



CHCS II Block 1 User's Manual Build 837.1

for the

Composite Health Care System II

Prepared for:

The CHCS II Program Office

and the

MHS Clinical Information Technology Program Office

6 October 2004

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Table 1: CHCS II Block 1 Changes

Functionality	Build	Module	Date
Medicomp Forms Tool	834	S/O (38.3)	3/9/04
Group A	835	Vitals (42.3)	4/29/04
Template Mgt Ph 1	835	Template Management	4/29/04
Allergy/Appt Triggers	836	Appointments Allergies	7/16/04
APV Turn-off	833.8 836	Appointments (6.4) Disposition (13.2)	7/16/04
CAC	836	Getting Started (1.6)	7/16/04
HIPAA 837	836	Appointments (6.4) A/P (8.2) Disposition (13.2) Screening (36.3) Vitals (43.3) Navigation Patient Encounter	7/16/04
IBWA	836	Appointments (6.4) Patient Encounter Previous Encounters Medications (19.3)	7/16/04
Immunizations Ph 1	836	Immunizations	7/16/04
Snareworks 5.16	836	Getting Started (1.2)	7/16/04
Wellness Enhancements	836	Wellness A/P (8.7) Reminder Mapping	7/16/04
Training System Convergence	837	CHCS II Training System	8/18/04
Hear 3.0	833.8 837	PKC Couplers	8/18/04

Table 1: CHCS II Block 1 Changes

Functionality	Build	Module	Date
Army Profiles	833.8 837	Army Profile	8/18/04

CHCS II User' Manual

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1.0 GETTING STARTED

1.1 CHCS II Overview

As the target healthcare system of the Department of Defense (DoD), the Composite Health Care System (CHCS) II provides a structured framework for accessing and integrating medical information for patients. CHCS II is the Military Health System (MHS) Computer-based Patient Record (CPR). It provides the DoD with an enterprise-wide system, governed by universal standards integrating data from multiple sources and displaying the data at the point of care. Appropriate portions are easily accessible to authorized users when and where needed. The CPR facilitates the worldwide delivery of healthcare, assists clinicians in making healthcare decisions, and supports leaders in making operational and resource allocation decisions.

CHCS II provides the essential capabilities, as identified by the functional community, to support the creation of a CPR. CHCS II integrates the best of Government and commercial off-the shelf (COTS) products by interfacing the existing MHS Automated Information Systems with new functionality.

1.2 Security Overview

CHCS II is installed in Military Treatment Facilities (MTFs) and clinics throughout the world. As the security of patient data is of paramount importance in the military's healthcare community, an elaborate and effective security methodology has been built into CHCS II. The system administrator strictly controls access to all parts of CHCS II.

An integral part of CHCS II security is the assignment of roles. Each user is assigned a CHCS II role. This role is determined by the user's job skill set. These roles are cumulative, allowing greater access to patient information as roles are added. Similar in concept to the CHCS user level, an individual's role determines what information can be accessed or changed.

CHCS II is developed to provide an interface to data contained in the military health care systems. The CHCS II product provides the DoD clinical team members with a single-sign-on capability to retrieve patient data from multiple sources and locations without the need to manually access each information repository. With the single-sign-on feature, CHCS II account users are able to retrieve site information stored in the Clinical Data Repository (CDR) at Defense Information Systems Agency (DISA) and to access their local CHCS application. The CHCS II account resides on the Enterprise Master Security Server (EMSS) at DISA with local control at each Host MTF.

The local access to the Enterprise system is granted, managed and inactivated at the local sites using the local security object, similar to the CHCS account creation, granting access to the local CHCS. The management of the local access to CHCS II is designed to meet MHS and DoD account management guidelines, while the Enterprise account remains intact for successful transfer to other CHCS II MTFs and access to global user account information. Local sites do have the capability to delete the

Enterprise accounts in the event of a security violation. User accounts can and will be suspended after 45 days and disabled/inactivated after 120 days of non-activity, or when a user leaves the MTF.

The CHCS II Enterprise account enables users to transfer from one CHCS II MTF to another CHCS II MTF, for reassignment or Temporary Duty (TDY), and continue to access their CHCS II account settings, such as personal templates, and gain access to the new CHCS II MTF clinical information. This process is referred to as Transferring a CHCS II account.

1.3 Account Creation Process

CHCS II user account creation is an automated process. This process is initiated with the creation of the CHCS user account. Upon creating and flagging the CHCS user account with the settings “Active CHCS II user,” the user account information is sent to the CDR and to SnareWorks to create the user account on the EMSS. Once the EMSS receives the request for the account, the system sends an email to the Security Administrator(s) at the local site, notifying the site that the account is ready for activation. The site system administrator then assigns the appropriate roles and privileges and provides local access to the CDR and CHCS.

Upon CHCS II account accreditation, the Security Administrator, through a local process, notifies the user that his/her account has been accredited and he/she can proceed to log into CHCS II. The user logs in to CHCS II using the CHCS Access/Verify code and is prompted to change his/her password and enter a new User ID. This updates the CHCS Verify code (password) and provides the user with a username for entering CHCS II and CHCS (single sign-on), but does not change the CHCS Access code.

Note: According to the MHS Security Guidelines, the CHCS II password must meet the following criteria.

- Minimum of 8 and maximum of 20 characters
- Minimum of 1 numeric character
- Minimum of 1 non-alphanumeric character
- Mixture of case
- It should not be previously used CHCS Verify code
- @ sign cannot be used in user ID or password
- Passwords must not consist of words found in the dictionary
- May not be names, dates, etc., that are easy to guess

In order to properly synchronize Clinical Workstation (CWS) user accounts between CHCS II and CHCS, passwords can neither exceed twenty (20) characters nor include the caret “^”, semi-colon “;”, colon “:”, or dash “-” special characters.

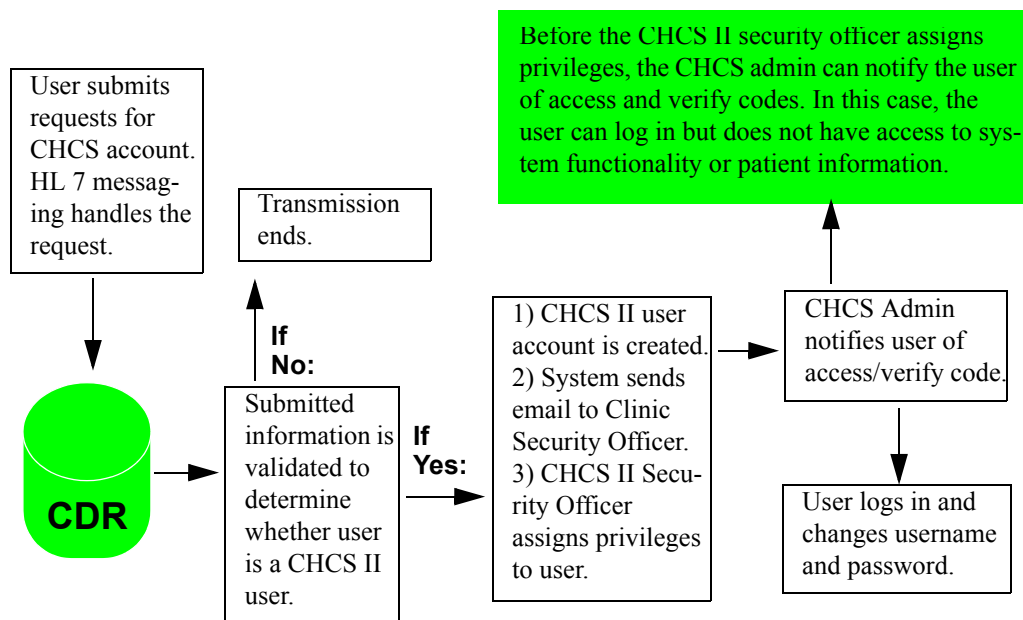


Figure 1-1: Account Creation Process

1.4 Transferring an Account from One MTF to Another MTF

Individuals who are on Permanent Change of Station (PCS) or are on Temporary Duty (TDY) to another CHCS II MTF can access their CHCS II account with the same user defaults and templates.

Follow the steps below to transfer an account to a new CHCS II MTF:

1. The user registers for a CHCS account at the new location to begin the account creation process. When account information is sent to the CDR, it is associated with the existing CHCS II information.
2. The system administrator at the new location must still credential the new account at the new MTF.
3. Once the Security Administrator accredits the local account with the CHCS II account information, the user is able to access the local CHCS and the site specific information on the CDR with his/her CHCS II User Name and Password. If the CHCS II account has not been accredited at the new MTF, the user can only access global information, such as Internet access.

Note: If a user prefers to have his/her new MTF Access and Verify code match his/her existing CHCS II User Name and Password, the user needs to contact the Security Administrator to have his/her account information updated.

1.5 Account Management

The ability to manage accounts is accessed through the local sites' Account Management web page. When users access the web page with their CHCS II logon information, they have the ability to reset passwords and change their personal contact information.

1.6 Logging Into CHCS II

There are two methods used to login to CHCS II:

- CHCS II Icon on Windows desktop
- Common Access Card (CAC)

Follow the steps below to login to CHCS II from the Windows desktop:

1. Double-click the **CHCS II** icon located on the Windows Desktop. The Snare-Works security warning window opens.



Figure 1-2: CHCS II Icon

2. Review the information in the window and click **Acknowledge** to accept the security message. The Login window opens.

A screenshot of a login window titled "Military Clinical Workstation Login". On the left is the Department of Defense seal. The text says "Please enter your user id and password to login." There are two input fields: "User Id:" and "Password:". Below the fields are three buttons: "CAC Login", "OK", and "Cancel". At the bottom, it says "First time users click [here](#) to setup a CHCSII account."

Figure 1-3: CHCS II Login Window

3. In the User ID field, enter the assigned User ID.
4. In the Password field, enter the assigned password.
5. Click **OK**. Upon successful login, the Military Clinical Desktop displays, configured as it was upon the last exit.

Note: This method of login is always available if you do not have a CAC or if login to CHCS II using your CAC fails.

Follow the steps below to login to CHCS II using a CAC:

1. Double-click the **CHCS II** icon located on the Windows Desktop. The Snare-Works security warning window opens.



Figure 1-4: CHCS II Icon

- Review the information in the window and click **Acknowledge** to accept the security message. The Login window opens.



Figure 1-5: Login Window

- At the Login screen, insert your CAC and click **CAC Login**.
- At the CAC Login screen, enter your 8-digit PIN.



Figure 1-6: CAC Login

Note: The first time you use your CAC to login to CHCS II, after you enter your PIN, you are prompted to enter your normal User ID and password for validation purposes. Thereafter, you need only insert your CAC and 8-digit PIN to login to CHCS II.

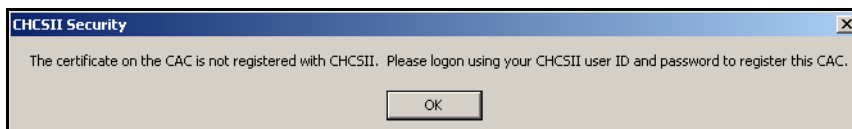


Figure 1-7: CHCS II Security Window

- Click **OK**. The Login screen displays.



Figure 1-8: Login Window

6. Enter your CHCS II User ID and Password and click **OK**. You are logged into CHCS II. As stated in the Note above, the next time you login you do not have to perform steps 5 and 6.

Note: If you make an error entering your PIN you receive the message shown below. After three unsuccessful attempts at entering your PIN, the CAC is locked. See your local CAC issuer for assistance.

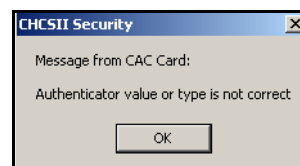


Figure 1-9: Warning Window

Note: If you want to leave the workstation, you may lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you reinsert your CAC and 8-digit PIN. During the time your session is locked, other users can use the workstation by inserting their CAC and 8-digit PIN or by using normal login procedures.

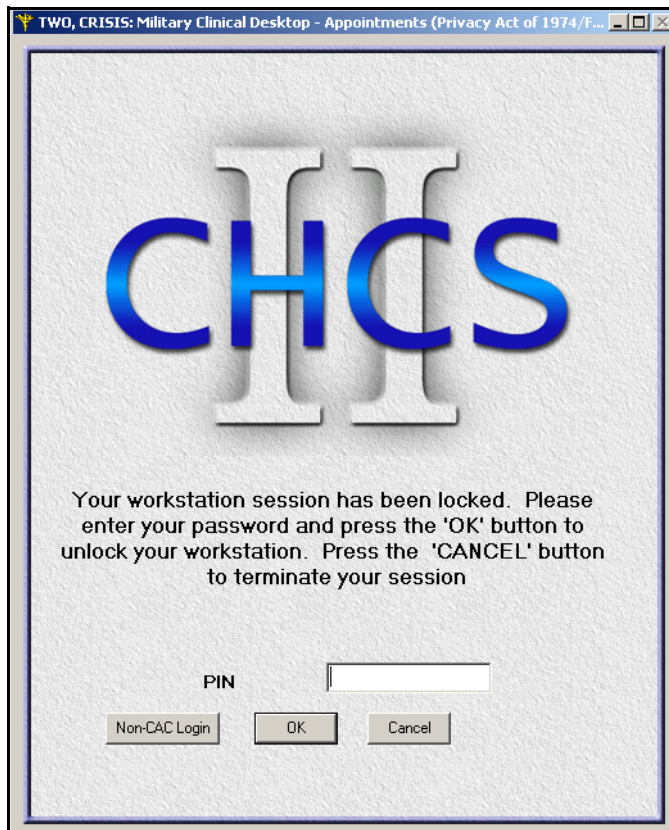


Figure 1-10: Log In Window

1.7 Changing the CHCS II Password

Upon 85 days after the creation of a new account or the last password change, the system prompts users to change their password within 5 days. This can be done directly through CHCS II. Changing the CHCS II password automatically changes the CHCS Verify code.

- If user does not change the password within 5 days, the account password is blocked. The Security Officer needs to unblock the account from the Web interface.
- If user does not log into CHCS II for 90 days, the system automatically places the account into dormant stage. The MTF must log a CHCS II Tier 1 ticket for assistance to remove an account from the dormant stage.

1.7.1 Changing CHCS II Password

Follow the steps below to change the CHCS II password:

1. Access the File menu and select **Change Password**.

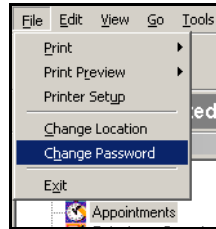


Figure 1–11: Change Password

2. Enter the existing password in the **Enter Old Password** field.
3. Enter the new password in the **New Password** field.

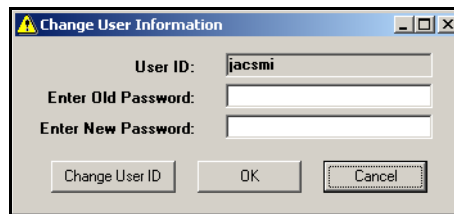


Figure 1–12: Change User Information Dialog Box

4. Click **OK**. A message displays stating that the password has been successfully changed.

1.7.2 Changing CHCS II User ID

Follow the steps below to change the User ID (username):

1. Access the File menu and select **Change Password**.
2. Click **Change User ID**.

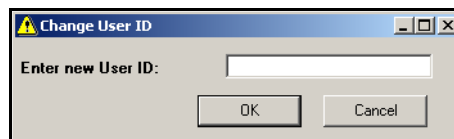


Figure 1–13: Change User ID Dialog Box

3. In the Change User ID dialog box, enter the new user ID in the **Enter New User ID** field.
4. Click **OK**. A message displays stating that the user ID has been successfully changed.

1.8 Exiting CHCS II

To exit CHCS II, do one of the following:

- Access the File menu and click **Exit**.

OR

- In the upper right-hand corner, click the ‘X’ as you would for any Windows application.

1.9 Protecting Sensitive Material

Do not provide data to persons contacting you by phone. Keep patient reports and confidential materials in a secure location. Report suspicious or malicious activity to your supervisor.

1.10 Protecting Your Assigned Username and Password

Change your password every 85 days. Create a password that avoids obvious words and combinations, such as your spouse's name, birthday, or telephone number. Do not use job titles. Use a maximum of eight characters, mixing letters and numbers. Never disclose your password to others. Memorize your password; do not write it down.

1.11 Protecting Your Workstation

Never leave your workstation unattended. Do not use password-protected screensavers—you must log off or lock CHCS II. You can lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you enter your CHCS II password in the CHCS II Lockout screen or reinsert your CAC and enter your 8-digit PIN. Position your workstation monitor so that it cannot be observed by passers-by. Never use a disk of unknown origin. Do not load unauthorized software onto the workstation. Make no changes to any workstation settings unless directed to do so by your supervisor.

1.12 Break the Glass Privileges

CHCS II provides authorized individuals with “Break the Glass” privileges to access sensitive patient information.

There are three types of users involving the “Break the Glass” privilege:

- Users who do not have the privilege at all.
- Users who do have the privilege.
- Users who already have the authority to see sensitive data and do not need the privilege.

If you have “Break the Glass” privileges, you receive a warning when trying to access sensitive data.

Click **Yes** to accept the warning message and view the sensitive results. CHCS II logs and audits this access.

If you do not want to accept the warning message, click **No**. You cannot view the sensitive information.

2.0 CHCS II NAVIGATION

2.1 Navigation Basics

The appearance and navigation functions within CHCS II are very similar to the appearance and navigation systems employed in other Windows operations. Many of the common icons for Windows are also used by CHCS II. For example, the icons in the upper-right corner of the screen are Minimize, Maximize, and Close. The Plus (+) and Minus (-) signs are called expand and collapse icons and are used to show that there are more folders above or below the folder that is currently being used. Also note that when a topic is selected, the icon text on the folder list becomes highlighted.

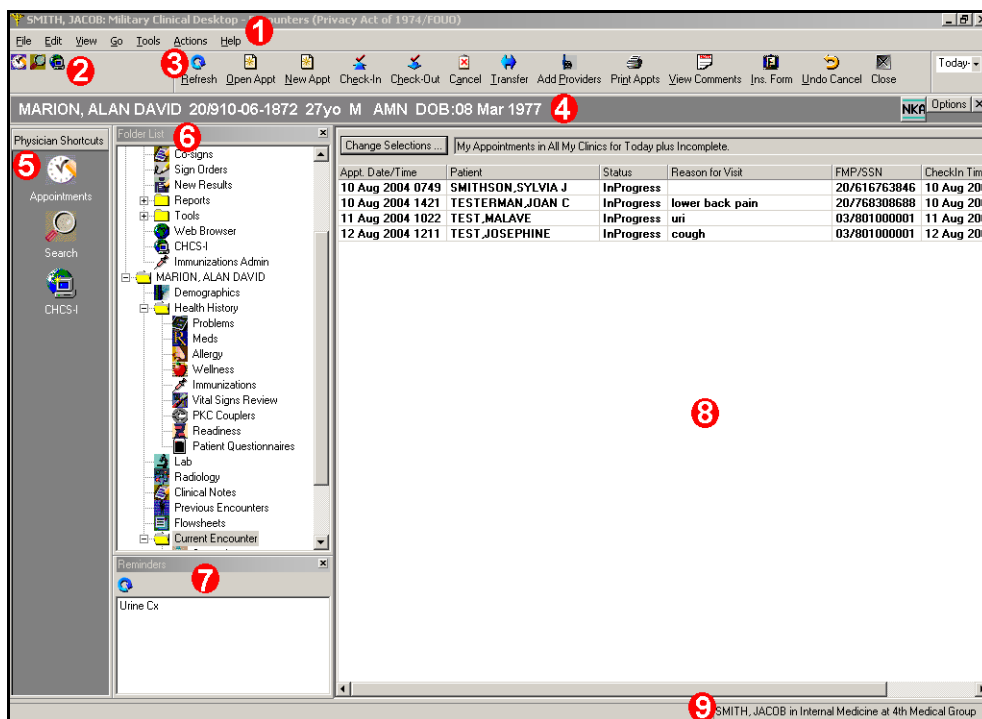


Figure 2-1: Military Clinical Desktop

1. **Menu Bar:** The Menu bar is located at the top of the application's user interface. It allows you to perform various functions that are Windows based (e.g., print, copy, paste), navigate to modules in CHCS II, and customize the appearance of CHCS II based on your user account.
2. **Tool Bar:** The Tool bar is located under the Menu bar and allows you to access CHCS II modules. You can customize the modules that display in the Tool bar to show words, icons, both, or nothing at all by accessing the View pull-down menu.
3. **Action Bar:** The Action bar is an extension of the Tool bar. It contains functionality that pertains to individual modules. As modules are opened and closed, the items on the Action bar change.

4. **Patient ID Bar:** The Patient ID bar is located under the Tool bar and Action bar. It includes Patient Demographic information and icons denoting Special Work Status, Command Interest, Command Security, allergy information and user alerts.
5. **Shortcuts:** Like the Tool bar, the Shortcuts allow you to access CHCS II modules. Clicking on a particular icon or label opens the associated module. The Shortcuts can be customized to show words, icons, both, or neither by accessing the View pull-down menu.
6. **Folder List:** The Folder List displays icons pertaining to the modules that are on the desktop in an hierarchical manner. It allows all of the folders within the system to be seen. The Folder List can be hidden using the View pull-down menu.
7. **Reminders Pane:** The Reminders Pane displays a listing of Wellness Reminders that are due for the selected patient. If a patient encounter is opened, double-clicking on a reminder navigates you directly to the Reminders tab in the Assessment and Plan (A/P) module so that you can address the reminder.
8. **Workspace:** The Workspace displays the open module and is where most actions are performed.
9. **Status Bar:** The Status bar is located at the bottom of the application and shows details about the screen currently displayed. The Status bar can be hidden using the View pull-down menu.

2.2 Customizing the CHCS II User Interface

You can customize CHCS II to match how you navigate through and use the application. CHCS II allows you to display or hide the Tool bar, Action bar, Shortcuts, Folder List, and/or Status bar.

2.2.1 Viewing/Hiding Folders

Follow the steps below to view/hide folders:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Click **Folders** to view or hide the Folder List. A checkmark indicates that the Folder List is viewable.

2.2.2 Viewing/Hiding Shortcuts

Follow the steps below to view/hide Shortcuts:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Shortcuts** to display the Shortcuts sub-menu and select either **Large Icons** or **Small Icons** to view or hide the Shortcuts bar.

2.2.3 Viewing/Hiding the Action Bar

Follow the steps below to view/hide the Action bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Action Bar** to display the Action Bar sub-menu and select one of the following:
 - **Icons:** Icons displays only icons on the Action bar.
 - **Text:** Text displays only text on the Action bar.
 - **Both:** Both displays icons and text on the Action bar.
 - **None:** None hides the Action bar.

2.2.4 Viewing/Hiding the Tool Bar

Follow the steps below to view/hide the Tool bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Hover your mouse over **Tool Bar** to display the Tool Bar sub-menu and select one of the following:
 - **Icons:** Icons displays only icons on the Tool bar.
 - **Text:** Text displays only text on the Tool bar.
 - **Both:** Both displays icons and text on the Tool bar.
 - **None:** None hides the Tool bar.

2.2.5 Viewing/Hiding the Status Bar

Follow the steps below to view/hide the Status bar:

1. Click **View** on the Menu bar. The View pull-down menu displays.
2. Click **Status Bar** to view or hide the Status bar. A checkmark indicates that the Status bar is viewable.

2.2.6 Customizing the Tool Bar and Shortcut Options

The Tool bar is located below the Menu bar and allows you to access modules you customized to display in the bar. Module icons and/or text display, depending on whether or not they are patient-specific or encounter-specific. Modules that are added to the Tool bar are also added to the Shortcuts.

Follow the steps below to customize the icons:

1. On the **View** menu, point to **Tool Bar** and click **Customize** to open the Customize Toolbar window.
2. From the Available Toolbar Buttons picklist, select the module icon(s) you want to display in the Tool bar.

3. Click **Add** to add the selected module icon(s) to the Selected ToolBar Buttons picklist.

Note: You may drag and drop button icons within the Selected ToolBar Buttons picklist to determine the order of presentation on the Tool bar. The icons and/or text display according to whether they require a loaded patient record, open encounter, or neither.

4. Click **OK**.

2.2.7 Opening a Module

There are generally four ways to access individual modules.

- In the Folder List, click the icon associated with the module you want to open.
- On the Shortcuts bar, click the icon associated with the module you want to open.
- On the Tool bar, click the icon associated with the module you want to open.

Note: Icons on the Shortcuts and the Tool bar are only present if the desktop has been customized to include them.

- Access the Go pull-down menu from the Main menu bar and select the desired module. All other modules can be found under the Tools pull-down menu.

2.3 Closing a Module

There are three ways to close a module. It is best to close each module before opening a new one. The modules are opened one on top of the other and use unnecessary memory.

Perform one of the steps below to close a module:

- Use the Actions pull-down menu and click **Close**.
- On the Action bar, click **Close**.
- In the upper, right-hand corner of the Workspace, click **X**.

2.4 Startup Options

CHCS II allows you to determine the module you want to display when you login to the application. These modules are not patient-specific; therefore, you do not need a patient record loaded or an encounter open.

Follow the steps below to select the module you want to display when you login:

1. On the Tools menu, click **Startup Options** to open the Startup Options window.

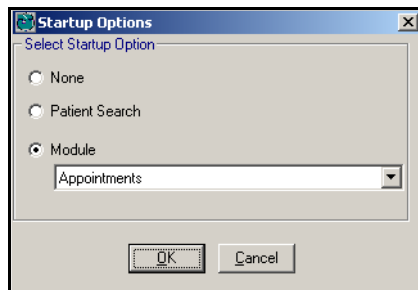


Figure 2-2: Startup Options

2. Select one of the options:
 - **None:** A blank workspace is displayed when you login.
 - **Patient Search:** The Patient Search module is displayed when you login.
 - **Module:** A module selected from the drop-down list is displayed when you login.
3. Click **OK** to save the selection. The change takes effect with your next login.
















2.5 Patient ID Bar

The Patient ID Bar is located under the Menu bar and includes patient demographic information and icons denoting Special Work Status, Command Interest, Command Security, allergy information and user alerts.

Patient-specific information is displayed when a patient record has been selected.

- Work Status can be documented in the Screening, Demographics, or Disposition modules. The Work Status icons are only documented in CHCS II and do not interface with other systems.
- The Allergy icons are based on the entries from the Allergy module and entries in CHCS.
- Command Interest and Command Security information is pulled from CHCS and is displayed on the Demographics module.
- An alert icon is displayed if you have items needing your attention.

2.5.1 Patient ID Bar Icons

 Diving Status	 Flying Status
 Jumping Status	 Mobility Status
 Military Police Status	 Personal Reliability Program Status
 Presidential Support Program	 Submarine Status
 Patient Has Allergies	 Allergies Have Not Been Addressed
 No Known Allergies	 Command Interest Status
 Security Command Interest Status	 New Results
 Priority Results and Co-Signs	 Orders to Sign Icon Group

The Patient ID Line icons display on the line, if applicable to the patient or user.

2.6 CHCS Access

Some functions cannot be completed within CHCS II and need to be done in CHCS; scheduling future appointments is a good example. CHCS II does contain the functionality to connect directly to CHCS through a telnet session. This window is independent of CHCS II.

Follow the steps below to access CHCS:

1. In the Tools menu, select **CHCS-I Access** or click **CHCS-I** from the Folder List.
2. A KEA! session opens, allowing tasks to be completed. CHCS II automatically logs the user onto CHCS using the user's access and verify codes.
3. Close the KEA! session by clicking **X** in the top, right corner. When the confirmation window appears, click **Yes** to return to CHCS II.

2.6.1 In More Depth

CHCS II automatically logs you into CHCS using your access and verify codes. The CHCS verify code and CHCS II password are synchronized during the CHCS II Account Creation process. This synchronization process links your CHCS and CHCS II accounts.

3.0 WORK FLOWS

3.1 Basic Front Desk Clerk Workflow

CHCS II Front Desk Clerk tasks typically include managing the appointments and demographic information. Other tasks can be included depending on the clinic and role of each individual clerk.

The basic front desk workflow may be:

1. Access the Appointments module.
2. Check-in a scheduled appointment.
3. Create a new walk-in appointment.
4. Review the demographic information and make any modifications.

Other modules the Front Desk Clerk can use include:

- Telephone Consults
- PKC Couplers
- Web Browser

3.2 Basic Support Staff Workflow

CHCS II support staff tasks typically include entering the reason for visit in the Screening module and documenting the vital signs. Other tasks can be included depending on the clinic and role of each individual.

The basic support staff workflow may be:

1. Access the Appointments module.
2. Double-click the appointment from the list.
3. From the Patient Encounter module, click **Screening** and enter the reason for visit.
4. On the Action bar, click **Vital Signs**. Enter the vital signs.
5. Close the Vital Signs module and the Patient Encounter module.
6. Return to the Appointments module to wait for the next patient.

Other modules the support staff can use include:

- Wellness
- Web Browser
- Allergy
- Clinical Notes
- Health History

- Reports
- Immunizations
- Medications
- Readiness

3.3 Basic Provider Workflow

CHCS II Provider tasks typically include selecting an encounter template, documenting the subjective and objective (S/O) portion, completing the assessment and plan (A/P), and ordering appropriate medications and laboratory and radiology tests. Other tasks can be included depending on the clinic and role of each individual provider.

The basic provider workflow may be:

1. Access the Appointments module.
2. Double-click the desired appointment.
3. Click **S/O**.
4. Select an encounter template to load into the encounter.
5. Document the exam using the various tabs from the S/O module.
6. Click **A/P**. Document the diagnosis and procedures.
7. Order radiology and/or laboratory tests, medications, or consults. Associate any procedures and/or orders with a diagnosis.
8. Click **Disposition**.
9. Complete the disposition.
10. Click **Sign**.
11. Enter the password and click **Sign**.

Other modules the Provider can use include:

- Alert Review
- Co-Signs Required
- Medications
- List Management
- Laboratory
- Patient List
- Radiology
- Flowsheets
- Problems
- Web Browser
- Consult Log

- Reports
- Previous Encounters
- Clinical Notes
- New Results
- Order Sets
- Sign Orders

4.0 ALLERGY

4.1 Allergy Overview

The Allergy module maintains current allergy information for a patient. This information is pulled from CHCS and synchronized at different times during the encounter documentation. The Allergy module allows information to be stored using data from the Healthcare Data Dictionary (HDD). A common list of allergens can also be created to make entering data more convenient.

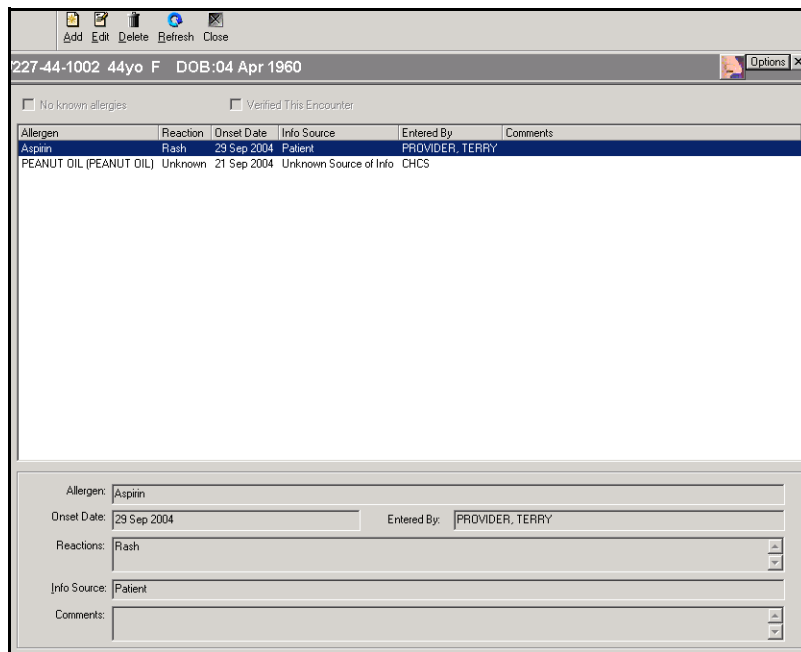





Figure 4-1: Military Clinical Desktop—Allergy Module

4.1.1 In More Depth

CHCS II uses three different Allergy icons to indicate the patient's allergy status. These icons appear on the Patient ID bar. Clicking on the allergy icon opens the Allergy module.

	No Known Allergies
	Patient Has Allergies
	No Allergies Specified

Allergy information is passed between CHCS and CHCS II every time there is a change to allergy information. Any changes in CHCS are loaded into the CDR and any changes in CHCS II are sent back to CHCS. Allergy synchronization occurs when a new unscheduled visit is created in CHCS II and when the Allergy module is opened. This ensures that the diagnoses and orders completed in each patient encounter are made with an awareness of the patient's current allergy profile. Clinical team members need to be aware of the patient's allergy profile when prescribing medications and administering immunizations; thus, allergy information is also available in the Medications and Immunizations modules.

If the patient has no known allergies, the Allergy module is blank except for the checkbox.

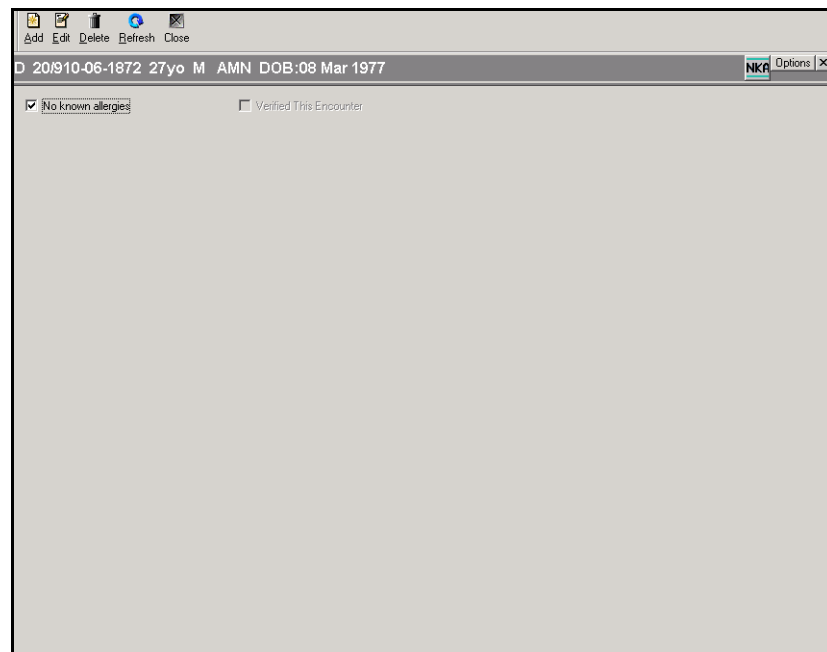


Figure 4–2: Allergy Module

Allergy information should be verified during every encounter. The Verified This Encounter checkbox is not active in the Allergy module when opening the module through the Allergy icon. The checkbox is active when the Allergy module is opened through the Screening module.

4.1.2 Creating a Common List of Allergens

The Properties window associated with Allergies allows for the creation of a list of allergens most often used. This list populates the drop-down list in the **Allergen** field on the New Allergy window. This eliminates the need to conduct a lengthy search. A default list is pre-populated when CHCS II is deployed; however, clinical team members can create their own list.

Follow the steps below to create a common list:

1. Click **Options** on the Allergy module. The Properties window opens.

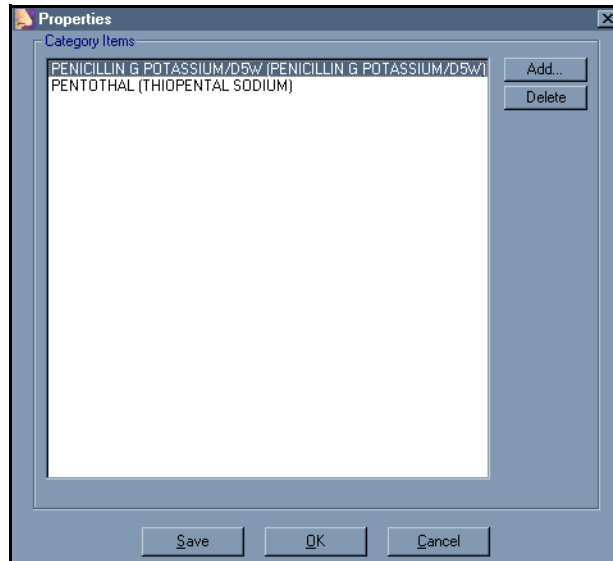


Figure 4-3: Allergy Module Properties Window

2. Click **Add**. The Add to Common List Items window opens.

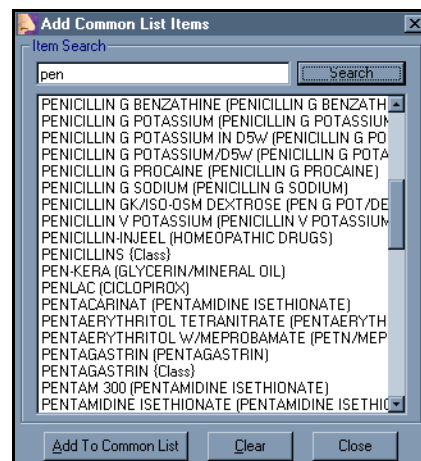


Figure 4-4: Add to Common List Items Window

3. Enter at least the first two letters of the allergen to be added.
4. Click **Search**. The search results are listed.

5. Select the desired item(s).
6. Click **Add to Common List**. Continue to add allergies to the list until all allergens you want have been selected.
7. Click **Close**. The Properties window displays the selected allergens.
8. Click **Save**.

Note: This list is combined with the pre-populated default list. Select the allergen and click **Delete** from the properties window to delete an allergen from the list.

4.2 Adding an Allergy

Clinical team members can add allergy information to a patient record through the Allergy module. If a patient has no allergies, the No Known Allergies checkbox is selected. If there is no allergy information for the patient, the No Known Allergies checkbox is available for selection.

Follow the steps below to add a new allergy:

1. Click **Add** on the Action bar. The New Allergy window opens.

Figure 4-5: New Allergy Window

2. Click **Allergen**. The Health Care Data Dictionary window opens, allowing you to search and add allergens.
3. Enter the allergen in the search field and click **Search**.
4. Select the desired allergen from the search results and click **OK**. You are returned to the New Allergy window with the selected allergen in the field.

Note: The allergen can also be selected from the common list of allergies. Access the list by opening the Allergen drop-down list.

5. Click **Reaction**. The Health Care Data Dictionary window opens, allowing you to search and add reactions.
6. Enter the reaction in the search field and click **Search**.

7. Select the desired reaction from the left column and click **Add>>** to move it to the right column. Search for and move additional reactions, as needed.
8. Click **OK**. You are returned to the New Allergy window with the selected reaction in the field.

Note: The reaction can also be selected from the common list of reactions. Access the list by opening the Reaction drop-down list.

9. Enter the appropriate information in the following fields:
 - **Info Source:** The Info Source is set by default to Patient and can be changed by selecting a different source from the drop-down list.
 - **Onset:** Enter a date in the date field (mm/dd/yyyy) to change the onset date (defaults to current date), or click **Onset** to use the Calendar.
 - **Entered By:** Click **Clinician** to open the Clinician Search window to change the associated clinician (defaults to clinician currently logged in), which allows a clinician to be selected.
 - **Comment:** In the Comment area, type any needed notes.
10. Click **Save**. The new allergy is added to the patient's list of allergies.

Note: In some instances, the exact allergen is not included in the HDD. In this case, search for and select the allergen **Other {class}**. On the New Allergy window, use the comments field to state the exact allergen.

4.3 Editing an Allergy

Follow the steps below to edit an allergy:

1. Select the allergy to be modified.
2. Click **Edit** on the Action bar. The Edit Allergy pane opens.

Figure 4–6: Edit Allergy Pane

3. Update the appropriate information in the following fields:
 - Reaction
 - Info Source

- Onset
- Entered by
- Comments

Note: The **Allergen** is not editable.

4. Click **Save**.

4.4 Deleting an Allergy

Follow the steps below to delete an allergy:

1. Select the allergy on the Allergy module.
2. Click **Delete** on the Action bar.
3. At the Confirm Deletion prompt, click **Yes**.

4.5 Verifying Allergies

Allergy information should be verified during every encounter. The verification of the allergy information, though, can only be done through the Screening module with an open patient encounter. The documentation of this process is written onto the electronic SF600 and becomes part of the medical record.

Follow the steps below to verify a patient's allergies:

1. In the Screening module, click **Verify Allergy** on the Action bar. You are transferred to the Allergies module.
2. Verify the patient's allergies in the Allergy module.

No known allergies Verified This Encounter

Allergen	Reaction	Onset Date	Info Source	Entered By	Comments
Penicillins	Rash	3/17/1962	Patient	NURSE, KAREN	

Allergen:

Onset Date: Entered By:

Reactions:

Info Source:

Comments:

Figure 4-7: Verify Allergies Pane

5.0 ALERT REVIEW MODULE

5.1 Alert Review Overview

The Alert Review module displays items that need immediate attention. It lists both primary end user and surrogate end user alerts. A surrogate end user is authorized to act on behalf of another end user. Unresolved alerts are in bold text and resolved alerts are in regular text. The gray and yellow colored alert icon in the patient ID bar signifies that an encounter needs to be cosigned, critical results and priority results. The blue and white colored alert icon signifies modified encounters, new results and orders to be signed.

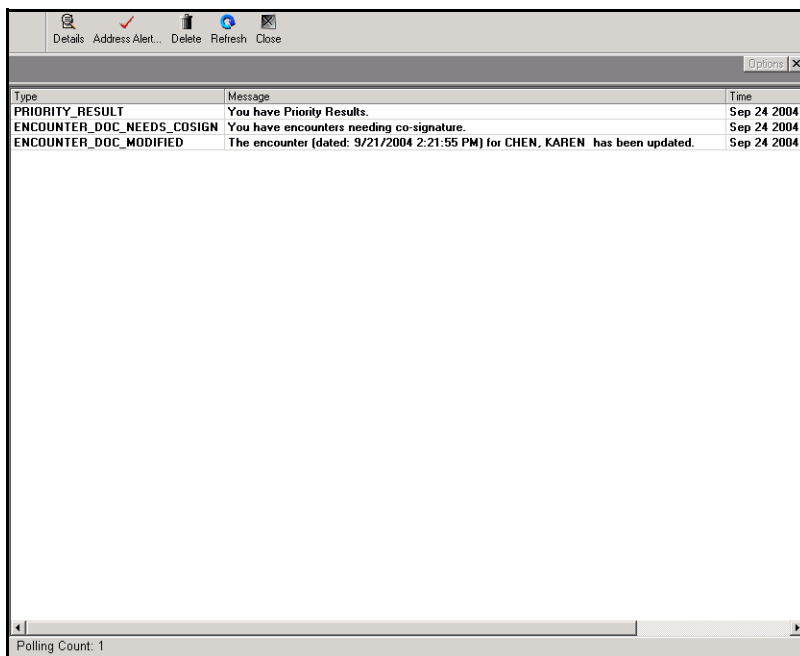


Figure 5-1: Military Clinical Desktop—Alert Review Module

5.1.1 In More Depth

An alert must be resolved within the module in which it resides.

New Result and Priority Result Alerts display as a result of actions performed in CHCS (such as lab tests). Priority Result Alerts are New Result Alerts that contain abnormal findings.

Types of Alerts:

- Encounter Doc Needs Co-signature
- You have priority results
- You have New Results

- Encounter Coding Information Has Modified
- Orders to Sign

An alert icon is displayed on the Patient ID bar when a user has an alert. Two alert icons exist, depending on the types of alerts. The gray and yellow colored alert icon signifies that an encounter needs to be co-signed and priority results. The blue and white colored alert icon signifies modified encounters, new results and orders to be signed.

If an order needs to be signed, an additional icon displays on the Patient ID bar next to the Alert icon.

5.1.2 Addressing an Alert

The primary end user or the surrogate end user can address an alert. If the primary end user addresses an alert, it is automatically removed from the list of alerts upon resolution. An alert resolved by the surrogate end user remains on the primary end user's list of alerts until the primary end user deletes it. Alerts that have not been addressed are indicated in bold text and alerts that have been addressed are indicated in plain text on the alerts list. An alert must be resolved within the module in which it resides. If, for example, you select a modified encounter alert to address, you are navigated directly to the relevant encounter in the Previous Encounters module.

Follow the steps below to address an alert:

1. Select the bolded alert.
2. Click **Address Alert** on the Action bar. The module containing the alert opens.
3. Address the alert by completing the tasks associated with the alert.
4. Click **Close**. The alert can now be deleted from the list.

