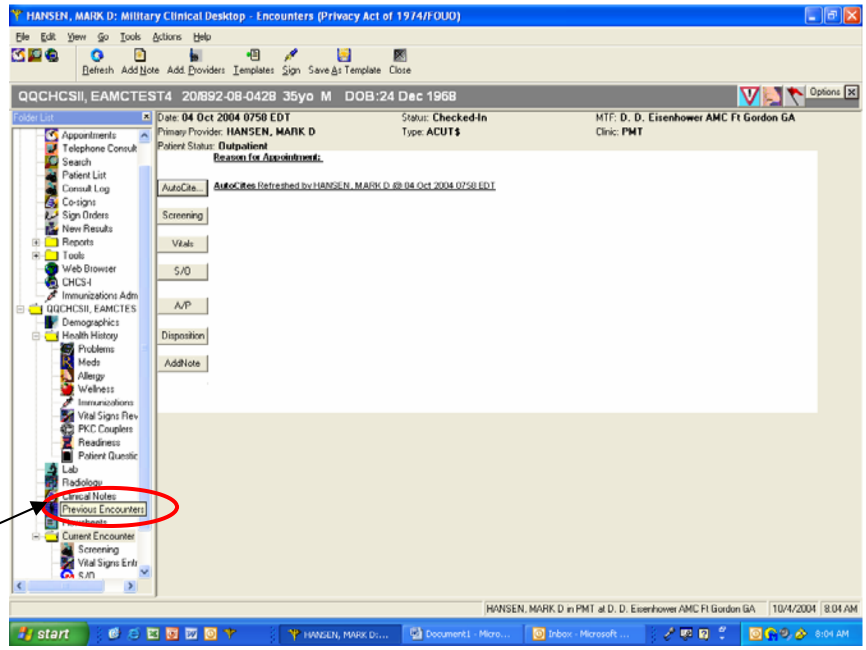
Copy Forward

The copy forward function will allow you to bring the S/O section of a previous note forward into the current encounter for your patient.

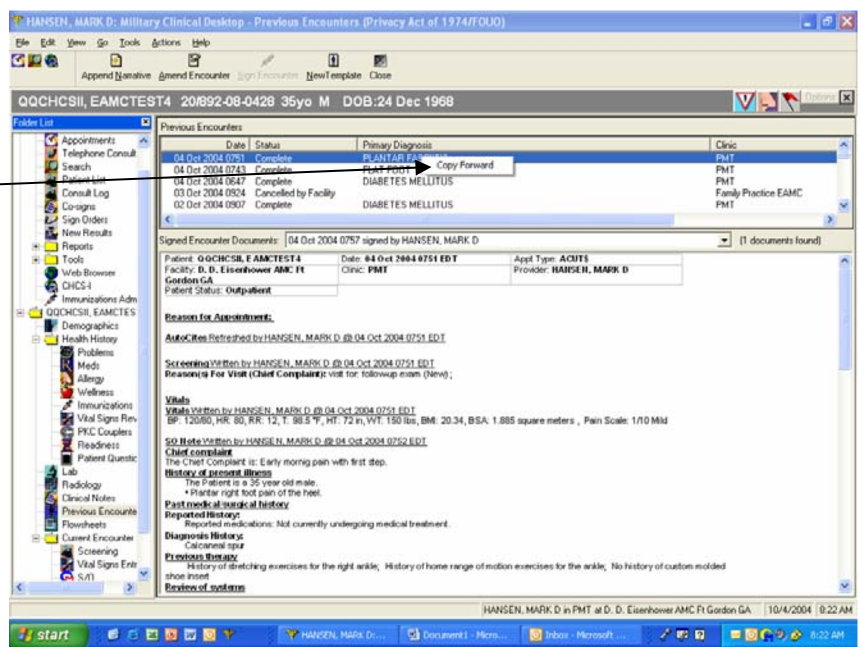
This is particularly handy for follow-up visits or visits where the note from last time is a good starting place for the note for your visits.

This can be done from any previous encounter, not only ones written by you.

