

MITRE / FLUX NOTES USE CASES: SELF-DOCUMENTING ENCOUNTER v01

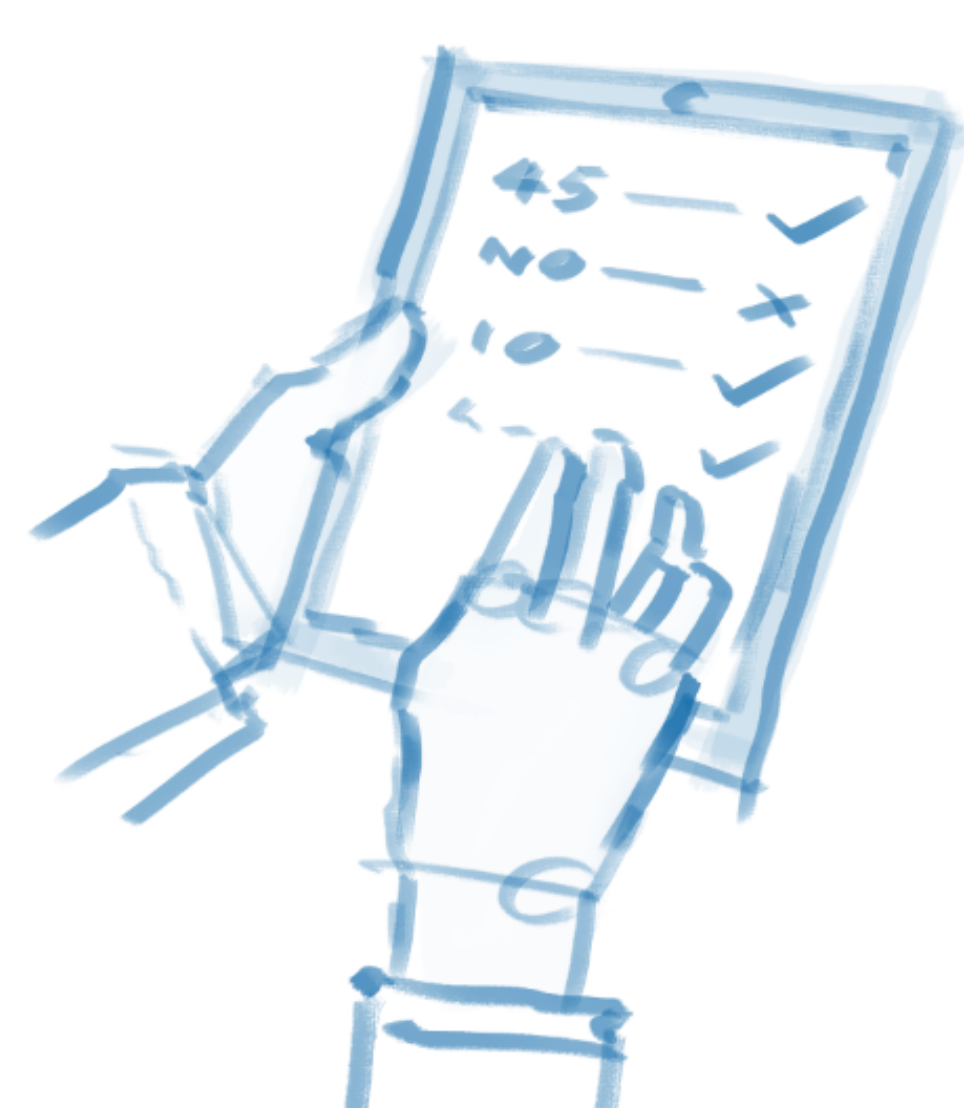
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Self-documenting encounter

The clinician opens FluxNotes and selects a visit-type template as she begins the exam. The patient discusses her concerns, and they discuss. The system listens, analyzes, and populates a note. The clinician then suggests a change in medication and a follow up visit. The system has already produced tentative changes in the SHR, along with new visualizations of the medication plan for them to review together. After the visit, the clinician quickly reviews the entries in the note, confirming or rejecting each one. She finishes by signing the note. (v4)

Encounter



Provider

Opens Flux Notes

Opens Flux Notes and the content is targeted to the specific specialty, encounter, and condition.

Selects template

Selects visit-type template as she begins encounter.

Discuss patient

Provider listens and discusses concerns with the patient.

Care plan review with patient

Provider reviews the generated plan of care with the patient.

Provider verifies care plan

Based on the new information, the clinician accepts the new care plan.

Provider verifies care plan

Based on the new information, the provider suggests a medication change.

Review new care plan with patient

Reviews the new plan of care with the patient.

Provider verifies clinical note

After the visit, the clinician quickly reviews the entries in the note, confirming or rejecting each one. She finishes by signing the note.



Flux Notes

Content curation

System organizes health record content to target to the specific specialty, encounter, and condition.

Autopopulate note

Autopopulates authoring note with relevant patient health record information.

Voice interaction

System listens, analyzes, and populates a note, and captures tentative SHR data.

Voice interaction analysis

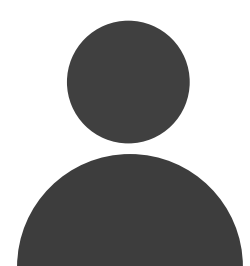
The system suggests a plan of care based on the new information, and produces visualizations for the patient and provider to review together.

Care plan update

The system produces tentative changes in the SHR, along with new visualizations of the medication plan for the patient and provider to review together.

Patient record update

The system saves the provider reviewed SHR data into the patients EHR.



Patient

Discusses concerns

Patient discusses concerns with the provider, including new information such as experienced side-effects.

Care plan review with provider

Patient reviews the generated plan of care with the provider.