5.2 Addressing New and Priority Result Alerts

New Result and Priority Result Alerts display as a result of actions performed in CHCS (such as lab tests). Priority Result Alerts are New Result Alerts that contain abnormal findings.

Follow the steps below to address new and priority result alerts:

1. Select the alert.
2. Click **Address Alert** on the Action bar. The Lab or Rad module opens, depending on the alert.
3. Select the **New Result** you want to review.
4. Either save or delete the result.

5.3 Deleting an Alert

Follow the steps below to delete an alert:

1. Select the alert.
2. Click **Delete** on the Action bar.

5.4 Viewing Details of an Alert

Follow the steps below to view details of an alert:

1. Select the desired alert.
2. Click **Details** on the Action bar. The Alert Details window opens.

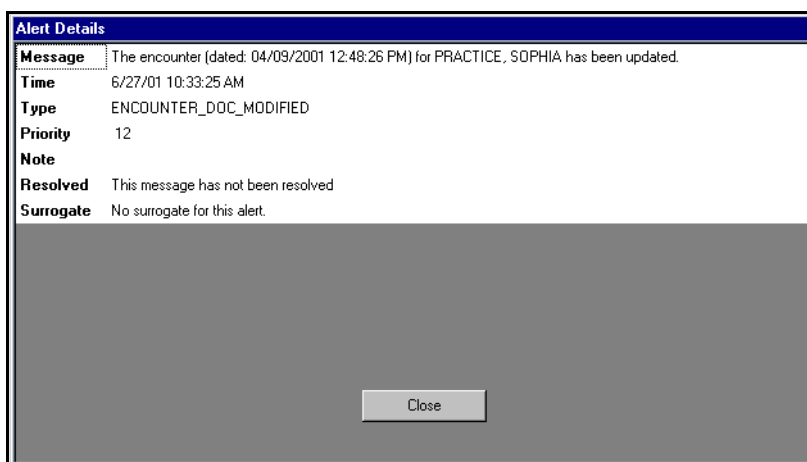


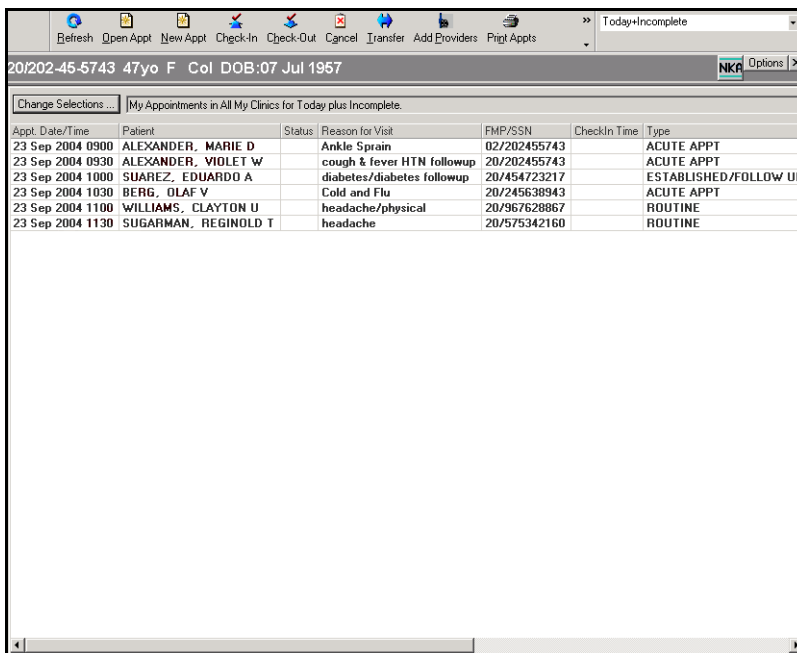
Figure 5–2: Alert Details Window

3. View detailed information on the selected alert.
4. Click **Close**.

6.0 APPOINTMENTS

6.1 Appointments Overview

The Appointments module enables appointments that have been created in both CHCS and CHCS II to be viewed according to clinics, providers, dates, or statuses. Appointments can be selected to check in, transfer, cancel, and checkout. Only unscheduled visits (walk-in, sick call) and telephone consults can be created in CHCS II. Scheduled appointments are still created in CHCS and then uploaded to CHCS II, real-time, along with appropriate patient information.



The screenshot shows a software interface for the Appointments Module. At the top, there is a menu bar with options: Refresh, Open Appt, New Appt, Check-In, Check-Out, Cancel, Transfer, Add Providers, and Print Appts. Below the menu bar, a patient information bar displays: 20/202-45-5743 47yo F Col DOB:07 Jul 1957. A toolbar contains a 'Change Selections...' button and a dropdown menu set to 'My Appointments in All My Clinics for Today plus Incomplete.' The main area is a table with the following data:

Appt. Date/Time	Patient	Status	Reason for Visit	FMP/SSN	CheckIn Time	Type
23 Sep 2004 0900	ALEXANDER, MARIE D		Ankle Sprain	02/202455743		ACUTE APPT
23 Sep 2004 0930	ALEXANDER, VIOLET W		cough & fever HTN followup	20/202455743		ACUTE APPT
23 Sep 2004 1000	SUAREZ, EDUARDO A		diabetes/diabetes followup	20/454723217		ESTABLISHED/FOLLOW UP
23 Sep 2004 1030	BERG, OLAF V		Cold and Flu	20/245638943		ACUTE APPT
23 Sep 2004 1100	WILLIAMS, CLAYTON U		headache/physical	20/967628867		ROUTINE
23 Sep 2004 1130	SUGARMAN, REGINOLD T		headache	20/575342160		ROUTINE

Figure 6-1: Military Clinical Desktop—Appointments Module

6.1.1 In More Depth

The Appointments module is comprised of several columns that can be re-arranged by clicking and dragging the columns with your mouse. The columns include the following:

- **Appt. Date/Time:** The date and time of the appointment.
- **Patient:** The name of the patient.
- **Status:** The status of the appointment (the location of the appointment in the clinical workflow—checked-in, waiting, in progress...).
- **Reason for Visit:** The reason for the patient visit.
- **FMP/SSN:** Family Member Prefix/Social Security Number.

- **Checkin Time:** The time the patient is checked in.
- **Type:** The appointment type.
- **Classification:** The status of the patient (outpatient or inpatient).
- **Home Phone:** The patient's home phone number.
- **Work Phone:** The patient's work phone number.
- **Comment:** Comments about the appointment.
- **Encounter:** A unique system generated ID that helps to track encounters.
- **Checkout Time:** The time the patient checks out. This is entered if the Check-Out option is used.
- **Appt IEN:** A unique ID generated by CHCS for an appointment that is unique for each MTF.
- **Appt ID:** A unique ID generated by CHCS for an appointment that is unique for each MTF.

The Appointments module is the default module that opens upon login. Most clinical team members use this module as a 'home base.' The individual appointment statuses can alert the team members as to where the patients are in the clinical workflow. For example, if an appointment has a status of checked-in, the support staff know that the patient is ready to be screened. Statuses include the following:

- **Pending (blank field):** CHCS scheduled appointment that has not been checked-in
- **Checked-in:** The front desk has checked-in the patient and the patient is ready for screening
- **Waiting:** The screening is complete and the patient is waiting for the provider
- **In Progress:** A clinical team member has opened the S/O, A/P, or disposition module
- **Complete:** The encounter has been signed.
- **Updating:** The signed encounter is being updated
- **Updated:** The signed encounter has been updated and re-signed
- **Needs Co-signature:** The encounter has been signed but is awaiting co-signature

Once an appointment is created, checked in, or canceled, CHCS II sends the appointment status of Kept back to CHCS. Because of this, appointments should not be modified in the End of Day processing in CHCS.

6.2 Setting the Properties of the Appointments Module

The Appointments Search Selection dialog box is used to filter appointments by clinic, provider, date and status. Once selections are made, they can be set as the default settings or for the current session only. The user can change the status that is

being viewed without using the Appointment Search Selections dialog box. A filter drop-down list can be accessed from the Appointments module.

The Appointment Search Selections dialog box is also used to set new column order defaults. First, rearrange the column order by dragging the column by the column header.

Follow the steps below to set the properties of the Appointments module:

1. On the Appointments window, click **Change Selections**. The Appointment Search Selections window opens.

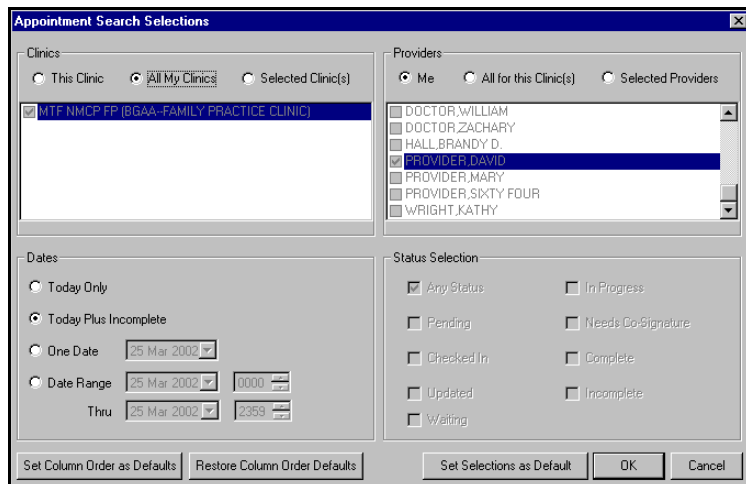


Figure 6–2: Appointment Search Selections Window

2. In the Clinic area, select the clinic(s) you want to view. If you select the **Selected Clinics** option, select the applicable clinic(s) from the list.
3. In the Provider area, select the provider(s) you want to view. If you select the **Selected Providers** option, select the applicable provider(s) from the list.
4. In the Dates area, select the appointment search date. If you select the **Date Range** option, select the applicable date range(s) from the drop-down list.
5. In the Status Selection area, select the appointment search status.
6. Click **Set Selections as Default**. The settings are now your default settings for the Appointment module. All appointments meeting the above criteria are listed on the Appointments module.

Tip:
It is recommended to set the date filter to Today Only. This will prevent the appointment list from showing appointments created prior to the implementation of CHCS II.

Tip:
The settings of the default view will primarily depend on your role. Front Desk Clerks and Support Staff generally view appointments for all clinics and all providers who are on duty on the given day. Providers usually set the filter to view assigned appointments for all clinics.

Note: To set the order of the columns, click **Set Column Order as Default**.

6.3 Filtering the List of Appointments

The list of appointments can be filtered by selecting a filter from the drop-down list in the upper-right corner of the workspace.

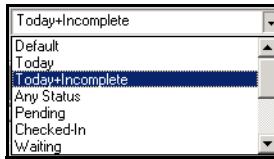


Figure 6–3: Appointments List Filter

This filter assumes the provider and clinic settings from the default filter and only changes based on the selection made. Changing the filter here only changes the view of the appointments for this session. When you open another module and then return to the Appointments module, the view is based on the default settings, set through the Change Selections button. Options include the following:

- **Default:** The Appointments filter default is set by clicking **Change Selections** and selecting the desired options. Click **Set Selections as Default** and then click **OK** to save the selections as default.
- **Today:** Appointments for the present day.
- **Today + Incomplete:** Appointments for the present day and all appointments that have a status of incomplete that fall within the selection made in the **Dates** field on the Appointment Search Selections window.
- **Any Status:** All appointments regardless of their status that fall within the selection made in the **Dates** field on the Appointment Search Selections window.
- **Pending Only:** Appointments that have a status of pending, which means they have not been checked in yet and meet the date criteria in the Appointment Search Selection window.
- **Checked In:** Appointments that have been checked in that meet the date criteria set in the Appointment Search Selections window.
- **Waiting:** Appointments for which the patient has been checked in but is waiting to be seen by the provider and meet the date criteria set in the Appointment Search Selections window.
- **In Progress Only:** Appointments that have been checked in, are in progress and meet the date criteria set in the Appointment Search Selections window.
- **Needs Co-Signature:** Appointments that must have a provider's co-signature in order to be give a completed status and that meet the date criteria set in the Appointment Search Selections window.
- **Updated:** Whenever an appointment is amended or appended, its status is changed to Updated. The updated appointments must meet the date criteria set in the Appointment Search Selections window.
- **Completed Only:** Appointments that have a completed status and meet the date criteria set in the Appointment Search Selections window.
- **Incomplete:** Appointments that are not complete and that meet the date criteria set in the Appointment Search Selections window.

- **Checked In or Pending:** Appointments that are currently checked in or show a pending status in CHCS and that meet the date criteria set in the Appointment Search Selections window.

6.4 Creating a New Appointment

Within CHCS II, only new Unscheduled Visit (USV) appointments can be created. Scheduled appointments are still set up through CHCS and are then pulled into CHCS II, along with accompanying patient information.

Telephone Consults can also be created in the Appointments module. Once scheduled, though, they can only be seen in the Telephone Consults module.

Follow the steps below to create a new appointment:

1. Click **New Appt** on the Action bar.
2. The New Unscheduled Appointment/Telcon Visit window opens, immediately overlaid by the Patient Search window. If the patient for whom the appointment is being created is already loaded, click **Cancel** on the Patient Search window.

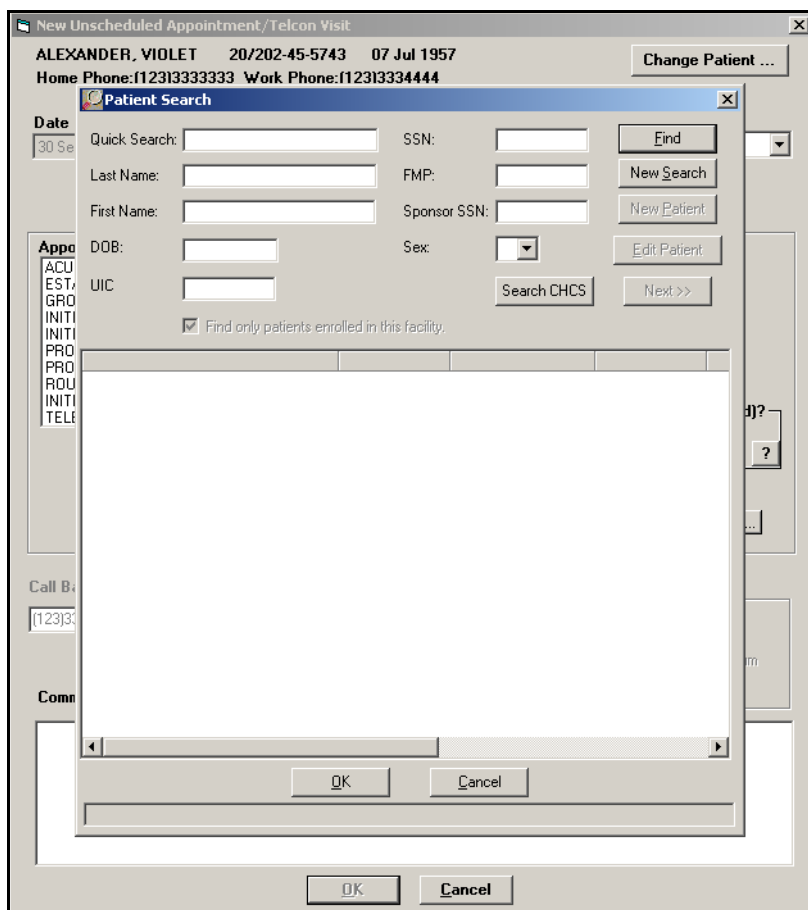


Figure 6-4: Patient Search Window

3. If the patient’s record is not loaded, search for the patient for whom you are scheduling the new appointment. After the patient record is loaded, the New Unscheduled Appointment/Telcon Visit window is fully displayed.

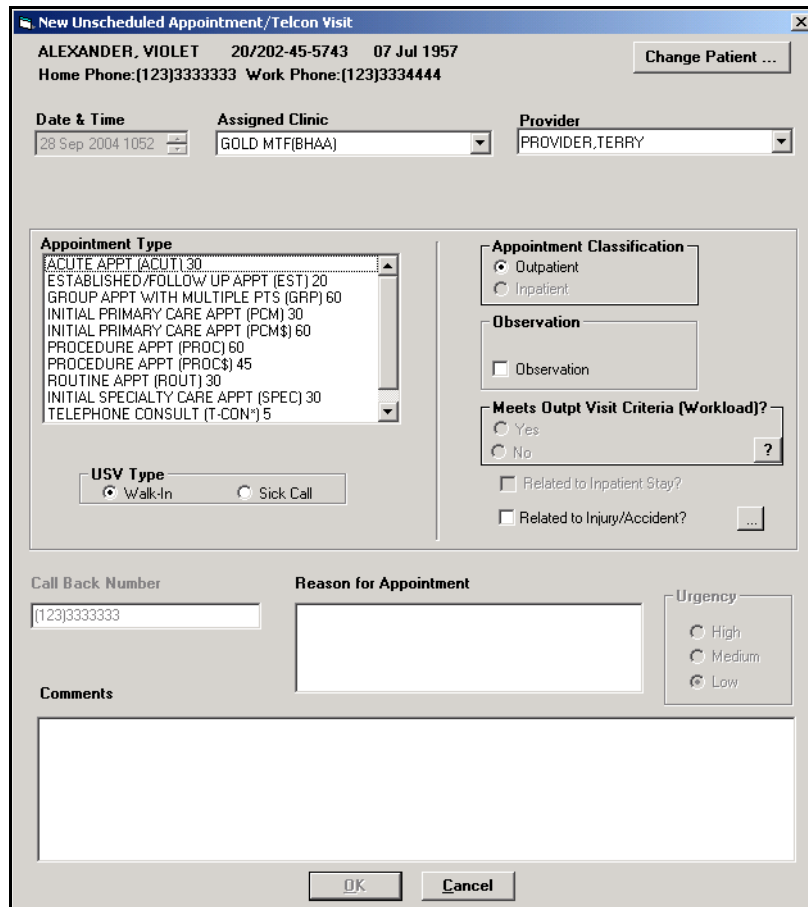


Figure 6–5: New Unscheduled Appointment Window

4. In the New Unscheduled Appointment window, complete the following fields:
 - **Appointment Date and Time:** The default is the current date and time and cannot be changed.
 - **Assigned Clinic:** Select the clinic from the drop-down list.

Note: Clinical Team Members are only able to create appointments for providers assigned to the clinics to which they have access.

- **Provider:** Use the drop-down list to select the desired provider. The provider must be associated with the selected clinic.

- **Appointment Type:** Select an appointment type from the pick list. Available options are based on the CHCS appointment types that are available for the clinic and provider selected.

Note: Appointment types with a \$ or * annotate those types of appointments that can only be created by the clinic.

- **USV Type:** Select Sick Call, as appropriate. The default is Walk-In.
- **Appointment Classification:** This is based on the appointment classification from CHCS and cannot be changed in CHCS II.
- **Observation:** Select **Observation**, if appropriate. A checkmark here effects the selection of E&M codes in the Disposition module.
- **Meets Visit Criteria:** This field determines whether this encounter is a count or no-count visit. Yes, is count; No is no-count. If No is selected, the available E&M codes are no-count codes.
- **Related to Inpatient Stay?:** If the selected patient has an appointment classification of inpatient, use this field to document the relationship between the reason the patient is admitted and the reason for the outpatient appointment. If this visit is related to the inpatient stay, the outpatient encounter is a no count. If the visit is not related to the inpatient stay, the encounter is counted as a regular outpatient visit.

Note: If the visit is not related to the inpatient stay, a confirmation window appears. Click **No** if the visit is not related.

- **Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code window appears.

Tip:
For CHCS scheduled appointments, this information can be captured in the A/P and Disposition modules.

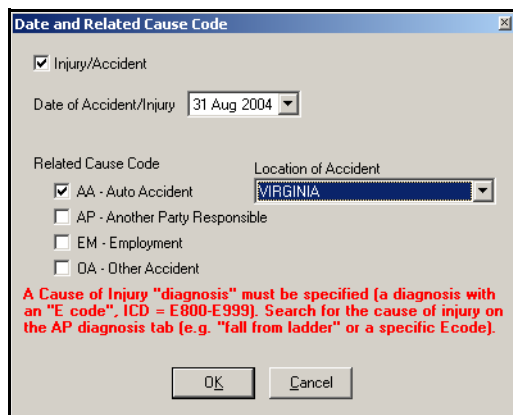


Figure 6–6: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an E-code as one of the diagnoses. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

- **Reason for Appointment:** Enter the reason the patient needs to be seen. This is a free text field.
- **Comments:** Enter any additional information, if needed.

Note: The Reason for Visit and Comments are displayed on the electronic SF600 once the encounter is opened.

- **Call Back Number:** This field is enabled when creating a telephone consult and defaults to the patient’s home phone number. Change the number, as appropriate.
 - **Urgency:** This field is enabled when a telephone consult is selected. Low is the default setting. Select the radio button next to High or Medium, as appropriate.
5. Click **OK**. The appointment is displayed on the appointment list and the status is checked-in.

Tip:
Double-click on an appointment to begin documentation and open the encounter, if role allows.

Note: If you want to change the patient for whom you are creating the new appointment, click **Change Patient**. The Patient Search window opens, allowing you to search for the desired patient.

6.4.1 Creating a Rounds Appointment

Rounds (RNDS) appointments can be created and completed in CHCS II. RNDS appointments are scheduled on a daily basis by CHCS and are pulled into CHCS II just like any other type of appointment. RNDS appointments can also be created in CHCS II, by providers only, for patients with an appointment classification of inpatient. The workflow for RNDS appointments in CHCS II is the same for that of outpatient appointments. RNDS appointments are no-count for workload purposes and are associated with the current “A” level Medical Expense Performance Reporting System (MEPRS) code.

Follow the steps below to create a RNDS appointment:

1. On the New Unscheduled Visit window, in the Clinic field, click the drop-down arrow and select the Industry Based Workload Alignment (IBWA) clinic. Notice that the RNDS appointment type becomes available and is selected.

2. In the provider field, the default is the logged in provider. To select a different provider, click **IBWA Provider Search** to search for and locate another provider. The provider must be associated with the selected clinic.
3. Click **OK**. The Inpatient Admissions window displays.

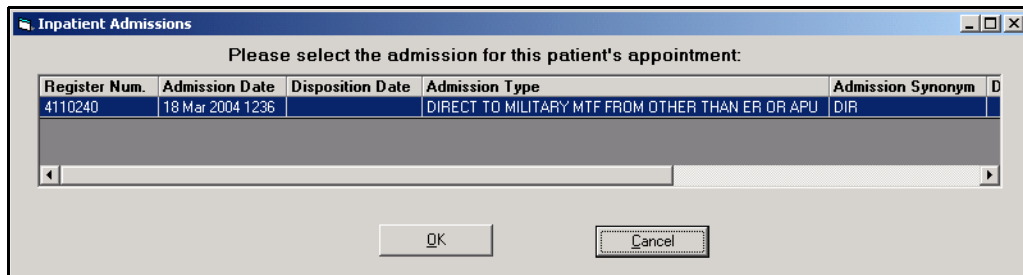


Figure 6-7: Inpatient Admissions Window

4. Select the admission for the patient.

Note: RNDS appointments require one of several admission types:

- ABS-AD DIRECT TO NON US MILITARY HOSPITAL NEVER TRNF TO MIL MTF
- RON-REMAIN OVERNIGHT
- CRO-CARDED FOR RECORD ONLY
- Absence Status

5. Click **OK**. The appointment is displayed on the appointment list and the status is checked-in.

6.5 Checking In a Patient

In the Appointments module, individual appointments that were scheduled in CHCS can be checked-in for their appointments. Appointments that are checked in from CHCS II do not need to be checked in on CHCS. Once an appointment is checked in, CHCS II updates the appointment status in CHCS to Kept. Patients arriving for a walk-in or sick call appointment are automatically checked-in upon creating the appointment in CHCS II.

Follow the steps below to check in a patient:

1. Select the appointment from the appointment list.

Note: You can only check in appointments whose status is Pending.

Tip:

To check-in multiple appointments, select an appointment from the appointments list and press Ctrl on your keyboard while selecting each

2. On the Action bar, click **Check-In**.

Note: Appointments should not be modified in the End of Day processing in CHCS. CHCS II writes back the appointment statuses of appointments managed in CHCS II. Modifications in the EOD should not be necessary.

6.6 Checking Out a Patient

The Appointment Check Out window enables a patient to be checked out from the selected appointment. This does not change the status of the appointment, nor is this step required. On this window, forms can be selected to print for the patient.

The check out function allows the user to print out a patient copy of the SF 600, DD 2766 or a clinic-specific patient information form. Any orders entered for the patient are automatically printed to this form along with any wellness items that are due.

Follow the steps below to check out a patient:

1. Select an appointment with a status of In Progress, Complete, or Updated from the appointments list.
2. On the Action bar, click **Check-Out**. The Check Out window opens.

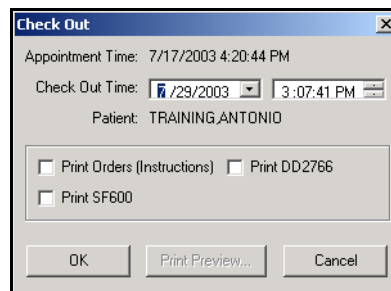


Figure 6–8: Check Out Window

3. Select the checkbox next to the associated print format.
4. Click **OK**. The forms are sent to your designated printer.

Tip:

You can select more than one form. Click **Print Preview** to view the forms before printing.

6.7 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.

Figure 6–9: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click the **ellipsis** button to search for a provider. The Clinician Search window opens.

Figure 6–10: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the Provider and Roles window.

- Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

- Click **OK**. The clinician(s) is(are) added to the appointment.

Tip:

To select multiple appointments, use the Ctrl key on your keyboard. If transferring multiple appointments, the patients must be from the same clinic.

6.8 Transferring an Appointment

The Appointment Transfer window enables an individual appointment or a group of appointments to be transferred to a different provider within the same clinic. Appointments can only be transferred to clinical team members who have the privilege to sign an encounter.

Follow the steps below to transfer an appointment:

- Select the appointment(s) to be transferred from the appointments list.
- On the Action bar, click **Transfer**. The Appointment Transfer window opens.

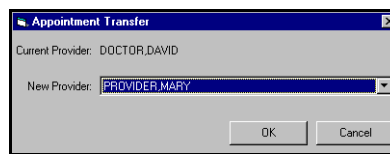


Figure 6-11: Appointment Transfer Window

- Select the new provider from the drop-down list. Only providers assigned to the specific clinic are available.
- Click **OK**. The appointment is assigned to the new provider.

6.9 Canceling an Appointment

The Cancel Appointment dialog box enables an appointment to be canceled. A reason for cancellation — Patient Cancelled, Facility Canceled, No Show, Left Without Being Seen — must be selected. Once an appointment is canceled, the appointment status is updated on the appointment list. If an appointment is inadvertently canceled, the user can undo the cancellation using the Undo button on the Action Bar. This action cannot be performed on appointments that were cancelled in the past.

Follow the steps below to cancel an appointment:

- Select the appointment to be canceled from the appointment list.
- On the Action bar, click **Cancel**. The Cancel Appointment window opens.

Tip:

To select multiple appointments, use the Ctrl key on your keyboard.



Figure 6–12: Cancel Appointment Window

3. Select a Reason for Cancellation.

Note: Once a patient has been checked in, the only cancel options available are Left Without Being Seen (LWOBS) or Facility Cancelled.

4. Click **OK**. This completes the encounter and the canceled appointment appears in the Previous Encounter module indicating that the appointment was cancelled.

Note: If the appointment(s) was(were) canceled by mistake, select the appointment and click **Undo Cancel** from the Action bar.

6.10 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Appointments and Demographics modules. This form defaults to the current date and includes demographic information with space to update the address, phone numbers, current insurance information, and questions for the patient to answer regarding any changes.

Follow the steps below to print the Insurance Form:

1. Click **Ins. Form** on the Action bar to print an insurance form for a patient. The Print Preview window opens.
2. Click the print icon on the Preview window to print the form. The form is sent to your designated printer.

6.11 Viewing a Comment Associated with an Appointment

If a comment was added on the New Appointment window, the full text of the comment can be viewed and edited. New comments can be added as well.

Follow the steps below to view a comment associated with an appointment:

1. Select the appointment that contains the comment.
2. On the Action bar, click **View Comments**. The Appointment Comments window opens.

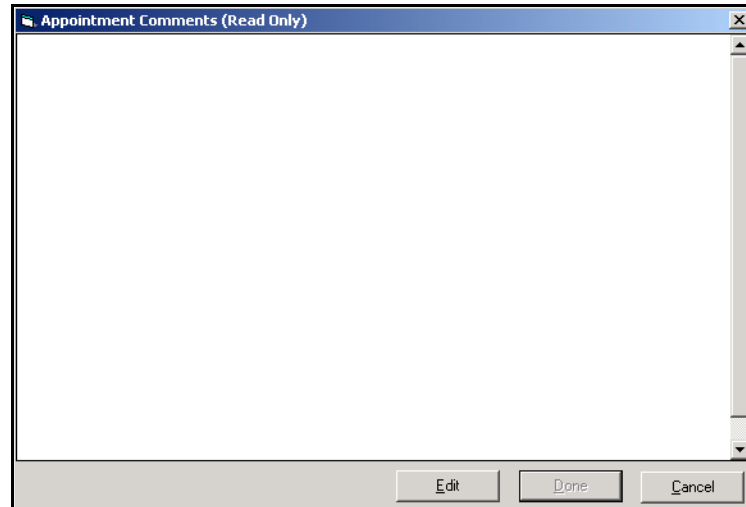


Figure 6-13: Appointment Comments Window

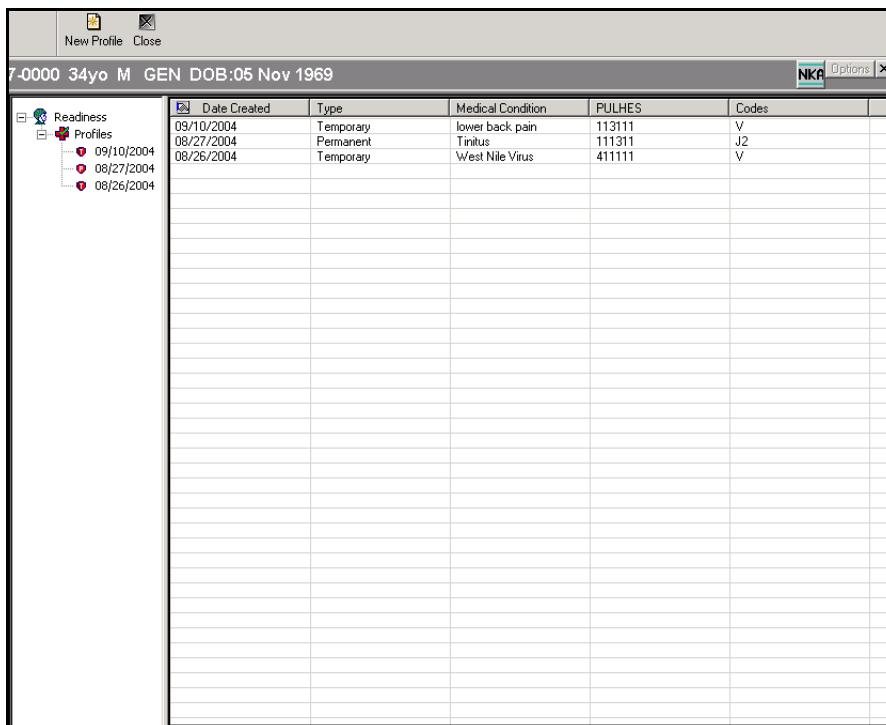
3. To edit the comments, click **Edit**. The Appointment Comments window changes from (Read Only) to (Edit Mode). Make the applicable changes.
4. Click **Done**.

7.0 ARMY PROFILE

7.1 Army Profile Overview

For users assigned appropriate roles, the Army Profile module enables you to create and track Army profiles for a patient. The profile form (DA FORM 3349) is implemented by surfacing the current Medbase profile functionality. As with the current Medbase product, a new profile can be filled out (with subsequent edits allowed) by using a blank profile or a profile template. Once a profile is complete, you can save it to the Army Profile module, save the profile as a template and print the DA FORM 3349 for required signatures on the hard copy and insertion in the patient's medical record.

Note: Authorization to use this functionality is currently limited to Fort Bliss. Its use by additional Army sites may be approved, in the future, by the Office of the Surgeon General (OTSG).



The screenshot shows a software window titled "7-0000 34yo M GEN DOB:05 Nov 1969". The window contains a table with the following data:

Date Created	Type	Medical Condition	PULHES	Codes
09/10/2004	Temporary	lower back pain	113111	V
08/27/2004	Permanent	Tinnitus	111311	J2
08/26/2004	Temporary	West Nile Virus	411111	V

Figure 7-1: Military Clinical Desktop— Army Profile Module

7.1.1 In More Depth

In the current release, this functionality is completely separate and distinct from the Temporary Profile capability that becomes available in the Disposition module when

the patient's disposition is "Released w/work/duty/limitations." Accordingly, if creating a Temporary Profile for a patient that is related to an encounter, the profile needs to be documented in the Disposition module so that it becomes a part of the encounter. Additionally, the Army Profile templates that are created and used in the Army Profile module are unrelated to other CHCS II template capabilities.

7.1.2 Creating a New Profile

Follow the steps below to create a new profile:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

Note: The window contains two generic System Templates.

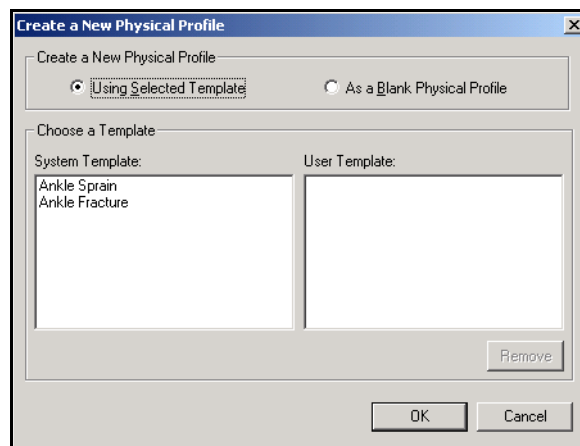


Figure 7-2: Create a New Physical Profile Window

2. Select the **As a Blank Physical Profile** radio button and click **OK**. A blank Physical Profile form appears on top of the module.

Figure 7-3: Blank Physical Profile Form

Note: The field numbers on the form do not correspond exactly to the numbers on the DA FORM 3349. For example, Blocks 13, 17 and 22 are blank fields for signatures on the DA FORM 3349 and do not appear on the profile form.

3. Complete blocks 1–5 of the form as follows:

- **Block 1:** Check either **Injury** or **Illness/Disease**, or both, if applicable, and enter the description.
- **Block 2:** Enter the appropriate Code(s).

Note: For a complete list of codes refer to Table 7-2 of Army Regulation (AR) 40-501.

- **Block 3:** Enter a single number from 1-4 in each of the boxes under the **P** (Physical Capacity), **U** (Upper Extremities), **L** (Lower Extremities), **H** (Hearing), **E** (Eyes), and **S** (pSychiatric) columns. If the Profile is to be Permanent, enter the numbers in the **Permanent** row.

Note: For a complete description of the numerical values used in the boxes, refer to Table 7-1 of Army Regulation (AR) 40-501.

- **Block 4:** For a Temporary Profile, select the **Expiration Date** from the pop-up calendar and select the **YES** radio button. When you do this, all remaining options related to Permanent Profiles become disabled. For a Permanent Profile, complete “b” and “c” as appropriate.

- **Block 5:** Select the appropriate **YES** or **NO** radio button for items a–f.
4. Complete blocks 6–11 as appropriate.
 5. Complete blocks 12–26 of the form as follows:
 - Click **Profiling Officer** in Block 12. The Signature of Profiling Officer window displays. Enter the Profiling Officer's **Name** and **Grade** and click **OK**.

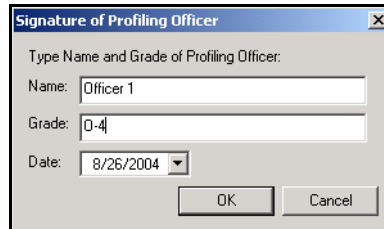


Figure 7–4: Signature of Profiling Officer Window

- Complete the same actions for the **Approving Officer** (Block 16) and **Unit Commander** (Block 19) blocks.
 - Select the appropriate radio buttons in Blocks 15 and 19.
6. Complete the **Medical Facility** field (Block 24). Enter the facility in the free text field or search for a MEPRS identifier by clicking **MEDICAL FACILITY**. The MEPRS Search window opens.

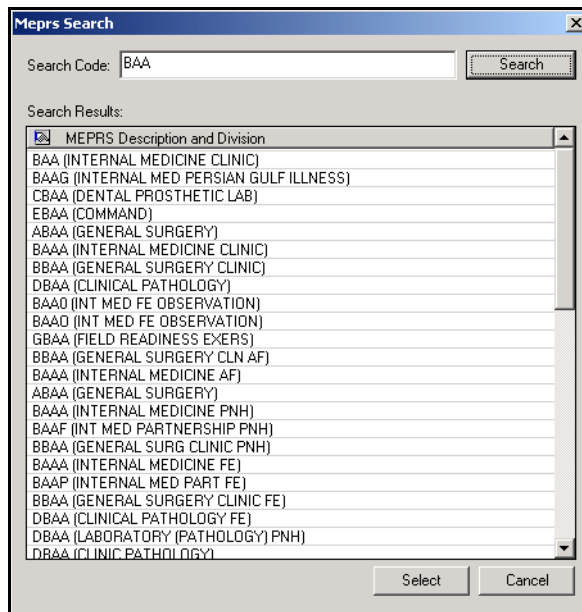


Figure 7–5: MEPRS Search Window

- Search for and select the desired MEPRS code and click **Select**. Block 24 populates with your selection.
7. Complete the **Unit** field (Block 25). Enter the unit in the free text field or search for a unit by clicking **UNIT**. The Unit Search window opens.

Code	Name
W0VA35	USA GAR HQ CD HQ CMD

Figure 7-6: Unit Search Window

- Search for the desired **Unit Code** or **Unit Name**. Highlight the appropriate item and click **Select**. Block 25 populates with your selection.
8. Complete the free text fields in Block 26, if desired.
 9. Click **Save** on the Action bar. The profile is saved to the Army Profile module. Click **Cancel** to clear the Profile Form from the desktop.

Date Created	Type	Medical Condition	PULHES	Codes
08/26/2004	Temporary	West Nile Virus	411111	V

Figure 7-7: Army Profile Module—Temporary Profile

Note: The letter “T” in the icon preceding the date in the Profile Tree identifies the profile as a Temporary Profile. The letter “P” identifies it as a Permanent Profile.

7.2 Creating a Profile Template

Follow the steps below to save a completed or partially completed Profile Form as a template:

1. Select the profile.
2. Click **Save as Template** on the Action bar. The New Physical Profile Template window opens.

New Physical Profile Template

Create a New Physical Profile Template

As a User Template As a System Template

Describe Template

Name: West Nile Virus

Medical Condition: West Nile Virus

OK Cancel

Figure 7-8: New Physical Profile Template Window

3. Select the type of template desired. Select the **As a System Template** radio button to save the template as an Enterprise template. Enterprise templates cannot be deleted.
4. The Template type defaults to **As a User Template** and the Name defaults to the medical condition you entered on the Profile form in Block 1. You can also change the Name of the template if you desire.
5. Click **OK**. The template is saved and is immediately available to you for use with another patient.

7.3 Using an Army Profile Template

Follow the steps below to use an Army Profile template:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

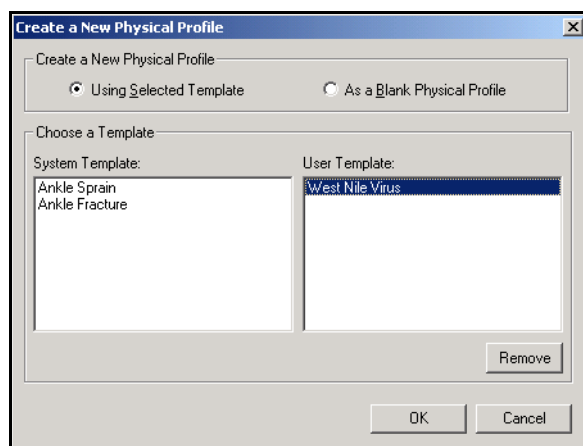


Figure 7-9: Create a New Physical Profile Window

2. Select either a **System** or **User Template** and click **OK**. The template Profile Form displays.

Note: The system contains several generic system templates. These include the following:

- Ankle Sprain
 - Ankle Fracture
-

Figure 7–10: User Template Loaded

3. Make any changes necessary to the Profile Form and click **Save**. The Physical Profile, with the changes you have made are saved to the Army Profile module. Click **Cancel** to close the Profile Form. The new profile is displayed in the Army Profile module.

Date Created	Type	Medical Condition	PULHES	Codes
08/26/2004	Temporary	West Nile Virus	411111	V

Figure 7–11: Army Profile Module—Temporary Profile

7.4 Viewing and Printing the DA FORM 3349

Follow the steps below to view and print the DA 3349:

1. Right-click the profile in the Profile Tree, and select **Preview Profile Report** from the pop-up menu. The DA 3349 displays.

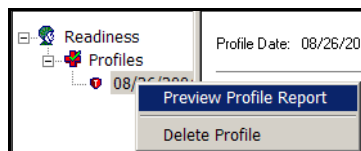


Figure 7-12: Right-Click Menu—Preview Profile Form Selected

 A screenshot of a web browser window displaying the DA FORM 3349 Physical Profile. The window title is 'Preview' and the address bar shows '1 of 1'. The form is titled 'PHYSICAL PROFILE' and includes instructions: 'For use of this form, see AR 40-501; the proponent agency is the Office of the Surgeon General.' The form is divided into several sections:

- 1. MEDICAL CONDITION:** Includes a text field for 'Description in lay terminology' (containing 'Tinnitus'), a checkbox for 'INJURY? Or', and a checked checkbox for 'ILLNESS/DISEASE?'. It also includes '2. CODES (table 7-2 AR 40-501)' with 'J2' entered and '3.' for 'Temporary' and 'Permanent'.
- 4. PROFILE TYPE:** Includes 'a. TEMPORARY PROFILE (Expiration date: YYYYMMDD)' and 'b. PERMANENT PROFILE (Reviewed and validated as a minimum with every periodic physical exam or after 8 years from the date of issue)'.
- 5. FUNCTIONAL ACTIVITIES FOR PERMANENT AND TEMPORARY PROFILES:** Includes 'a. ABLE TO CARRY AND FIRE INDIVIDUAL ASSIGNED WEAPON', 'b. ABLE TO MOVE WITH A FIGHTING LOAD AT LEAST 2 MILES (45 LBS. Includes helmet, boots, uniform, LBE, weapon, protective mask, pack, etc.)', 'c. ABLE TO WEAR PROTECTIVE MASK AND ALL CHEMICAL DEFENSE EQUIPMENT', 'd. ABLE TO CONSTRUCT AN INDIVIDUAL FIGHTING POSITION (dig, fill & lift sand bags, etc.)', 'e. ABLE TO DO 3-5 SECOND RUSHES UNDER DIRECT AND INDIRECT FIRE', and 'f. IS SOLDIER HEALTHY WITHOUT ANY MEDICAL CONDITION THAT PREVENTS DEPLOYMENT?'.
- 6. APFT:** A table with columns for 'YES', 'NO', and 'ALTERNATE APFT (Fill out if unable to do APFT run otherwise)'. Rows include '2 MILE RUN', 'APFT SIT-UPS', and 'APFT PUSH UPS', with sub-rows for 'APFT WALK', 'APFT SWIM', and 'APFT BIKE'.
- 7. STANDARD OR MODIFIED AEROBIC CONDITIONING ACTIVITIES:** A table with columns for 'UNLIMITED RUNNING', 'UNLIMITED WALKING', 'UNLIMITED BIKING', and 'UNLIMITED SWIMMING', and rows for 'OR RUN AT OWN PACE & DISTANCE', 'OR WALK AT OWN PACE & DISTANCE', 'OR BIKE AT OWN PACE & DISTANCE', and 'OR SWIM AT OWN PACE & DISTANCE'.
- 8. UPPER BODY WEIGHT TRAINING (See FM 21-20)** and **9. LOWER BODY WEIGHT TRAINING (See FM 21-20)**.