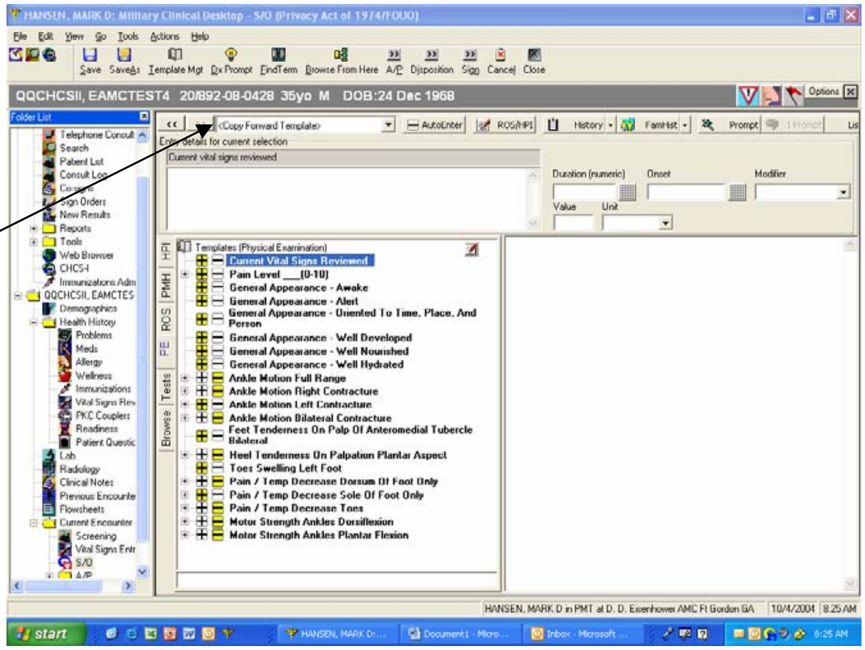
With an encounter open, go straight to the Previously Encounters module. In this module, single click and review the previous encounter(s).



On the encounter, right click and you will be presented with an option to COPY FORWARD.



In the current encounter you will find a new "template" called Copy Forward Template. This may automatically take affect or you will need to select it from the pull down menu.



Each line item that was selected in the previous encounter will be displayed in this template and indicated in yellow, the way that item was used.

You then would select the items you need. If you want all the other items in your note unchanged from the previous note, the autoneg button changes to an auto enter button and when clicked, all items in yellow (either the positive or negative) will be selected and entered in your note.

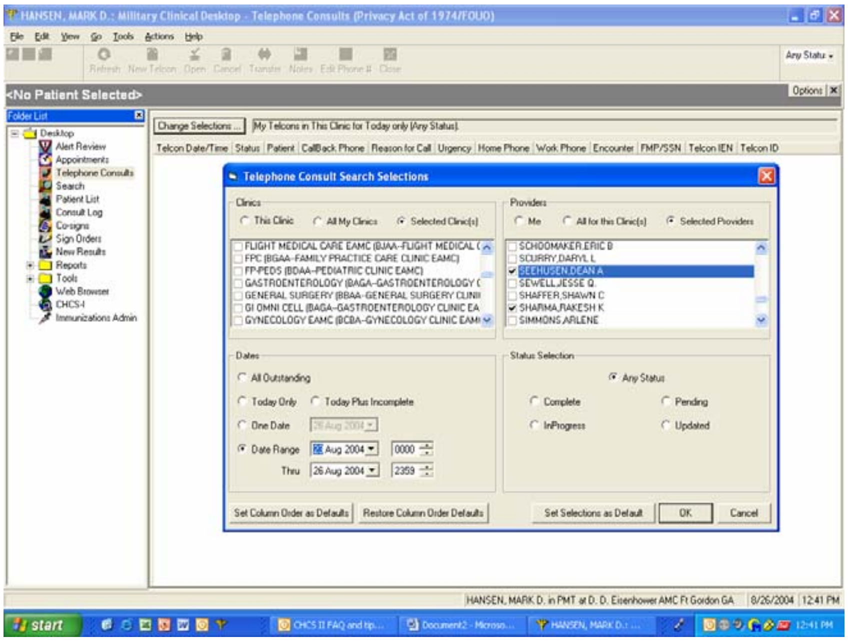
When you are seeing a follow-up patient, this can give you a good indication of how the patient was during the last visit and can determine how the patient has improved since the last visit.

Copy Forward can also be used for part of the note. For example, you can have a technician or nurse use Copy Forward to bring forward just the past medical history section of your patients for your easy review. Then put an item in your template saying PMH reviewed.

