Provider (See also Section VI — Best Practice for Utilizing Other Technologies with AHLTA)

1. Reviews information entered by staff. *(Notes: If in a wireless environment and using a laptop or tablet this can be done prior to entering the exam room to speed up the encounter. Without wireless, the review is conducted by clicking on the S/O section. The provider should limit the numbers of jumps from S/O to A/P as this adds time to the encounter. This issue is resolved in Build 3.2.)*

   A. Assumes control of the S/O note started by staff using the "EDIT—NO—YES" steps and edits initial information entered by staff if needed.

   B. Addresses pain and compliance issues, as appropriate, in encounter note

2. S/O—Completes S/O using AIM form specific for voice recognition pilot. It will usually be most efficient to complete the A/P section with the patient present and then dictate the A/P section immediately after the patient leaves the exam room. Extra noise in the room and interruptions make dictation specifically and S/O completion generally more difficult.

   A. AIM form for specialty is designed with specialty input. The AIM form contains only necessary terms for clinical documentation and to meet coding or other requirements. The MEDCIN terms chosen often take into account the fact that only ½ page or 2,000 characters can be entered into any comment or free text box in AHLTA. The only area that can accept large areas of free text is the AddNote section.

   B. Recommended Work process

      1) Utilize the team documentation and update Problem List and Past Medical History items in the problem list. DO NOT use free text or dictation to add past medical, surgical, or family history in the note. Entering the information on the problem list allows this data to be entered once by all providers.

      2) After reviewing the items entered by staff, move the appropriate free box after a MEDCIN term to enter free text. You can type, dictate, or use handwriting recognition for this. Dictate only the finding related to that term. Remember that the limit is ½ page.

      3) Continue dictating or entering free text to complete your note as above.

      4) It is also important to use narrative comments in the Comment Box under the Diagnosis in the A/P window. This can also be done by typing, dictation, or handwriting recognition.

      5) If there is a lengthy comment or discussion that needs to be added to the note, the AddNote section should be utilized.
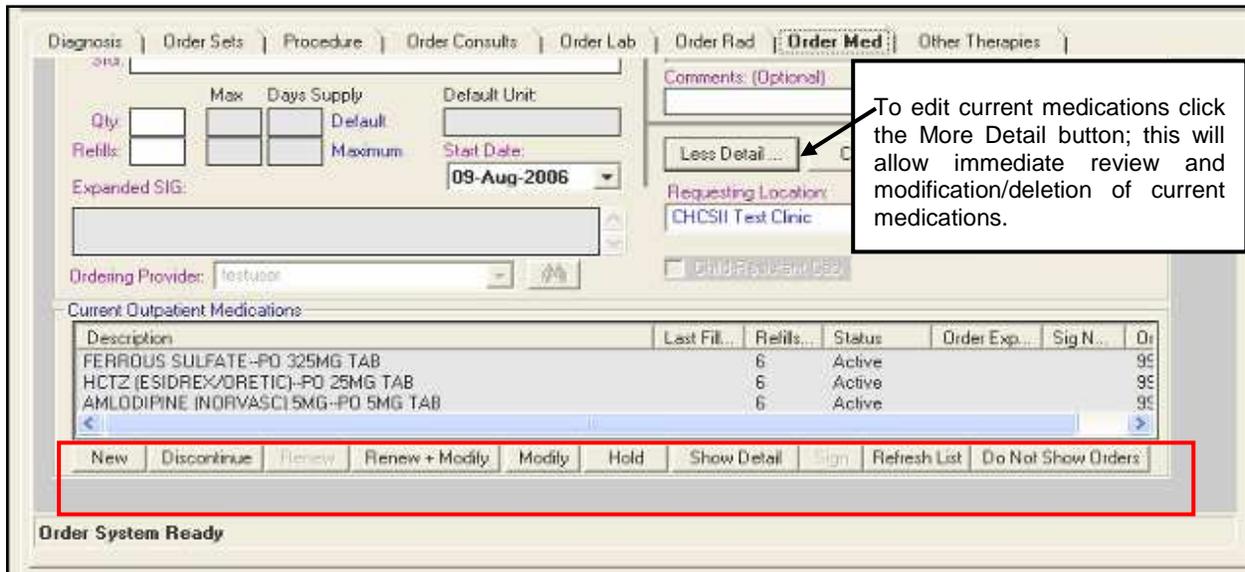
3. A/P Module *(Note: If using a tablet, it is best to have the tablet in keyboard mode as the A/P section is not optimized for tablet entry.)*

   A. Diagnosis and Procedures

      1) Use the patient Problem List to re-enter the previous diagnosis by double-clicking. This is the fastest method and keeps the Problem List cleaner. (The ability to do this is fixed in AHLTA Version 838.20).

      2) The pre-configured Clinic Favorite List should include most common Diagnoses and Procedures.

      3) The Order Set attached in the default encounter template can also include those ancillary orders that are most commonly used in the clinic or by the individual.

To edit current medications click the More Detail button; this will allow immediate review and modification/deletion of current medications.

B. Medications

    1) Enter modifications to any medication that the person is currently taking, to include modifying current prescriptions and deleting/making inactive medications that are duplicates or no longer needed.

    2) As noted, most short-term medications that are prescribed should be on the Order Set tab that is associated with the specific AIM form being used.

    3) The provider should add any OTC meds or adjust items entered by staff via the medication module.

C. Wellness Reminders — Sign or address wellness reminders as appropriate.

D. Past Medical or Surgical History — Update/modify as appropriate using the Problem List if the staff has not completed or if modifications are needed.

E. Ancillary Orders

    1) Common orders should be included in the order set associated with the AIM form in the default encounter template.

    2) Clinic favorites for each of the ancillary tests should also be created and used to prevent searching for items.

4. Readiness Module (when mapped)

A. Review items

B. Documents

    1) PHA Date completed (Date of that exam).

    2) Deployable status — as of that date.

C. Use AHLTA profile module as appropriate

5. Signing — Signing notes indicates review and concurrence with team-entered documentation.

6. Future State:

A. Vital signs will no longer have to be clicked in template or AIM form. The patient status as an established or new appointment will also be automatically determined. (Part of Coding automation enhancements — Build 844)

B. The provider will be automatically signed into CHCS and the CDR so that module changes will be faster at the point they open a patient's encounter. (Part of Performance Enhancement — Build 844).