Figure 7-13: DA FORM 3349

2. Click the **printer** icon on the Print Preview window. The DA 3349 prints and the hardcopy can then be signed and inserted in the patient's medical record.

Note: If you do not want to view a print preview, click **Print** on the Action bar.

7.5 Deleting a Profile

Follow the steps below to delete a profile:

1. Right-click the profile in the Profile Tree and select **Delete Profile** from the pop-up menu. A warning window displays.



Figure 7–14: Delete Warning Window

2. On the warning window, click **Yes**. The profile is removed from the Army Profile module.

7.6 Removing a User Profile Template

Follow the steps below to remove a user profile template:

1. Click **New Profile** on the Action bar. The Create a New Physical Profile window opens.

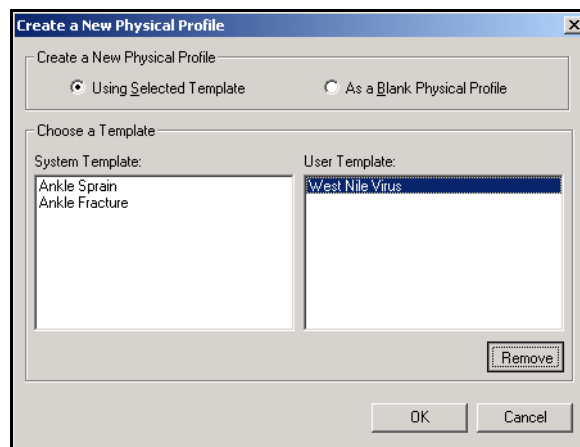


Figure 7–15: User Template Selected for Removal

2. Select the User Template you want to remove and click **Remove**. The Delete Profile Template Warning window displays.

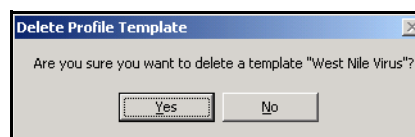


Figure 7–16: Delete Profile Template Warning Window

3. Click **Yes**. The User Template is removed.

Note: You cannot remove Enterprise (System) level templates.

8.0 ASSESSMENT AND PLAN (A/P)

8.1 Assessment and Plan Overview

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

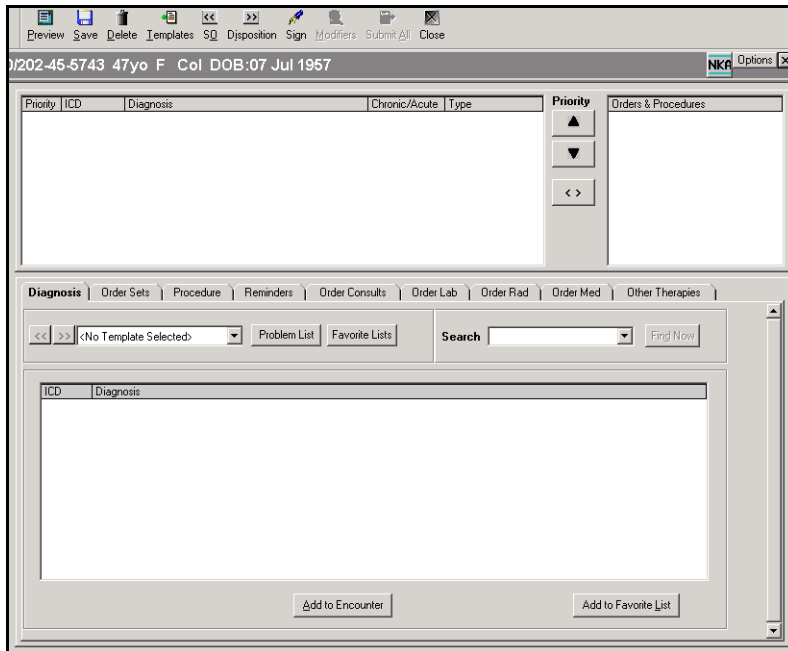


Figure 8-1: Military Clinical Desktop—Assessment and Plan Module

8.1.1 In More Depth

When the A/P module is opened, the Diagnosis tab is displayed by default. The rest of the tabs, along with the Diagnosis tab, are where you locate items to add to the Diagnosis box at the top of the module. This box displays the diagnoses for this patient and is the interface by which you associate procedures and order consults, medications, lab and radiology tests to one or more diagnoses. Provided buttons also enable the priority of a diagnosis to be changed and orders to be submitted from the queue. Each of these tasks are covered in this section.

8.2 Associating Procedures, Orders, and Instructions

You can enter procedures, orders, and consults (patient instructions) without associating a diagnosis. If you enter one without associating a diagnosis and attempt to close the A/P module, the system displays an alert.

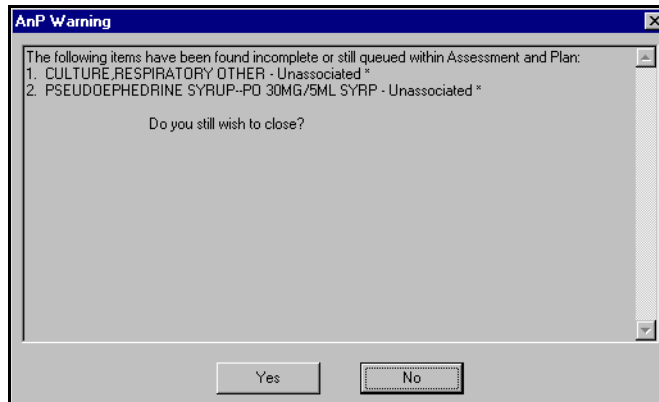


Figure 8–2: AnP Warning Window

All orders without a diagnosis receive a Count/No Count message if you attempt to sign the encounter without associating a diagnosis to a procedure, order, or consult.

8.3 Documenting a Diagnosis

When displayed, a diagnosis entry includes the name of the diagnosis and its associated ICD code. This is one of the ways CHCS II merges documentation and coding. By simply adding the diagnosis, the corresponding ICD code is documented as well. E-Codes, for injuries or accidents, cannot be selected as a primary diagnosis. An information box displays if you attempt to select E-Code as a primary diagnosis.

The diagnoses are added in the order in which they are selected and priorities are also associated in the same order. The first four diagnoses are sent to Standard Ambulatory Data Record (SADR). This is similar to the “bubble sheet” process of selecting diagnoses in priority order of 1–4. The maximum number of diagnoses allowed in CHCS II is 15.

Follow the steps below to document a diagnosis:

1. On the A/P module, click **Diagnosis** to view the Diagnosis tab.

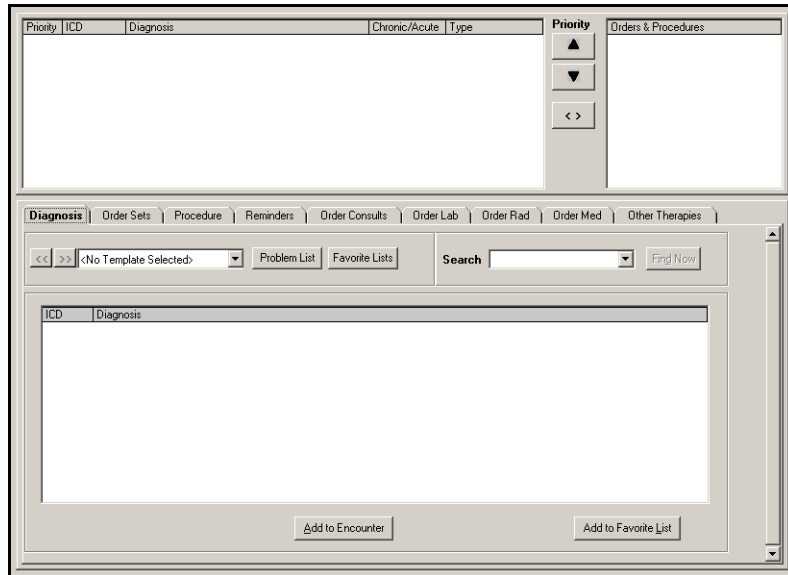


Figure 8–3: A/P Diagnosis Tab

2. Locate the diagnosis using one of the following methods:
 - **Template List:** If an encounter template is loaded, the list defaults to the diagnoses associated with the encounter template. Use the drop-down list to select an encounter template and view default diagnoses for the selected encounter template. Click the backward and forward buttons to view templates you have already loaded without using the drop-down list.
 - **Problem List:** Active Acute or Chronic diagnoses listed in the Problems module display if you click Problem List.
 - **Clinic List:** This list allows you to view diagnoses established by a clinic or user in the List Management module.
 - **Search:** In the Search field, enter the diagnosis and click **Find Now**. At least 2 characters must be entered. An alert message displays if the search criteria returns more than 150 results.
3. In the list of diagnoses, select the diagnosis you want to add to the encounter. The diagnosis must have an associated ICD code to be added.
4. Click **Add to Encounter**. The diagnosis is added to the list above in the Diagnosis box.

Note: Click **Add to Favorite List** if you want to add the selected diagnosis to your Favorites List. The diagnosis also display in the List Management module.

- Highlight the diagnosis to be changed and click on either the ▲ or ▼ button to move the item up or down to change the priority of the diagnosis.
-

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up	▲ ▼ <>	

Figure 8-4: Added Diagnosis

5. A comment may be entered for an added diagnosis.
 - a. Select a diagnosis that was added to the Diagnosis box. Be sure the diagnosis has been expanded to display the comment underneath.
 - b. Click **Comment**. The Extended Comments window opens.
 - c. In the Comments box, enter a comment.
 - d. Click **OK**.
6. When a diagnosis is added, it is labeled *Chronic* or *Acute*. Select the added diagnosis, and click the default label (Chronic or Acute) to change the default. A drop-down list displays allowing you to select **Chronic** or **Acute**.

Note: When you perform a diagnosis search using an ICD code, the result is based on a chart that lists those diagnoses that should be chronic and those that should be acute. Diagnoses selected from the patient's problem list default to Chronic.

7. When the diagnosis is added, the type is either *New* or *Follow-up*. Select the added diagnosis and click the default type (New or Follow-Up) to change the diagnosis type. A drop-down list displays allowing you to select **New** or **Follow-Up**. If a diagnosis is on the patient's problem list, it is automatically set to Follow-Up.

8.3.1 Documenting an E-code for Injury/Accident

If the appointment is related to an injury or an accident an E-code diagnosis must be documented to explain the related cause. Enter the clinical diagnosis as the primary diagnosis and the E-code as a secondary diagnosis. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

Follow the steps below to add an e-code:

1. Search for and locate the appropriate E-code. E-codes range from E800 - E999.
2. Select the diagnosis and click **Add to Encounter**. The Date and Related Cause Code window appears.

Figure 8–5: Date and Related Cause Code Window

3. Complete all the fields and click **OK**. If this encounter has already been marked as related to an injury or accident, you simply need to verify the information in the Related Cause Code window.

8.4 Creating an Order Set from A/P

Building an order set is not an intuitive process and must be done inside an open encounter. The best method is to use the A/P module to locate and save orders as part of an order set. Although orders should not be submitted as part of this process, it is best to be safe and create an appointment for a test patient in the test clinic.

Follow the steps below to create an order set from A/P:

1. In the A/P module, begin on one of the Order Entry tabs (Labs, Rads, or Meds).
2. Locate the first order you want to include in the order set.
3. When you have located the order, click **Save to Queue**. This saves the order without submitting it.
4. Continue with all three tabs, as appropriate, locating individual orders and clicking Save to Queue.

Tip:

Once an order has been submitted, it cannot be included in an order set. Orders must be located and then Saved to Queue.

Note: For Med and Rad orders, the SIG and clinical impression is used as the default for those orders. These can be changed when using the order set in an actual encounter.

5. Once you have finished locating the orders you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

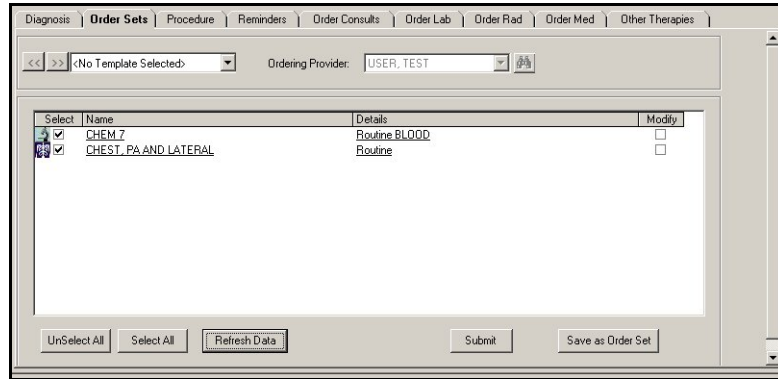


Figure 8–6: Order Sets Tab

6. Click **Save as Order Set**.
7. In the Save Encounter Template window **Template Name** field, enter the template name you want to use for the order set.
8. Click **Save** to save the order set. The order set encounter template can now be merged with other encounter templates and/or accessed in the Template Management and A/P modules.

8.4.1 Adding Orders to an Existing Encounter Template

An order set can also be saved as part of an encounter template that has already been built.

Follow the steps below to add orders to an existing template:

1. Locate your order(s) and save them to queue, following steps 1 - 4 above.
2. Once you have finished locating the order(s) you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

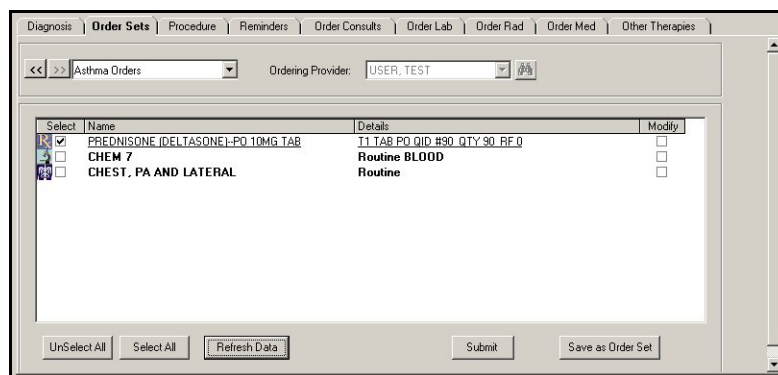


Figure 8–7: A/P Order Sets Tab

3. Click **Save as Order Set**.
4. In the Save Encounter Template window, select the encounter template to add to and click **Save**.

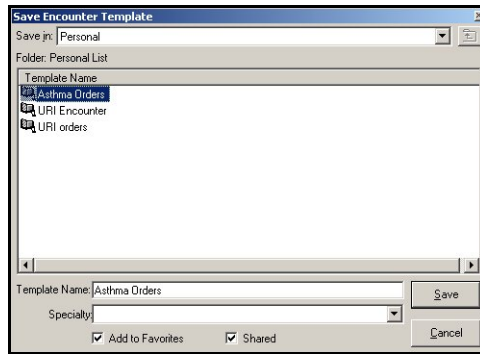


Figure 8–8: Save Encounter Template Window

5. A pop-up window opens asking if you want to Replace or Add To the existing template. Click **Add To**. The selected order(s) is(are) added to the existing template and can be viewed in the Template Management module or within A/P when the template is loaded.

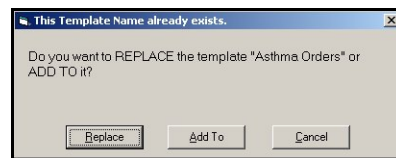


Figure 8–9: Template Name Option Box

8.5 Documenting a Procedure

The Procedure tab allows you to document and take credit for in-office procedures. Workload credit can be given to the clinical team member performing the procedure as well.

Just like the diagnoses, each procedure includes the associated CPT code. These codes are part of how CHCS II enables you to code as you document. Each procedure added here automatically adds the corresponding code to the E&M calculator in the Disposition module, ensuring accurate and complete coding for performed procedures.

Each procedure must be associated with a diagnosis and can be associated with multiple diagnoses. Associating each procedure with at least one diagnosis is a CMMS rule and is required for billing purposes. At the Enterprise-level, this association is a quality of care issue that enables the MHS to ensure that proper procedures are being performed for appropriate diagnoses.

Follow the steps below to document a procedure:

1. On the A/P module, click **Procedure** to view the Procedure tab.

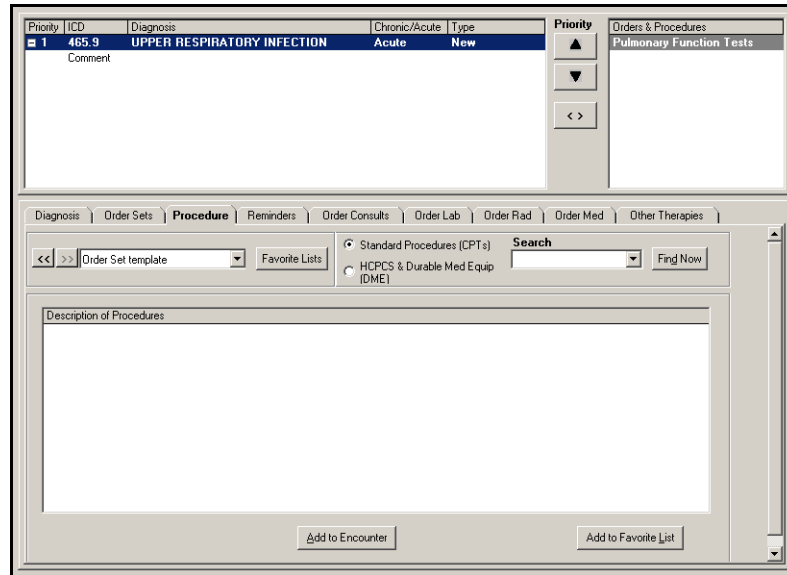


Figure 8–10: A/P Procedure Tab

2. The procedure list can be viewed using the following methods:
 - **Template List:** If an encounter template is loaded, the list defaults to the procedures associated with the encounter template. Use the drop-down list to select an encounter template and view default procedures for the selected encounter template. Click the backward and forward buttons to view templates you have already loaded without using the drop-down list.
 - **Clinic List:** Click **Clinic List** to view a list of pre-selected procedures created at the clinic or user level.
 - **Search:** In the Search field, enter the procedure and click **Find Now**. At least 2 characters must be entered. If you want to search for standard procedures, select **Standard Procedures (CPTs)**. If you want to search for Health Care Financing Administration Common Procedure Coding System (HCPCS) and durable medical equipment, select **HCPCS and Durable Med Equip (DME)**.
3. In the list of procedures, select the procedure you want to add to the encounter.
4. In the Diagnosis box, select the diagnosis with which to associate the procedure.
5. Click **Add to Encounter**. The procedure is added to the Orders and Procedures area.

Note: Click **Add to Favorite List** if you want to add the selected procedure to your Favorites List. The procedure also displays in the List Management module.

Note: If you attempt to exit the A/P module and the procedure is not associated to a diagnosis, a warning message displays. Click **Yes** to save and close the mod-

ule without associating the procedure to the diagnosis or **No** to go back and associate the procedure with the diagnosis.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up		Pulmonary Function Tests Peak Flow

Figure 8–11: Added Procedures

8.6 Linking a Clinical Team Member to a Procedure

Provider Procedure Linking enables users to link additional clinical team members to a procedure. All information is sent to ADM easily recording correct workload credit.

1. On the A/P module, click the **procedure** added to the encounter. The Procedure Details window displays:

Procedure Details for Complete Colonoscopy For Foreign Body Removal

Unit of Service:

Modifier(s):

Comments:

Appointed Provider: Role:

Additional Provider #1: ... Role:

Additional Provider #2: ... Role:

Figure 8–12: Procedure Details Window

2. Click the **ellipsis button** next to the Additional Provider #1 field. The Clinician Search window displays.

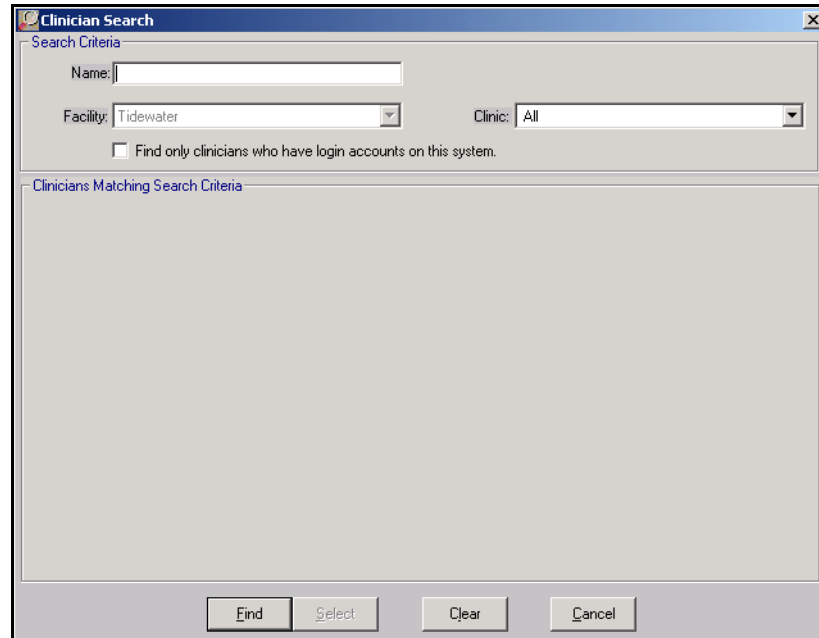


Figure 8–13: Clinician Search Window

3. In the **Last Name** field, enter the last name of the desired clinician.
4. Select a facility from the drop-down list.
5. Select a clinic from the drop-down list.
6. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
7. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
8. Select the desired clinician.
9. Click **Select**.
10. Click the drop-down arrow in the Roles field next to the Additional Provider #1 and select **Additional Provider Role**.

Figure 8–14: Selected Role

11. Click the checkbox next to the clinical team member who performed the procedure. Be sure to deselect the primary provider, as appropriate.
12. Click **OK**. The additional provider is now associated to the procedure.

8.7 Addressing Reminders

The Reminders tab enables you to view and address patient reminders. The reminders listed on the Reminders tab in A/P are the same reminders that are in the Reminder pane below the Folder List and those that are listed on the Due Reminders tab in the Wellness module. The Reminders tab in A/P helps to streamline the process to address these reminders. Reminders highlighted in yellow are due within 30 days and reminders highlighted in red are overdue.

Each reminder is associated with a default diagnosis and some with a default action. A full list of the default diagnoses and actions can be found in the Reminder Mapping module under the Tools folder on the Folder List. Once a reminder has been addressed, the default diagnosis is automatically added to the encounter and the default action is completed.

8.7.1 Viewing Reminders

When the Reminders tab is opened, the due reminders and immunizations that are overdue or are due in one month, display, based on the default filter.

Follow the steps below to change the list of reminders:

1. On the A/P module, click **Reminders**. The Reminders tab displays.
2. Set the Reminders filter, if desired, by making a selection from the drop-down list.

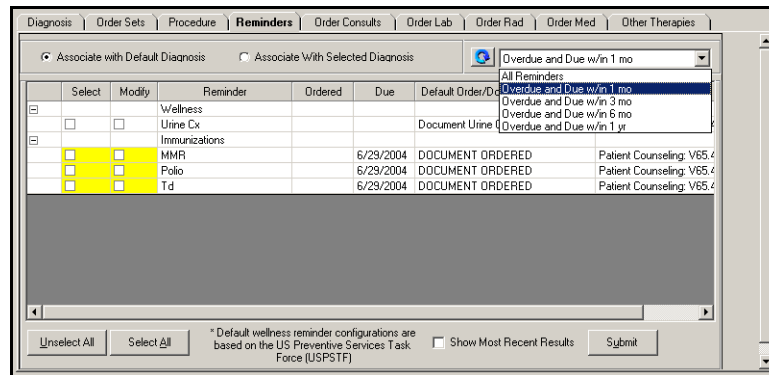


Figure 8–15: Reminders Tab—Drop-down List

3. Select the **Show Most Recent Results** checkbox to show the most recent results for the listed reminders. These are results from past lab and radiology orders or documented vital signs.

8.7.2 Addressing Reminders

Follow the steps below to address patient reminders:

1. On the A/P module, click **Reminders**. The Reminders tab displays.

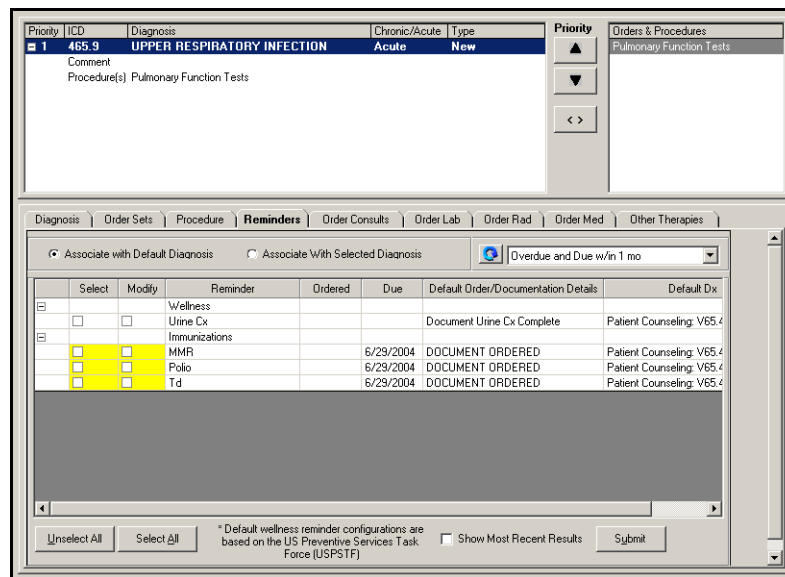


Figure 8–16: Reminders Tab

2. Click the checkbox in the Select column for those reminders that are to be addressed with no modifications.

Note: Click **Select All** to select all reminders. Click **Unselect All** to deselect all reminders.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New	
2	V65.40	Patient Counseling	Acute	New	

Select	Modify	Reminder	Ordered	Due	Default Order/Documentation Details	Default Dx
<input type="checkbox"/>	<input type="checkbox"/>	Wellness				
<input type="checkbox"/>	<input type="checkbox"/>	Urine Cx			Document Urine Cx Complete	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	MMR		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Polio		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Td		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4

Figure 8–17: Reminders Tab

- If you want to associate the reminder with a different diagnosis than the default, select the diagnosis, and click the **Associate With Selected Diagnosis** radio button.
- Click **Submit**. The reminder is documented in the Diagnosis box under the associated diagnosis and any actions are completed.

Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority
1	465.9	UPPER RESPIRATORY INFECTION	Acute	New	
2	V65.40	Patient Counseling	Acute	New	

Select	Modify	Reminder	Ordered	Due	Default Order/Documentation Details	Default Dx
<input type="checkbox"/>	<input type="checkbox"/>	Wellness				
<input type="checkbox"/>	<input type="checkbox"/>	Urine Cx			Document Urine Cx Complete	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	MMR		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Polio		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Td		6/29/2004	DOCUMENT ORDERED	Patient Counseling V65.4

Figure 8–18: Reminders Tab

8.7.2.1 Modifying a Reminder

Follow the steps below to modify and address a reminder:

- Click the checkboxes in the Select and Modify columns.

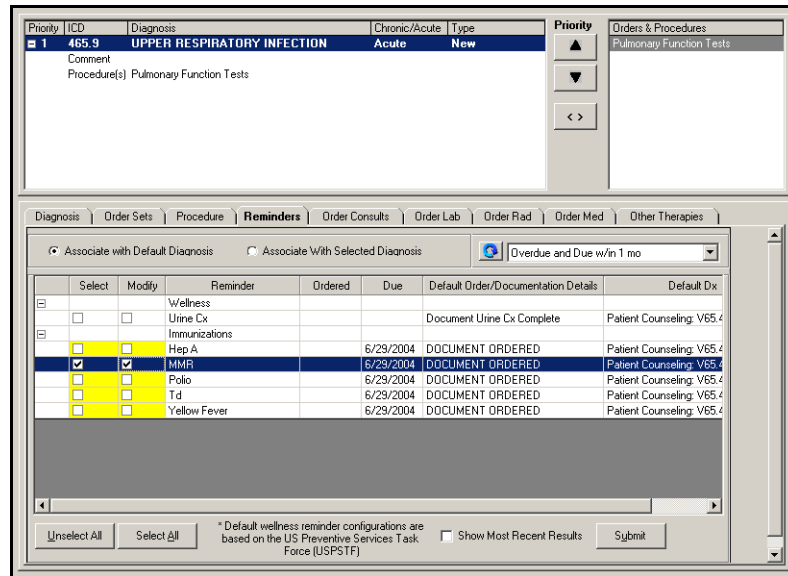


Figure 8-19: Reminders Tab—Select and Modify

2. If you want to associate the reminder with a different diagnosis than the default, select the diagnosis, and click the **Associate With Selected Diagnosis** radio button.
3. Click **Submit**. The reminder is documented.

Note: To edit the comments, click **Comment** under the appropriate diagnosis.

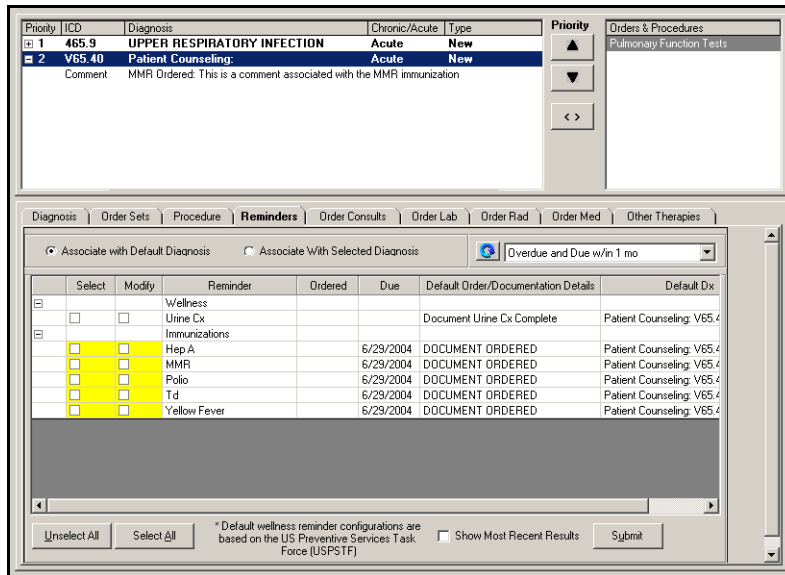


Figure 8–20: Reminders Tab – Immunizations Documented

Note: The immunizations Reminders continue to persist until the appropriate action of vaccination is taken in the patient’s Immunization module.

8.8 Ordering a Consult

The Order Consults tab allows you to enter a consult request for a specific encounter. Follow the steps below to order a consult:

1. Click the Order Consults tab. The Order Consults tab displays.

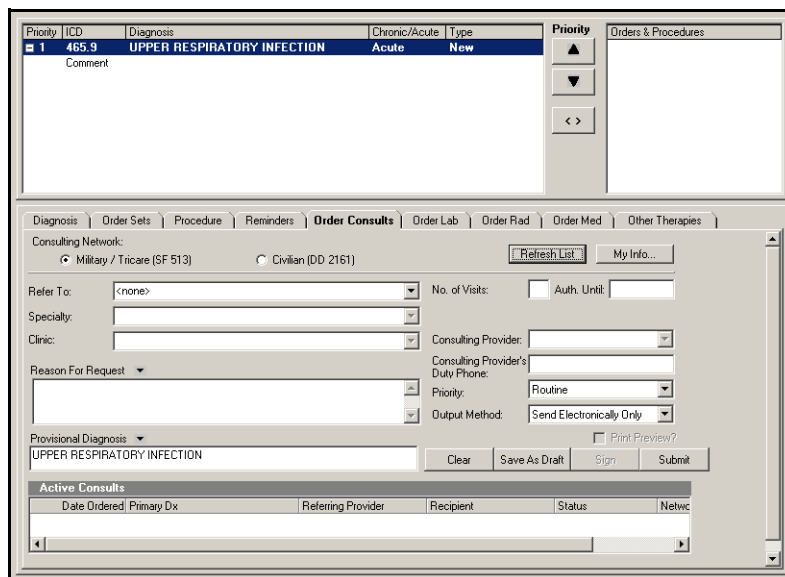


Figure 8–21: A/P Order Consults Tab

2. When placing an order for a consult, complete the required fields:

Note: The system requires an entry or selection for each field except phone.

- **Consulting Network:** Select the appropriate radio button. The Consulting Network group of radio buttons includes Military/TRICARE (SF513) and Civilian (DD2161). The default is Military/TRICARE Medical Care (SF513).
- **Refer To:** Select the recipient of the consult from the drop-down list. The associated specialty or clinic is automatically displayed in the corresponding fields.
- **Specialty:** This field defaults with the associated specialty from the item selected in **Refer To**.
- **Clinic:** This field defaults with the associated clinic from the item selected in **Refer To**.
- **Reason for Request:** The system enables the referring provider to enter a free-text description. Click inside the text box and type the reason.
- **Provisional Diagnosis:** A provisional diagnosis is the referring provider's best estimate of the patient's actual diagnosis. Often the patient is being referred because the diagnosis is uncertain, hence Provisional. If the Diagnosis code has been completed, it automatically populates the *Provisional Diagnosis* field. If the diagnosis has not been documented, enter the provisional diagnosis in the *Provisional Diagnosis* field.

Note: CHCS II defaults the provisional diagnosis field to the diagnosis selected.

- **No (Number) of Visits:** This number refers to the recommended number of visits to complete the consult. Enter the desired number.
 - **Referral Authorized until:** The date until which this consult order is active. It is pre-filled with a date 30 days from the current date. Enter the appropriate date.
 - **Consulting Provider:** Select the consulting provider from the drop-down list.
 - **Priority:** Select the desired priority from the drop-down list.
 - **Output Method:** Select an output method from the drop-down list. The Output Method refers to how the results of the consult should be communicated. The choices include Send Electronically Only, Send and Print, and Print Only. The default is Send Electronically Only.
 - **Consulting Provider's Duty Phone:** If a clinic provider was selected, the phone number displays here. The number is taken from information entered during the initial registration.
3. After you enter the required information, click one of the following:
 - **Submit:** The system submits the newly created consult orders to CHCS for routing and scheduling with the selected specialty. The status is then changed

to Submitted. The consult is also added to the Assessment and Planning module in the upper right corner with the list of procedures and is associated with the highlighted diagnosis. Highlight the desired diagnosis and double-click the consult to re-associate the consult with a different diagnosis.

- **Save As Draft:** The consult request status is saved in draft form because the request has not been submitted and can be edited.
- **Clear:** Cancels the information entered for the consult.

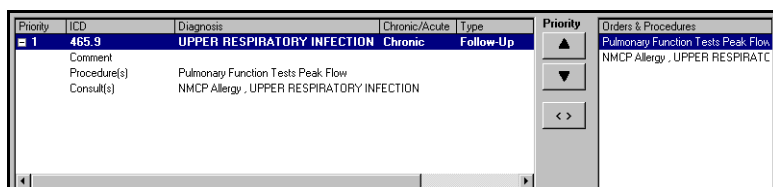


Figure 8-22: Added Consults

8.8.1 Managing Active Consults

The Active Consults area at the bottom of the workspace lists consults by other providers for this patient as well as the ones ordered by you. The statuses for these consults include the following:

- Pending Results
- Updated
- Draft
- Pending Appointment
- Pending Review

Active consults can be edited, copied as new, or deleted. You can also view the history of the consult to track its progress through the workflow.

Follow the steps below to edit or copy the consult:

1. Select the consult from the Active Consults list.
2. Perform a right mouse click and select either **Edit** or **Copy as New**. The consult fields are populated with the details from the active consult.
3. Make any necessary changes and click **Submit**.

Follow the steps below to delete an active consult:

1. Select the consult from the Active Consult list.
2. Perform a right mouse click and select **Delete**. The consult is deleted from the Active Consults list.

Follow the steps below to view the history of a consult:

1. Select the consult from the Active Consult list.
2. Perform a right mouse click and select **History**. The Consult History window opens.

- Review the history and click **OK** to return to the A/P module.

8.9 Ordering a Laboratory Test

The Order Lab tab allows you to enter a laboratory test for a specific encounter in the A/P module.

Follow the steps below to order laboratory tests:

- Click the Order Lab tab. The Order Lab tab displays.

Figure 8–23: A/P Order Lab Tab

- Complete the following sections:
 - Search:** Enter the name of the desired lab test and click **Search**. The results populate the Lab Test Name drop-down list.
 - Lab Section:** Select the departments for the desired procedure. This narrows the results of the search, but is not necessary. Select **All Sections** to see all available departments.
 - Lab Test Name:** The results of the search populate the drop-down list. Select the desired laboratory test.

Note: If the pre-verify process identifies any conflicts regarding the order, the Lab Override window opens. Type a reason for the override in the Warnings window and click **Accept Override** to override the warning message. Click **Cancel Order** and select an alternative order to ignore the warning override.

One Drug Order warning returned

Order: AMOXICILLIN 250MG-PO 250MG CAP

1) Allergic Reaction Class
Patient allergies to: PENICILLINS; CEPHALOSPORINS; CARBAPENEM

Count: 1
Type: Drug Order

Specify a reason for this override:

Accept Override Cancel Order

Figure 8–24: Lab Override Window

Note: The CHCS pre-verify process also identifies the laboratory test specimen, type, and container requirements. If there is more than one option, the Lab Collection Choices window opens and allows you to select preferences.

Lab Collection Choices: [MONONUCLEOSIS SCREEN]

Choose a COLLECTION SAMPLE

Choices for Collection Sample and Type

Collection Sample	Specimen-Type	Container
BLOOD	PLASMA	LAVENDER

Search for specimen-type

Search keyword

Search

Results of specimen-type search

Collection results for the order screen:

SAMPLE: BLOOD
CONTAINER: LAVENDER
COMMENT: COLLECT 4-7 CC BLOOD IN SST OR LAVENDER TOP TUBE

STATUS

OK

Figure 8–25: Lab Collection Choices Window

- Showing Panel Contents:** If a laboratory test is associated with two or more subtests, the **Show Items in Panel** button is enabled. Click the button to display the Lab Panel Elements window for the selected laboratory test. Click **OK** to return to the Lab Orders tab.

- **Processing Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
- **Comments or Instructions:** In the **Comments** field, enter comments.

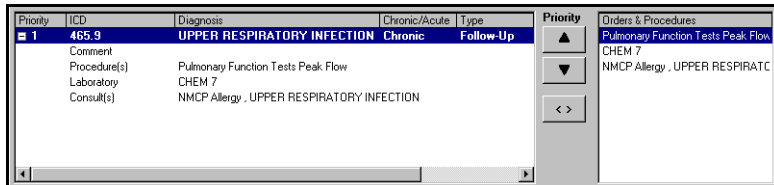
Note: Lab free-text persists in the *Comments* field during an Order Entry session.

- **Show Collection Choices:** If a laboratory test has two or more collection options, the Lab Collection Choices window opens displaying the available choices. Click **Show Collection Choices** to select specimen collection methods.
 - **More Detail:** Click **More Detail** to view options for Schedule, Collection Priority, Collection Method, and Requesting Location. Once you click **More Detail**, the button changes to Less Detail.
 - **Schedule:** Click the **One-Time** or **Continuous** radio button. The default is One-Time and Continuous is grayed out if the option is not appropriate for the selected test. If **Continuous** is selected, the *Timing*, *Start Date*, *Frequency*, and *Duration* fields become active. These fields have default values depending on the test selected.
 - **Timing:** Use the drop-down list to change the time.
 - **Start Date:** In the **Start** field, enter the desired date (or use the arrow keys in the field to select a date). The start date may only be the current date or a date in the future.
 - **Frequency (for Continuous tests only):** Use the drop-down list to change the frequency.
 - **Duration (Days) (for Continuous tests only):** In the **Duration (Days)** field, enter the preferred number of days.
 - **Collection Priority:** Use the drop-down list to select a priority. The default is Routine.
 - **Collection Method:** Use the drop-down list to select a collection method. The default is Send Patient to Lab.
 - **Requesting Location:** Use the drop-down list to select a requesting location. The default is the location of the workstation.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Laboratory Orders area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, Click **Save to Queue**. This saves the order so you can submit it later.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated

with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the lab order to associate an order with a diagnosis.



Priority	ICD	Diagnosis	Chronic/Acute	Type	Priority	Orders & Procedures
1	465.9	UPPER RESPIRATORY INFECTION	Chronic	Follow-Up		Pulmonary Function Tests Peak Flow
		Comment				CHEM 7
		Procedure(s)				NMCP Allergy, UPPER RESPIRATC
		Laboratory				
		Consult(s)				

Figure 8–26: Added Laboratory Test

8.9.1 Anatomic Pathology Worksheets

Anatomic Pathology worksheets display for lab tests requiring additional pathology information than what is needed for ordering other lab tests. The worksheet displays when you search for a specified anatomic pathology lab test on the Order Labs tab in the A/P module. There are five Anatomic Pathology worksheets:

- Autopsy
- Bone Marrow
- Cytologic Gyn
- Cytologic Non-Gyn
- Tissue Exam

Note: The results for ordered Anatomic Pathology tests can be viewed in the Clinical Notes module. Open the Clinical Notes module for the selected patient to view results. Click **Filter** to access the Filter tab on the Properties window and select **Specific Note Types**. Click **Add** to access the Healthcare Data Dictionary Search for Clinical Note Types and search for Anatomical Pathology Reports. Add this as your filter to view results for ordered anatomic pathology tests.

8.9.1.1 Completing Autopsy Worksheets

The Autopsy Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

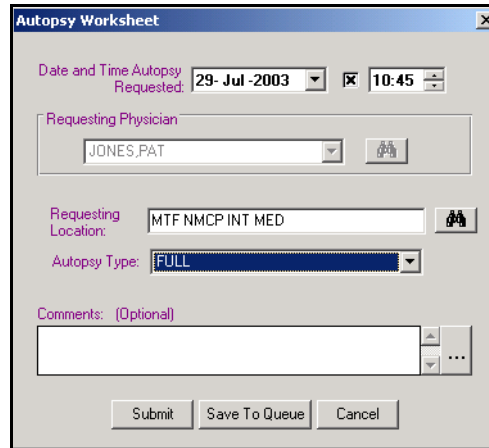


Figure 8–27: Autopsy Worksheet

Follow the steps below to complete an Autopsy worksheet:

1. Select a date and time for the requested autopsy. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
3. Select the **Autopsy Type** being performed from the drop-down list.
4. If necessary, enter any comments in the **Comments** field.
5. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

8.9.1.2 Completing Bone Marrow Worksheets

The Bone Marrow Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Figure 8–28: Bone Marrow Worksheet

Follow the steps below to complete a bone marrow worksheet:

1. Select a date and time for the bone marrow specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specific information, if necessary.

6. Enter a brief clinical history for the specimen.
7. Enter a brief PreOp diagnosis for the specimen.

8. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

8.9.1.3 Completing Cytologic Gyn Worksheets

The Cytologic Gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Figure 8–29: Cytologic Gyn Worksheet

Follow the steps below to complete a Cytologic Gyn worksheet:

1. Select a date and time for the cytologic gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select a **Specimen** from the drop-down list.
3. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
4. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
5. Indicate whether the patient is taking any of the following:

- Birth Control Pills
 - IUD
 - Post-Menopausal
 - Hysterectomy
 - Hormone Therapy
6. If the patient is pregnant or recently gave birth, select the number of weeks from the drop-down list.
 7. Indicate the start dates for any of the following:
 - Last Menses
 - Radiation Therapy
 - Cytotoxic Therapy
 8. Enter any related results or previous cytology diagnoses.
 9. Enter any related cytology comments.
 10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

8.9.1.4 Completing Cytologic Non-gyn Worksheets

The Cytologic Non-gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Figure 8-30: Cytologic Non-gyn Worksheet

Follow the steps below to complete a Cytologic Non-Gyn worksheet:

1. Select a date and time for the cytologic non-gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the check-box is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.

9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

8.9.1.5 Completing Tissue Exam Worksheets

The Tissue Exam Worksheet window appears when you order an anatomic pathology lab test in the A/P module.