Telephone Consult

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 the additional providers' telephone consults.

Within the Telephone Consults module, click the **Change Selections** button.

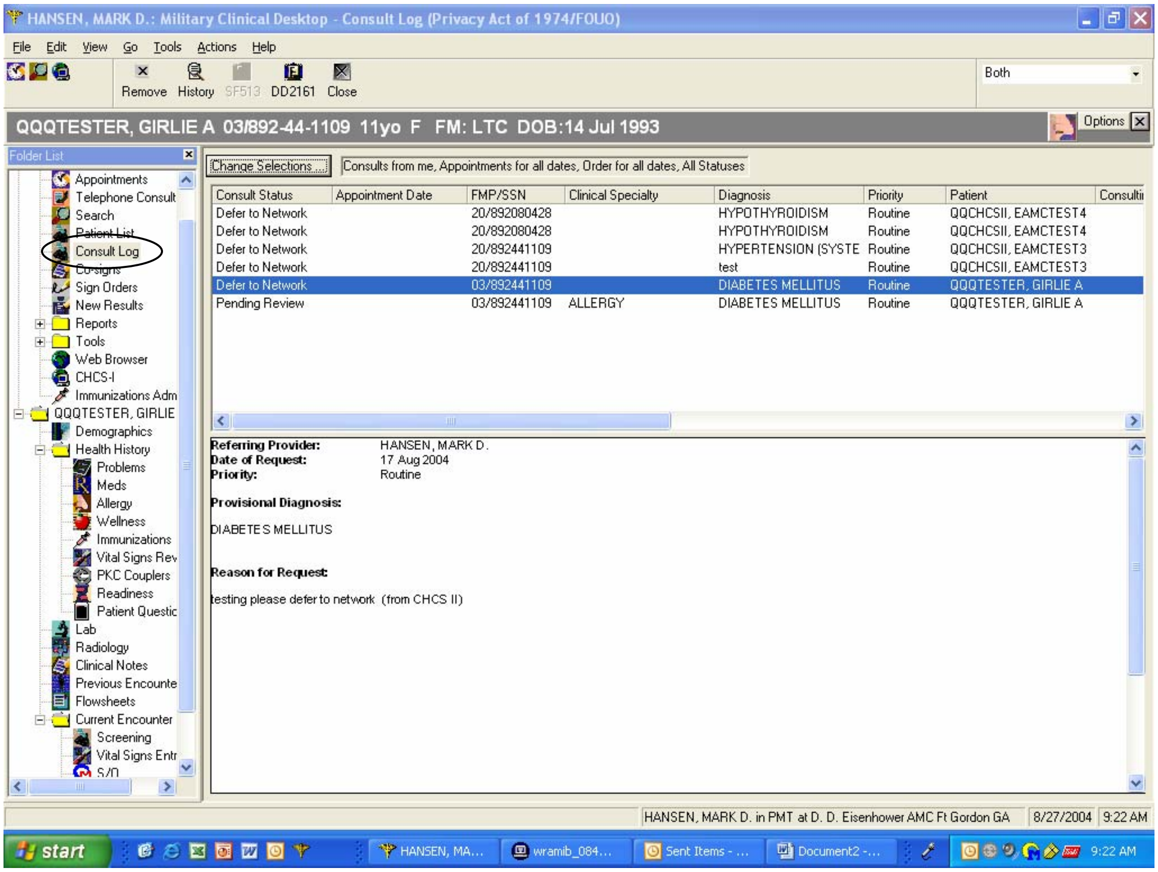


Within the Change Selections dialog box, select the provider(s) you are assisting.

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.

Consult Log Module

The Consult Log Module will track the consults you have ordered as well as those consulted to you. This module is a provider-specific module, meaning it will not track consults for a particular patient. The consult status for a particular patient can be viewed at the bottom of the Order Consult tab.



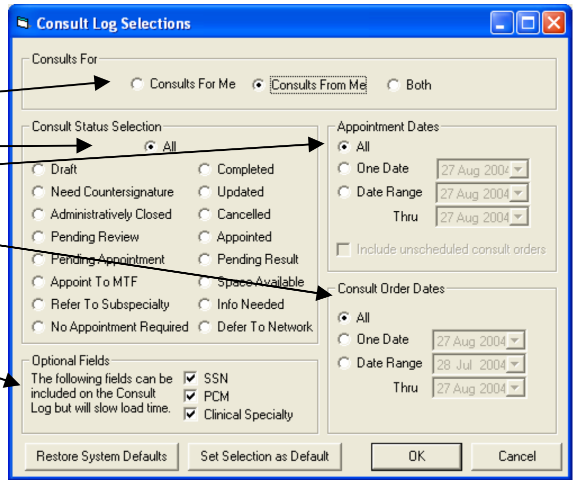
The Consult Log Module is located on the Folder List. When selecting this module you can be presented with the consults you have written or the consults written to you.

Consults written to your clinic will not be displayed because a particular provider is not listed in the consult.

Within the Consult Log module there is a Change Selections box that can further define what consults you can see.

You define:
Which consults you wish to see.
What status you wish to view*
Date range of the appointment
Date Range of the consult

Additional Optional Fields can be included in the report if you wish.