Figure 8–31: Tissue Exam Worksheet

Follow the steps below to complete a tissue exam worksheet:

1. Select a date and time for the tissue specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.

4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.
9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

8.10 Ordering a Radiology Procedure

The Order Rad tab allows you to order a radiology procedure for a specific encounter. Follow the steps below to order a radiology procedure in the A/P module:

1. Click the Order Rad tab. The Order Rad tab displays.

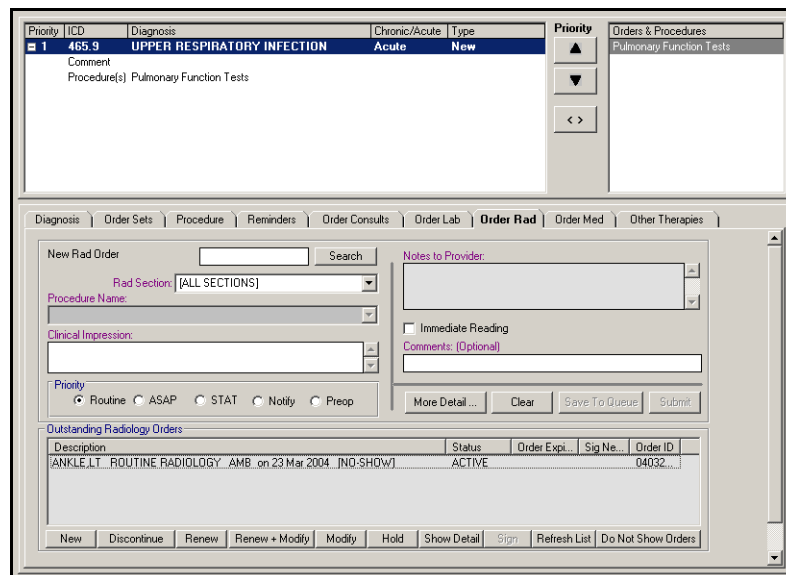


Figure 8–32: A/P Order Rad Tab

2. Complete the following fields:

-
- **New Rad Order:** In the *Search* field, enter the name of the desired radiology test and click **Search**. The results populate the Procedure Name drop-down list.
 - **Rad Section:** Select the departments for the desired procedure from the drop-down list. This narrows the results of the search but is not necessary. Select **All Sections** to see all available departments.
-

Note: The pre-verify process identifies and displays warnings regarding the Radiology order. Type a reason for the override in the Warnings window and click **Accept Override** to override the warning. Otherwise, click **Cancel Order** and select an alternative order.

- **Procedure Name:** Select the desired test from the drop-down list.
 - **Clinical Impression:** Enter the reason(s) for ordering the radiology procedure. This is a mandatory field.
-

Note: The previous clinical impression can carry over to the next radiology order by selecting **Yes** in the dialog box.

- **Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
 - **Immediate Reading:** Click the **Immediate Reading** check box to denote that the test should be read immediately.
 - **Comments or Instructions:** Enter any comments or instructions related to the radiology procedure.
 - **More Detail:** Click **More Detail** to view options for Schedule, Patient Mobility, and Requesting Location. After you click **More Detail**, the button changes to **Less Detail**.
 - **Schedule:** Select **one-time** or **continuous**.
-

Note: **Timing**, **Frequency** and **Duration** are only available if the continuous radio button is checked in **Schedule**.

- **Timing:** Select either **AM** or **HS** from the drop-down list.
 - **Start Date:** Click the drop-down arrow to open the calendar window. Select the start date.
 - **Frequency:** Click the drop-down list and select the frequency.
 - **Duration (Days):** Enter the duration.
 - **Patient Mobility:** Select the option that best defines the patient's mobility from the drop-down list.
-

- **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Radiology Orders area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order, allowing you to submit it at a later time.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the procedure to associate the procedure to a diagnosis.

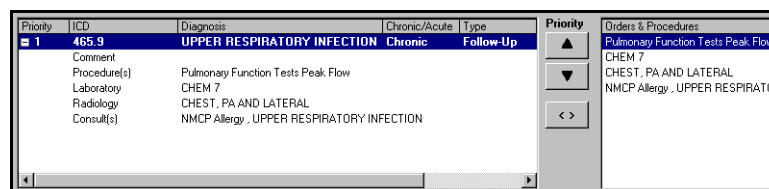


Figure 8–33: Added Radiology Test

8.11 Ordering a Medication

As you submit an outpatient medication order, the order is verified in CHCS to ensure that you have the proper privileges and that the selected medication is available. You can submit new orders and modify, renew, discontinue or change the status of previously processed orders. CHCS validates each order as it is submitted and alerts you to any requirements (such as co-signature required) or limiting circumstances (such as availability or patient allergies).

Follow the steps below to order a medication:

1. Click the Order Med tab. The Order Med tab displays.

The screenshot displays the 'A/P Order Med Tab' interface. At the top, a patient record is shown with the following details: Priority 1, ICD 465.9, Diagnosis UPPER RESPIRATORY INFECTION, Chronic/Acute Acute, and Type New. Below this, there is a 'New Med Order' section with various input fields: 'Item Name' (with a search bar and dropdown), 'SIG' (with an 'Expand SIG' button), 'Qty' (with 'Max' and 'Days Supply' sub-fields), 'Refills' (with a 'Maximum' sub-field), 'Default Unit', 'Start Date' (set to 29-Jun-2004), and 'Dispersing Location' (set to PROVIDER ORDER ENTER). There are also buttons for 'More Detail...', 'Clear', 'Save To Queue', and 'Submit'. At the bottom, a 'Current Outpatient Medications' table is visible with columns for Description, Last Fill, Refills, Status, Order Expl., Sig Ne., and Order ID. The interface includes navigation buttons like 'New', 'Discontinue', 'Renew', 'Renew + Modify', 'Modify', 'Hold', 'Show Detail', 'Sign', 'Refresh List', and 'Do Not Show Orders'.

Figure 8–34: A/P Order Med Tab

2. Complete the following sections:

- **New Med Order:** In the **Search** field, enter the medication name and click **Search**. The results populate the Item Name drop-down list.
- **Item Name:** Select the desired medication from the drop-down list populated by the search function.
- **SIG:** Enter a new SIG or use the one returned by the pre-verify process. If you follow the SIG with a number preceded with the number sign (e.g. #30), and press the <Enter> key, the Quantity field is populated with the number you entered. Click **Expand SIG** to view an expanded version of the displayed SIG code. The expanded **SIG** field provides a detailed explanation of the SIG codes returned from CHCS.
- **Quantity:** Enter the quantity to be dispensed. Use the unit of measure shown in the **Default Unit** field on the right side of the tab or the quantity shown with the name/description of the medication. Default = 30-days' supply, calculated from the **SIG**, **Quantity**, and **Refill** fields.
- **Refills:** Enter the number of refills. (Look in the **Maximum** field for the maximum number of refills allowed.) An error message displays if the number of refills is greater than the maximum (Maximum = maximum number of days' supply allowed).
- **Start Date:** Enter the date the medication is to start (or use the arrow cursor in the field to select a date). The start date can only be the current date or a date in the future.
- **Child Resistant Cap:** If you do not want a child resistant cap, deselect **Child Resistant Cap**.
- **Comment:** Enter comments you want associated with the medication.

- **More Detail:** Click **More Detail** to view options for the dispensing and requesting locations. After clicking **More Detail**, the button changes to **Less Detail**.
 - **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.
 - **Dispensing Location:** This field defaults to the associated pharmacy. Use the drop-down list to select another location.
3. Do one of the following:
- If all necessary information has been added and you want to submit the order, click **Submit**. You can see the order in the Current Outpatient Medications area.
 - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

CHCS pre-verifies the order against patient and medications records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. In addition, CHCS II now provides connectivity to the Pharmacy Data Transaction System (PDTS), a central data repository containing patient medication profiles for all beneficiaries. In order entry—meds, in the Assessment and Plan module, PDTS provides the CHCS II user with:

- Excessive and insufficient dose warnings
- Interaction, overlap and duplicate warnings, and warning override capabilities
- Warning overrides on renew and modify orders

If the pre-verify process identifies warnings regarding the order, the CHCS and PDTS warnings display in the same window. Select a reason for override with the **Warning Override Reasons** radio buttons to override the warning. Select a radio button under the **Order Cancellation Reasons** to cancel an order.

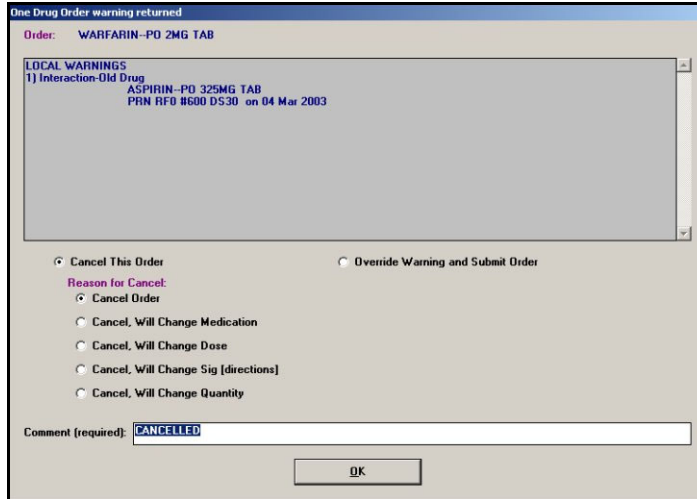


Figure 8–35: CHCS and PDS Warning Window

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

Note: Select the desired diagnosis and double-click the order to associate the order with a diagnosis.

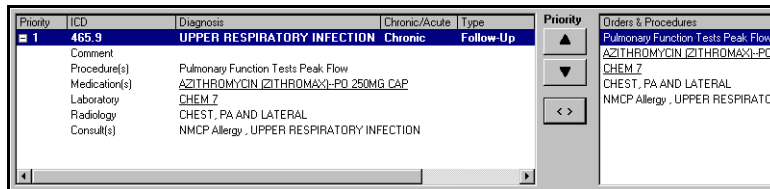


Figure 8–36: Added Medications

8.12 Requesting Location

Follow the steps below to select a requesting location:

1. Click the **More Detail** button.

Figure 8-37: Order Med Tab

2. Click the **Search** icon. The Find Requesting Location window opens.

Figure 8-38: More Detail

Figure 8-39: Find Requesting Location Window

- If necessary or desired you may refine a search by making a selection from the Location Type drop-down list in conjunction with entering a search string.

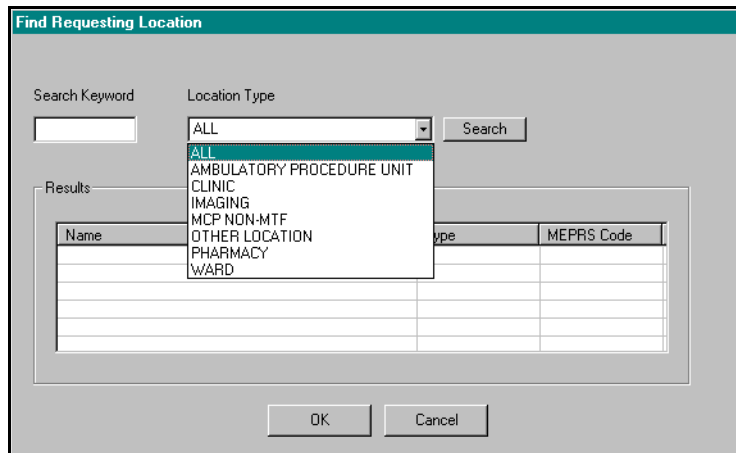


Figure 8–40: Location Type Drop-down List

- Alternatively, enter a search string and click the **Search** button. The search results display.

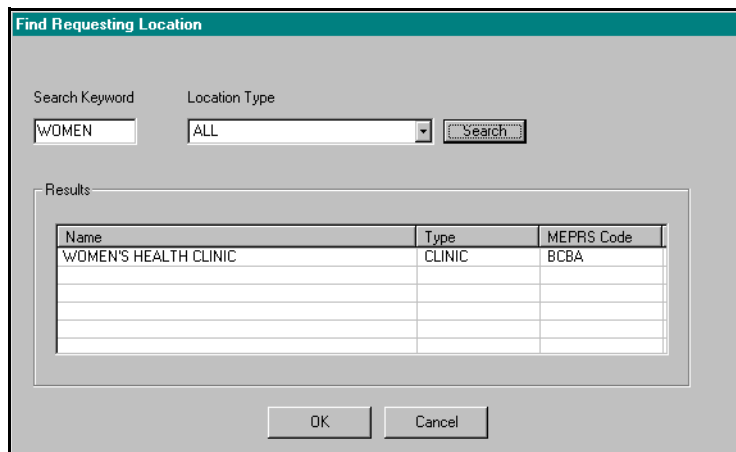


Figure 8–41: Search Results Displayed

- Select the desired search results and click **OK**. The selected Requesting Location display in the **Requesting Location** field.

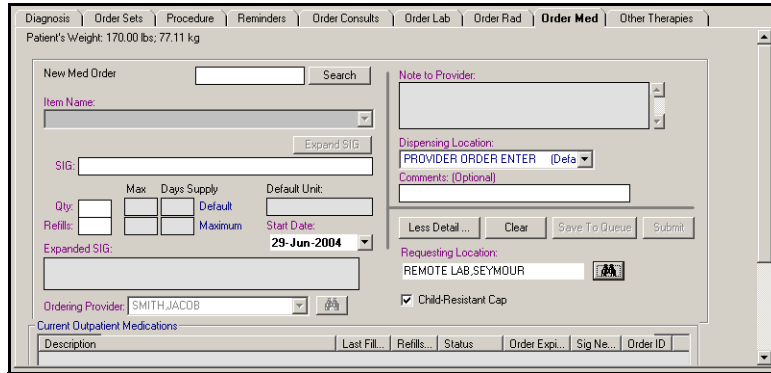


Figure 8-42: Requesting Location Field Populated

8.12.1 Adding Patient Instructions

The Other Therapies tab allows you to add patient instructions for a specific encounter. The instructions should be associated with selected diagnoses or procedures. They are not associated with patient handouts that may be provided to the patient.

Follow the steps below to enter other therapies:

1. On the A/P module, click **Other Therapies** to view the Other Therapies tab.

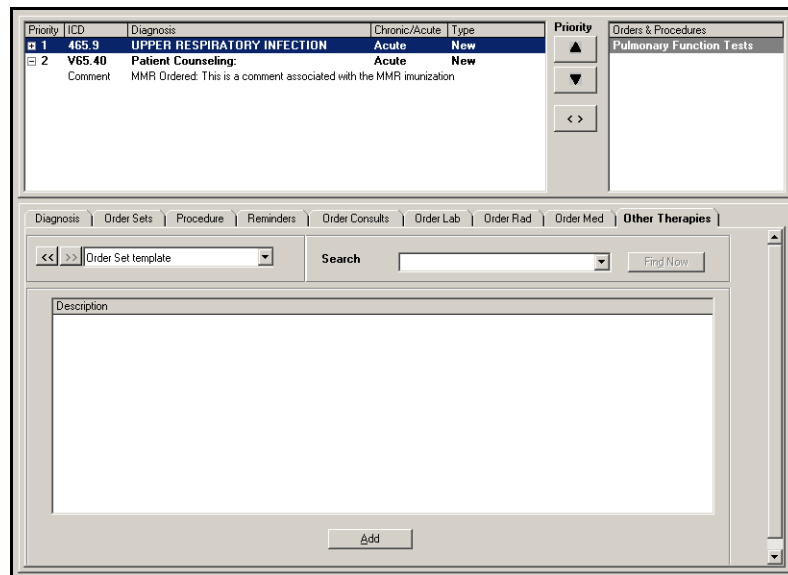


Figure 8-43: A/P Other Therapies Tab

2. Patient Instructions may be selected using the following methods:
 - Template List (see online help for descriptions)
 - Search (see online help for descriptions)

3. Select the instructions you want to add to the encounter.

Note: Instructions with a plus sign (+) next to them can be expanded to view associated instructions at a lower level. A minus sign (-) next to the instruction indicates the instruction is at the lowest level.

4. Click **Add**.
The instruction is added to the Orders and Procedures area and is associated with the selected diagnosis.
 - Follow the steps below to associate the order with a different diagnosis:
 - a. In the diagnosis list, select the instruction under the associated diagnosis.
 - b. Click the **Associates/Unassociates Orders & Procedures** icon.
 - c. Select the instruction and the diagnosis, and click the **Associates/Unassociates Orders & Procedures** icon to associate the instruction with the alternative diagnosis.
5. On the Action bar, click **Close**. The completed A/P is AutoCited in the Patient Encounter module.

Tip:

If the instruction was not automatically associated to the diagnosis, highlight the appropriate diagnosis and select the instruction.

Multiple instructions can be added using the same procedure.

8.13 Discontinuing an Order

Follow the steps below to discontinue an order:

1. From the Current Orders window at the bottom of the Order Entry window, select the order to be discontinued.
2. Click **Discontinue**.

8.14 Placing an Order on Hold

Follow the steps below to place an order on hold:

1. From the Current Orders window at the bottom of the Order Entry window, select the order.
2. Click **Hold**. The status of the order is changed to Hold.

8.15 Showing the Details of an Order

Follow the steps below to show details of an order:

1. From the Current Orders window at the bottom of the Order Entry window, select a specific order.
2. Click **Show Detail** to view the Detail window.
3. Click **OK** to return to the Order Entry window.

8.16 Renewing/Modifying an Order

Follow the steps below to renew an order:

1. From the Current Orders area at the bottom of the Order Entry tab, select the desired order.
2. Click **Renew**. The order is resubmitted exactly as it was previously ordered.

Follow the steps below to modify and renew an order:

1. From the Current Orders area at the bottom of the Order Entry tab, select the desired order.
2. Click **Renew & Modify**. The Enter Reason for Action window opens. Enter a reason for action and click **OK**.
3. Make the changes you want, then click **Submit**.

9.0 CLINICAL NOTES

9.1 Clinical Notes Overview

The Clinical Notes module displays patient-specific notes that are not associated with an encounter, including those that have been imported from non-CHCS II system text notes. Clinical Notes can be copied into the Add Note portion of the Encounter Summary (SF600).

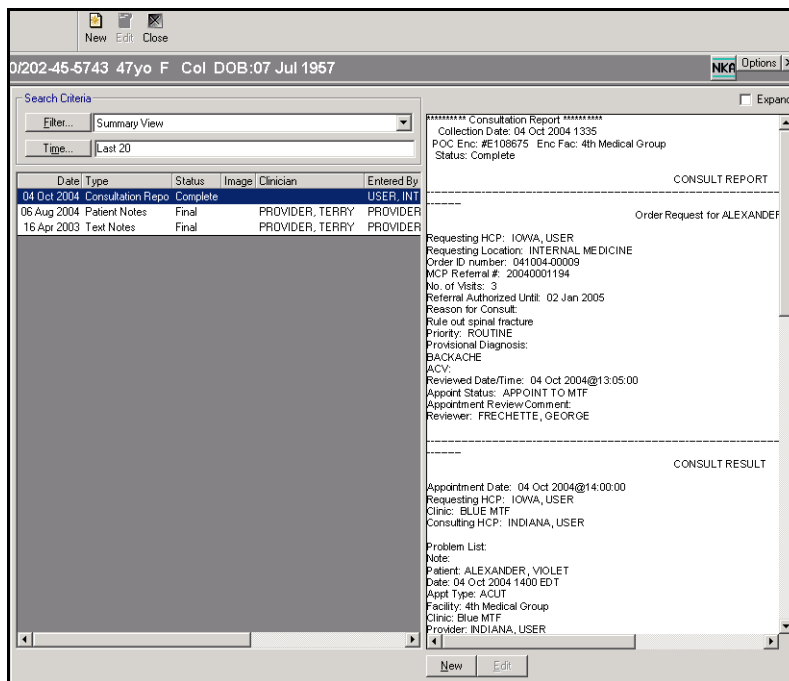


Figure 9-1: Military Clinical Desktop—Clinical Notes Module

9.1.1 In More Depth

The Clinical Notes module allows a CHCS II user to enter, view, and edit notes for a patient that are not associated with an encounter document.

The left side of the Clinical Notes screen displays a list of all the notes entered into the patient's medical record. The notes displayed are based on the Filter and Time search criteria selected by the end user. For each clinical note, the following fields are displayed:

- Date
- Type
- Status
- Image
- Clinician

- Entered By
- Edited By
- Point of Care (POC) Facility

When you highlight a note from the left pane, a preview of the note appears in the right side of the screen. The Expand checkbox in the upper right corner of the screen allows you to review an expanded view of a selected clinical note. Deselecting the checkbox returns the module to the default view.

In addition to creating and saving new notes to a patient's record in the Clinical Notes module, you can also view clinical notes that originate outside of the module. A consult ordered and completed in CHCS is viewable in the CHCS II Clinical Notes module as a Consult Report. Similarly, a consult ordered in CHCS II and completed in CHCS I is also viewable in the CHCS II Clinical Notes module.

9.1.2 Setting the Filter Properties for the Clinical Notes Module

The Filter tab enables the filter name, note type, and associated clinician to be selected.

Follow the steps below to set the filter properties for the Clinical Notes module:

1. Click **Filter** on the Clinical Notes module. The Properties window opens with the Filter tab displayed.

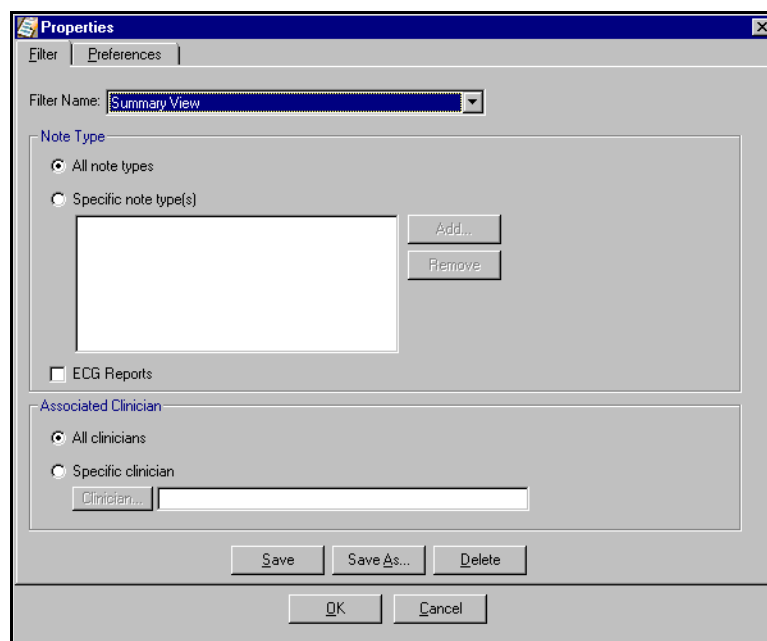


Figure 9–2: Clinical Notes Properties Window (Filter Tab)

2. Select a filter name from the drop-down list.
3. Do one of the following:
 - If you want to view a list of all note types, select **All Note Types**.

- If you want to view selected note types:
 - a. Select **Specific Note Type(s)**.
 - b. Click **Add**. The Healthcare Data Dictionary Search for Clinical Note Types window opens.

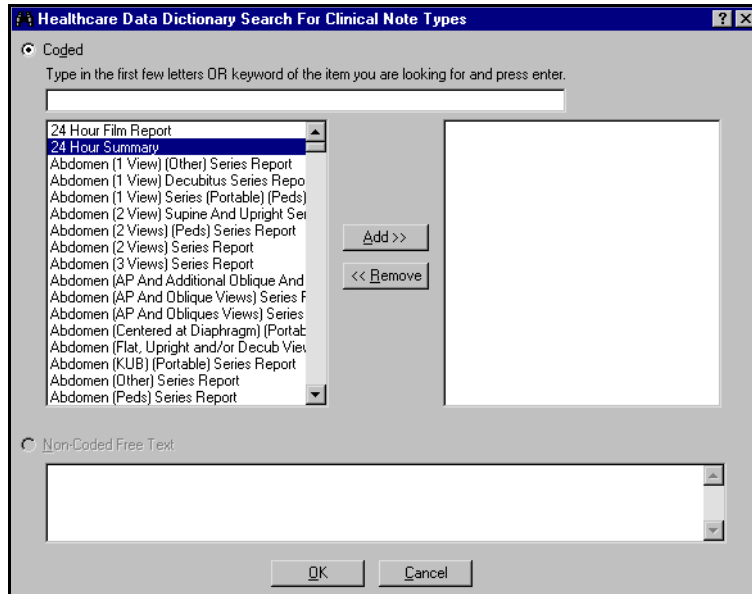


Figure 9-3: Healthcare Data Dictionary Search for Clinical Note Types Window

- c. Select the report(s) you want to add.
 - d. Click **Add**.
 - e. When you have finished adding the selected report(s), click **OK**. The selected reports display in the specific note type(s) area.
4. Do one of the following:
 - If you want to view clinic notes for all clinicians, select **All Clinicians**.
 - If you want to view clinic notes for selected clinicians:
 - a. Select **Specific Clinician**.
 - b. Click **Clinician**. The Clinician Search window opens.

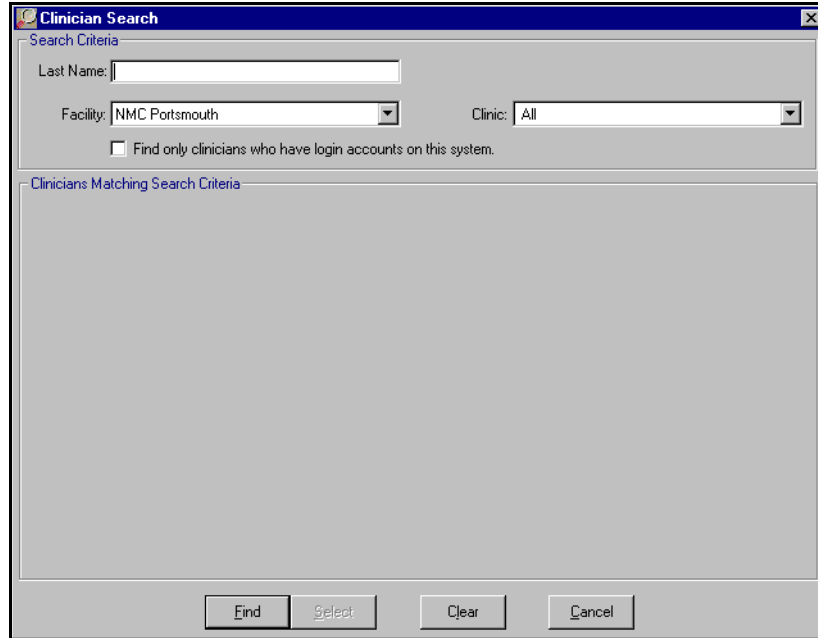


Figure 9-4: Clinician Search Window

- c. Search for the clinician.
5. Click **Save**.

Note: If it is a new filter selection, click **Save As**, enter the name of the new filter and click **Save**.

9.2 Setting Time Preferences for the Clinical Notes Module

The Preferences tab allows you to customize default times to be displayed on the Clinical Notes module.

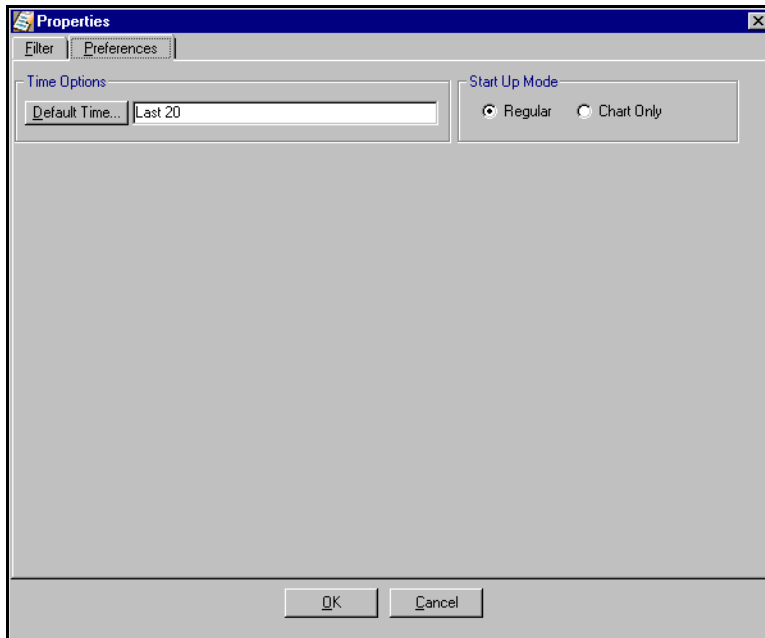


Figure 9-5: Clinical Notes Properties Window (Preference Tab)

Follow the steps below to set time preferences for the Clinical Notes module:

1. Click **Default Time** on the Preferences tab. The Time Search window opens.

Tip:
You can also set time preferences by clicking **Time** on the Clinical Notes module.

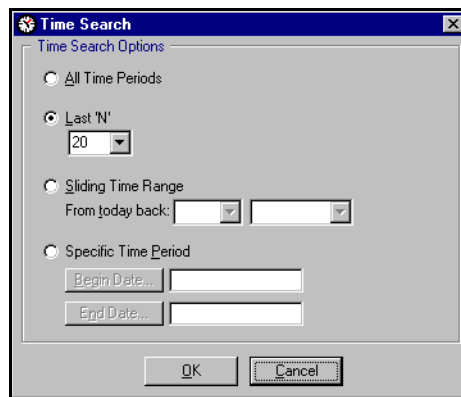


Figure 9-6: Time Search Window

2. Select a time search option.
3. Click **OK**.

Note: The data on the Clinical Notes module is refreshed according to the selected search option. All clinical notes meeting the criteria are listed on the Clinical Notes module. These become your default settings.

9.3 Creating a New Note

Follow the steps below to create a new clinical note for a patient:

1. Click **New** on the Clinical Notes module. The New Clinical Note window opens.

Note: The **Date** field defaults to the current date. If you want to change the date, enter a date or click **Date**. The Calendar window opens and a date can be selected.

Note: The **Clinician** field defaults to the name of the clinician who is currently logged on. If you want to change the clinician, click **Clinician** to search for the clinician you want to add.

Note: The **POC** field defaults to the facility name of the person logged on. Select a facility from the **POC** drop-down list to change the default facility.

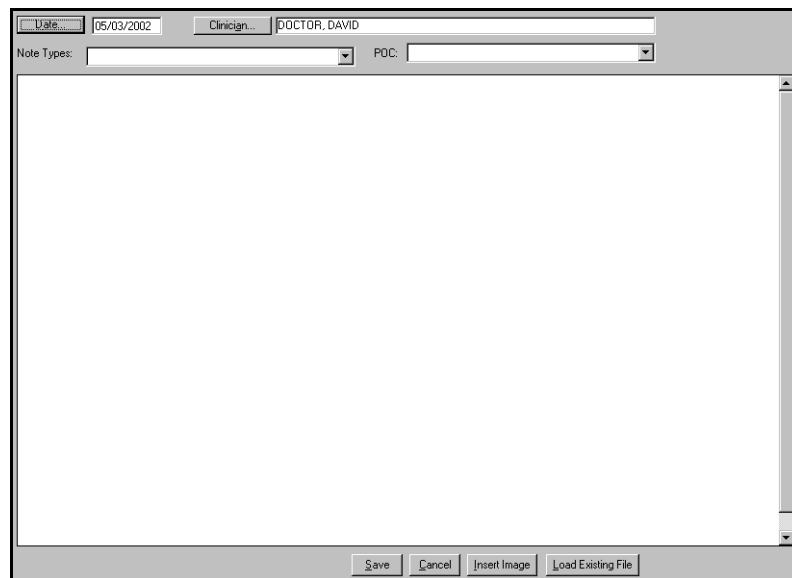


Figure 9–7: New Clinical Note Window

2. Select a Note type from the drop-down list.
3. In the text field, enter the note.
4. Do one of the following:
 - If you want to insert an image file (i.e., .tif, .bmp, .wmf) in the note:
 - a. Click **Insert Image**.
 - b. Select the file from the Select Destination File window.

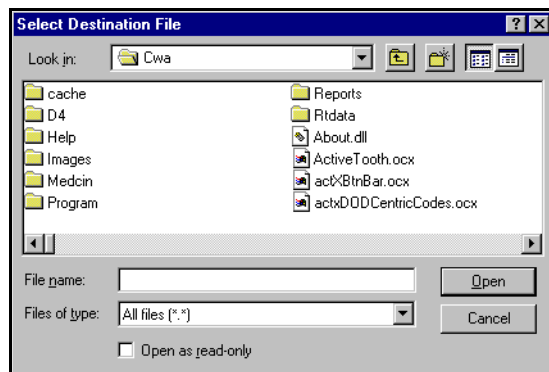


Figure 9–8: Select Destination File Window

- c. Click **Open**. The contents of the file are inserted in the note.

Note: Graphics that are imported must be 500K or less. If the file size is over this amount, the system gives you a message prompt.

- If you want to insert an existing file (e.g., .txt, .rtf, .html) in the note:
 - a. Click **Load Existing File**.
 - b. Select the file from the Select Destination File window.
 - c. Click **Open**. The contents of the file are inserted in the note.
5. Click **Save**. The note displays in the Clinical Notes module.

9.4 Editing a Note

Only the author of the note can modify clinical notes.

Follow the steps below to edit a note:

1. Select the note from the list of notes on the Clinical Notes module. The text of the note displays in the text section of the workspace.
2. Click **Edit** on the Action bar. The Edit window opens.
3. Enter the applicable changes.
4. Click **Save**. The modifications display in the note.

Note: Text notes imported from non-CHCS II systems cannot be edited.

10.0 CONSULT LOG

10.1 Consult Log Overview

The Consult Log module displays all of your consults, both ordered and received. The log displays and continually updates statuses and other information for each consult as it progresses through its lifecycle. In this fashion, the system establishes a tracking log of all actions. The Consult Log can be viewed by Consults Log For Me, Consults Log From Me or Both.

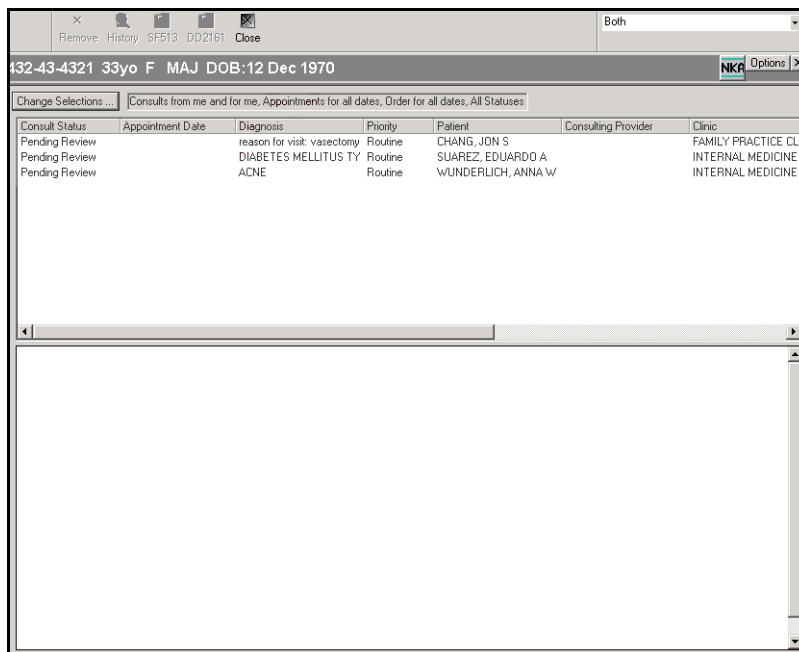


Figure 10-1: Military Clinical Desktop—Consult Log Module

10.1.1 In More Depth

Consults can be sorted (by consult status, appointment date, FMP/SSN, clinical specialty, diagnosis, priority, patient, consulting provider, or PCM) by simply clicking on the perspective column header.

Any actions that have occurred in reference to a consult listed in the Consult Log area of the Consults module can be viewed. The SF 513 and DD 2161 can be printed from the Consult Log module.

10.2 Setting the Consult Log Filter

The Consult Log can be viewed by Consults Log For Me, Consults Log From Me, or both.

Tip:
Use the scrollbar at the bottom of this area to view the additional Consult Log fields.

Select the filter from the drop-down list in the top, right corner of the Consult Log window to set the Consult Log filter. The consults meeting the criteria appear in the list of consults.

10.3 Setting the Consults Change Selection Criteria

The Consult Log filter allows the user to show consults for the provider, from the provider, or both. The Consult Log Selections Dialog box enables you to apply more advance filters. Options are available to select a consult status, appointment date, consult order date, patient SSN, PCM, or clinical specialty. Once selections are made, you can make them the default settings or just for the current session.

Follow the steps below to set the consults change selection criteria:

1. Click **Change Selections** on the Consult Log module. The Consult Log Selections window opens.

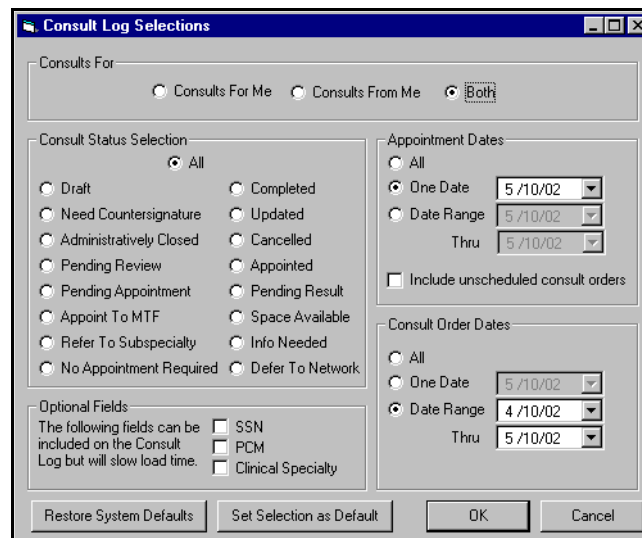


Figure 10–2: Consult Log Selections Window

2. Select an option in the Consults For area.
3. Select an option in the Consult Status Selection area.
4. Select an appointment date or range.
5. Select a consult order date or range.
6. Select the optional fields, as necessary, you want to display. The optional fields display as additional columns in the Consult Log workspace.
7. Click **OK** to set the selected search criteria. The data on the Consult Log is refreshed according to the search criteria.

10.4 Printing a Consult

You have the capability to print a selected consult on an SF513 form.

Follow the steps below to print a consult:

1. Select the consult you want to print from the Consult Log.
2. Click **SF513** on the Action bar. A Print Preview window opens.

The screenshot shows a 'Print Preview' window with a toolbar at the top (83% zoom, navigation arrows, 1 of 1 page, printer icon). The form content is as follows:

MEDICAL RECORD		CONSULTATION SHEET	
REQUEST			
TO:	FROM: (Requesting physician or facility)	DATE OF REQUEST	
	DOCTOR, COX1	27 SEP 2002	
REASON FOR REQUEST (Complaint and findings)			
Allergic Rhinitis not controlled with medication and environmental measures. Please consider for testing and immunotherapy.			
ANTICIPATED LENGTH OF TREATMENT:			
PROVISIONAL DIAGNOSIS			
ALLERGIC RHINITIS			
DOCTOR'S SIGNATURE	APPROVED*	PLACE OF CONSULTATION	URGENCY
		<input type="checkbox"/> RESIDE <input type="checkbox"/> ON CALL	Routine
CONSULTATION REPORT			
Referring Provider: DOCTOR, COX1			
Date of Request: 27 Sep 2002			
Priority: Routine			
Provisional Diagnosis:			
ALLERGIC RHINITIS			
Reason for Request:			
Allergic Rhinitis not controlled with medication and environmental measures. Please consider for testing and immunotherapy.			
SIGNATURE AND TITLE		DATE	

Figure 10-3: Consult Print Preview Window

3. Click the print icon. The form is sent to your designated printer.

10.5 Removing a Consult

A consult with a status of Draft or Pending Appointment can be removed from the Consult Log. Consults should be removed from the log when appropriate. This reduces the number of consults to be pulled from the database; therefore, reducing the amount of time it takes to open a consult log module.

Follow the steps below to remove a consult:

1. Select the consult from the Consult Log.
2. Click **Remove** on the Action bar.

Consult Status	Appointment Date	FMP/SSN	Clinical Specialty	Diagnosis	Priority	Patient
Pending Appointment	01/528253211			chest pain	Routine	GADD, ALEX
Pending Appointment	03/426062578			DERMATOLOGY - BACTE	Routine	LUCKY, BRANDON
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Cancelled	20/225874141			DERMATITIS DUE TO CO	Routine	SASAL, GEORGE
Pending Review	99/806700102			CHRONIC FATIGUE SYND	Routine	DOE, JOHN494
Cancelled	02/272403597			reported a family history of -	Routine	CHASE, ADAM
Cancelled	02/272403597			reported a family history of -	Routine	CHASE, ADAM
Pending Appointment	02/272403597			HEAT RASH	Routine	CHASE, ADAM
Cancelled	01/253373241			HEAT RASH	Routine	JOHNSON, KEANNA
Pending Appointment	02/272403597			DIAPER RASH	Routine	CHASE, ADAM

Figure 10-4: Consult Status—Cancelled

10.6 Viewing the History of a Consult

Any actions that have occurred in reference to a consult listed can be viewed.

1. Select the appropriate consult from the Consult Log list.
2. Click **History** on the Action bar. The Consult History window opens.

Date	User	Action
05 Jul 2001 17:07:40	PROVIDER, DYLAN	Submitted consult order
05 Jul 2001 17:25:26	PROVIDER, EMMA	Created Appointment

Figure 10-5: Consult History Window

3. View the information in the Consult History window.
4. Click **OK**.

11.0 Co-SIGNS

11.1 Co-signs Overview

The Co-Signs module displays a list of all of the encounters that an individual provider needs to co-sign. The provider can co-sign the appropriate encounters from this module as well as view encounter details, amend the encounter, and add a narrative.

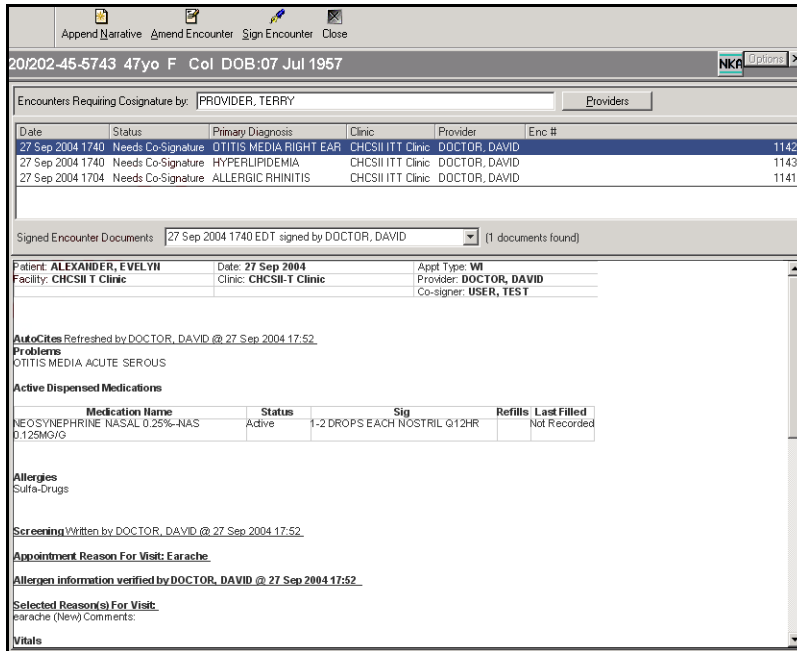


Figure 11–1: Military Clinical Desktop— Co-signs Module

11.1.1 In More Depth

The top of the module displays a list of all the encounters requiring co-signatures for the provider logged in. View details of a specific encounter by clicking once on the desired encounter and viewing the details in the bottom half of the workspace.

Clinical team members can set a co-signer when signing an individual encounter or as a default in the AutoCite Properties window.

11.2 Co-Signing an Encounter

All encounters needing co-signatures from the provider currently logged in are listed at the top of the window with the status of Needs Co-Signature.

Follow the steps below to co-sign an encounter:

1. Select the encounter you want to co-sign.
2. Click **Sign Encounter**. The Co-Sign Encounter window opens.

Tip:
Click the **Sensitive** checkbox if you want to mark the appended note as sensitive.

Co-Sign Encounter

Patient: **ALEXANDER, EVELYN L** Date: **27 Sep 2004 17:40 EDT** Appt Type: **WI**
 Facility: **CHCSII ITT Facility** Clinic: **CHCSII ITT Clinic** Provider: **DOCTOR, DAVID**
 Patient Status: _____ Co-signer: **USER, TEST**

Reason for Appointment:
AutoCites Refreshed by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT
Problems
 OTITIS MEDIA, ACUTE SEROUS

Active Dispensed Medications

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Allergies
 Sulfa-Drugs

Screening Written by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT
Appointment Reason For Visit: Earache
Allergen information verified by DOCTOR, DAVID @ 27 Sep 2004
Selected Reason(s) For Visit:
 earache (New) Comments:

Vitals
Vitals Written by DOCTOR, DAVID @ 27 Sep 2004

Enter Your Password: Auto-Print Sensitive

Figure 11-2: Co-Sign Encounter Window

3. In the **Enter Your Password** field, enter your password.
4. Click **Sign**.

11.3 Co-Signing an Encounter for Another Provider

Any provider with co-signing privileges can access and subsequently co-sign encounters assigned to another provider.