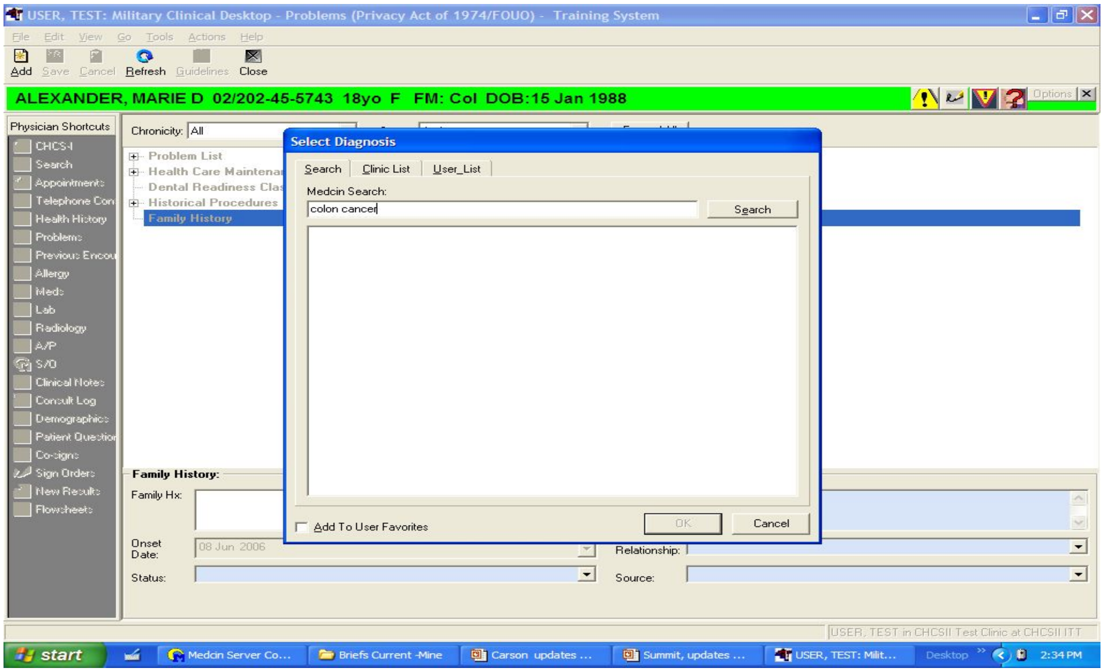


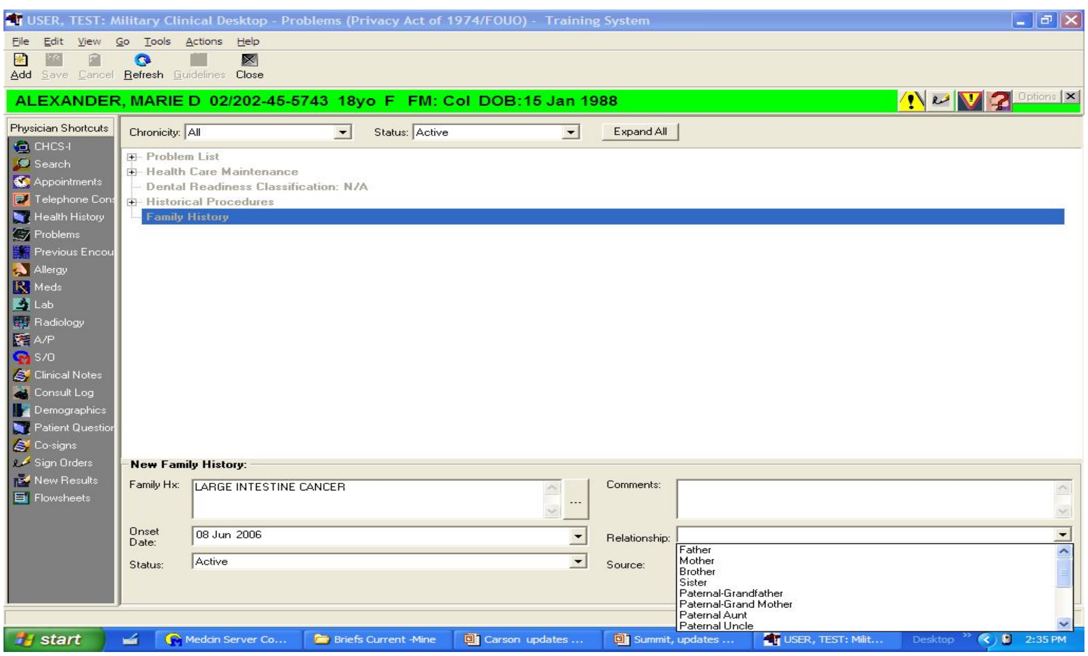
This consult log will help discover the status of the consults written for your patients to insure the consults are being appointed. Additionally, a consult that is listed as being complete should have a result in AHLTA if the consult was done within the MTF. You can review it by reviewing the patient's previous encounters. If the consult was done outside the MTF, you will know that results are available and hopefully the results have been copied or scanned into the patients ADD Note or the Clinical Note section of the patient's AHLTA record.

*For reviewing the status of consults that YOU have ordered, it is best to select "All" so that you can follow the progress of your consults.

Cleaning Up the Problem List

(Adding and Removing items to improve usefulness)
The screener will hopefully have reviewed and updated the information before you see the patient.
Reviews and updates as necessary these areas with the patient Documenting the history on the problem list keeps the list current and easily available for all. Items can be added, deleted or made inactive. Short term problems and administrative items should be made inactive. You should set your filter to show only active problems but you can change the filter if you wish to the entire historic list.
Maintaining the Patient's Problem List in AHLTA (Clearing clutter and updating)

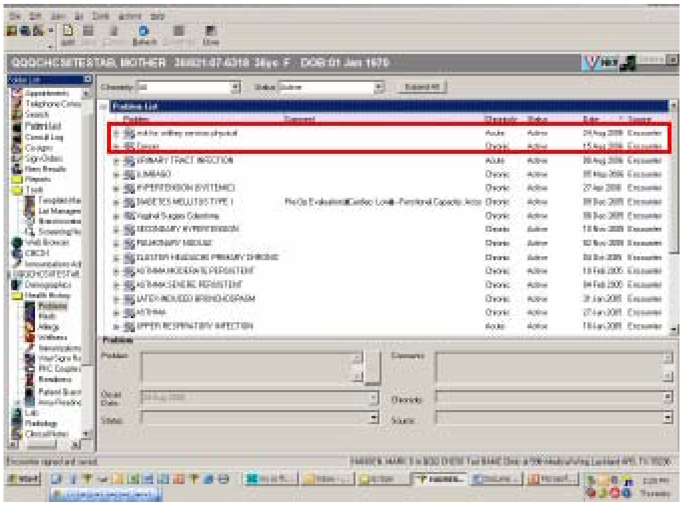




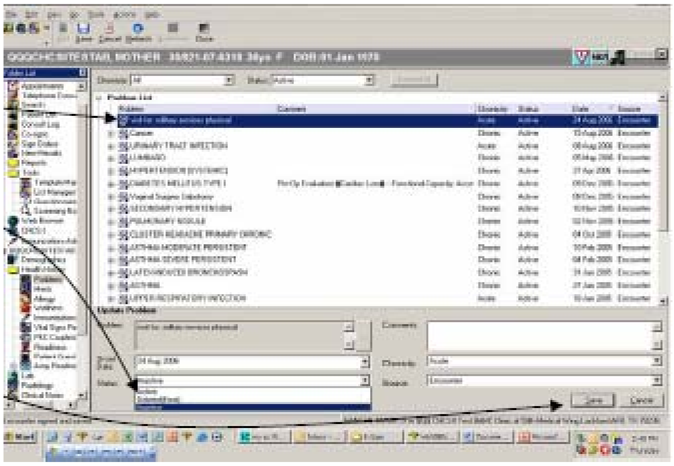
Note: Coding Credit is obtained from stating in your note that items were review and updated.

The Problem List (PL) will auto-populate with diagnoses from encounters as they are completed. Because of this, some of the entries will not need to be maintained long-term. (Acute illnesses, Visit for Screening, Sprained Ankle, etc). The problem list will need to be maintained so that it shows the patient’s significant medical problems as well as the patient’s surgical/procedure history and their family history.

With a patient chart open in AHLTA, open the Problems Module. After expanding the problem list, you will see the list of items on problems previously assigned. Listed in our example is a “problem” of Visit for Military Services physical and Cancer. The “Visit For” was a diagnosis used when our patient received a physical. The cancer diagnosis was really a Family History of Cancer and should be removed.

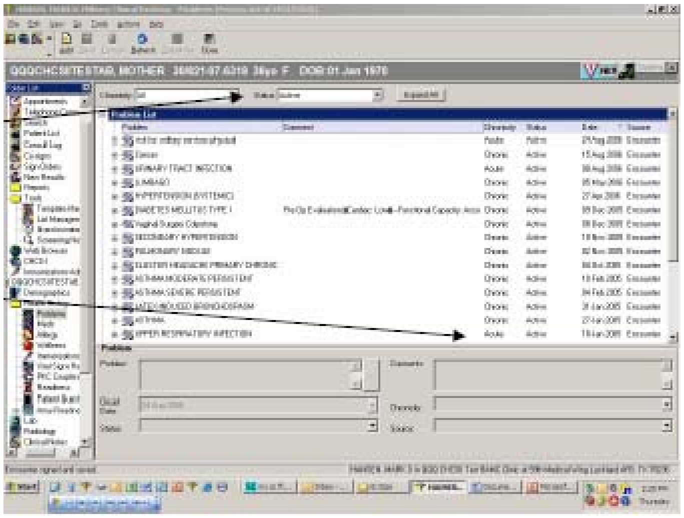


The removal of these items is simple. Single-click the unwanted diagnosis and select either **Inactivate** or **Delete (error)**.



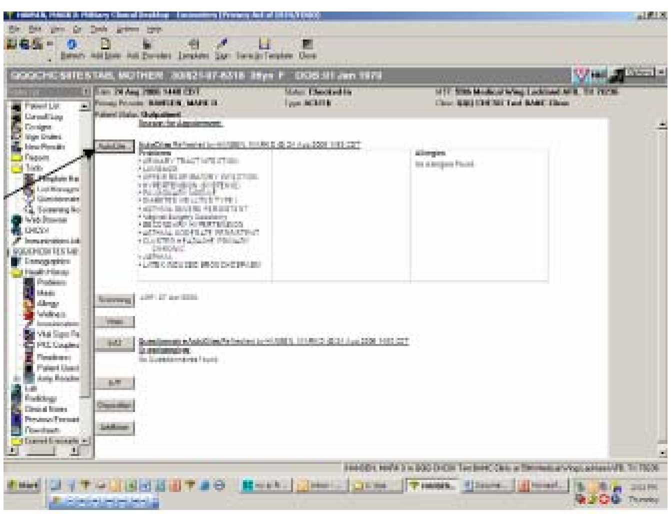
Next, just click the **Save** button to save your work. Repeat this process for all items that need to be deleted.

You can change the setting of the Status filter to see only Active, Deleted, Inactive or ALL problems. The items are not erased.