Follow the steps below to co-sign encounters for another provider:

1. Click **Providers** on the Co-Signs window. The Clinician Search window opens.
2. Search for the clinician. The Co-Signs window displays the list of encounters requiring the selected provider's co-signature.
3. Select the encounter to be co-signed.
4. Click **Sign Encounter**. The Co-Sign Encounter window opens.
5. In the **Enter Your Password** field, enter your password.
6. Click **Sign**.

11.4 Appending a Narrative

The Append Narrative function enables you to attach text or a graphic file to an encounter. Graphics that are imported cannot be greater than 500K. The narrative

appears at the bottom of the encounter, stamped with the time, date, and author's name. After appending a narrative, the note must still be co-signed.

Follow the steps below to append a narrative:

1. Select an encounter.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens.

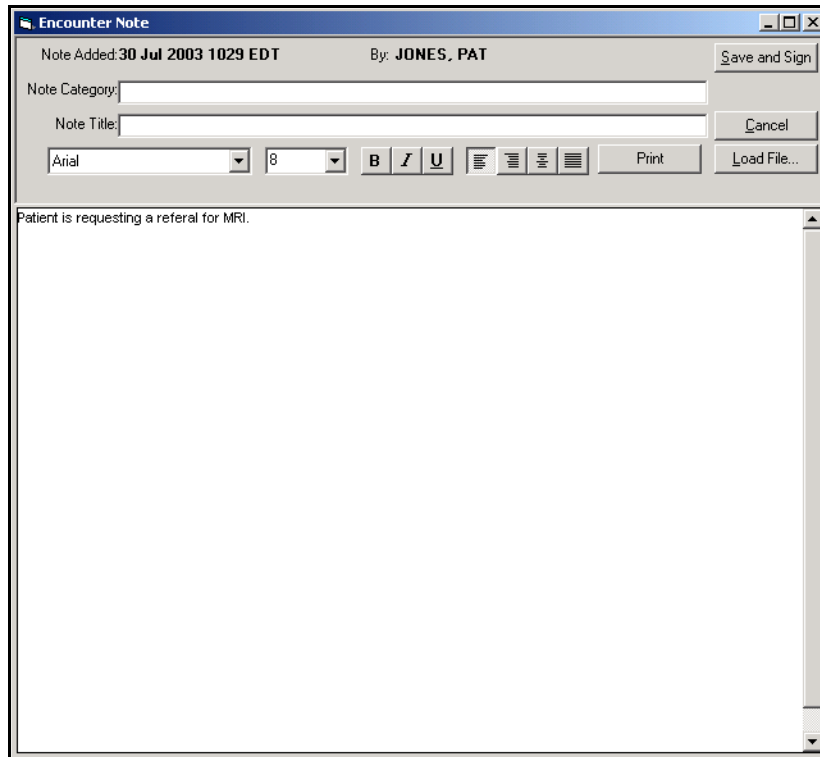


Figure 11–3: Encounter Note Window

3. Enter a note category, if appropriate.
4. Enter a note title, if appropriate.
5. Enter the note in the text box.
6. Do one of the following:
 - If you want to insert a file into the note:
 - a. Click **Load File**. The Select Destination File window opens.

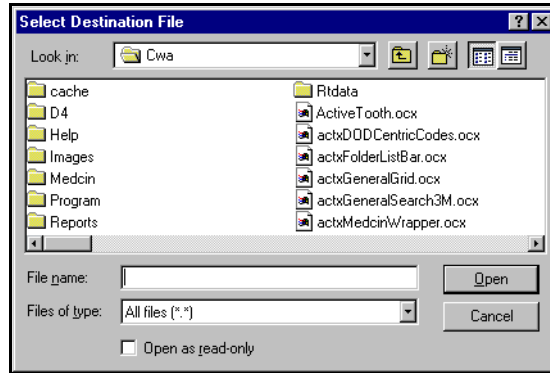


Figure 11-4: Select Destination File Window

- b. Select the desired file to be added.
- c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Save and Sign**. The Sign Appended Note window opens, so you can review the narrative before signing.

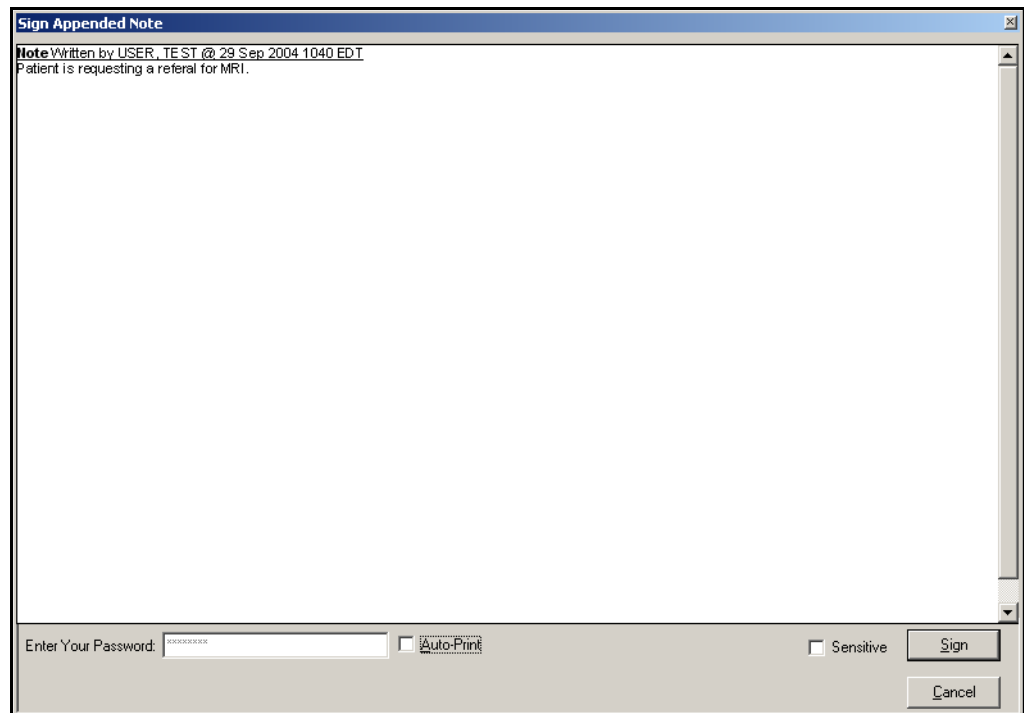


Figure 11-5: Sign Appended Note Window

8. In the **Enter Your Password** field, enter your password.

- Click **Sign**. The narrative appears at the bottom of the encounter summary with the Time, Date, and Provider name next to the narration.

11.5 Amending an Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. Each section that is amended includes the co-signer's name and date stamp. A note is added to the document under Change History at the bottom of the encounter summary stating that the encounter has been amended.

Follow the steps below to amend an encounter:

- Select the encounter you want to amend.
- Click **Amend Encounter** on the Action bar. The Patient Encounter window opens for the selected encounter.

Note: The original AutoCited information is moved to the Change History section of the electronic SF600. The AutoCites are refreshed with current information.

The screenshot displays a patient encounter summary window with the following details:

- Date:** 27 Sep 2004 1740 EDT
- Status:** Needs Co-Signature
- MTF:** NMC Portsmouth
- Primary Provider:** DOCTOR, DAVID
- Type:** WI
- Clinic:** MTF NMCP Int Med
- Patient Status:** Reason for Appointment:
- AutoCite:** AutoCites Refreshed by @ 27 Sep 2004 1713 EDT
- Problems:** OTITIS MEDIA ACUTE SEROUS
- Active Dispensed Medications:**

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded
- Allergies:** Sulfa-Drugs
- Screening:** Screening Written by DOCTOR, DAVID @ 27 Sep 2004 1713 EDT
- Appointment Reason For Visit:** Earache
- Allegen information verified by:** DOCTOR, DAVID @ 27 Sep 2004
- Selected Reason(s) For Visit:** earache (New Comments)
- Vitals:** Vitals Written by DOCTOR, DAVID @ 27 Sep 2004. HR: 90, RR: 16, T: 100.1 °F, WT: 12 kg
- S/O:** S/O Note Written by DOCTOR, DAVID @ 27 Sep 2004 1740 EDT
 - Chief complaint:** The Chief Complaint is: Earache.
 - History of present illness:** The Patient is a 2 year 3 month old female who reported a fever of 102.2 axillary. Treated with Motrin and did come down but will return in 8-8 hours. She reported an earache in the right ear and pulling at the right ear for 3 days.
 - Past medical/surgical history:**
 - Diagnosis History:** OTIS media age 18m
 - Personal history:** Family: The child is enrolled in day-care.

Figure 11–6: Patient Encounter Summary

- Update applicable sections of the encounter.

Note: Any changes replace the original information on the electronic SF600. The original information is moved to the Change History section.

- Once the changes have been made, you must sign the amended encounter. Click **Sign** on the Action bar. The Co-Sign Encounter window opens.

Note: If information is changed in or added to the A/P module, you receive a warning message suggesting you return to the Disposition module to verify the E&M code.

Co-Sign Encounter

Patient: **ALEXANDER, EVELYN L** Date: **27 Sep 2004 17:40 EDT** Appt Type: **WI**
 Facility: **CHCSII ITT Facility** Clinic: **CHCSII ITT Clinic** Provider: **DOCTOR, DAVID**
 Patient Status: _____ Co-signer: **PROVIDER, TERRY**

Reason for Appointment:

AutoCites Refreshed by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT

Problems
 OTITIS MEDIA ACUTE SEROUS

Active Dispensed Medications

Medication Name	Status	Sig	Refills	Last Filled
NEOSYNEPHRINE NASAL 0.25%-NAS 0.125MG/G	Active	1-2 DROPS EACH NOSTRIL Q12HR		Not Recorded

Allergies
 Sulfa-Drugs

Screening Written by DOCTOR, DAVID @ 27 Sep 2004 17:13 EDT

Appointment Reason For Visit: Earache

Allergen information verified by DOCTOR, DAVID @ 27 Sep 2004

Selected Reason(s) For Visit:
 Earache (New) Comments:

Vitals
 Vitals Written by DOCTOR, DAVID @ 27 Sep 2004

Enter Your Password: Auto-Print Sensitive

Figure 11-7: Co-Sign Encounter Window

- In the **Enter Your Password** field, enter your password.
- Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments and you are returned to the Appointments module.

12.0 DEMOGRAPHICS

12.1 Demographics Overview

The Demographics module displays the patient's demographic information. Certain demographic information can be updated. The patient's home address, city, state, zip code, country, home and work phone, e-mail address, religion, comments, and the location of the records can be modified in the Edit mode. Third-Party insurance information, Special Work Status, and Required Fields information can be viewed and modified. Information on a patient's Primary Care Manager (PCM) and the Defense Enrollment Eligibility Reporting System (DEERS) eligibility cannot be modified.

The screenshot shows a software interface for patient demographics. At the top, there is a menu bar with 'Edt', 'Save', 'Cancel', 'Ins. Form', and 'Close'. Below the menu bar, the patient's ID '20/202-45-5743' and other details '47yo F Col DOB:07 Jul 1957' are displayed. The main area is divided into several sections: 'Patient Information' with fields for Name, SSN, Medicare Eligibility, Birth Date, Age, Marital Status, Race, Patient Category, Home Address, City, State/Country, Zip, Email, Home Phone, Work Phone, and Religion; 'FMP' (Family Member Profile) with fields for FMP number, Enrollment Facility, Facility Description, and ADV/Enrollment Status; 'Prim. Care Mgr.' (Primary Care Manager) with a dropdown menu; 'Spec Wk Status' (Special Work Status) with a dropdown menu; 'DEERS Eligibility' (Defense Enrollment Eligibility Reporting System) with a dropdown menu showing 'Eligible'; 'Required Fields' (SADR Data Complete) with a dropdown menu; 'Sponsor Information' with fields for Name, SSN, UIC, Rank/Grade, and Service; and 'Insurance Information' with a table for Insurance Company Name, Address, Policy Number, Group Name, Group Number, and Insurance Co. Phone. At the bottom, there is a button 'Enter Changes to Patient Insurance Information' and a 'Completed' status indicator.

Figure 12-1: Military Clinical Desktop—Demographics Module

Note: Any edits to the demographic information in CHCS II are overwritten by CHCS and DEERS updates.

12.1.1 In More Depth

The Demographics module contains pertinent information about the patient that is pulled from CHCS. Although certain demographic elements can be edited in the Demographics module, any edits to the demographic information are overwritten by the information held in the Defense Eligibility Enrollment Reporting System (DEERS).

Most of the demographic information can be viewed and edited outside of an encounter. A current encounter must be open in order to modify the patient's Special Work Status or enter new third-party insurance information.

12.1.2 Editing Demographic Information

Certain demographic information can be updated in the Patient Demographics module. These fields include a patient's religion, home address, home and work phone, comments, and the location of the records. The rest of the information on the left is read-only and can only be updated in CHCS.

Follow the steps below to edit demographic information:

1. In the Appointments List, select a patient name.
2. In the Folder list, click **Demographics**. The Demographics module opens.
3. On the Action bar, click **Edit**.

The screenshot displays the Demographics Module interface for patient ALEXANDER, VIOLET. The form is divided into several sections:

- Patient Information:**
 - Name: ALEXANDER, VIOLET
 - SSN: 202-45-5743
 - Medicare Eligibility: (blank)
 - Birth Date: 07 Jul 1957
 - Age: 47yo
 - Sex: F
 - Marital Status: Married
 - Race: Black
 - Patient Category: M11 USMC ACTIVE DUTY
 - FMP: 20
 - Enrollment Facility: 4th Medical Group
 - Facility Description: (blank)
 - ACV/Enrollment Status: (blank)
 - Home Address: 789 MAIN ST
 - City: ANYWHERE
 - State/Country: NY
 - Zip: 12345
 - Email: (blank)
 - Home Phone: 123 - 333 - 3333
 - Work Phone: 123 - 333 - 4444
 - Religion: (drop-down menu)
 - Comments: (text box)
 - Command Interest: (text box)
 - Command Security: (text box)
 - Prim. Care Mgr: (button)
 - Spec W/ik Status: (button)
 - DEERS Eligibility: (button)
 - Required Fields: Eligible
 - SADR Data Complete: (button)
 - Records Maintained At: (drop-down menu)
- Sponsor Information:**
 - Name: ALEXANDER, VIOLET
 - Sponsor SSN: 202-45-5743
 - UIC: SM1CFH76 (0004 TRANSPOR...)
 - Rank/Grade: COLONEL
 - Service: MARINES
- Insurance Information:**

Insurance Company Name	Address	Policy Number	Group Name	Group Number	Insurance Co. Phon
[Empty table with scroll bar]					

At the bottom of the form, there is a button labeled "Enter Changes to Patient Insurance Information" and a "Completed" status indicator.

Figure 12–2: Demographics Module

4. Update the necessary fields in the Demographics module.
 - **Home Address, Phone Numbers, and E-Mail:** Enter necessary changes in the applicable fields. Tab or use the mouse to move to the next field.

Note: The **Country** field is limited to 12 characters including spaces.

- **Religion:** Use the drop-down list to select the desired religion.
- **Comments:** In the Comments text box, enter information applicable to the Demographics module.
- **Records Maintained At:** Use the drop-down list to select the location of the patient's paper records. Use the scroll bar to view all options.

5. On the Action bar, click **Save**. Once the information is saved, it is visible upon returning to the Demographics module, unless it has been overwritten by CHCS or DEERS.

Tip:
Right-click in any of the test fields to access the editing functions (cut, copy, paste).

12.2 Viewing Primary Care Provider Information

Follow the steps below to view primary care provider information:

1. Click **Prim. Care Mgr**. The Primary Care Manager Information window opens containing read only information.

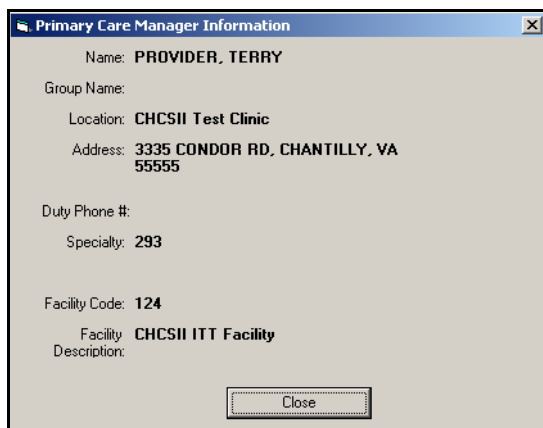


Figure 12-3: Primary Care Manager Information Window

2. Click **Close** to return to the Demographics module.

12.3 Modifying Special Work Status

An encounter must be open in order to modify Special Work Status. If an encounter is not open, the **Special Work Status** button is disabled. When an encounter is open, the button is enabled and Special Work Status information can also be modified. This information can be modified in the Demographics module, the Screening module, and the Disposition module.

Follow the steps below to modify special work status:

1. Click **Spec Wrk Status**. The Special Work Status window opens.

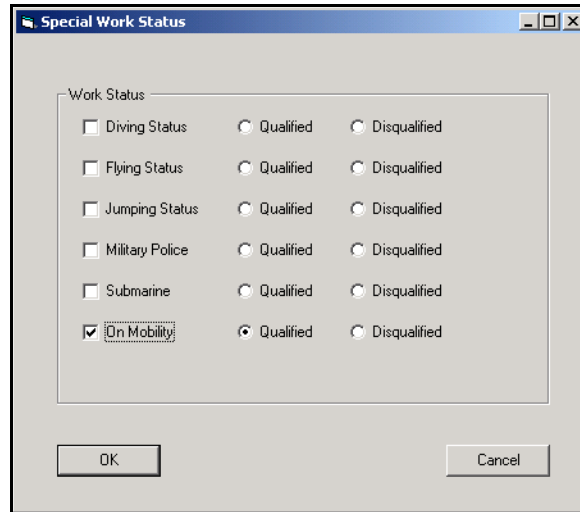


Figure 12–4: Special Work Status

2. Select the checkbox next to each applicable work status.
3. Select **Qualified** or **Disqualified** for the associated work status.
4. Click **OK**. You are returned to the Demographics module and the icon associated with the selected work status appears on the Patient ID Bar.

12.4 Viewing DEERS Eligibility

Follow the steps below to view DEERS Eligibility:

1. Click **DEERS Eligibility**. The DEERS Eligibility window opens. This is a read-only window.

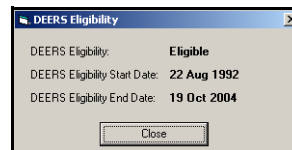


Figure 12–5: DEERS Eligibility Window

12.5 Updating Required Fields

If the fields that are required for each patient have not been completed, SADR Data Incomplete appears in red beside the button.

Follow the steps below to update required fields:

1. Click **Required Fields**. The Required Fields window opens.

Figure 12–6: Required Fields Window

2. The following fields must be updated if there are any changes or errors:
 - **Family Member Prefix (FMP):** Enter the FMP.
 - **Military Grade/Rank:** Enter the correct grade or rank.
 - **Health Care Delivery Program (HCDP):** Use the drop-down list to select the additional insurance plan.
3. Click **Save Changes** to update the record and open the Demographics module. Once the SADR information is complete, SADR Data Complete appears beside the **Required Fields** button.

12.6 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Appointments and Demographics modules. This form defaults to the current date and includes demographic information with space to update the address, phone numbers, current insurance information, and questions for the patient to answer regarding any changes.

Follow the steps below to print the Insurance Form:

1. Click **Ins. Form** on the Action bar to print an insurance form for a patient. The Print Preview window opens.
2. Click the print icon on the Preview window to print the form. The form is sent to your designated printer.

12.7 Entering New Third-Party Insurance Information

An encounter must be open in order to enter third-party insurance information. If an encounter is not open, No Encounter Open displays next to the disabled **Enter Changes to Patient Insurance Information** button. When an encounter is open, the button is enabled and insurance information can be documented.

Follow the steps below to enter new third-party insurance information:

1. Click **Enter Changes to Patient Insurance Information**. The Patient Insurance Information window opens.

Does patient have health insurance other than Medicare or Champus?
 Yes No

Has any health insurance information changed since last visit?
 Yes No

Insurance Company Name:

Insurance Company Telephone:

Insurance Company Address:

Insurance ID Number:

Group Name:

Group Number:

Subscriber's Name:

Patient's Relationship to Subscriber:

Effective Date... 30 Jul 2003

Expiration Date... 30 Jul 2003

Person Capturing Information:

Information Source:

Comments:

Figure 12--7: Patient Insurance Information Window

2. Click either **Yes** or **No** in response to the first two questions.
3. Enter the applicable information into the following fields:
 - **Insurance Company Name:** Enter the name of the insurance company.
 - **Insurance Company Telephone:** Enter the company's phone number.
 - **Insurance Company Address:** Enter the company's address.
 - **Insurance ID Number:** Enter the policy number.
 - **Group Name:** Enter the name of the group with which the subscriber is associated.
 - **Group Number:** Enter the group number.
 - **Subscriber's Name:** Enter the name of the policy holder.
 - **Patient's Relationship to Subscriber:** Enter the relationship of the patient to the person subscribed to the insurance policy.
 - **Effective Date/Expiration Date:** Select these buttons to access the Calendar window in order to select the effective date and the expiration date for the insurance policy.

Note: The system defaults to the current date.

- **Person Capturing Information:** Enter the name of the person filling out this form.
 - **Information Source:** Enter the source of the insurance information.
 - **Comments:** Enter any comments for this entry.
4. Click **Save**.

13.0 DISPOSITION

13.1 Disposition Overview

The Disposition module is used to document the disposition and E&M codes of an encounter. In this module, you can record the discharge status of the patient from the clinic, follow-up information, and the patient's understanding of the assessment and plan. In addition, the E&M codes are calculated and selected.

The screenshot shows the Disposition Module interface. At the top, there is a menu bar with options: Save, Add Providers, S/O, A/P, Sign, Cancel, Clear All, Close. Below the menu bar, the patient information is displayed: 1202-45-5743 47yo F Col DOB:07 Jul 1957. The interface is divided into several sections:

- Disposition:** A dropdown menu set to "Released w/o Limitations".
- Encounter Context:** Two checkboxes: "Related to Injury/Accident?" and "Patient Pregnant", both unchecked.
- Billing and Admin:** "Billing Chief Complaint:" dropdown set to "465.9 - UPPER RESPIRATORY INFECTION". "Appt Class:" dropdown set to "Outpatient". "Meets Outpt Visit Criteria (Workload)?" dropdown set to "Yes".
- Follow Up:** Checkboxes for "PRN", "With PCM", and "In Clinic". "When" and "For Tx:" dropdowns.
- Discussed:** Checkboxes for "All Items Discussed", "Diagnosis", "Medication(s)/Treatment(s)", "Potential Side Effects", and "Alternatives". A dropdown for "indicated understanding" and a "Comments..." button.
- Time Factor:** Checkboxes for ">50% time spent counseling or coordinating care" and "Total face to face or floor time in minutes:" with a numeric input set to 30.
- Calculated | Selection | Additional E&M Coding:** A section with "Patient Status:" dropdown set to "Existing Patient", "Exam Type:" dropdown set to "General Multi-System", and a "Reset" button.
- Setting:** Dropdown set to "Outpatient".
- Service Type:** Dropdown set to "Outpatient Visit".
- E&M Calculator Table:** A table with columns: HPI, RDS, PFSH, Overall History, Exam, Dx/Mgt Options, Complexity of Data, Overall MDM, Problem Risk, Tests Risk, Mgt Risk, Overall Risk. Each cell contains a grid of numbers 1, 2, 3, 4.
- Default Calculation:** A dropdown set to "99213 - Estab Outpatient Expanded H&P - Low Complexity Decisions".
- With User overrides:** A checkbox that is unchecked.

Figure 13-1: Military Clinical Desktop—Disposition Module

13.1.1 In More Depth

The Disposition module is typically the last module in the patient encounter process. It collects information from the entire process and begins the coding and billing processes. Options found on the Disposition module are dependent on the appointment type, appointment classification and whether or not the appointment is a count or no-count visit.

The bottom part of the module houses the E&M Calculator. CHCS II calculates a suggested code for the encounter based on the structured terms and documentation entered in the S/O and A/P modules and the appointment type, patient status, service type and whether or not the encounter was a counseling visit. Calculation is completed

using the 1997 Documentation Guidelines from the Centers for Medicare and Medicaid Services (CMS).

Note: The CMS organization was previously known as the Healthcare Financing Administration (HCFA).

13.2 Completing the Disposition

13.2.1 Assigning a Disposition

Follow the steps below to assign a disposition:

1. Select the appropriate disposition from the Disposition drop-down list. You can only select one option. Depending on whether the patient's appointment classification is outpatient or inpatient, different options are available.

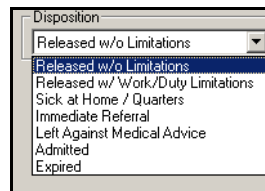


Figure 13–2: Disposition Drop-down List Outpatient

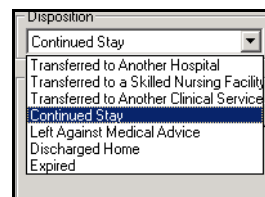


Figure 13–3: Disposition Drop-down List Inpatient

Based on your selection, additional fields become active and require input:

- If **Released with Work/Duty Limitations** is selected, click **Profile** to document the limitation. The Temporary Profile window opens.

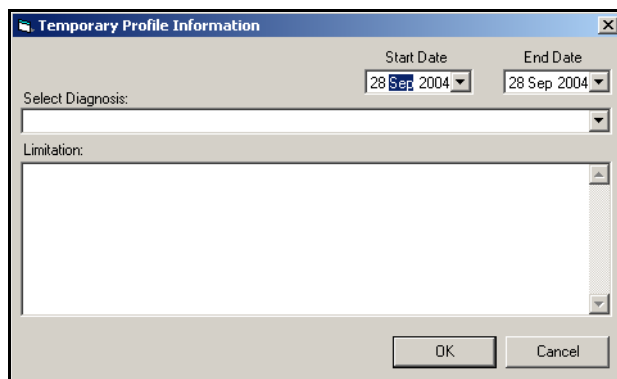


Figure 13–4: Temp Profile Window

- **Start Date and End Date:** Select the appropriate time frame by clicking the drop-down arrow and selecting the dates from the calendar.
- **Diagnosis:** Select the diagnosis causing the limitation from the drop-down list.
- **Limitation:** In the Limitation free text field, describe the patient's limitations.
- Click **OK**. The profile is documented and is displayed on the electronic SF600.

Note: You are still required to complete a paper profile form to be sent to the patient's supervisor.

- If **Sick at Home/Quarters** is selected, specify the correct time period (24, 48, or 72 hours).
- If **Immediate Referral** is selected, enter the provider's name to whom the patient is being referred.
- If **Left Against Medical Advice** is selected, click **Comments** to document detailed information on the patient's action.
- If **Admitted** is selected, click **Comments** to document detailed information concerning the admission.
- If **Expired** is selected, click **Comments** to document additional information.

13.2.2 Completing the Encounter Context Fields

The Encounter Context fields display in other areas of the application and simply need to be reviewed here. The injury/accident designation typically occurs when creating the appointment in CHCS II or in the A/P module when documenting an e-code diagnosis.

- **Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code window appears.

Figure 13–5: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an E-code as one of the diagnoses. A notification appears when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

Tip:

If the pregnancy and/or injury/accident information was added in the Screening module, then you can review the information here. If the information was not added in the Screening module, you can record the information now.

Pregnancy information, for female patients, is gathered in the Screening module but changes can be made in the Disposition module as well.

The fields associated with Female Only Data display for female patients 12 years of age or older.

Follow the steps below to add female only data:

1. Click the **Patient Pregnant** checkbox to open the Pregnancy Related window.
2. In the Female Only Data area, select the checkboxes to all the fields that apply.
 - **Pregnant**

Note: If the patient is pregnant, the Last Menstrual Period and the Estimated DOB are required fields.

- **Post Menopause**
- **Post Hysterectomy**
- **Last Menstrual Period:** Select this checkbox to activate the date drop-down field. Select the appropriate date.

-
- **Estimated DOB:** Select this checkbox to activate the date drop-down field. Select the appropriate date.

Note: On the electronic SF600, the estimated DOB is written as the EDC (Estimated Date of Confinement).

- **Birth Control Method:** Click the checkbox next to the appropriate birth control method.
 - **G, P, A, LC:** Click the drop-down list and select the appropriate value.
3. Click **OK**.

13.2.3 Filling out the Billing and Admin Fields

These fields are completed based on information gathered in the Appointments and A/P modules.

Follow the steps below to change the Billing and Admin information:

1. To change the Billing Chief Complaint, click the drop-down arrow to select another diagnosis that was entered in the A/P module.
 - Use the ellipses to search for a diagnosis that was not documented in the A/P module. The Select Diagnosis window opens.
 - Check the Clinic and Favorites tab for the appropriate diagnosis. If the diagnosis is not on one of these tabs, click the **Search** tab.
 - Enter the diagnosis and click **Search**.
 - Select the diagnosis from the list and click **OK**. The selected diagnosis fills in the appropriate field.
2. To change the Appointment Classification, click the drop-down arrow to select from the options. The options available in the drop-down list will vary, based on the patient's appointment classification in CHCS. If the classification is Inpatient, this field cannot be changed.
3. Click **Admin Options** to document additional information and work status. The Administrative Options window opens.

The screenshot shows the 'Administrative Options' dialog box. It is divided into two main sections: 'Admin Options' and 'Work Status'.
 In the 'Admin Options' section, there are five checkboxes: 'Consultation requested' (checked), 'Referred to another provider', 'Convalescent leave', 'Medical board', and 'Medical hold'.
 In the 'Work Status' section, there are six rows, each with a checkbox and two radio buttons labeled 'Qualified' and 'Disqualified':
 - Diving Status: [] checkbox, [] Qualified, [] Disqualified
 - Flying Status: [] checkbox, [] Qualified, [] Disqualified
 - Jumping Status: [] checkbox, [] Qualified, [] Disqualified
 - Military Police: [] checkbox, [] Qualified, [] Disqualified
 - Submarine: [] checkbox, [] Qualified, [] Disqualified
 - On Mobility: [] checkbox, [] Qualified, [] Disqualified
 At the bottom left, there are two rows of text: 'DMIS: 0090' and 'PATCAT: M11 USMC ACTIVE DUTY' on the first row, and 'MEPRS: BHAA' and 'ADV:' on the second row. At the bottom right, there are 'OK' and 'Cancel' buttons.

Figure 13–6: Administrative Options Window

- In the Admin Options area, select items that apply.
- Click the checkbox next to the applicable work status(es) and select either **Qualified** or **Disqualified**.
- Click **OK**.

4. **Meets Visit Criteria:** This field determines whether this encounter is a count or no-count visit. Yes, is count; No is no-count. If No is selected, the available E&M codes are no-count codes.

Tip:

For a more detailed description on Count vs. Non-Count, click the **question mark icon** next to the drop-down list.

13.2.4 Documenting Follow-up Information

This area allows you to document the instructions given to the patient about further treatment or appointments. This information is written to the electronic SF600. Data entered here concerning follow-up appointments does not trigger the scheduling of an appointment. This must be done using the current process.

Follow the steps below to document follow-up information:

1. Click the checkbox to denote a follow-up appointment as needed (PRN) or with the primary care manager (PCM).
2. Complete the time and location fields, as appropriate.
 - **When:** Select this option to enter a timeframe for the follow-up appointment.
 - Click the **ellipsis** button. The Follow-up in window opens.

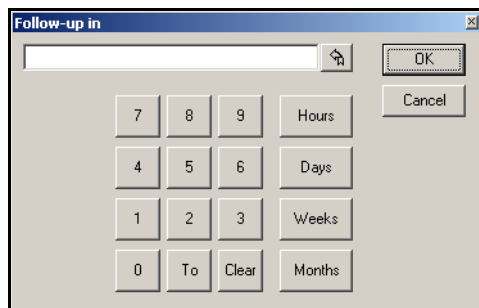


Figure 13-7: Follow-up in Window

- Click the appropriate numeric value and then the timeframe. Click **OK**. Your selection populates the When field.
- **For Tx:** The Follow-Up for Treatment window allows you to enter a specified period of time and number of visits regarding treatments associated with the current encounter.
 - Click the **ellipsis** button. The Follow-up for Treatment window opens.



Figure 13-8: Follow-up for treatment Window

- Select the applicable abbreviation (e.g., QIW = 4 times a week) and the timeframe required for the treatment.
 - Select the time period and click **OK**. Your selection populates the For Tx field.
 - **In Clinic:** Use the drop-down arrow and select the clinic in which the patient needs to follow-up.
3. Enter comments, as necessary.

13.2.5 Document a Patient's Understanding of the A/P

This area allows you to document which items were discussed with the patient and that the patient indicated understanding of each item.

Follow the steps below to document understanding:

1. Select items that were discussed with the patient.

Tip:

The default setting can be set via the AutoCite Properties window off the Encounter Summary module (electronic SF600).

2. If all items were discussed and the patient understood each item, click the check-box next to **All Items Discussed**. This marks each item as well as document the patient's understanding.
3. If the discussion occurred with someone other than the patient, use the drop-down list to select the appropriate party.
4. Enter comments, as necessary.

13.2.6 Selecting an E&M Code

The E&M calculator provides a suggested E&M code. It takes into account each structured term documented in the S/O note, the documented assessment and plan items, and the settings of key filters to determine the suggested E&M code.

The 1997 HCFA Documentation Guidelines are the basis for E&M coding. There are twelve parameters used to calculate the code. The CHCS II Disposition module pulls data for each of these parameters from the structured data entered in the note. The most important parameters are Overall History, Exam, and Medical Decision Making (MDM).

Because the calculator uses structured terms to determine the code, if a provider uses a lot of free text, the calculator is not as accurate. It is important, from a coding perspective, then, to build and use templates that are made up of the structured terms.

In addition to the structured terms, the calculator relies on three filters to produce an accurate code: Time Factor, Patient Status, and Service Type.

Follow the steps below to select the appropriate E&M code:

1. Change the following filters, as appropriate.
 - **Time Factor:** Select this option for visits in which more than 50% of the time was spent counseling or coordinating care. In this case, the E&M code is based on the amount of time spent with the patient. Adjust the Face-to-Face Floor time, as appropriate. The time field defaults to the scheduled appointment duration.
 - **Patient Status:** The E&M code is partially based on the type of patient being seen; a new patient or an existing patient. 'New' means that this is the first time this patient has been seen in the clinic. 'Existing' means a chart exists for that patient at that clinic. These two different options affect the coding for an encounter because a new patient is calculated differently.

Note: Patient Status defaults to New Patient if the patient has not been seen in the same Clinic/Specialty within the past three (3) years.

- **Setting:** Use the drop-down list to select the appropriate setting for this encounter.
- **Service Type:** The most common selection is **Outpatient Visit**. Use the **Preventive Evaluation or Management Type** for routine physicals and well-

baby checks. With these types of appointments, the E&M code is based on the patient's age.

Note: The options available in the Setting and Service type drop-down lists are based on the appointment type and appointment classification.

- **Exam Type:** The default exam type is General Multi-System. Use the drop-down list to select a more specific exam type.
2. Review and accept the suggested E&M code. If you wish to override the code, go to step 3.

Note: The level of each of the twelve parameters is listed under the headings with a blue highlight.

3. The suggested E&M code can be changed from the Calculated tab. Click the desired numerical button underneath the parameters to indicate what the level should be. As you change the levels, an additional E&M code is displayed beneath the suggested code.

Note: The user overrides are highlighted in red.

Figure 13–9: Calculated Tab - User Override Selected

4. As you change the levels, an additional E&M code is displayed beneath the suggested code. Click the **With User overrides** radio button to select the new E&M code.

13.2.6.1 To manually select the E&M Code:

1. Click the **Selection** tab.

Figure 13–10: Selection Tab

2. Select an **E&M Category** from the drop-down list.
3. Select an E&M code from the results list for the associated E&M category. The **E&M code** and **E&M help** fields automatically populate with detailed code information.

Note: The available options are determined by the patient’s status and the appointment type.

13.2.6.2 To add Additional E&M Codes or E&M Modifiers:

E&M code modifiers allow you to document altered services or procedures performed during the patient encounter (i.e., an evaluation and management service with a procedure on the same day).

E&M code modifiers most frequently used include:

- **-21 Prolonged Evaluation and Management Services:** Used only with the highest level of service within a given category or subcategory of E&M services. This modifier is appended to the E&M service(s) when the service(s) provided is prolonged or otherwise greater than usually required for the highest level of E&M service with a given category.
- **-24 Unrelated Evaluation and Management Service By the Same Physician During a Postoperative Period:** Used when a physician who has provided a surgical service related to one problem, now provides an E&M service unrelated to the problem requiring the surgery, during the period of follow-up care for the surgery. The modifier -24 is also used to describe a visit to treat an underlying condition following surgery.
- **-25 Significant, Separate Identifiable Evaluation and Management Service By the Same Physician on the Day of a Procedure:** The physician may need to indicate that on the day a procedure or other service identified by a CPT-4 code was performed, the patient’s condition required a significant, separately identifiable E&M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.
- **-57 Decision For Surgery:** Used to indicate that this encounter was the encounter that resulted in the initial decision to perform surgery. While some carriers will not pay E&M visits by the surgeon within a certain time period, this modifier

should indicate that this visit should be considered as a separate charge from the surgery due to the nature of the initial work-up. For Medicare, this modifier pertains to encounters the day before, or the day of, a major surgery (90 day postoperative period).

Follow the steps below to add a modifier or additional E&M code:

1. Click the **Additional E&M Coding** tab.

Note: The Calculated and Additional E&M Coding tabs are only enabled if the Workload is set to **Count**.

2. Select additional coding modifiers from the drop-down lists. Up to three modifiers can be associated with one E&M code. Select or uncheck the associated diagnoses, as appropriate.
3. Add additional E&M codes, as appropriate.
 - Click the ellipses button next to E&M Code 2 to open the Selection window.
 - Select an **E&M Category** from the drop-down list.
 - Select an E&M code from the results list for the associated E&M category. The **E&M code** and **E&M help** fields automatically populate with detailed code information
4. Click **Save** on the Action bar.

Tip:
Tool Tips are available when you hover your mouse over an individual modifier.

14.0 FLOWSHEETS

14.1 Flowsheets Overview

The purpose of the Flowsheets module is to display multiple data items such as lab values, medication profile (drug, dosage, and frequency), and vital signs in a chronological descending format over a period of time without having to open an encounter. You must select a patient to access this module.

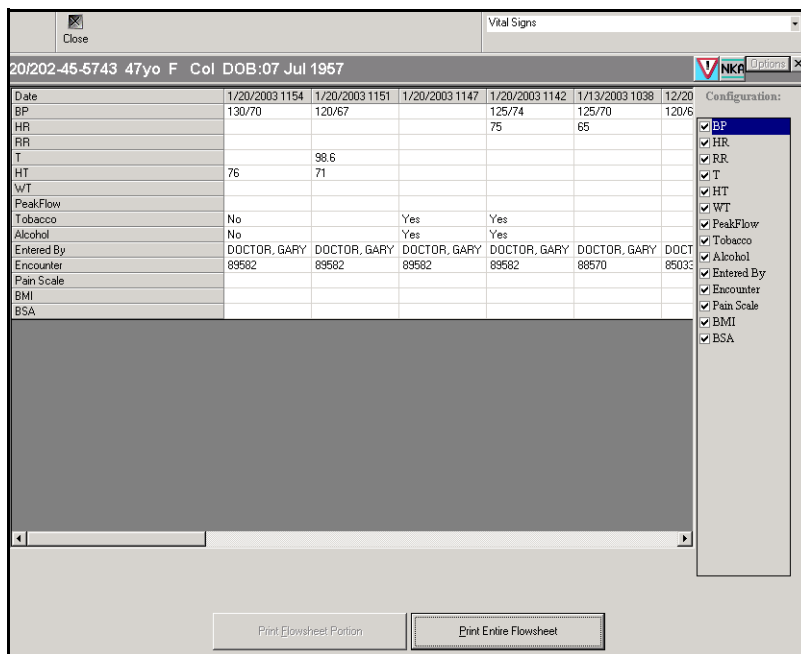


Figure 14–1: Military Clinical Desktop—Flowsheets Module

14.2 Viewing Flowsheets

When you access the Flowsheet module, the Vital Signs Flowsheet is displayed by default.

Follow the steps below to view a flowsheet:

1. Select **Lab Results** or **Medications** in the drop-down filter in the upper, right corner to view additional flowsheets. A flowsheet is created with all past data.
2. The Flowsheet can be configured to show desired information by clicking in the checkbox next to the desired information shown at the right of the Flowsheet module.

Note: Items in the Configuration Panel pertain only to the selected flowsheet.

14.3 Printing Flowsheets

Follow the steps below to print flowsheets:

1. Select the flowsheet you want to print:
 - Vital Signs
 - Lab Results
 - Medications
2. Do one of the following:
 - If you want to print the entire flowsheet, click **Print Entire Flowsheet**. The worksheet is sent to your local printer.
 - If you want to print a portion of the flowsheet:
 - a. Select the portion of the flowsheet you want to print.
 - b. Click **Print Flowsheet Portion**.

Note: The **Print Flowsheet Portion** button is inactive until the columns are selected.

15.0 HEALTH HISTORY

15.1 Health History Overview

The Health History module displays historical patient data from various modules in one window. The window can be customized to show different modules containing the patient's information.

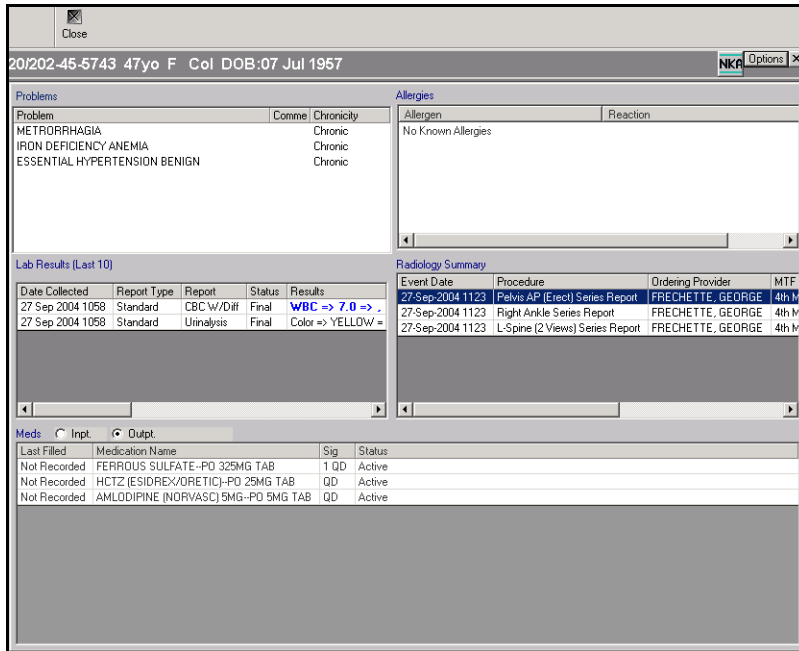


Figure 15-1: Military Clinical Desktop—Health History Module

15.1.1 In More Depth

When opening the Health History module for the first time, you must select the modules to display in the Health History module and design the window layout. The Health History module is useful to the clinical team members because it provides a quick “snapshot” of the patient's medical history. Reviewing a patient's medical history is an important step in the patient evaluation process because information about allergies, lab results, problems, etc. can affect the current evaluation.

15.2 Customizing the Health History Module

Follow the steps below to customize the Health History module:

1. Click **Options** on the Health History module. The Design Summary window opens.

Note: If opening Health History for the first time, you will receive a message stating that no modules have been selected. Click **OK** and proceed with step 1.

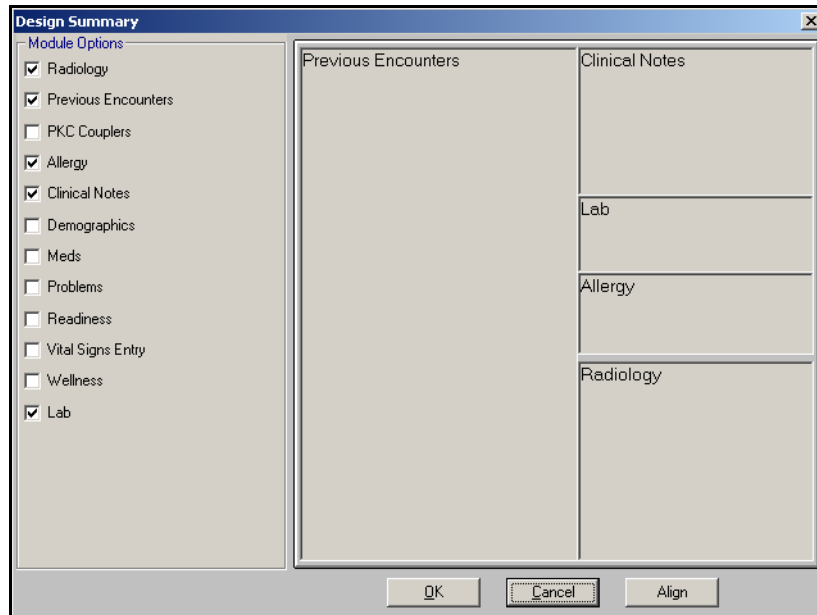


Figure 15–2: Design Summary Window

2. Select **Module Options** for which you want patient information to display in the Health History module. Each module selected is placed in the middle of the design screen. Click and drag the module to position it within the design screen.
3. Click **Align** to allow the system to place the selected modules.

Note: You can also position and size each selected module by clicking and dragging each one separately.

4. Click **OK**.

15.3 Viewing Historical Modules

Modules selected for display on the Health History module are easily accessible.

Historical modules can be accessed and viewed by double-clicking the desired module in the Health History module. The selected module opens. To return to the Health History module, simply close the current module.

16.0 IMMUNIZATION ADMIN

16.1 Immunizations Admin Overview

The Immunization Admin module is used to administer and manage vaccines, providers, reports, user groups, and refrigeration temperature logs. It is also used to document multiple vaccine entries for selected patients. The Immunizations Admin module contains two tabs: Admin and Multiple Entry. The Immunizations Admin module can be accessed without loading a patient's medical record.

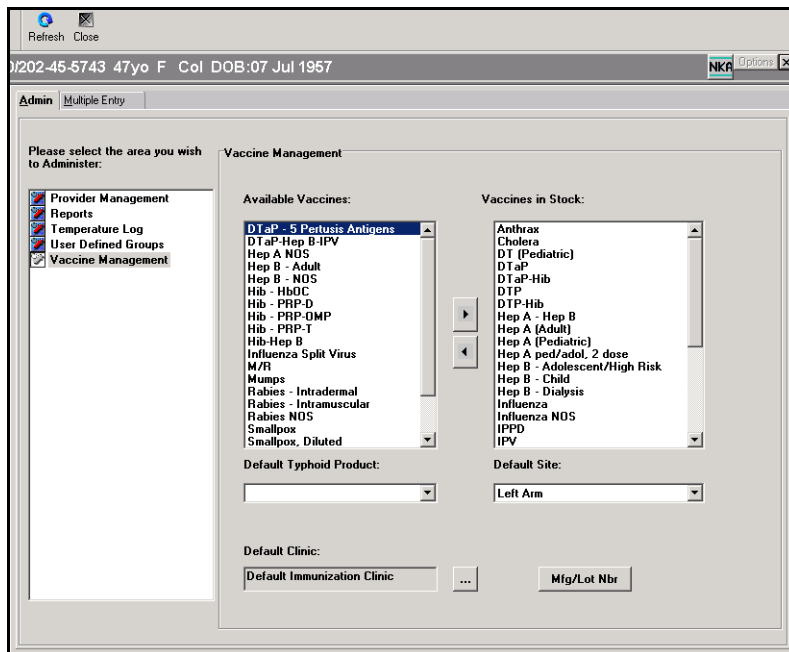


Figure 16–1: Military Clinical Desktop—Immunizations Admin Module

16.1.1 In More Depth

The Immunizations Admin tab is used to setup the Immunizations Clinic at an MTF. Before immunizations can be administered to a patient, the vaccines must be placed in stock in the Immunizations Clinic using CHCS II.

The recommended workflow for deploying CHCS II to a brand new Immunizations Clinic is as follows:

- Evaluate existing CHCS business processes
- Establish business processes for CHCS II
- Establish CHCS II user roles for clinic team members
- Inventory vaccines

- Immunization Admin updates Vaccine Management area in CHCS II (Vaccine in Stock) with Vaccine Inventory for default clinic or multiple clinics
- Immunization Admin sets up clinic defaults on applicable workstations
- Develop a default encounter template for use by the Immunizations Clinic
- Train Immunizations Clinic team members

A user with immunization administrator privileges is able to create or select a default clinic. The Default Immunization Clinic in the Vaccine Management area is a pre-loaded clinic. When CHCS II is deployed to a brand new Immunizations Clinic, the Vaccines in Stock lists all of the vaccines known by CHCS II. When a new clinic is created, the immunization administrator has to select the vaccines in stock from the list of Available Vaccines. Available Vaccines are standard throughout the DoD system. CHCS II allows you to enter specific vaccine elements such as vaccine name, series, manufacturer, lot number, dosage, site, route, etc. for each vaccine schedule.

New vaccines are added to the list of available vaccines in CHCS II per approval by a federal government panel. Following the approval process, the vaccine can be added to the local MTF, but only by an end user with Enterprise-level access privileges. End users at the local MTFs can not change vaccine schedules per new guidelines issued by the Centers for Disease Control and Prevention.

If CHCS II is being deployed to an existing Immunizations Clinic, the Vaccines in Stock may have already been populated by an immunization administrator. This information is stored in a database table.

The Immunization Admin can set up clinic defaults on applicable workstations. Setting the clinic defaults establishes the origin of vaccine information when vaccines are administered to patients.

The Immunizations Admin Multiple Entry tab is used to document multiple vaccine entries for patients selected from a Unit/UIC. You can access the Rapid Data Entry option to quickly enter vaccine information using a bar code reader.

16.2 Adding User-Defined Groups

A user-defined group is a required set of immunizations for specified patient groups. The groups can be created per clinic, patient, or deployment requirements. When a Service member is assigned to a user-defined group, the required immunizations automatically adjust to include the immunizations that are a part of the group.

CHCS II allows you to create new user-defined groups. Service-specific groups defined by the DoD are preloaded in the application.

Follow the steps below to add user-defined groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays.

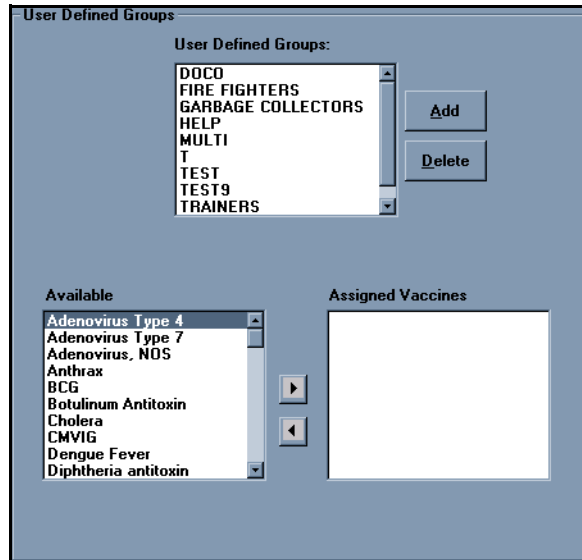


Figure 16–2: Immunizations Admin—User Defined Groups

2. Click **Add**. The Add User Defined Group window opens.

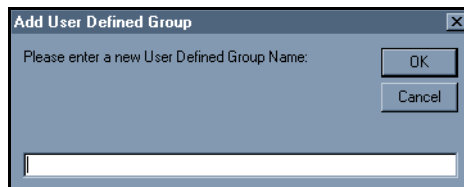


Figure 16–3: Add User Defined Group Window

3. Enter the name of the user group you want to add.
4. Click **OK**.

16.2.1 Adding a Refrigerator

Follow the steps below to add a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.

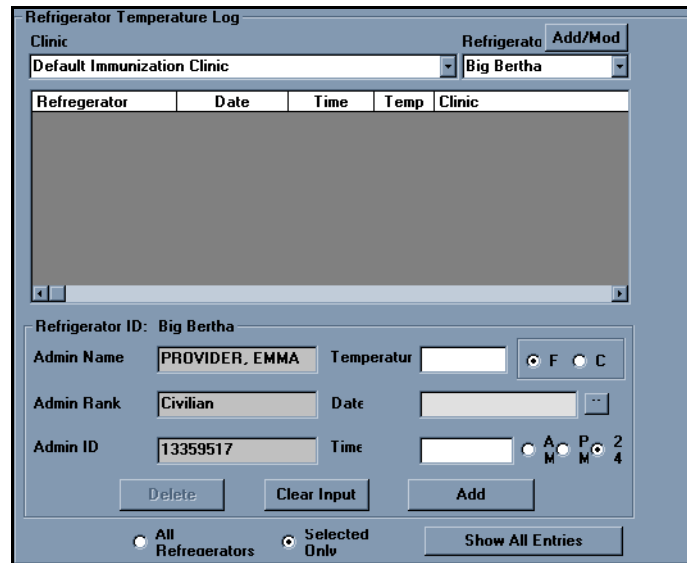


Figure 16-4: Immunizations Admin—Temperature Log

2. Select the clinic for which you are adding the refrigerator.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens.

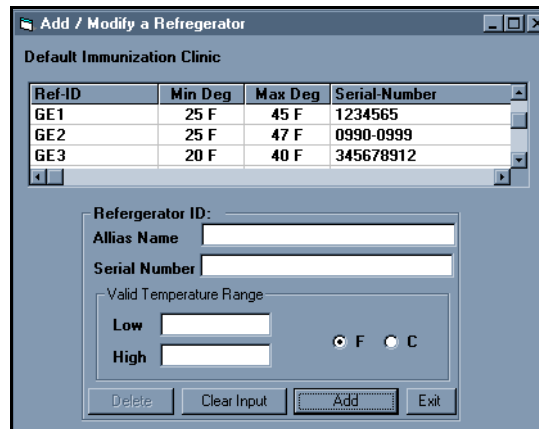


Figure 16-5: Add/Modify a Refrigerator Window

4. Complete the following fields:
 - **Alias Name:** Enter the name of the refrigerator (such as Maytag, GE, Westinghouse).
 - **Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.
 - **Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature at which the refrigerator should ever operate.
 - **High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature at which the refrigerator should ever operate.
5. Click **Add**.

16.3 Adding a Vaccine for Multiple Entry

Follow the steps below to add a vaccine for Multiple Entry:

1. Click **Add** on the Multiple Entry tab. The Vaccines in Stock window opens.

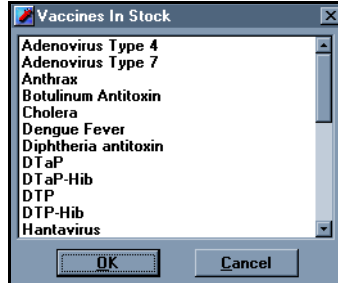


Figure 16–6: Vaccines in Stock Window

2. Select a vaccine from the list of available vaccines.
3. Click **OK**. The vaccine is added to the list of vaccines on the Multiple Entry tab.

Note: Select a vaccine and click **Delete** to delete the vaccine from the multiple entry list.

Note: In order to edit vaccine information from the multiple entry list, click in the field you want to edit. Click the **down arrow** to open the applicable window and modify the information.

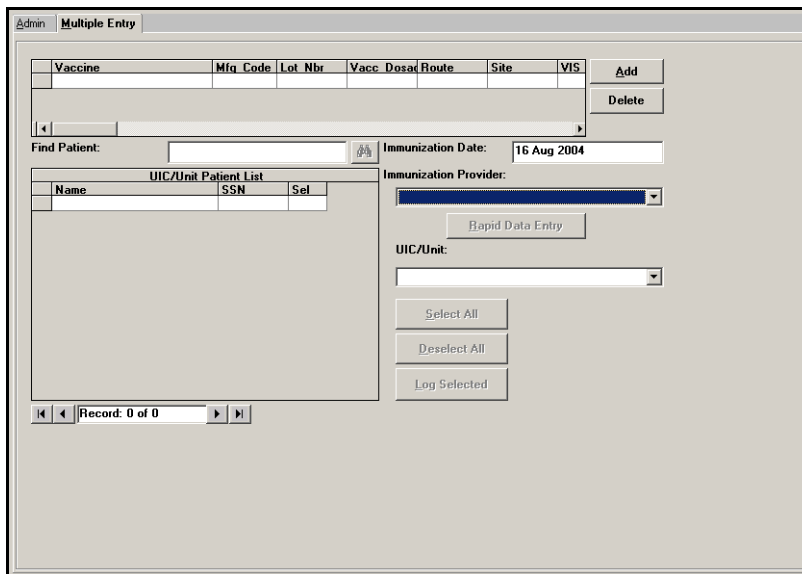


Figure 16–7: Immunizations Admin—Multiple Entry Tab

4. Clicking the **Rapid Data Entry** button enables you to enter vaccines by bar code reader.

16.4 Assigning Vaccines to User Defined Groups

Follow the steps below to assign vaccines to User Defined Groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays.

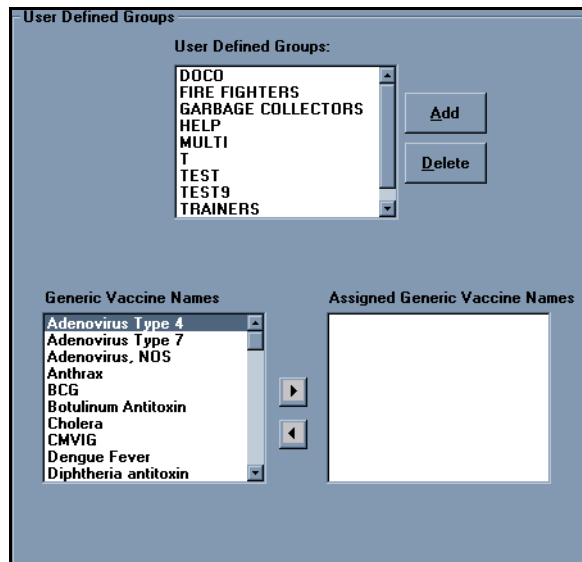


Figure 16–8: Immunizations Admin—User Defined Groups

2. Select a **User Defined Group**.
3. Select a vaccine from the Generic Vaccine Names list.
4. Click the **Right Arrow** button to move the vaccine to the Assigned Generic Vaccine Names list.

16.5 Deleting Providers from Administering Immunizations

A provider can be deleted from administering immunizations; however, the provider is added back to the eligible provider list when he/she administers a vaccine.

Follow the steps below to delete a provider from administering immunizations:

1. Click **Provider Management** on the Admin tab. The Provider Management area displays.

Provider Management				
	Imm ProviderID	Last Name	First Name	MI
▶	13306108	OCHS	STEVEN	E
	13303303	PRATT	LAURA	
	13359516	PROVIDER	DAVID	
	13359530	PROVIDER	DYLAN	
	13359517	PROVIDER	EMMA	
	13365870	PROVIDER	FIFTY	
	13365863	PROVIDER	FIFTY	
	13365868	PROVIDER	FIFTY	F
	13365861	PROVIDER	FORTY	
	13365859	PROVIDER	FORTY	S
	13365849	PROVIDER	FORTY	T
	13376945	PROVIDER	SEVENTY	F
	13376944	PROVIDER	SEVENTY	F

Delete

Figure 16-9: Immunizations Admin—Provider Management

2. Select a provider from the list in the Provider Management area.
3. Click **Delete**.

16.6 Entering Multiple Vaccines for a Patient

Follow the steps below to enter multiple vaccines for a patient:

1. Select an **Immunization Provider** from the drop-down list on the Multiple Entry tab.

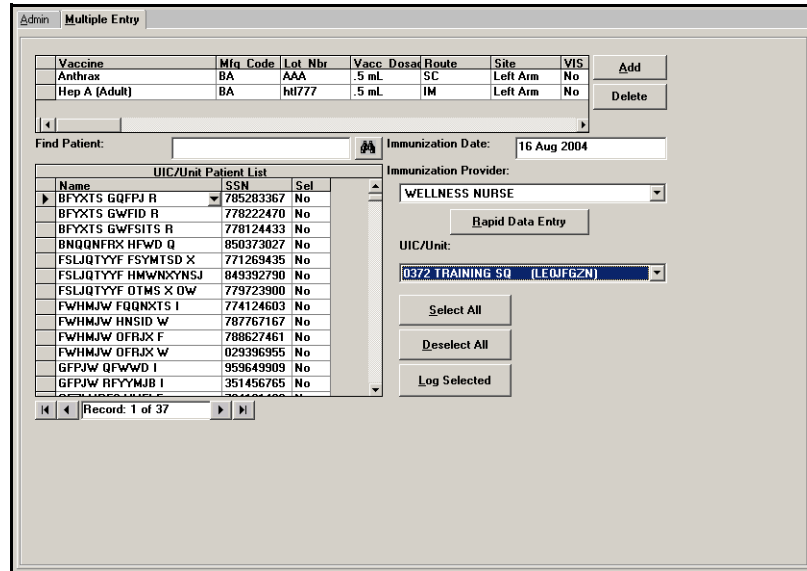


Figure 16-10: Immunizations Admin—Multiple Entry Tab

Note: The **Immunization Date** field defaults to the current date. Enter the applicable date in the field if the current date is not the correct date.

2. Select the patient for whom you want to enter multiple vaccines.
3. Click the **Select** field for the associated patient and click the **down arrow** to select the patient.

Note: Click **Select All** if you want to enter the same multiple vaccines for every patient in the list.

4. Click **Log Selected**.

16.7 Logging Refrigerator Temperatures

Follow the steps below to log refrigerator temperatures:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.

Figure 16–11: Immunizations Admin—Temperature Log

2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.
4. Complete the following fields:
 - **Temperature:** Enter the temperature of the refrigerator you are logging in the system. You can enter a temperature in degrees Fahrenheit or Celsius.
 - **Date:** Enter the date you are logging the temperature in dd mm yyyy format.
 - **Time:** Enter the time you are logging the temperature. You can enter the time in AM, PM, or Military.
5. Click **Add**.

Note: Click the **All Refrigerators** radio button, then click **Show All Entries** to view all logged refrigerator temperatures for the selected clinic.

16.8 Modifying Refrigerator Temperature Logs

Follow the steps below to modify refrigerator temperature logs:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.

4. Select the **Selected Only** radio button.

Note: Click the **All Refrigerators** radio button, then click **Show All Entries** to view all logged refrigerator temperatures for the selected clinic.

5. Click **Show All Entries**.
6. Update the following fields, as necessary:
 - Temperature
 - Date
 - Time
7. Click **Modify**.

16.9 Modifying a Refrigerator

Follow the steps below to modify a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens.

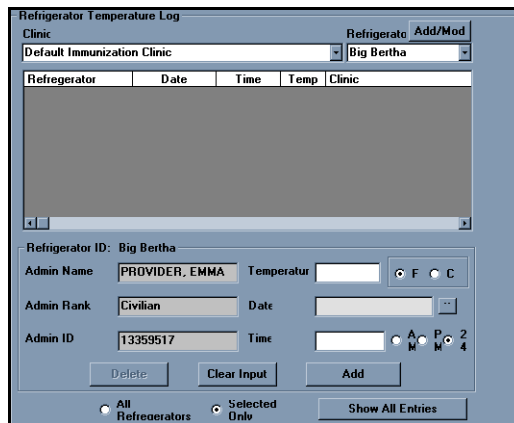


Figure 16–12: Immunizations Admin— Add/Modify a Refrigerator

4. Double-click the refrigerator you want to modify.
5. Update the following fields, as necessary.
 - **Alias Name:** Enter the name of the refrigerator (such as Maytag, GE, Westinghouse).
 - **Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.
 - **Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature at which the refrigerator should ever operate.

- **High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature at which the refrigerator should ever operate.

6. Click **Modify**.

Note: If you want to delete the refrigerator, click **Delete** and click **Yes** at the confirmation prompt.

16.10 Printing Immunization Reports

Follow the steps below to print immunization reports:

1. Click **Reports** on the Admin tab. The Report Options area displays.

Figure 16–13: Immunizations Admin—Reports

2. Select a report from the drop-down list.

Note: Information for the selected report displays in the Report area. The information displayed depends on what report you select.

3. Click **Print**.
4. Select a print range on the Print window.
5. Click **OK**.

16.11 Selecting a Default Vaccination Clinic

Follow the steps below to select a default vaccination clinic:

1. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays.

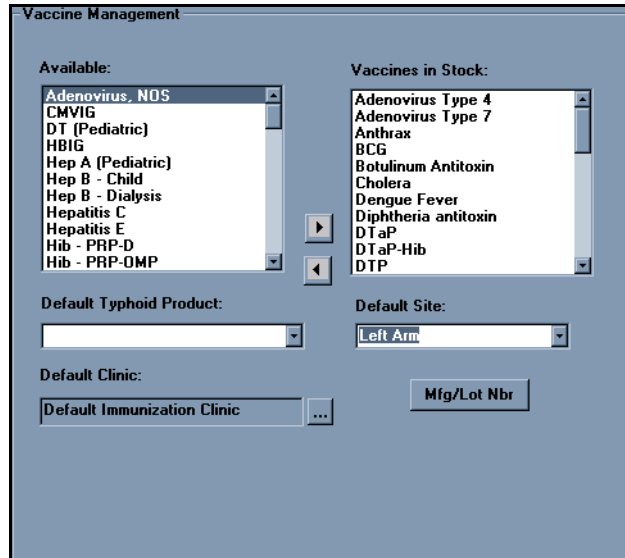



Figure 16–14: Immunizations Admin— Vaccine Management

2. Click the **Ellipsis** button  next to the **Default Clinic** field. The Clinic List Edit window opens.

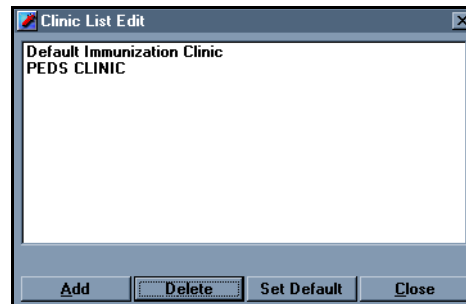



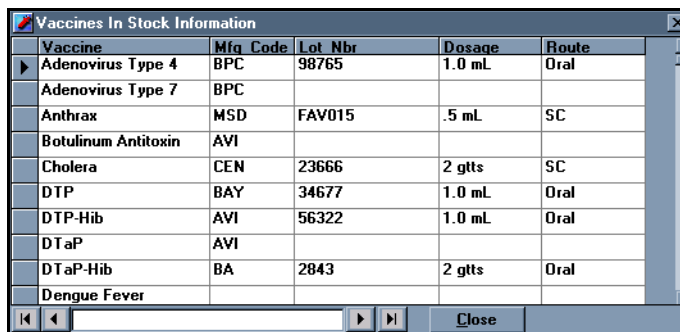
Figure 16–15: Clinic List Edit Window

3. Select the clinic from the list.

Note: If the clinic you want to select is not listed, click **Add**. In the text field, enter the clinic name and press **Enter** on your computer keyboard.

4. Click **Set Default**. You are returned to the Vaccine Management area.
5. Do one of the following:
 - If you want to associate stocked vaccines to the default clinic:

- Select a vaccine from the list of available vaccines.
- Click the **Right Arrow**  button. The vaccine is moved to the Vaccines in Stock list.
- If you want to set the default typhoid product, select the typhoid product from the drop-down list.
- If you want to set the default body area where the vaccine is given, select the site from the drop-down list.
- If you want to view the manufacturer and lot number information for the vaccines in stock:
 - Click **Mfg/Lot Nbr**. The Vaccines in Stock Information window opens.



Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Adenovirus Type 4	BPC	98765	1.0 mL	Oral
Adenovirus Type 7	BPC			
Anthrax	MSD	FAV015	.5 mL	SC
Botulinum Antitoxin	AVI			
Cholera	CEN	23666	2 gttts	SC
DTP	BAY	34677	1.0 mL	Oral
DTP-Hib	AVI	56322	1.0 mL	Oral
DTaP	AVI			
DTaP-Hib	BA	2843	2 gttts	Oral
Dengue Fever				

Figure 16–16: Vaccines In Stock Information Window

- Click **Close** to return to the Admin tab.

16.12 Viewing the Vaccine Lot Number List

Follow the steps below to view the Vaccine Lot Number List:

1. Click **Reports** on the Admin tab. The Reports area displays.

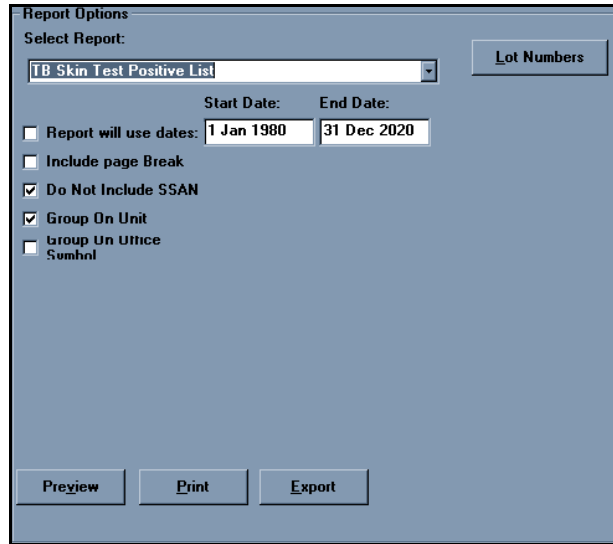


Figure 16–17: Immunizations Admin—Reports

2. Click **Lot Numbers**. The Vaccine Lot Number List window opens.

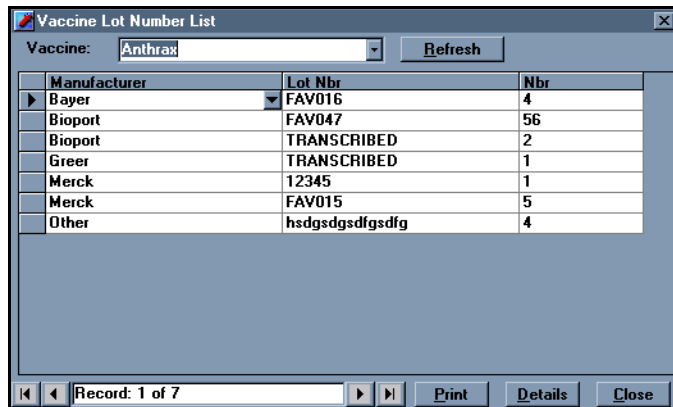


Figure 16–18: Vaccine Lot Number List Window

3. Select a vaccine from the drop-down list. Manufacturer information displays for each manufacturer associated with the selected vaccine.
4. Select a manufacturer.
5. Click **Details**. All patients associated with the vaccine distributed by the selected manufacturer display.

Note: Click **Details** to edit the immunization history for the selected patient.

Note: You can also click the drop-down arrow to view detailed information for manufacturers and patients.

17.0 LABORATORY

17.1 Laboratory Overview

The Lab module is designed to display the results of laboratory tests. Results are viewed, not ordered, from this module. Lab results are pulled from CHCS and an alert is triggered when new results are received.

Type	Date Collected	Date Ordered	Date Resulted	Report	Ordering Provider	MTF	Site/Specimen	Sample
Standard Lab	27 Sep 2004 1058	27 Sep 2004 1035	27 Sep 2004 1113	CBC w/Diff	FRECHETTE, GEORGE	4th Medical Group	BLOOD	BLOOD
Standard Lab	27 Sep 2004 1058	27 Sep 2004 1035	27 Sep 2004 1107	Urinalysis	FRECHETTE, GEORGE	4th Medical Group	URINE	RND/URI

Test / Result Name	Site/Specimen	Collection Date / Result Values
CBC w/Diff	Site/Specimen	27 Sep 2004 1058
WBC	BLOOD	7.0
RBC	BLOOD	3.90 (L)
Hgb	BLOOD	10.1 (L)
Hct	BLOOD	33.0 (L)
MCV	BLOOD	78.0 (L)
MCH	BLOOD	27.0 (L)
MCHC	BLOOD	32.0 (L)
RDW-CV	BLOOD	12.0
Grans	BLOOD	5.0 (L)
Lymphs	BLOOD	8.0 (L)
Mono	BLOOD	8.0
Eos	BLOOD	5.5
Baso	BLOOD	8.0 (H)
Plt	BLOOD	200
MPV	BLOOD	11.0 (H)

Figure 17-1: Military Clinical Desktop—Laboratory Module

17.1.1 In More Depth

During site activation or when an appointment is first made in CHCS II for a particular patient, 36 months worth of patient lab results are pulled from CHCS and are stored in the CDR. These results are accessible through the Lab module.

Lab tests are ordered through CHCS II in the A/P module. The order is sent back to CHCS for processing. When the test is complete and the results are entered into CHCS, they are sent to the CDR and an alert is triggered in CHCS II for the ordering provider. All lab results, then, are reviewed in the Lab module.

17.2 Creating a Search Filter in the Lab Module

The results listed in the Lab module can be filtered. You can create a filter to sort lab results for which you are interested in.

Follow the steps below to create a filter for viewing lab results:

1. Click **Options** on the Lab module. The Lab Results Properties window opens.
2. Click the Filter tab.

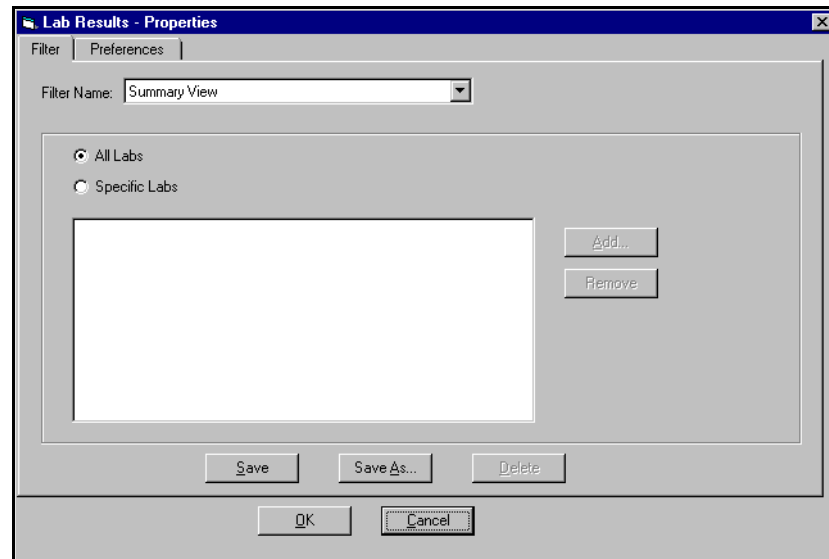


Figure 17-2: Lab Results—Properties Window—Filter Tab

3. Select the applicable radio button for the lab results you want to view.
 - If **All Labs** is selected, all of the listed lab results are displayed.
 - If **Specific Labs** is selected, click **Add** to open the Add Lab Type window to add specific lab results.
4. Click **Save As**. If this is a change to a pre-existing filter, click **Save**.

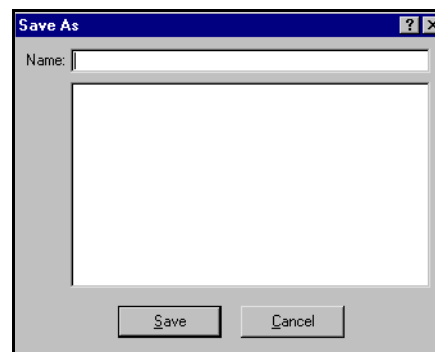


Figure 17-3: Save As Window

5. Enter the name for the filter.
6. Click **Save**.

Note: To delete a personal filter, select the filter from the drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.

- Click **OK**.

17.3 Setting Laboratory Module Preferences

The Preferences tab allows you to set default times and viewing options. Each time you open the Lab module, the listed results match these defaults.

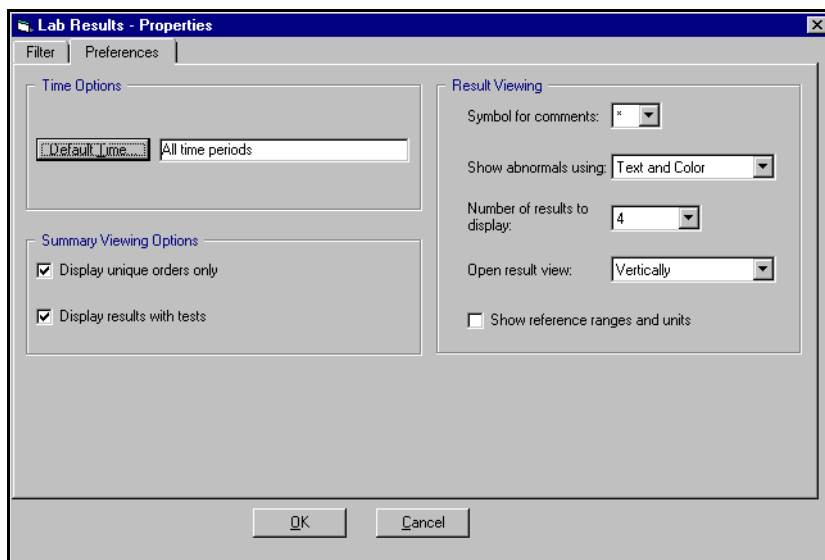


Figure 17-4: Lab Results—Properties Window—Preferences Tab

Follow the steps below to set Lab module preferences:

- Click **Options** on the Lab module. The Lab Results Properties window opens.
- Click the **Preferences** tab.
- Click **Default Time**. The Time Search window opens.

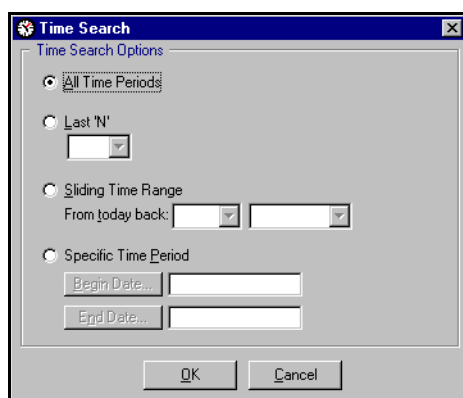


Figure 17-5: Time Search Window

4. Select the radio button for the applicable Time Search Option and click **OK**.

Note: The items in the Summary Viewing Options area have no bearing on the default display.

5. In the Result Viewing area, complete the following fields:
 - **Symbol for comments:** This field has no bearing on the Lab module.
 - **Show abnormals using:** This field has no bearing on the Lab module.
 - **Number of results to display:** Select the number of results to be displayed in the Lab module.
 - **Open result view:** Select the desired view for the results. Options include vertically and horizontally.
6. Click **Show Reference Ranges and Units** to display units upon opening the Lab module.
7. Click **OK**.

17.4 Viewing Lab Results

Once the search criteria have been defined, the lab test results are displayed.

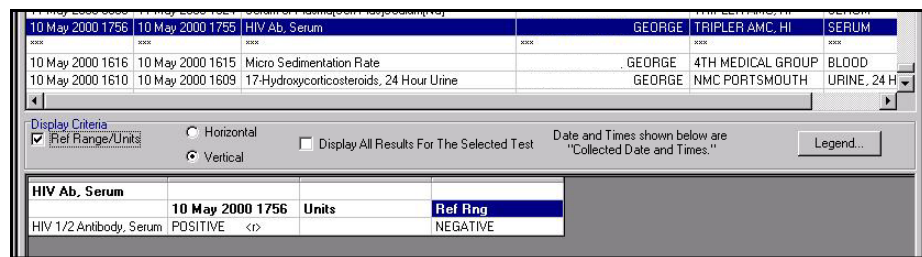


Figure 17–6: Lab Test Results

Tip:

To view any comments associated with the result, double-click on a cell with <o>, <i>, <r>, or <a> to view the order comments, interpretations, results comments, and amendments.

Select the desired test data to be viewed by selecting the test name. The data is displayed in the bottom of the Lab module. The Lab Result Profile area can be changed according to individual preference.

- **Display All Test Results:** Click **Select All Results** to view all test result data in the test viewing area simultaneously.
- **Ref Range/Units:** Select the check box to view the CHCS II normal range and unit for each test.
- **Change Viewing Format:** The layout of the results can either be seen vertically or horizontally. Select the appropriate radio button.
- **Legend:** Click **Legend** to view the codes used in the test results.

17.5 Viewing Sensitive Lab Results

Sensitive lab results are displayed with asterisks. Remaining columns are viewed as normal. You must have “break the glass” privileges to view sensitive lab results.

Follow the steps below to view sensitive results:

1. Double-click the result. A security message is displayed stating that all further actions are audited. If you do not have sufficient security privileges, a security message is displayed and you cannot proceed.

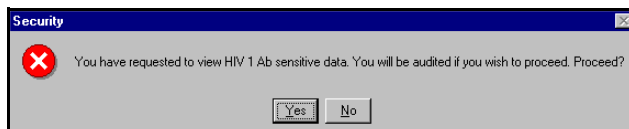


Figure 17–7: Security Warning

2. Click **Yes** to continue. The sensitive lab results are displayed in the bottom portion of the workspace.

17.6 Copying Lab Results to a Note

Details of a lab result can be copied to the clipboard or copied and placed directly into the S/O portion of the current patient encounter summary.

Follow the steps below to copy lab results to a note:

1. Select the desired result so the details are in the bottom of the Lab module.

Type	Date Collected	Date Ordered	Date Resulted	Report	Ordering Provider	MTF	Site/Specimen
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1340	25 Sep 2002 2134	Creatinine	MIL R, RI IALD	NMC Portsmouth	URINE
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1340	25 Sep 2002 2134	Protein, 24 Hr Urine	MIL R, RI IALD	NMC Portsmouth	RANDOM
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1339	25 Sep 2002 1514	Chem 17	MIL R, RI IALD	NMC Portsmouth	SERUM
Standard Lab	25 Sep 2002 1340	25 Sep 2002 1339	25 Sep 2002 1411	Urinalysis W/Microscopic	MIL R, RI IALD	NMC Portsmouth	URINE
Standard Lab	20 Aug 2002 1459	20 Aug 2002 1438	20 Aug 2002 1839	Chem 7	MIL R, RI IALD	NMC Portsmouth	SERUM
Standard Lab	13 Aug 2002 0815	13 Aug 2002 0815	14 Aug 2002 1455	Lipid Panel, Complete	GIA TTTC ID, J 'M	NMC Portsmouth	SERUM
Standard Lab	13 Aug 2002 0815	13 Aug 2002 0815	14 Aug 2002 1455	Alanine Aminotransferase	GIA TTTC ID, J 'M	NMC Portsmouth	SERUM

Test / Result Name	Site/Specimen	Collection Date / Result Values	Units	Ref Ring
Chem 17	Site/Specimen	25 Sep 2002 1340		
AST	SERUM	30	IU/l	15-46
Albumin	SERUM	4.0	g/dl	3.4-5.0
Alk. Phos	SERUM	86	IU/l	39-126
Bilirubin, Total	SERUM	0.4	mg/dl	0.0-1.3
CD2	SERUM	24	mmol/l	22-33
Calcium	SERUM	9.2	mg/dl	8.4-10.5
Chloride	SERUM	107	mmol/l	98-108
Creatinine, Serum/Plasma	SERUM	1.1	mg/dl	0.7-1.3
GGT	SERUM	20	IU/l	5-85
Glucose	SERUM	90	mg/dl	70-120
LDH	SERUM	464	IU/l	313-618
Phosphate	SERUM	4.3	mg/dl	2.4-4.6

Figure 17–8: Lab Results Window (Copy Lab Results)

2. Select the result(s) you want to copy.
3. Perform a right-mouse click, then select either:
 - **Copy:** Copies the selection on the clipboard so it can be used in another location.

Tip:
To select the results, click inside the top, left box. Continue holding down the mouse button and drag the mouse to the lower-right corner.

- **Copy to Note:** Copies the details directly into the S/O portion of the current patient encounter summary.

Note: You must open an encounter to use the Copy to Note function. The result is pasted directly into the patient encounter. Once copied, the results cannot be deleted from the note, so ensure that you only select the **Copy to Note** option once, to avoid duplication.

18.0 LIST MANAGEMENT

18.1 List Management Overview

The List Management module allows you to create and manage various lists within CHCS II. These lists include Diagnoses, Procedures, and Complaints. The customized lists are available within various modules to streamline the documentation process.

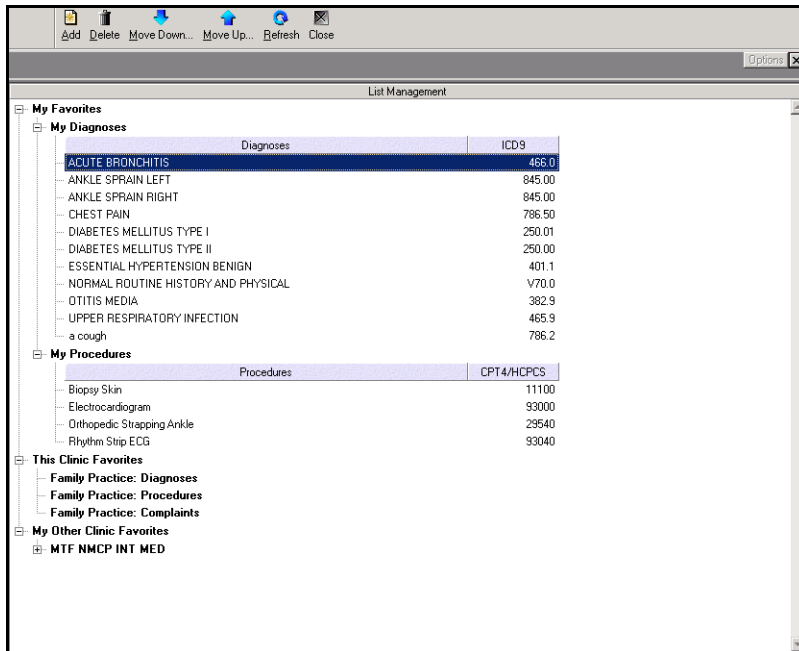


Figure 18-1: Military Clinical Desktop—List Management Module

18.1.1 In More Depth

Diagnoses and Procedures can be added to a user favorite list and all three items, including Complaints can be added as clinic favorites. When creating each list, the List Management module searches the MEDCIN nomenclature. The same nomenclature that is used in the Screening, S/O, A/P, Disposition, Problems, and Template Management modules. Because it uses the same organization of clinical findings, these lists are available in multiple modules.

Diagnoses:

- A/P module, Diagnosis tab
- Problems module, when adding a problem or Family History

Procedures:

- A/P module, Procedures tab
- Problems module, when adding a historical procedure

Complaints:

- Screening module

The creation of personal and clinic favorites lists can reduced the amount of time spent searching for common diagnoses, procedures, and complaints. You must have the appropriate privileges to add to or remove from a clinic list.

The personal favorites lists can be created in the A/P and Problems modules as well. Look for the **Add to Favorite List** button on the Diagnosis and Procedure tabs in the A/P module. In the Problems module, look for the **Add to User Favorites** checkbox when adding problems, historical procedures, or family history.

Once the personal favorites list is created, it is saved with your profile so your list is available from any computer in your clinic.

18.1.2 Adding an Item to a Favorites List

Follow the steps below to add an item to a Favorites List:

1. Select the list to which you want to add an item (i.e., My Diagnoses). The Add icon is not active until you select a list heading.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.

Note: The title of the window changes, depending on the type of list you have selected to add (such as diagnosis, procedure, clinic, user).