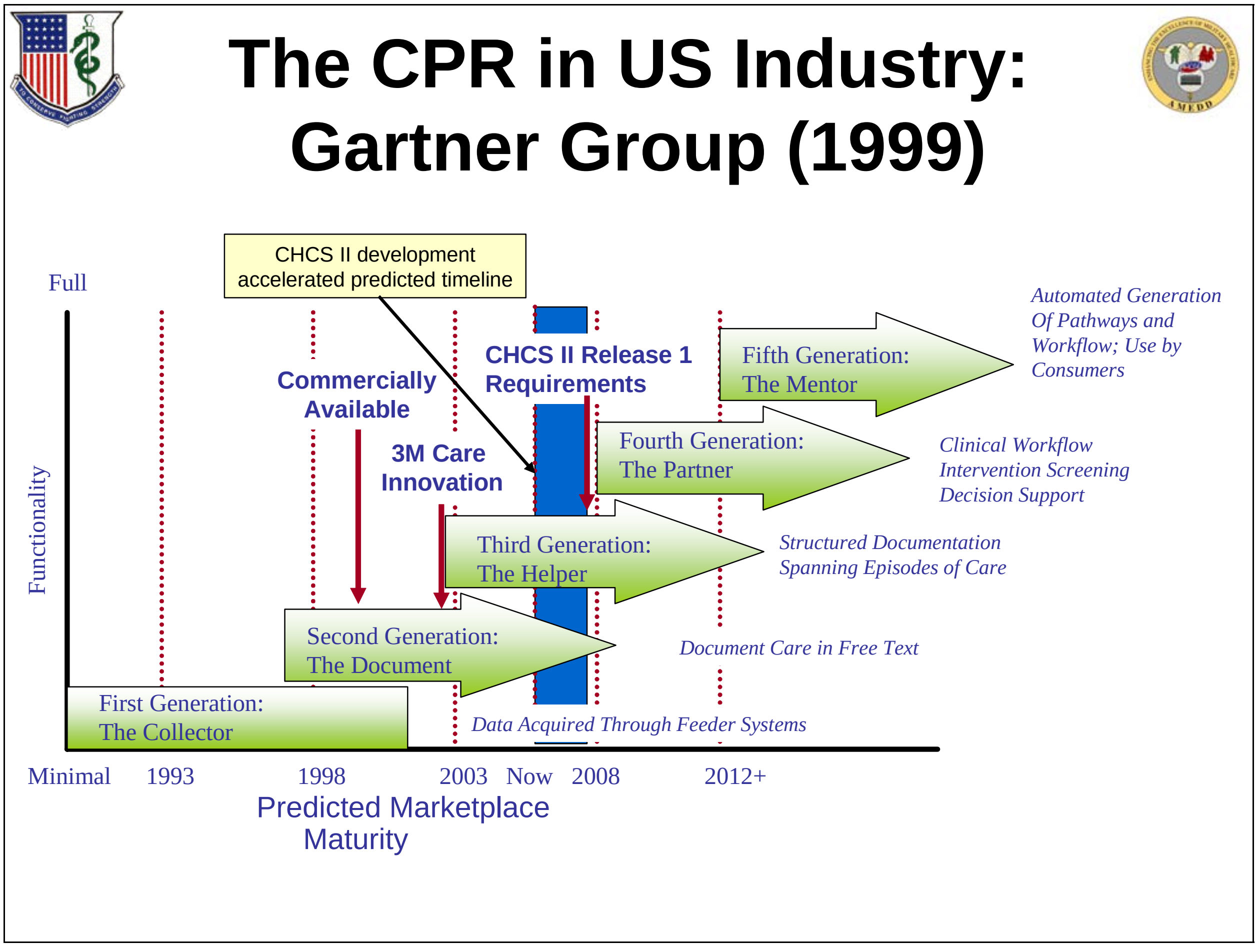
Note: A problem that is listed as Acute will automatically be removed in 6 months. We are working to get that reduced to 1 month to save time spent on maintaining the problem list.

If this process is completed while an encounter is open, you will have to use the AutoCite refresh button to update your encounter with the current information in the problem list. Click on the AutoCite button to reload the current information.



Adding/Deleting Surgical and Family History is done using a similar method.

Appendix A



The CPR in US Industry:
Gartner Group (1999)
CHCS II development accelerated predicted timeline
Full
Functionality
Commercially Available
3M Care Innovation
CHCS II Release 1 Requirements
Fifth Generation: The Mentor
Automated Generation Of Pathways and Workflow; Use by Consumers
Fourth Generation: The Partner
Clinical Workflow Intervention Screening Decision Support
Third Generation: The Helper
Structured Documentation Spanning Episodes of Care
Second Generation: The Document
Document Care in Free Text
First Generation: The Collector
Data Acquired Through Feeder Systems
Minimal
1993
1998
2003
Now
2008
2012+
Predicted Marketplace Maturity