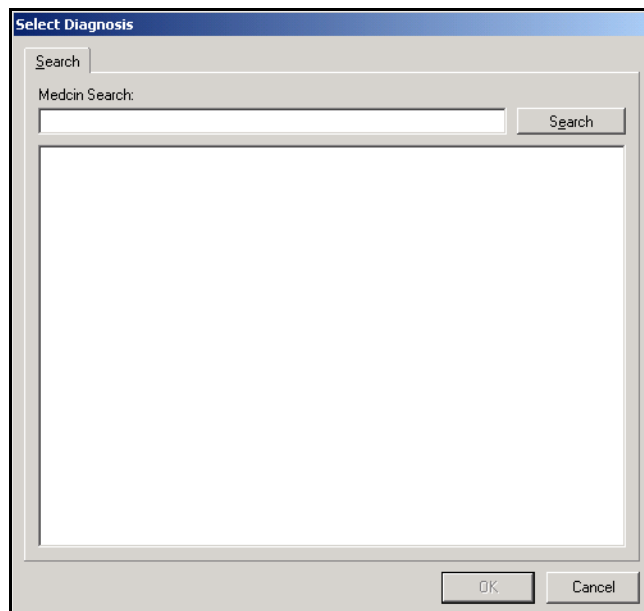


Figure 18–2: Select Diagnosis to Add to Clinic List Window

3. Enter search criteria.

4. Click **Search**. The bottom of the window populates with items matching the search criteria.
5. Select the item to be added.
6. Click **OK**. The new item is added on the List Management module.

Note: Each item is added to your list with its associated ICD or CPT code.

18.1.3 Deleting an Item From a Favorites List

Follow the steps below to delete an item from a Favorites List:

1. Select the item you want to delete from the Favorites List.
2. Click **Delete** on the Action bar.

18.2 Changing Location of Items on a List

Follow the steps below to change the location of an item on a list:

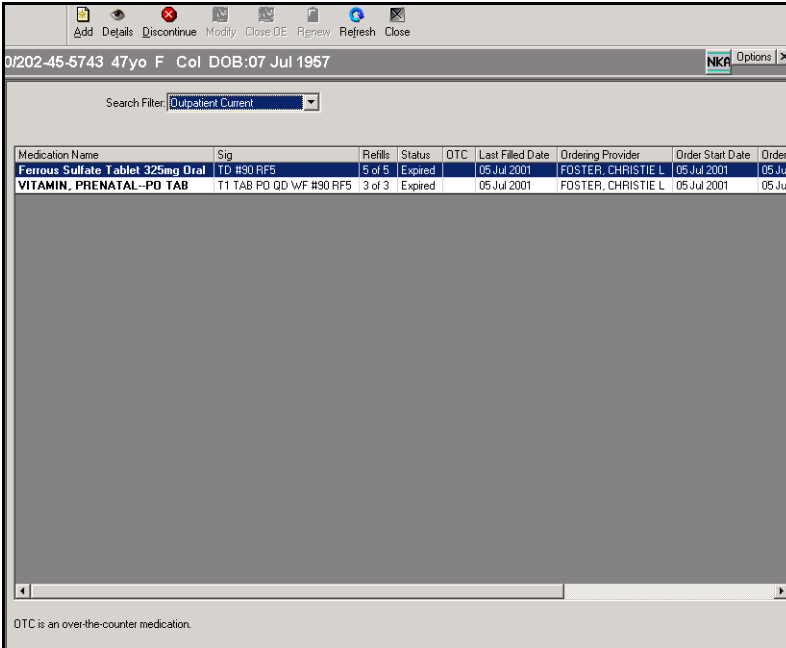
1. Select the item to want to relocate.
2. Click **Move Down** or **Move Up** until the item is where you want it.

Tip:
Organize your list for easy selection; most common to least common, or alphabetical.

19.0 MEDICATIONS

19.1 Medications Overview

The Medications module lists the patient's past and present medications. The list includes over-the-counter (OTC), outside, and CHCS II-ordered medications. Current medications can be viewed, re-ordered, or modified and new medications can be added and ordered. Only OTC/Outside medications can be documented without an open encounter. A current encounter must be open in order to re-order, modify, or order new medications.



The screenshot shows a software interface for a patient's medication list. At the top, there is a patient information bar with the ID '01202-45-5743', age '47yo', gender 'F', race 'Col', and date of birth 'DOB:07 Jul 1957'. Below this is a search filter set to 'Outpatient Current'. The main area contains a table with the following data:

Medication Name	Sig	Refills	Status	OTC	Last Filled Date	Ordering Provider	Order Start Date	Order
Ferrous Sulfate Tablet 325mg Oral	TID #30 RF5	5 of 5	Expired		05 Jul 2001	FOSTER, CHRISTIE L	05 Jul 2001	05 Jul
VITAMIN, PRENATAL--PD TAB	T1 TAB PD QD WF #90 RF5	3 of 3	Expired		05 Jul 2001	FOSTER, CHRISTIE L	05 Jul 2001	05 Jul

At the bottom of the window, there is a note: 'OTC is an over-the-counter medication.'

Figure 19–1: Military Clinical Desktop—Medication Module

19.1.1 In More Depth

Typically, a medication is ordered through the A/P module and is sent to CHCS for processing. Once the prescription has been filled in the pharmacy, the medication is displayed in the Medication module in CHCS II.

Information available for each entry includes the SIG, quantity, refills, days supply, dispensing location, clinic, status of the prescription, order information, and ordering end user.

The default list of medications includes outpatient current medications for patients with an appointment classification of Outpatient. When the Medications module is opened for a patient whose classification is Inpatient, the default filter is Inpatient Current.

In the list of medications, active medications appear in bold text and inactive medications appear in regular text. Those medications that were added as an OTC/Outside medication will have a check in the OTC column.

19.1.2 Setting the Filter of the Medications Module

The default filter, either Outpatient Current or Inpatient Current, can be changed. The Properties window in the Medications module contains the Default Filter drop-down list. The Default Filter is used to set the default Search Filter in the Medications module.

Follow the steps below to change the filter:

1. Click **Options** on the Medications module. The Properties window opens.

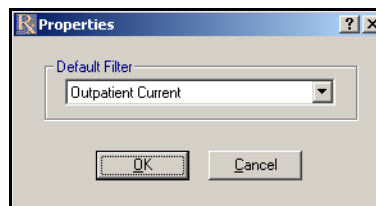


Figure 19–2: Properties Window

2. Select the desired filter from the Default Filter drop-down list.

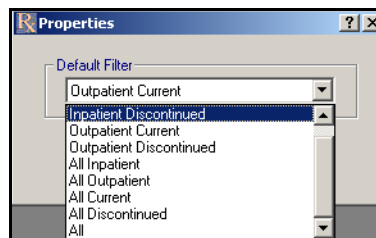


Figure 19–3: Default Filter Drop-Down List

3. Click **OK**. The list of medications is refreshed based on the selected filter.

19.2 Documenting an OTC/Outside Medication

An OTC/Outside medication can be documented in the Medications module. Medications added as an OTC/Outside medication are not considered during the pre-verify process that occurs when a medication is ordered. There are no dru-drug-, dru-allergy, or duplicate order warnings based on these documented medications.

Follow the steps below to document an OTC/Outside medication:

1. Click **Add** on the Action bar. The Select Type of New Medication window opens.

Note: In order to add new medications, an encounter must be open and the filter must be set to Outpatient Current.

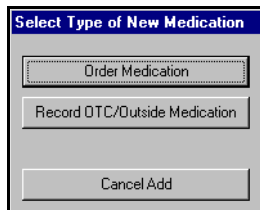


Figure 19–4: Select Type of New Medication Window

2. Click **Record OTC/Outside Medication**. The New OTC/Outside Medication window opens at the bottom of the window.

Figure 19–5: New OTC/Outside Medications Window

3. Click **Medications** to search for and locate the medication.
4. Enter the name of the medication and click **Search**.
5. Select the correct medication and click **OK**.
6. On the New OTC/Outside Medication window, complete the following fields:
 - Sig: free text field
 - Ordering Provider: free text field
 - Order Start Date: Click **Order Start Date** to enter the correct date using the calendar or enter the date directly in the Start Date field.
 - Comment
7. Click **OK**. The OTC is added to the patient's medication list.

19.3 Ordering a New Medication

Medications can be ordered directly from the Medications module if an encounter is open.

Tip:

To add a new medication, you must set the filter to **Outpatient Current**.

Follow the steps below to add a new medication:

1. Open the appropriate encounter.
2. In the Medications module, click **Add** on the Action bar. The Select Type of New Medication window opens.

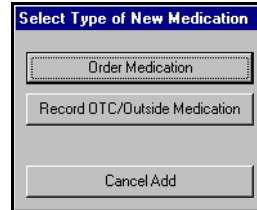


Figure 19–6: Select Type of New Medication Window

3. Click **Order Medication**. The New Order window displays at the bottom of the screen.

Medication Name (Dispensed Only)	Sig	Refills	Status	OTC	Last Filled Date	Ordering Provider	Order Start Date	Order Expir...
DIGOXIN (LANOXICAPS)-PO 0.05MG CAP	TEST #30 RFO	NR	Expired	0	22 Oct 2002	JONES, PAT	22 Oct 2002	20 Nov 20...
GLYBURIDE, 2.5MG	1 po bid	NR	Active	0	Not Recorded	Dr. Jones	13 Apr 2002	Not Recor...

0 in OTC column indicates an outside medication.

Allergies: No Known Allergies **Weight:** 155 lbs / 70.31 kg
10 Jun 2003
BSA: 1.814 square

Age: 46yo **Sex:** F **LMP:** Not Recorded **Pregnant:** No **Show Last Creatinine:**

New Med Order [Search] **Note to Provider:**

Item Name: [Dropdown] **Expand SIG**

SIG: [Text Field]

Qty: [Text Field] **Max:** [Text Field] **Days Supply:** [Text Field] **Default Unit:** [Text Field]

Refills: [Text Field] **Maximum:** [Text Field] **Start Date:** [Text Field]

Expanded SIG: [Text Field]

Start Date: 31-Jul-2003

Dispensing Location: [Dropdown] YDRKTOWN (NAVY) PHARMACY

Comments: (Optional) [Text Field]

Clear **Close** **Submit**

Requesting Location: [Text Field] MSC YT

Ordering Provider: JONES, PAT Child-Resistant Cap

Figure 19–7: Order Entry Medications Window

4. Enter the name of the medication in the Search field and click **Search**.
5. Select the test name from the results displayed in the Item Name field.
6. Complete the following fields:
 - SIG

Note: If a CHCS sig exists for the selected medication, it auto-populates this field. The SIG can be edited and changed.

- Quantity
- Refills

- Start Date
 - Child Resistant Cap
 - Comment
 - Expanded SIG
 - Requesting Location
 - Dispensing Location
 - Ordering Provider
7. When all the necessary information has been added, click **Submit**. The ordered medication displays on the medication list once it has been filled by the pharmacy.

Note: CHCS pre-verifies the order against patient and medication records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. Warnings include duplicate orders and drug–drug and drug–allergy interactions. To override a warning in the Warnings window, enter a reason for the override and click **Accept Override**. To ignore the warning override, click **Cancel Order**.

19.4 Reviewing a Medication

Follow the steps below to review a medication:

1. Select the medication you want to review.
2. Click **Details** on the Action bar. The Details window opens.

Allergies: TETRACYCLINES, ASPIRIN FREE ANALGESIC (ACETAMINOPHEN/PHENYLTOLX CIT)		Weight: 185 lbs - 07 May 2001 09:38
		BSA: 2.061 square
Age: 26yo	Sex: M	Show Last Creatinine...
Review Medication		
Medication Name		NDC
AMOXICILLIN-PO 250MG CAP		No NDC
Sig: T1 CAP PO TID F10 #7 RFO		
Quantity: 7		Status: Expired
Refills: none		Order Number: 020124-00070
Refills Remaining: 0		Order Start Date: 24 Jan 2002
Days of Supply: 10		Order Expiration Date: 03 Feb 2002
Dispensing Location: PORTSMOUTH MAIN PHARMACY		Last Filled Date: 24 Jan 2002
Clinic: DERMATOLOGY NMCP		Event Date: 24 Jan 2002@1147
Ordering Provider: PROVIDER, DAVID		Comment: NONE
		Close Detail

Figure 19–8: Review Medication Pane

3. The Details window is read-only. Click **Close Detail** to return to the full Medication Review window.

Tip:

You can still view information for a discontinued medication by setting up a filter that displays discontinued medications.

19.5 Discontinuing a Medication

Both ordered and OTC/Outside medications can be discontinued from the Medications module. An encounter must be open, though, to discontinue an ordered medication.

Follow the steps below to discontinue a medication:

1. Select the medication to be discontinued.
2. Click **Discontinue** on the Action bar.

Note: There is no confirmation message when discontinuing an ordered medication.

3. At the Inactive Medications confirmation prompt, for an OTC/Outside medication, click **OK**.

Note: There is no confirmation message when discontinuing an ordered medication. A message is displayed stating that the medication has been successfully discontinued.

19.6 Renewing a Medication

When the renew action is taken from the Medication module, the system automatically brings up the Order Entry Medication window. This function is only available for prescriptions that were originally ordered through the pharmacy and if an encounter is open.

Follow the steps below to renew a medication:

1. Select the medication to be renewed.
2. Click **Renew** on the Action bar. The Order Entry Medication window opens.

Search Filter: Outpatient Current

Medication Name (Dispensed Only)	Sig	Refills	Status	DTC	L...
ZAZITHROMYGIN-PO 250MG TAB	2 TABS PO ON DAY ONE, THEN ONE DAILY UNTIL FINISHED #6 RFD	NR	Expired	1..	
SODIUM CHLORIDE-0.225% SOLN	11 TB PO BID RFD	NR	Expired	1..	
ASPIRIN/CAFF/BUTALBITAL (FIORINAL)-PO TAB	AS NEEDED #50 RFD	NR	Expired	0..	
GUAIFENESIN/CODEINE (ROBI AC EQ.)-PO SYRP	AS DIRECTED #120 RFD	NR	Expired	0..	

0 in DTC column indicates an outside medication

Allergies: SALT PETER (POTASSIUM NITRATE) Weight: 185 lbs - 20 Nov 2001 15:45
BSA: 2.061 square meters
20 Nov 2001 15:45

Age: 40yo Sex: M Show Last Creations

New Med Order Search

Item Name:

SIG:

Qty: Max Days Supply Default Unit:
Refills: Maximum Start Date:

Expanded SIG:

Note to Provider:

Child-Resistant Cap

Comments: (Optional)

Requesting Location:
DERMATOLOGY NMCP

Dispensing Location:

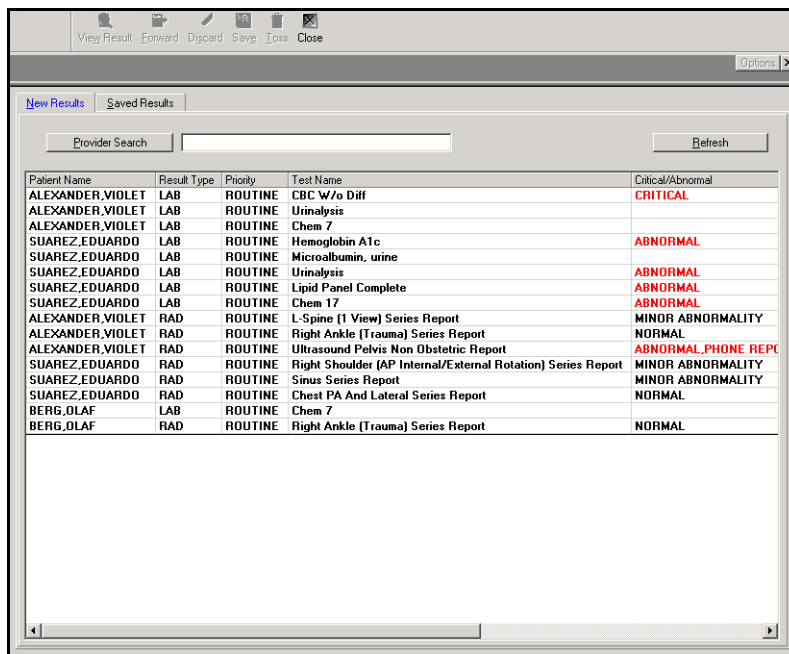
Figure 19-9: Order Entry Medication Window

3. Change the SIG, Quantity or Refills, as appropriate.
4. Click **Submit**.

20.0 NEW RESULTS

20.1 New Results Overview

The New Results module displays a list of completed radiology procedures and laboratory tests. Once a procedure or test is completed in CHCS, the order is displayed in the New Results module, allowing you to keep track of orders you have placed. You can either view a high level summary or detailed result information for a specific order. New Results can be viewed, which creates an electronic signature, discarded with no electronic signature, tossed after viewing, forwarded to another provider, or saved within the New Results module.



The screenshot shows a software window titled "New Results" with a menu bar (View Result, Forward, Discard, Save, Toss, Close) and an Options button. Below the menu is a "Provider Search" field and a "Refresh" button. The main area contains a table with columns: Patient Name, Result Type, Priority, Test Name, and Critical/Abnormal. The table lists various lab and radiology tests for patients like ALEXANDER,VIOLET and SUAREZ,EDUARDO, with results such as CRITICAL, ABNORMAL, and NORMAL.

Patient Name	Result Type	Priority	Test Name	Critical/Abnormal
ALEXANDER,VIOLET	LAB	ROUTINE	CBC W/o Diff	CRITICAL
ALEXANDER,VIOLET	LAB	ROUTINE	Urinalysis	
ALEXANDER,VIOLET	LAB	ROUTINE	Chem 7	
SUAREZ,EDUARDO	LAB	ROUTINE	Hemoglobin A1c	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Microalbumin, urine	
SUAREZ,EDUARDO	LAB	ROUTINE	Urinalysis	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Lipid Panel Complete	ABNORMAL
SUAREZ,EDUARDO	LAB	ROUTINE	Chem 17	ABNORMAL
ALEXANDER,VIOLET	RAD	ROUTINE	L-Spine (1 View) Series Report	MINOR ABNORMALITY
ALEXANDER,VIOLET	RAD	ROUTINE	Right Ankle (Trauma) Series Report	NORMAL
ALEXANDER,VIOLET	RAD	ROUTINE	Ultrasound Pelvis Non Obstetric Report	ABNORMAL,PHONE REPC
SUAREZ,EDUARDO	RAD	ROUTINE	Right Shoulder (AP Internal/External Rotation) Series Report	MINOR ABNORMALITY
SUAREZ,EDUARDO	RAD	ROUTINE	Sinus Series Report	MINOR ABNORMALITY
SUAREZ,EDUARDO	RAD	ROUTINE	Chest PA And Lateral Series Report	NORMAL
BERG,OLAF	LAB	ROUTINE	Chem 7	
BERG,OLAF	RAD	ROUTINE	Right Ankle (Trauma) Series Report	NORMAL

Figure 20-1: Military Clinical Desktop –New Results Module

20.1.1 In More Depth

Typically, a lab test or radiology procedure is ordered in the A/P module of CHCS II and is sent to CHCS for processing. Once the procedure or test is complete, the results are sent to the CDR, an Alert icon shows up in CHCS II, and the result appears in the New Results module, as well as either the Lab or Radiology module.

In the summary view, critical results appear in red and results that are normal or have minor abnormalities appear in black.

There are two tabs that make up the New Results module: New Results and Saved Results. The New Results lists all of the results that have been completed in CHCS. The Saved Results tab lists those results that have been saved from the New Results tab.

20.1.2 Viewing New Results

The New Results module allows you to view detailed information for a selected result. The New Results module interfaces with the Labs and Radiology modules when viewing detailed result information, depending on the selected result.

Follow the steps below to view results:

1. On the New Results tab, select the result you want to view.
2. Click **View Result** on the Action bar.
3. View the result in the Labs or Radiology module.
4. When you are finished viewing the detailed result information, close the Labs or Radiology module to return to the New Results module.

20.2 Discarding New Results

The New Results module allows you to discard selected results. You can discard results without viewing the result (e.g., the result appears in your New Results list, but the result was forwarded to you for a patient from another provider). The discarded results are removed from your list without an electronic signature. To create an electronic signature, view the result and then use the Toss functionality to remove the results from the list.

Follow the steps below to discard results:

1. On the New Results tab, select the result you want to discard.
2. Click **Discard** on the Action bar.
3. At the discard confirmation prompt, click **Yes**.

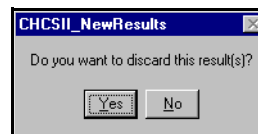


Figure 20–2: Discard Prompt Window

20.3 Saving New Results

The New Results module allows you to save selected results. Saving a new result removes the result from the New Results tab and displays it on the Saved Results tab. You must first view the result before you can save it.

Follow the steps below to save results:

1. On the New Results tab, select the result you want to save.
2. Click **Save** on the Action bar.
3. At the save confirmation prompt, click **Yes**.

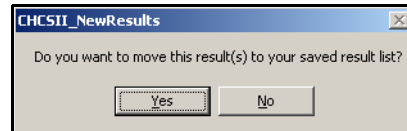


Figure 20-3: Save New Results Prompt

4. View the result on the Saved Results tab.

Patient Name	Result Type	Priority	Test Name	Critical/Abnormal	Date of Birth	Sex	FMP/SSN	Order Number	Exam Number
FRECHETTE,VELVA	RAD	ROUTINE	Right Ankle Series Report	NORMAL	09 JAN 1946	F	30/800-46-0109	020718-00008	02000480
GARRETT,AFTON	RAD	ROUTINE	Right Hip Series Report	NORMAL	10 SEP 1930	M	20/229-32-5444	020726-00010	02000497

Figure 20-4: Saved Results Tab

Note: Click **New** on the Action bar to move the results back to the New Results tab. At the confirmation prompt, click **Yes**.

20.4 Forwarding New Results

The New Results module allows you to forward new results to other providers. When you forward a result to another provider, a copy of the result is made and added to the forwarding provider's New Results list. A provider can only have a single copy of the result. If you forward a saved result to a provider, the result displays in the forwarding provider's New Results list.

Follow the steps below to forward a new result to a provider:

1. Click **Provider Search** to locate the provider to whom you are forwarding the new result.

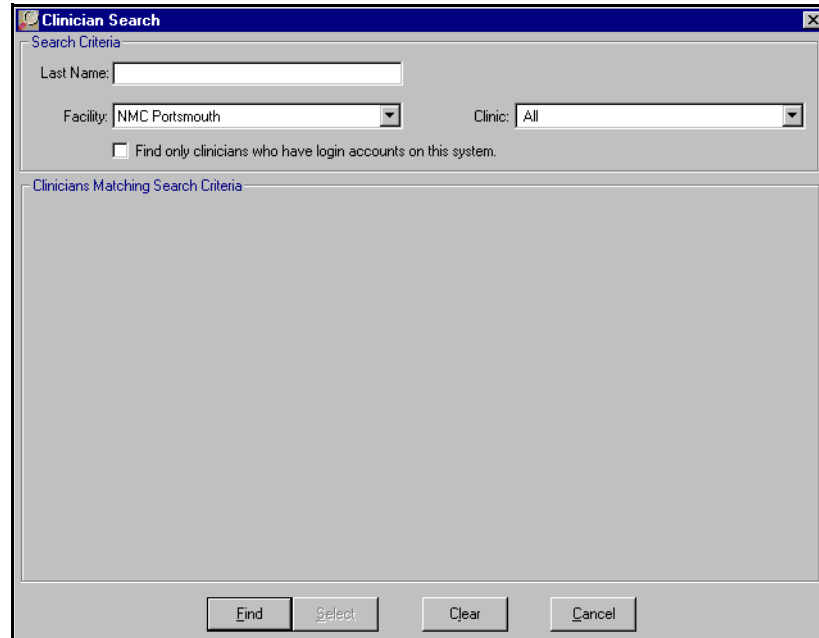


Figure 20–5: Clinician Search Window

2. In the **Last Name** field, enter the last name of the desired clinician.
3. Select a facility from the drop-down list.
4. Select a clinic from the drop-down list.
5. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
6. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
7. Select the desired clinician.
8. Click **Select**.
9. On the New Results tab, select the result you want to forward.
10. Click **Forward** on the Action bar.
11. At the forward confirmation prompt, click **Yes**.

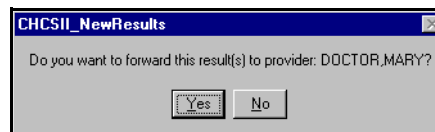


Figure 20–6: Forward Confirmation Prompt Window

20.5 Tossing New Results

The New Results module allows you to remove new results from the New Result list. You cannot toss a result that has not been viewed. If the result is on the Saved Results list, it has already been viewed and therefore already has a signature.

Follow the steps below to toss results:

1. On the New Results tab or Saved Results tab, select the result you want to toss.
2. Click **Toss** on the Action bar.
3. At the toss confirmation prompt, click **Yes**.

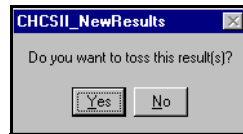


Figure 20–7: Toss New Results Prompt Window

21.0 ORDER SETS

21.1 Order Sets Overview

Order sets are templates of laboratory, radiology, or medication orders that streamline the ordering process. Order sets are created and saved as encounter templates and can be managed in the Template Management module. Once an order set has been created, it can be included in encounter templates.

21.1.1 In More Depth

Order sets can be created and organized in a variety of ways. Some users create order sets based on a specific diagnosis; diabetes, for example. Others create an order set template that includes the top twenty lab, radiology, and medication orders. This encounter template is then merged with disease- or symptom-specific encounter templates.

21.2 Creating an Order Set from A/P

Building an order set is not an intuitive process and must be done inside an open encounter. The best method is to use the A/P module to locate and save orders as part of an order set. Although orders should not be submitted as part of this process, it is best to be safe and create an appointment for a test patient in the test clinic.

Follow the steps below to create an order set from A/P:

1. In the A/P module, begin on one of the Order Entry tabs (Labs, Rads, or Meds).
2. Locate the first order you want to include in the order set.
3. When you have located the order, click **Save to Queue**. This saves the order without submitting it.
4. Continue with all three tabs, as appropriate, locating individual orders and clicking Save to Queue.

Tip:
Once an order has been submitted, it cannot be included in an order set. Orders must be located and then Saved to Queue.

Note: For Med and Rad orders, the SIG and clinical impression is used as the default for those orders. These can be changed when using the order set in an actual encounter.

5. Once you have finished locating the orders you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

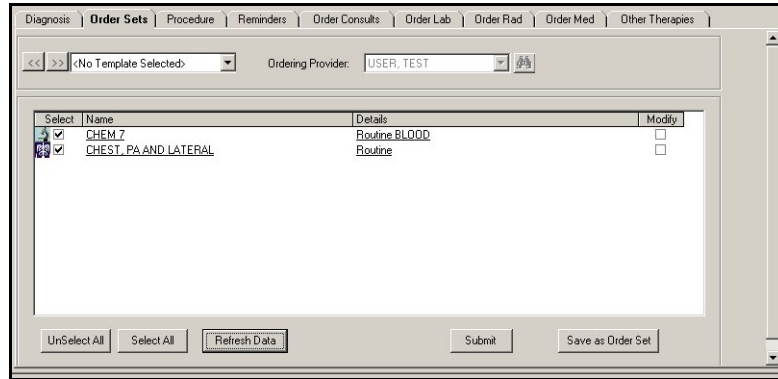


Figure 21-1: Order Sets Tab

6. Click **Save as Order Set**.
7. In the Save Encounter Template window **Template Name** field, enter the template name you want to use for the order set.
8. Click **Save** to save the order set. The order set encounter template can now be merged with other encounter templates and/or accessed in the Template Management and A/P modules.

21.2.1 Adding Orders to an Existing Encounter Template

An order set can also be saved as part of an encounter template that has already been built.

Follow the steps below to add orders to an existing template:

1. Locate your order(s) and save them to queue, following steps 1 - 4 above.
2. Once you have finished locating the order(s) you want to include in your order set, click the **Order Set** tab to display the orders that have been saved to queue.

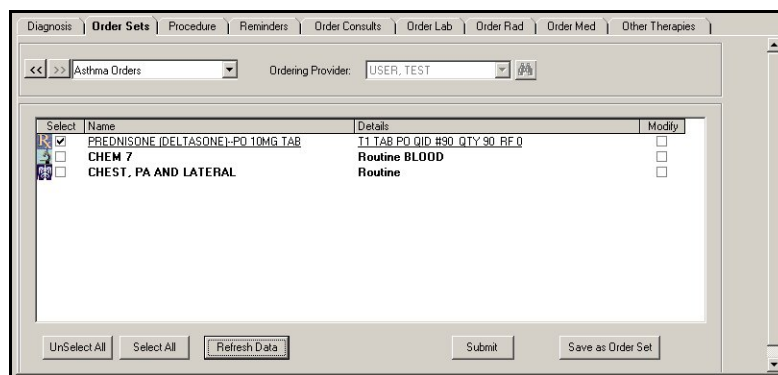


Figure 21-2: A/P Order Sets Tab

3. Click **Save as Order Set**.
4. In the Save Encounter Template window, select the encounter template to add to and click **Save**.

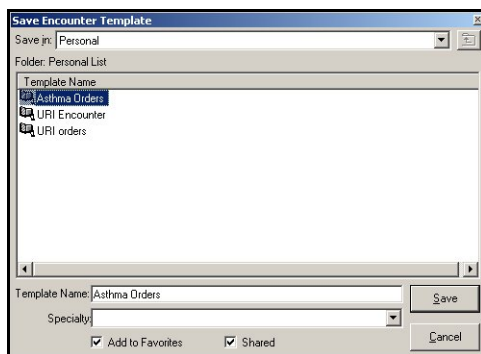


Figure 21-3: Save Encounter Template Window

5. A pop-up window opens asking if you want to Replace or Add To the existing template. Click **Add To**. The selected order(s) is(are) added to the existing template and can be viewed in the Template Management module or within A/P when the template is loaded.

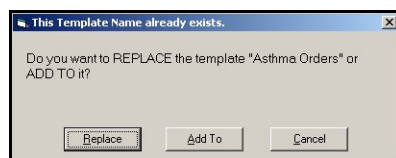


Figure 21-4: Template Name Option Box

21.3 Using an Order Set in A/P

Since an order set is considered an encounter template, you must select and load the Encounter template into the A/P module in order to view and use the associated order set.

Follow the steps below to load and use an order set:

1. Click the **Order Sets** tab.
2. If an encounter template with orders has not been loaded, use the template drop-down list to select the appropriate template. The orders associated with the Encounter template are available.

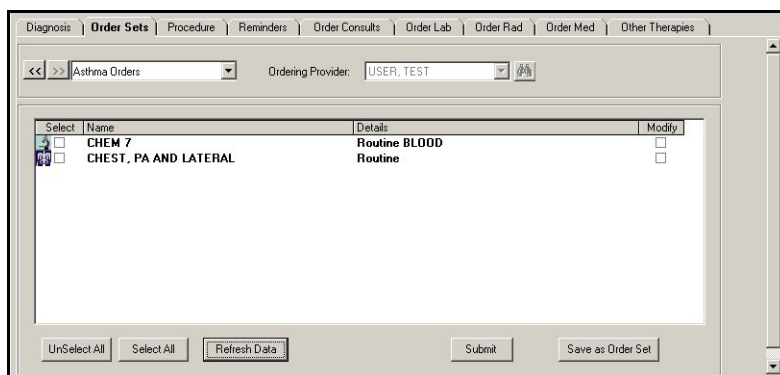


Figure 21-5: A/P Order Sets Tab

3. Do one of the following:

- If you want to select and submit all orders with no modifications, click **Select All**.
- If you want to select specific orders, click the checkbox in the Select column next to each applicable order.

Note: You can also click the checkbox in the Modify column next to each applicable order. Clicking a checkbox in the Modify column automatically puts a checkmark in the checkbox in the Select column.

4. Click **Submit**.

Note: Orders that were selected but not modified are sent out automatically. For orders needing modification, the appropriate order entry module opens. Make the desired modifications and click **Submit** on the order entry module.

22.0 PATIENT ENCOUNTER

22.1 Patient Encounter Overview

The CHCS II encounter document design is based on, and replaces, the SF600. Therefore, this module is commonly referred to as the electronic SF600. As the patient progresses through the clinic workflow and as clinical team members document the encounter, the Patient Encounter module collects and displays all of the documentation from each team member. It also contains buttons that correspond to each of the different sections of the entire note. This makes for easy navigation to the various modules that are used to document the encounter.

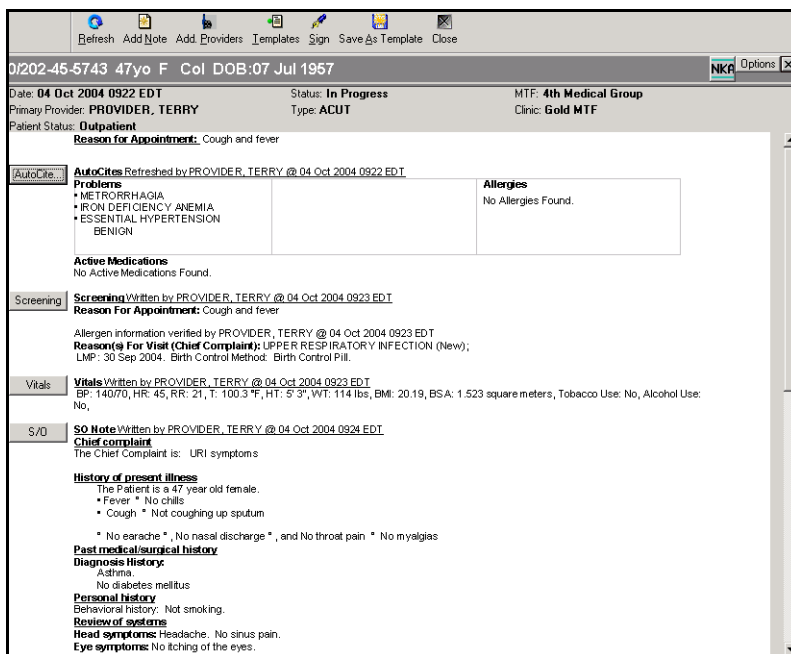


Figure 22-1: Military Clinical Desktop—Encounter Summary

22.1.1 In More Depth

The encounter document is the central interface for documenting the patient encounter, including documenting the S/O portion, performing the assessment and plan, recording the patient disposition and signing the encounter.

At the top of the Patient Encounter module is the AutoCite area. This customizable area contains patient information that is already known about the patient. Information is pulled from various CHCS II modules, including Allergies, Problems, Medications, Vital Signs and the result retrieval modules.

The encounter document workspace has a row of buttons along the left margin and the text display area to the right. The buttons are used to access the different modules within the encounter both to enter new information and review and/or edit current

information. Modules accessible from this area include Screening, Vitals, S/O, A/P, and Disposition.

As data is entered into each of these modules, it displays in note form in the related workspace once the entry module is closed. When you have completed the encounter, this encounter document displays all the information documented for the patient visit.

This workspace design and application functionality support team-based care and the clinic workflow. Multiple individuals can work within one encounter at the same time. The system places time, date, and name stamps on each entry added to the encounter note.

Once the support staff, nurse, and provider gather all the information, the encounter is signed by the provider assigned to the encounter when the appointment was made.

22.2 Setting the Properties of the Patient Encounter Module

In the Patient Encounter module, the Signature Block and the items in AutoCite can be customized. Once set, these configurations become the default for every encounter you open.

Follow the steps below to set the properties of the Patient Encounter module:

1. Click **Options** in the top, right corner of the Patient Encounter module. The Encounter Summary Properties window opens.

Figure 22–2: Encounter Summary Properties Window

2. In the Signature Block, enter the text you want for lines 2 and 3.

Note: Line 1 defaults to you and cannot be changed.

- If you need a co-signer for every encounter you sign, click **Search** to assign a default co-signer. The Clinician Search window opens allowing you to search for a provider to select as a co-signer.

Note: With a default co-signer selected, each time you sign an encounter, an alert is triggered for the co-signing provider.

- In the AutoCite Preferences area, click the check box next to the items you want to AutoCite. A check denotes the selected items.
 - Active Problems, Allergies, Active Medications, Active Family History, Questionnaire, Expired Medications:** Click the checkboxes to AutoCite the patient's information. The AutoCited information is pulled from the Problems, Medications, Allergy, and Patient Questionnaire modules.
 - Vitals, Labs, Rads:** Select the checkboxes to AutoCite the patient's information. In the **Last** field, enter a numerical value and select the radio button to select the time setting.
 - A/P Active Order Default:** Select the checkbox(es) if you want to display active medication, laboratory, or radiology orders when opening order entry tabs.
 - Autosave S/O:** Enter a numeric value to denote the frequency of the autosave. The system saves the Form Tool or List Tool Notes according to this setting.
- In the Disposition Follow Up Discussed with Default area, click the drop-down list and select the person with whom the disposition follow up is discussed.
- Select the Auto-Print checkbox to auto-print.
- Select the Auto-save S/O checkbox to have the encounter automatically save S/O at designated intervals. Click in the **Min** checkbox and enter the time.

Note: When vitals, labs, or rads are selected to AutoCite, additional fields become active. In the **Number** field, enter the desired number and then select the appropriate radio button. The system AutoCites vitals, labs, and rads according to these settings.

- Click **OK**. The settings are saved.

22.2.1 Adding a Note

You can add a note to the Encounter Document. This narrative appears in the note section of the Patient Encounter module with the Time, Date, and user name next to the narration.

Follow the steps below to add a note:

- On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.

Tip:
For efficient system performance, it is recommended to only select those items that are needed for every encounter. CHCS II pulls this information from the CDR and large amounts of data could delay this process.

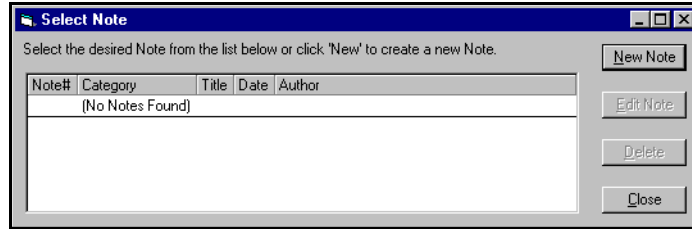


Figure 22-3: Select Note Window

2. Click **New Note** to begin a new note. The Encounter Note window opens, allowing you to add notes to any phase of the encounter.

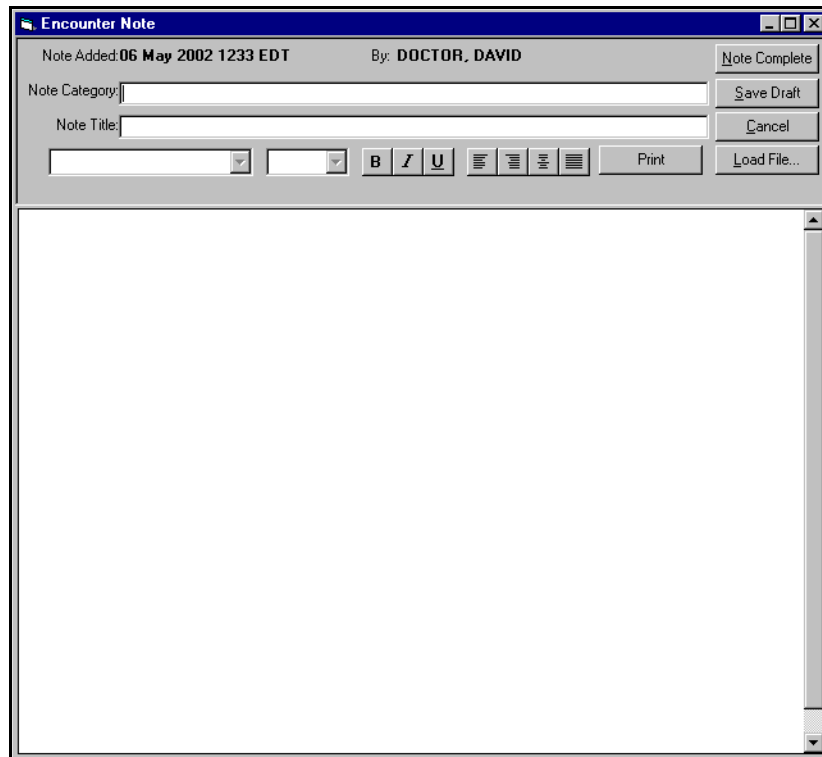


Figure 22-4: Encounter Note Window

3. Enter a **Note Category**, if necessary.
4. Enter a **Note Title**, if necessary.
5. Enter a note in the text box.
6. Do one of the following:

- If you want to insert a file into the note:
 - a. Click **Load File**.
 - b. Select the desired file to be added.
 - c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Note Complete**. The note appears in the encounter document.

Note: Click **Save Draft** to save the note as a draft. The note is displayed on the Patient Encounter module in the Note section as a draft. The encounter cannot be signed if a note exists in draft form.

22.3 Deleting a Note

Follow the steps below to delete a patient encounter note:

1. On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.

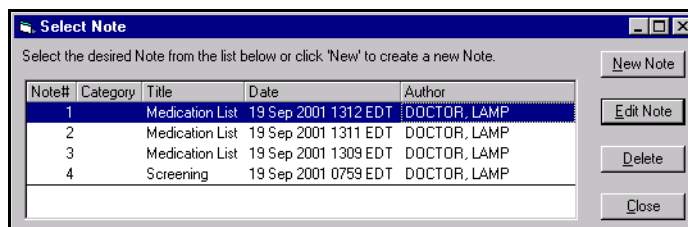


Figure 22-5: Select Note Window (With Data)

2. Select the note you want to delete.
3. Click **Delete**.
4. Click **Yes**. The Confirm Deletion of Note message appears.

22.4 Editing a Note

Follow the steps below to edit a note:

1. On the Patient Encounter module, click **Add Note** on the Action bar. The Select Note window opens.
2. Select the note you want to edit.
3. Click **Edit Note**. The Encounter Note window opens.

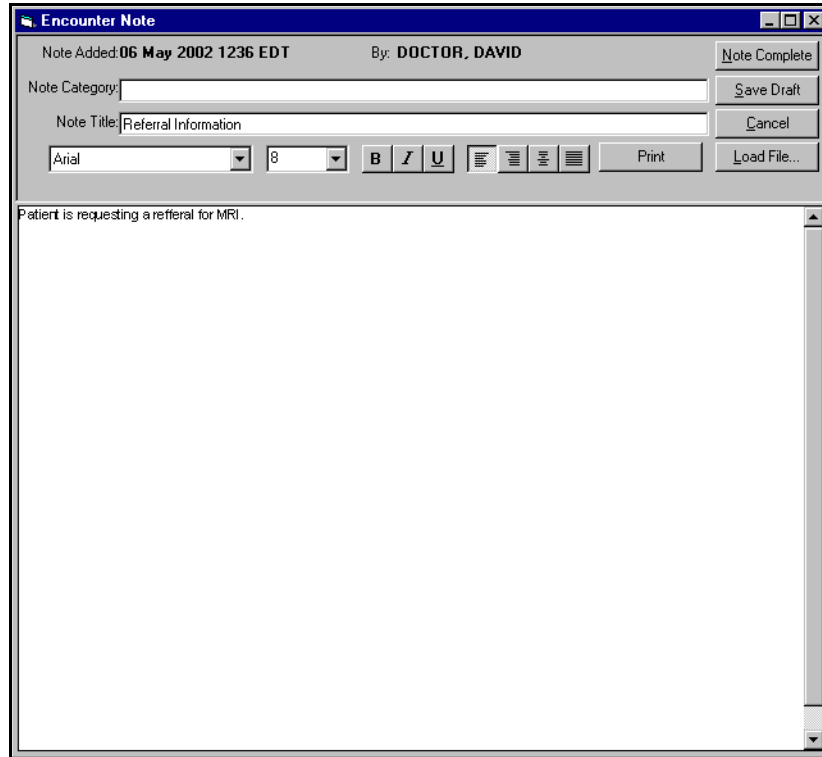


Figure 22–6: Encounter Note Window (Edit Mode)

4. Make the applicable edits to the note.
5. Click **Note Complete**.

Note: If the note you are editing has been created by another person, a message prompt appears asking if you want to create a note starting with the contents of the note you selected—click **Yes** to use the contents of the selected note, or **No** to create a note with no previous contents.

22.5 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.

Figure 22–7: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click the **ellipsis** button to search for a provider. The Clinician Search window opens.

Figure 22–8: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the Provider and Roles window.

11. Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

12. Click **OK**. The clinician(s) is(are) added to the appointment.

22.6 Loading an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter Template contains diagnoses, procedures, S/O templates, orders, and patient instructions. Encounter templates are typically loaded directly through the S/O or A/P modules to streamline the documentation process.

Follow the steps below to select an encounter template:

1. On the Patient Encounter module, click **Templates** on the Action bar. The Template Selections tab opens within the Template Management module.

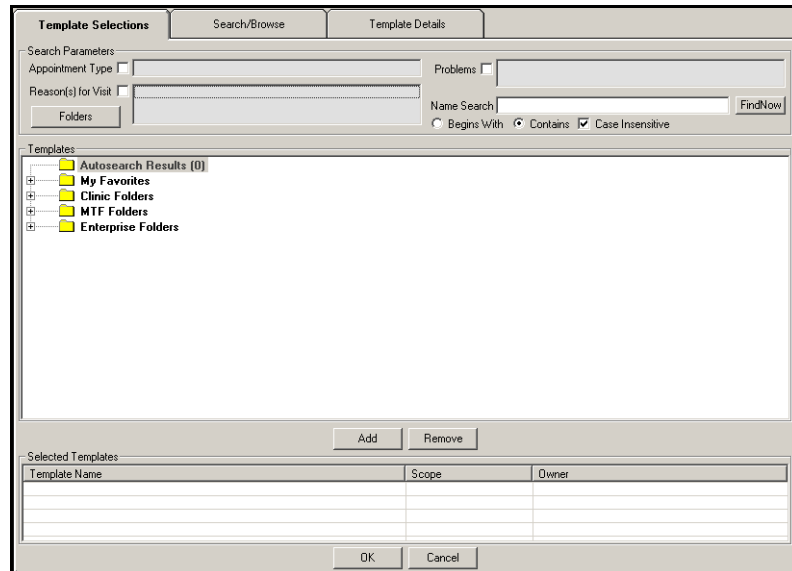


Figure 22–9: Template Management Window—Template Selections Tab

2. Locate the template using one of the following:
 - Expand My Favorites, or Clinic, MTF, or Enterprise Folders.
 - Conduct a search for the template.
 - Enter the name of the template in the Name Search field and click **Find Now**.
 - The search results display in the Name Search Results Folder.
3. Select the template.

4. Click **Add**. The template is moved to the Selected Templates List.

Note: More than one template can be added to the encounter.

5. Click **OK** to load the template(s) in the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the S/O (Notes template) and A/P (Diagnoses, Procedures, Orders, and Patient Instructions) modules.

22.7 Signing the Encounter Overview

When the provider is satisfied that the encounter is complete, the final step in the encounter process is to sign the encounter. The primary provider performing the encounter documentation must sign the encounter.

22.7.1 Requirements for Signing an Encounter

If an encounter is incomplete, the Encounter is not Complete window opens explaining which sections are incomplete. The primary provider has the option to return to the current encounter to complete it.

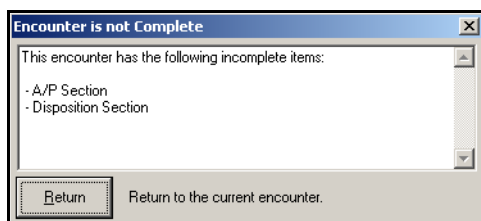


Figure 22–10: Encounter is not Complete Window

To be complete, an encounter must contain the following:

- At least one diagnosis
- Disposition
- E&M code

In addition, a note or consult cannot be in draft form. If the encounter is marked as related to an Injury/Accident an E-code (diagnosis) must be included as a diagnosis.

Follow the steps below to sign the encounter:

1. Click **Sign** on the Action bar. The Sign Encounter window opens.

Sign Encounter

Patient: **ALEXANDER, VIOLET** Date: **04 Oct 2004 0922 EST** Appt Type: **ACUT**
 Facility: **4th Medical Group** Clinic: **Gold MTF** Provider: **PROVIDER, TERRY**
 Patient Status: **Outpatient**

Reason for Appointment: Cough and fever

AutoCites Refreshed by PROVIDER, TERRY @ 04 Oct 2004 0922 EST

Problems • METRORRHAGIA • IRON DEFICIENCY ANEMIA • ESSENTIAL HYPERTENSION BENIGN	Allergies No Allergies Found.
---	---

Active Medications
 No Active Medications Found.

Screening Written by PROVIDER, TERRY @ 04 Oct 2004 0933 EST
Reason For Appointment: Cough and fever

Allergen information verified by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT
Reason(s) For Visit (Chief Complaint): UPPER RESPIRATORY INFECTION (New);
 LMP: 30 Sep 2004. Birth Control Method: Birth Control Pill.

Vitals
 Vitals Written by PROVIDER, TERRY @ 04 Oct 2004 0923 EDT
 BP: 140/70, HR: 45, RR: 21, T: 100.3 °F, HT: 5' 3", WT: 114 lbs, BMI: 20.19, BSA: 1.523 square meters, Tobacco Use: No, Alcohol Use: No,

SO Note Written by PROVIDER, TERRY @ 04 Oct 2004 0924 EST
Chief complaint
 The Chief Complaint is: URI symptoms

History of present illness
 The Patient is a 47 year old female.

Enter Your Password: Auto-Print Sensitive
 Cosigner Required

Figure 22–11: Sign Encounter Window

2. In the **Enter Your Password** field, enter your password.
3. Do one of the following:
 - If you do not want to auto-print the signed encounter, deselect the **Auto-Print** checkbox. The system defaults to print the encounter summary.
 - If a co-signer is required:
 - a. Click the **Co-Signer Required** checkbox.
 - b. Click **Search**. The Clinician Search window opens.
 - c. Search for the clinician you want to designate as a co-signer.
 - If you want to mark the encounter as sensitive, click the **Sensitive** checkbox. The system marks the encounter as sensitive.

Note: When opening the Previous Encounters module that contains a sensitive encounter, asterisks display in place of the sensitive data. The provider must have “break the glass” privileges to view the data.

4. Click **Sign** to sign the encounter.

Note: Only the provider who was assigned the appointment can sign the encounter. Other Clinical Team Members can add to the encounter but cannot sign it.

22.8 Saving an Encounter as a Template

After an encounter has been documented, the structure and orders can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

Follow the steps below to save an encounter as a template:

1. Document the encounter.
2. On the Action bar, click **Save As Template**. The Template Details tab on the Template Management module opens. Details from the selected encounter display in their appropriate sections.

The screenshot displays the 'Template Details' tab of the Template Management window. It features several sections for editing a template:

- Template Name:** Created from Encounter 106929
- Owner Type:** Personal
- User:** JONES, PAT
- Specialty:** (Empty dropdown)
- EM Code Category:** (Empty dropdown)
- Associated Reasons for Visit:** (Empty list with Add... and Remove buttons)
- Associated Appointment Types:** WI (with Add... and Remove buttons)
- Associated Problems:** a decrease in height 781.91, ANKLE SPRAIN RIGHT 845.00, ACUTE BRONCHITIS 465.0, ASTHMA MILD INTERMITTENT 493.90, DIABETES MELLITUS TYPE II 250.00 (with Add... and Remove buttons)
- Items to AutoCite into Note:** (Empty list with Add... and Remove buttons)
- Diagnoses:** ANTERIOR DISLOCATION OF LENS PSEUDOPHAKIC 379.33 (with Add... and Remove buttons)
- Procedures:** Pulmonary Function Tests Peak Flow 94150 (with Add... and Remove buttons)
- Notes Templates:** (List) URI (with Add... and Remove buttons)
- Orders:** (Rad)CHEST,PA (with Add... and Remove buttons)
- Other Therapies:** Oral Fluids Frequent, Return To Clinic If Worse Or New Symptoms (with Add... and Remove buttons)

Figure 22–12: Template Management Window—Template Details Tab

3. Add or remove information from the following areas:
 - **Associated Reasons for Visit, Associated Problems, Associated Appointment Types:** These three areas are rarely used within CHCS II. These areas determine those templates that the system suggests when you go to load a template.
 - **Items to AutoCite into Note:**
 - Click **Add**.
 - Select an AutoCite selection from the list and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
 - **Diagnoses, Other Therapies, Procedures:**
 - Click **Add** next to the appropriate section.
 - In the **Search Term** field, enter the first few letters of the procedure and click **Search**.

- Select the item from the search results and click **Add Items**.
 - Click **Done** to return to the Template Details tab
 - **Notes Templates:**
 - Click **Add**.
 - Click **Search** to open the List Note Template Search window.
 - Enter search criteria in the window and click **Search**.
 - Select the note template and click **Add Items**.
 - Click **Done** to return to the Template Details tab.
4. Click **Save As** on the Action bar. The Save Encounter Template window opens.

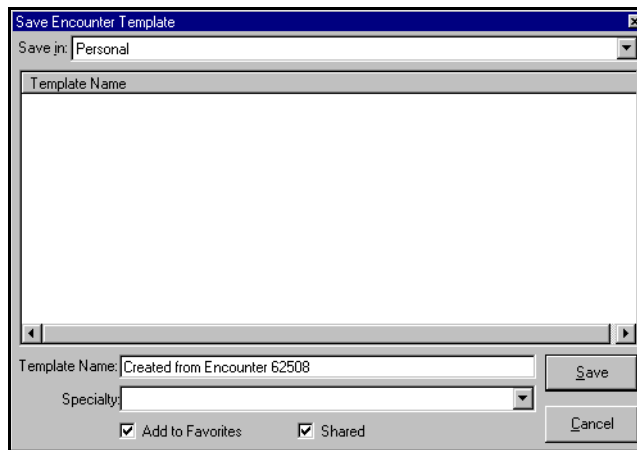


Figure 22–13: Save Encounter Template Window

5. Select the **template type** from the Save-in drop-down list.
6. In the **Template Name** field, enter the template name.
7. Select the **Specialty** from the drop-down list.
8. Click the checkboxes to denote whether the template should be added to your Favorites List or shared with other Clinical Team Members.
9. Click **Save**.

22.9 Unlocking an Encounter

More than one clinical team member can view and document a patient's record at the same time. The S/O Note is the only module of the current encounter that can be documented concurrently. If this is the case, both S/O notes are saved to the patient encounter. Only the primary provider can sign the encounter. The primary provider is the provider who owns the appointment.

22.9.1 Two Providers Accessing the Same Module

Two providers cannot document the A/P or the Disposition at the same time. If this occurs, a provider can take the section from the original provider. For example, if one provider is documenting A/P and a second provider accesses the A/P module, a message window appears, stating that A/P is being used and asks whether to break the lock. If the lock is broken, the second provider can document A/P. The original provider is informed upon saving A/P that this section was taken and no information from that section can be saved.

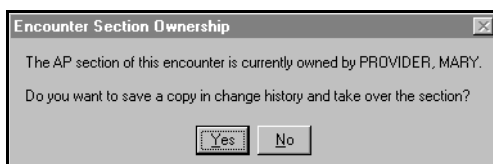


Figure 22–14: Encounter Section Ownership Window

22.9.2 Second Provider Changing First Provider's Information

A second provider can go behind the original provider and change the A/P or Disposition section of the encounter. When this occurs, the documentation done by the original provider is saved in the Notes section of the encounter under the heading of Change History.

23.0 PATIENT IMMUNIZATIONS

23.1 Patient Immunizations Overview

The Immunizations Module is used to manage and track patient immunization records and vaccine history. The Immunizations module contains two tabs: Individual Immunizations and Vaccine History. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

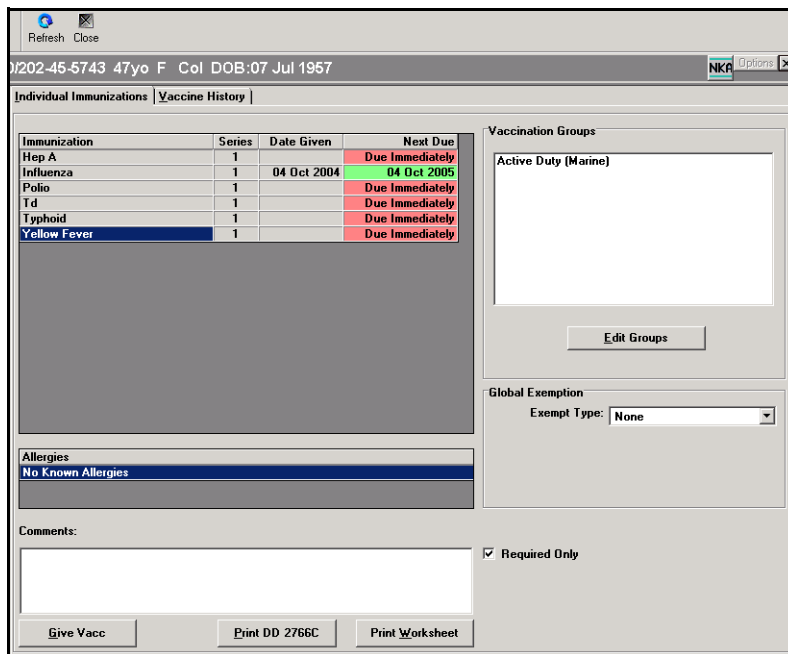


Figure 23-1: Military Clinical Desktop—Patient Immunizations Module

23.1.1 In More Depth

Active duty service personnel have a required set of immunizations that must be administered in order for the service member to be eligible for duty either in the United States or overseas. These immunizations can be administered at any DoD clinic and the immunization data must be updated.

The Individual Immunizations tab is used to select and administer vaccines to a patient and allows you to view immunization information. A color status indicator is used to quickly confirm immunizations that are current and those that are overdue per the established vaccine schedules for the individual vaccinations. The patient's allergy information is displayed as read-only data. The Vaccine History tab is used to add a vaccination to the patient's record, edit an immunization history, or delete an immunization history.

The recommended workflow for documenting CHCS II encounters in the Immunizations Clinic is as follows. Some of the steps may not be applicable based on each clinic's established business processes:

- Create a new walk-in appointment
- Open the appointment
- Document screening and verify allergies
- Document vital signs
- Administer immunization(s) to patient and document in CHCS II
- Print DD 2766C for the patient chart
- Document appropriate diagnostic and procedural codes in A/P module
- Document disposition
- Sign encounter

The DD Form 2766C in CHCS II is the Vaccine Administration Record. This form contains the same information as the SF 601 currently used in Immunizations clinics. For this reason, it is recommended that after the vaccinations have been documented in CHCS II, the end user should print the DD 2766C and place it in the patient's chart. It is not necessary to print the SF 600 for the patient's chart.

In the A/P module, a diagnosis and procedure code should be selected for each vaccine administered to the patient.

Note: A default encounter template should be created for use by the entire clinic staff to streamline the documentation process. The encounter template should contain all of the diagnostic and procedural codes used in the Immunizations clinic. The encounter template can also contain a S/O visit template to document the reason for visit as immunization.

If multiple vaccines are given for a single diagnosis, the appropriate procedure code for the first vaccine given should be associated to the diagnosis. The appropriate procedure code for each additional vaccine given should also be associated to the diagnosis. When administering multiple vaccinations, the users should use CPT multipliers to accurately document vaccines and generate accurate workload credit for the clinic.

23.2 Adding a Vaccination

Vaccinations can be added to a patient's record.

Follow the steps below to add a vaccination:

1. Click the Vaccine History tab on the Immunizations module. The Vaccine History tab displays.

Immunization	Date	Series	Result	Mfg	Lot Nbr	Next Due	Exempt	Expires	Last Edit	D
Influenza	9 Aug 2001	1		TRS	3ANSCRIBE	1 Oct 2001	None		9 Aug 2001	

Figure 23–2: Immunizations module— Vaccine History Tab

- Click **Add**. The Vaccines window opens.

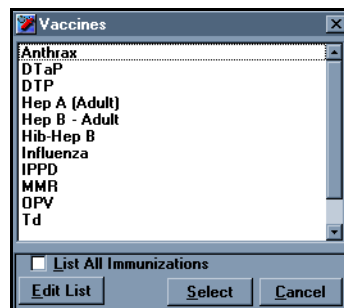


Figure 23–3: Vaccines Window

- Select the vaccine you want to add.

Note: Click the List All Immunizations checkbox to view a list of all vaccines in stock. All vaccines in stock appear on the list. Click **Edit List** to edit the list of favorite vaccines. On the Edit Favorite Vaccine List window, select a vaccine from the All Vaccines list and click the **right arrow** to move the vaccine to the Selected Vaccines list. Click **Close**.

- Click **Select**. The Add Vaccine window opens.

Figure 23–4: Add Vaccine Window

5. Complete the following fields:
 - **Vacc Date:** Enter a date, or click the **ellipsis** button and select a date from the calendar, to assign a vaccination date.
 - **Series Number:** Enter the series number of the vaccine, if necessary.
 - **Manufacturer:** Select a manufacturer from the drop-down list, if necessary.
 - **Lot Number:** Enter the lot number of the vaccine, if necessary.
 - **Dosage:** Select a dosage for the vaccine from the drop-down list, if necessary.
 - **Site:** Select an area of the body where the vaccine is given from the drop-down list, if necessary.
 - **Route:** Select the vaccine route from the drop-down list, if necessary.
 - **Next Vaccination Due:** Click **Recalc** to automatically calculate the next vaccination due date. The date is automatically entered.
 - **Exempt:** Select an exemption from the drop-down list, if necessary.
 - **Provider:** Select a provider from the drop-down list, if necessary.

Note: The Immunization Provider selected from the drop-down list should be the clinic team member who actually administered the vaccine(s) to the patient.

6. Click **Update** to save the data and return to the Vaccine History tab.

23.2.1 Deleting Immunization History

Follow the steps below to delete an immunization History:

1. Select the immunization you want to delete.

2. Click **Delete**.

Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.

23.3 Editing Immunization History

If you note any discrepancies between the patient's physical immunizations record and the CHCS II record, you can edit the electronic record to match the physical record. All new, modified, or deleted immunizations are automatically batch updated to DEERS. All immunization history data in DEERS for the patient is replaced with the contents of the database immunization record. This ensures consistent data for patients across all Services.

Follow the steps below to edit an immunization history:

1. Select the immunization you want to edit.
2. Click **Edit**. The Immunization History Edit window opens.

The screenshot shows a window titled "EDIT: BARTON CLARA H CPO 80657050120". The window contains the following fields and controls:

- Vaccine: Influenza
- Vacc Date: 31 Jul 2003
- Series: 1
- Manufacturer: Transcribed (dropdown)
- Lot Number: TRANSCRIBED
- Dosage: (dropdown)
- Site: Unknown (dropdown)
- Route: UNK (dropdown)
- VIS Version: (text field with ellipsis button)
- Next Vacc Due: 31 Jul 2004 (with Recalc button)
- Exempt: None (dropdown)
- Provider: (dropdown)
- Update button
- Last Edited By: JONES PAT
- Cancel button

Figure 23-5: Immunization History Edit Window

3. Complete the following fields:
 - Series
 - Manufacturer
 - Lot Number
 - Dosage
 - Site
 - Route

- Next Vacc Due
 - Exempt
 - Provider
4. Click **Update** to save the data and return to the Vaccine History tab.

23.4 Editing Vaccination Groups

All vaccination groups established for service type or occupational status are listed in the Vaccination Groups field.

The patient receives vaccinations assigned to the selected group(s).

Follow the steps below to edit the Vaccination Groups:

1. Click **Edit Groups** in the Individual Immunization tab. The Immunization Groups window opens.

Note: All vaccination groups established for service type or occupation status are listed in the Immunization Groups list. The vaccination groups assigned to the unit to which this patient belongs are shown in the Required Groups field. These groups are assigned in the Unit window, and cannot be edited. Groups defined by the support staff are listed in the User-Defined Groups field.

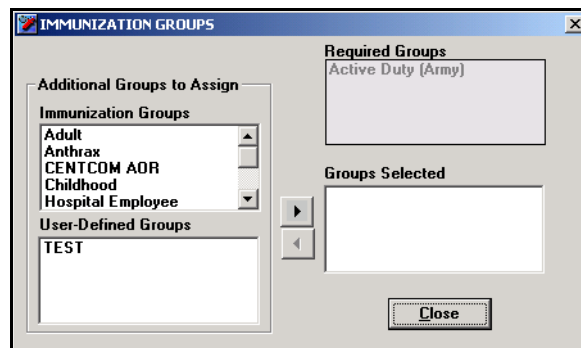


Figure 23–6: Immunization Groups Window

2. Select a group name from the Immunization Group or User-Defined Group list.
3. Click the **right arrow** to move the selected group to the Groups Selected list.

Note: Multiple groups can be selected to appear in the Vaccination Groups list.

4. Click **Close**. The selected groups appear on the Individual Immunization tab in the Vaccination Groups list.

23.5 Printing Immunization Records

There is an option to print the worksheet and the DD 2766C from the Individual Immunization window. The report prints to your default printer.

Follow the steps below to print immunization records:

- **Print Worksheet:** Use this function to print required immunizations for the selected patient.
- **Print DD 2766C:** Use this function to print a Vaccine Administration Record.

23.6 Reviewing Immunization Records

This area of the Individual Immunization tab displays all immunizations the patient is required to have based on the vaccination groups to which the patient is assigned. When immunizations are due, but have not been given, the column under Next Due displays in red. Once the required immunizations have been given through the Give VAX function, the column changes to green.

23.7 Selecting an Immunization

Follow the steps below to select an immunization:

1. Click **Give Vacc** on the Individual Immunizations tab. The Select Immunization window opens.

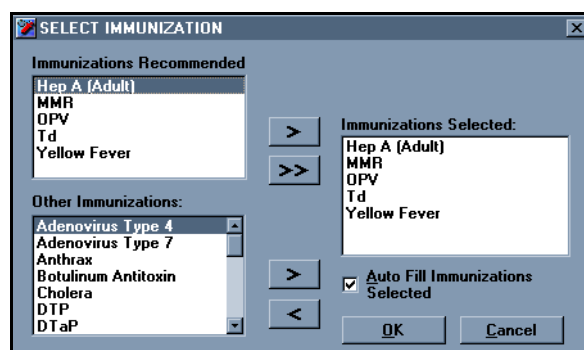


Figure 23–7: Select Immunization Window

2. Select an Immunization.

Note: The Immunizations Recommended list is based on the vaccination groups to which the patient is assigned. The Other Immunizations list is a list of all vaccines.

- Click the **right arrow** to move the items from the Immunizations Recommended list or Other Immunizations list to the Immunizations Selected list.

Note: Click the **double arrow** to move the entire group of Immunizations Recommended to the Immunizations Selected list.

Note: Click the **left arrow** to remove the selected immunization from the Immunizations Selected list back to the Immunizations Recommended or Other Immunizations list.

- Click **OK**. The Vaccine Select window opens displaying the selected vaccines.

The screenshot shows a window titled "Vaccine Select" with a close button (X) in the top right corner. Below the title bar, there is a "Vacc Date: 9 Aug 2001" label and an "Immunization Provider" dropdown menu currently set to "PROVIDER EMMA". The main area contains a table with the following data:

Vaccine	Series	Mfg Code	Lot Nbr	Dose	Site	Route
Hep A (Adult)	1	CHI	856	1.0 mL	Left Arm	SC
MMR	1	OTC	6755	4 caps	Left Arm	Oral
DPV	1	AVI	222	2 gtts	Left Arm	IM
Td	1	NAB	29999	2 gtts	Left Arm	IM
Yellow Fever	1				Left Arm	

At the bottom of the window are "OK" and "Cancel" buttons.

Figure 23–8: Vaccine Select Window

- Select the vaccine(s).
- Select the Immunization Provider from the drop-down list.

Note: The Immunization Provider selected from the drop-down list should be the clinic team member who actually administered the vaccine(s) to the patient.

- Click **OK**.

23.8 Selecting the Immunization Exempt Type

Follow the steps below to select the immunization exempt type:

- Global:** If a patient has never been given any of the immunizations that are listed in the vaccination record section, he/she can be exempted using this function from the Individual Immunization tab.
- Focused:** If an exemption has been given for that immunization, the exempt function must be performed from the Vaccine History tab.

Follow the steps below to make a global exemption for all immunizations in the Individual Immunizations tab:

1. Select an **Exempt Type** from the drop-down list.

Note: If you select **Medical (Temp)**, **Admin (PCS)**, or **Admin (Temp)** as an Exemption Type, an exempt date is required. The system formats that date.

2. Click, **Click to Save Exemption**.

Follow the steps below to make a focused exemption for a specific vaccination in the Vaccine History tab:

1. Select the vaccination to be exempted.
2. Click **Edit**. The Immunization History Edit window opens.

Figure 23–9: Immunization History Edit Window

3. Select the exempt type from the **Exempt** drop-down list.

Note: Depending on the reason, an exempt date may be required. The system formats the date.

4. Click **Update**. The Exempt Reason appears on the Vaccine History tab.

24.0 PATIENT LIST

24.1 Patient List Overview

The Patient List module displays your customized list of patients. You can set up the patient list to contain patients specific to your caseload. Typically, this module is used to manage patients frequently seen or patients with common problems. Patient records can also be accessed from this module.

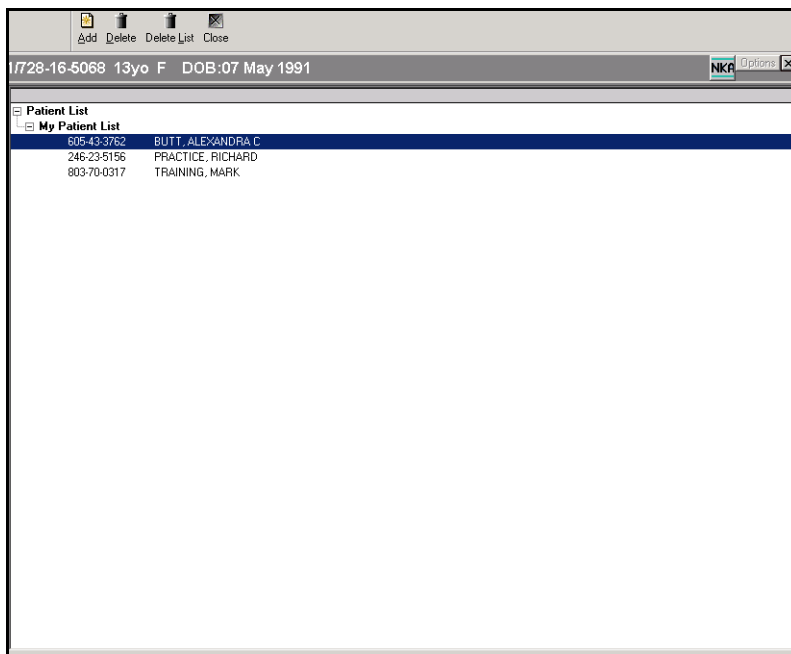


Figure 24–1: Military Clinical Desktop—Patient List Module

24.2 Adding a Patient Name

If the Patient List module is blank upon opening, no patients have been added.

Follow the steps below to add a patient name:

1. Click **My Patient List** on the Patient List window.
2. Click **Add** on the Action bar. The Patient Search window opens.

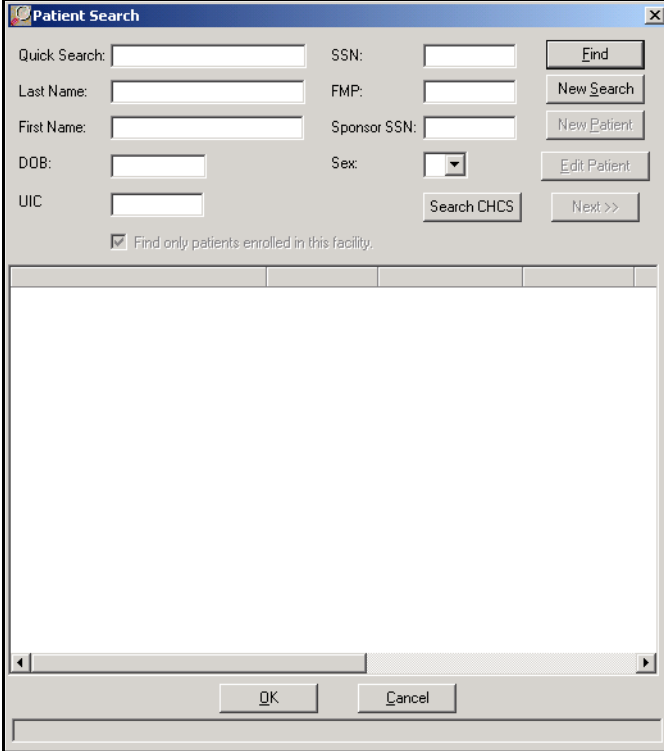


Figure 24–2: Patient Search Window

3. Conduct a patient search. The selected patient is displayed in the list.
4. Repeat the process until all desired patient names have been added.

Note: Select a patient from the Patient List to open the record for the selected patient.

24.3 Deleting a Patient Name

Follow the steps below to delete a patient name:

1. Select the patient name to be deleted from the Patient List module.
2. Click **Delete** on the Action bar. The patient name is deleted from the list.

24.4 Deleting the Entire List of Patients

Follow the steps below to delete the entire patient list:

1. Click **Delete List** on the Action bar. The Delete All Patients option window displays.
2. Click **OK**. All patient names are removed from your patient list.

25.0 PATIENT QUESTIONNAIRES

25.1 Patient Questionnaires Overview

The Patient Questionnaires module is used to administer questionnaires created in the Questionnaire Setup module. Patients can complete questionnaires by using a kiosk or through an interview process with a clinical team member. Patient questionnaires can be viewed, modified, and/or associated to an encounter.

From CHCS II, the end user is able to quickly navigate to the Patient Questionnaires module by loading a patient record and clicking Patient Questionnaires in the Folder List.

A questionnaire can be administered in Single Question or Multiple Question View. In Single Question View, questions are displayed one at a time as the patient completes the questionnaire. In Multiple Question View, all questions are displayed in the module as the patient completes the questionnaire.

The current practice for administering patient questionnaires is to interview the patient and document their responses on the electronic questionnaire in CHCS II. There is CHCS II functionality that allows the patient to use an assigned PIN to access and complete a questionnaire using a dedicated kiosk or other display device. Each MTF will determine how its clinics will use the Patient Questionnaires module to administer patient questionnaires.

25.1.1 In More Depth

From CHCS II, the end user is able to quickly navigate to the Patient Questionnaires module by loading a patient record and clicking Patient Questionnaires in the Folder List.

A questionnaire can be administered in Single Question or Multiple Question View. In Single Question View, questions are displayed one at a time as the patient completes the questionnaire. In Multiple Question View, all questions are displayed in the module as the patient completes the questionnaire.

The current practice for administering patient questionnaires is to interview the patient and document their responses on the electronic questionnaire in CHCS II. There is CHCS II functionality that allows the patient to use an assigned PIN to access and complete a questionnaire using a dedicated kiosk or other display device. Each MTF will determine how its clinics will use the Patient Questionnaires module to administer patient questionnaires.

25.2 Viewing Questionnaires in an Encounter Document

Follow the steps below to view a questionnaire in an Encounter document:

1. On the Patient Encounter module, click **Options**. The Encounter Summary Properties window opens.
2. In the AutoCite preferences area, select the **Questionnaires** checkbox.
3. Click **OK**.

25.3 Assigning a Questionnaire to a Patient

Follow the steps below to assign a questionnaire to a patient:

1. Within an open encounter, expand the Health History folder and select the Patient Questionnaires option.

Questionnaire/Test History				
Date	Questionnaire/Test	Encounter	Status/Score	Source
	Eds new questionnaire		PIN Assigned	Member Entry
	Eds new questionnaire		PIN Assigned	Member Entry
8/12/2004 1:52:05 PM	Eds Latest Questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:16:12 PM	Eds new questionnaire	48399	Complete	Interview by PROVIDER, TERRY
8/12/2004 1:12:59 PM	Eds new questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:12:30 PM	Eds new questionnaire		Complete	Interview by PROVIDER, TERRY
8/12/2004 1:09:58 PM	Eds new questionnaire	48399	Incomplete	Interview by PROVIDER, TERRY
8/11/2004 10:03:31 AM	Patient Satisfaction Survey for the MTF		Complete	Interview by WARDCLERK, BILL

TEST, MALAVE

Eds Latest Questionnaire Version: 2

Answer each question as honestly as possible

The selected provider for Eds Latest Questionnaire is PROVIDER, TERRY in the Gold MTF Clinic.

1. When was your last cholesterol check?
 Answer: 01 Jan 2004 (Enter answer using the following format 'dd mmm yyyy')

Figure 25-1: Questionnaire Module

2. When the Patient Questionnaires module opens, select the questionnaire that you want to assign to the encounter and click **Setup** from the Action bar. The Assign PIN for Patient Questionnaire/Test window opens.

Assign PIN for Patient Questionnaire/Test

Patient Name: CRUZ, NEDSMOM

Patient ID: 217208

PIN: 44441

Print Instruction Sheet

Figure 25-2: Assign PIN for Patient Questionnaire/Test

- The patients are then supplied with the login credentials that they use at the kiosk to answer the questionnaire.

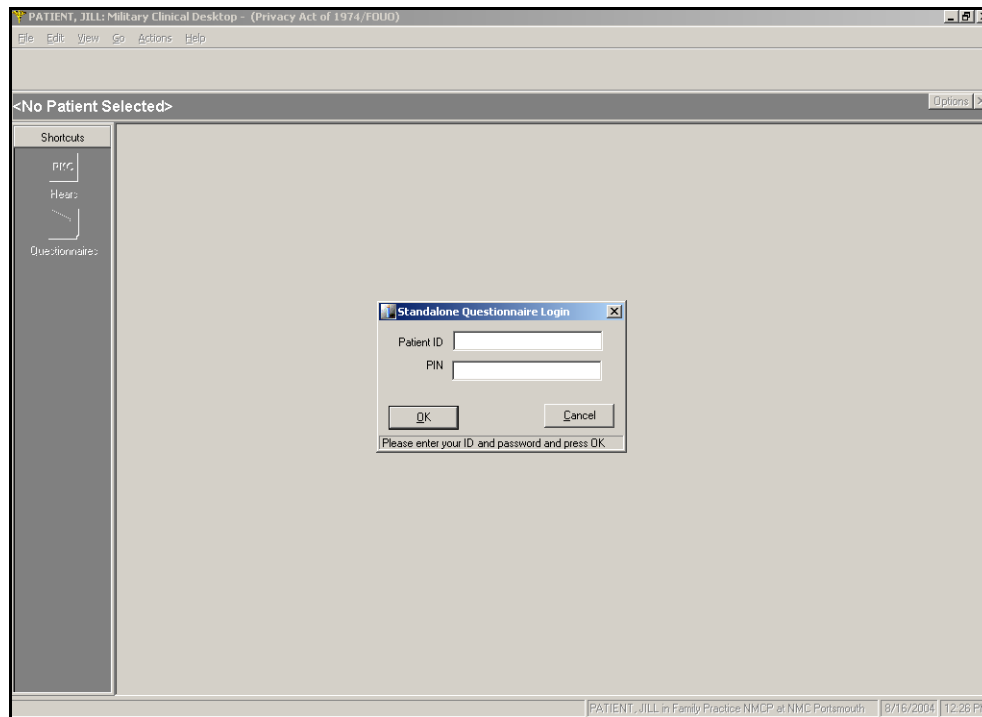


Figure 25–3: Kiosk and Login

- The patients then proceed to the kiosk to answer the questionnaire. Patients select **Questionnaire** from the folder list and the login window opens, prompting them to enter their Patient ID and PIN.
- Patients enter the requested information and click **OK**.
- Patients then answer the questions that appear on screen.

Diabetes Self-Management Initial	
Click here to add comment on Questionnaire as a whole.	
1. Add Comment	Do you drink alcohol? <input type="radio"/> Yes <input checked="" type="radio"/> No
2. Add Comment	Do you use tobacco or tobacco products? <input checked="" type="radio"/> Yes <input type="radio"/> No
3. Add Comment	Do you have low blood sugar reactions? <input checked="" type="radio"/> Yes <input type="radio"/> No
4. Add Comment	Do you know what to do for a low blood glucose reaction? <input type="radio"/> Yes <input checked="" type="radio"/> No
5. Add Comment	Do you monitor your blood glucose? <input checked="" type="radio"/> Yes <input type="radio"/> No
6. Add Comment	How many times per day do you check your blood sugar? Answer: <input type="text" value="1"/>
7. Add Comment	Do you exercise? Answer: <input type="text" value="yes"/>
8. Add Comment	Type of exercise? <input checked="" type="radio"/> walk <input type="radio"/> run <input type="radio"/> bicycle <input type="radio"/> aerobics <input type="radio"/> swim <input type="radio"/> other

Figure 25–4: Questions

- When the questions have been answered, the patients click **Save** and then **Done** from the Action bar.

25.4 Reviewing a Completed Questionnaire

You and your patients can review and modify a completed questionnaire, as necessary, and assign it to an encounter.

1. Under the Health History Questionnaire Folder, the provider sees a completed Questionnaire screen. The Status shows Complete.

Questionnaire/Test History				
Date	Questionnaire/Test	Source	Encounter	Status/Score
5/24/01 12:42:54 PM	Diabetes Self-Management Initial	Interview by CHCSII, PATIENT		Complete

The Status now shows Complete.

Figure 25–5: Completed Questionnaire

2. The questionnaire can be reviewed with the patient and you can make changes to the patient's answers, as needed. A correction notation appears on any answers that have been changed.

Diabetes Self-Management Initial

1. Do you drink alcohol? Yes No

2. Do you use tobacco or tobacco products? Yes No

3. Do you have low blood sugar reactions? Yes No

4. Do you know what to do for a low blood glucose reaction? Yes No

5. **Correction entered by CHU2, NEDSMUM@25 May 2001 12:30**
Answer changed from Yes to NO Yes No

6. How many times per day do you check your blood sugar?

Figure 25–6: Correction Notation

3. You can link the questionnaire to an open encounter by clicking **Encounter** from the Action bar. All open encounters for that particular patient appear.
4. Select the desired encounter and click **OK**. Click **Cancel** to return to the current encounter.
5. Before you can view questionnaire data in the Encounter document, you must set the encounter summary properties by selecting the Properties—Encounter option from the Tools pull-down menu.
6. In the Encounter Summary Properties window, select **Questionnaires**.
7. Click **AutoCite** to refresh the current encounter. In the S/O section the Questionnaire information is displayed.

Click Autocite to refresh the screen.

Date: 01 May 2001 1501 EDT Status: Updating MTF: NMC PORTSMOUTH
 Primary Provider: TMSSC, FOUR Type: WALK IN Clinic: DERMATOLOGY NMCP

Autocites Refreshed by PROVIDER, MARY @ 25 May 2001 1251 EDT

Problems
 DIABETES MELLITUS
 Headache
 BLOOD VESSEL INJURY MULTIPLE HEAD AND NECK VESSELS

Medications

Medication Name	Status	Sig	Refills	Last Filled
METFORMIN (GLUCOPHAGE)-PO 1,000MG TAB	Active	T1 #100 RF3	3	02 May 2001

Allergies
 Penicilins

Screening: Screening Written by TMSSC, FOUR @ 01 May 2001 1510 EDT

Appointment Reason For Visit: appointment.

Selected Reason(s) For Visit:
 Diabetes Follow-up

Vitals: BP: 190/80 , HR: 55, RR: 40, T: 102.5 °F , HT: 69, WT: 350 lbs, BMI: 51.69, BSA: 2.62 square meters 5/1/2001 1504 EDT (TMSSC, FOUR)

S/O: Questionnaire Autocites Refreshed by PROVIDER, MARY @ 25 May 2001 1251 EDT

Questionnaires
 Diabetes Self-Management Initial Completed On: 24 May 2001

1. Do you drink alcohol?:
2. Do you use tobacco or tobacco products?: Yes
3. Do you have low blood sugar reactions?: No
4. Do you know what to do for a low blood glucose reaction?:
5. Do you monitor your blood glucose?: Yes
6. How many times per day do you check your blood sugar?: 1
7. Do you exercise?: Yes
8. Type of exercise?: walk

Questionnaire Data.

Figure 25-7: Questionnaire in Encounter

26.0 PATIENT SEARCH

26.1 Patient Search Overview

The Patient Search module allows a specific patient record to be selected. Once a patient name is selected, patient-specific functions are available. These modules are visible in the Go pull-down menu, the Shortcuts, the Folder list, and the Tool bar.

26.2 Conducting a Search

In order to do any work with a specific patient's record, a patient search must be conducted.

Follow the steps below to conduct a search:

1. On the Folder List, click **Search**. The Patient Search window opens.

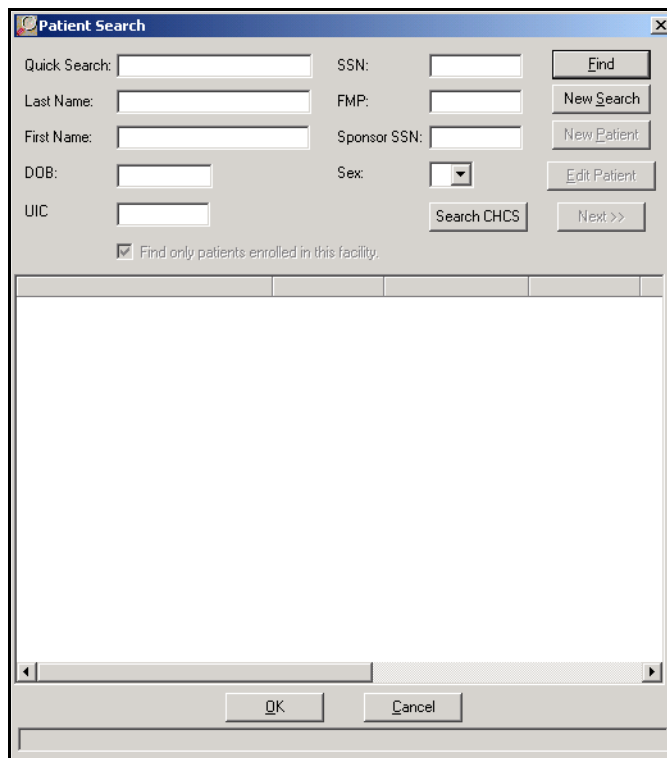


Figure 26–1: Patient Search Window

2. Enter search criteria into the appropriate field(s).
 - **Quick Search:** The Quick Search function allows a patient to be selected using the following criteria:
 - L1234: Performs a search using the first letter of the last name and last 4 digits of the sponsor's SSN

- L/1234: Performs a search using the first letter of the last name and last 4 digits of the patient's SSN
- 20/123456789: FMP/Sponsor SSN
- **Last Name:** Performs a search using the patient's last name (use any combination of upper and lower-case).
- **First Name:** Performs a search using the patient's first name (use any combination of upper and lower-case).
- **DOB:** Performs a search using the patient's date of birth (use the format mm/dd/yyyy). The search program returns all patients who were born in a four-year range from two years before the date to two years after the date.
- **UIC:** Performs a search using the location of the patient's/sponsor's unit command.
- **SSN:** Performs a search using the patient's Social Security Number.
- **FMP:** Performs a search using the Family Member Prefix.
- **Sponsor SSN:** Performs a search using the sponsor's Social Security Number.
- **Sex:** Performs a search using the patient's gender (choose a value from the list).

Note: The value B (for Both) doesn't make the program search regardless of gender. Rather, it indicates a search for the patients with a gender value of **B**, indicating that they are both male and female. **U** is for unknown (identifying remains).

- **Find only patients enrolled in this facility:** This function searches for only those patients enrolled in your selected facility.
3. Click **Find** to view all patients who meet the selected criteria.
 4. Select the patient from the list of results.
 5. Click **OK**. The record opens in the Folder List with all available options.

Note: Click **Search CHCS** when creating unscheduled appointments for CHCS patients who need to be seen. In some cases, these patients are not found through a generic search in CHCS II, so they need to be located through an advanced search of CHCS.

Tip:
*When searching CHCS II, if the number of patients meeting the criteria exceeds 50, a prompt is shown, asking to continue the search. Click **Yes** to continue or **No** to end the search and display the first 50 matches.*



Figure 26–2: Selected Patient’s Record in the Folder List

26.3 Selecting a Patient Without a Search

The system allows the last 20 patient records to be accessible without a search. The system lists the last 20 patient records so they can be retrieved without having to perform a search.

Follow the steps below to select a patient without a search:

1. On the Go menu, point to Patient.
2. Select the desired patient from the list of recently viewed patient records.

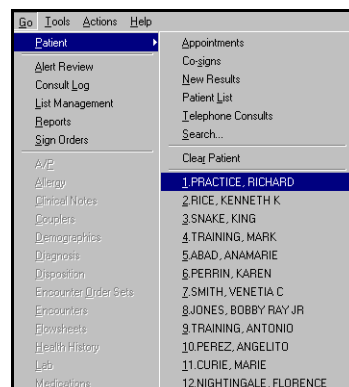


Figure 26–3: Select Patient Using the Go Drop-down Menu

27.0 PKC COUPLERS

27.1 PKC Couplers Overview

The questionnaires associated with the Problem Knowledge Couplers, Inc. (PKC) Couplers module automate the collection of demographic and health data for patients. The questionnaires provide the care provider a “snapshot” of the patient's health, habits and other factors that can affect his/her overall health. The data is then used to assess preventive service needs, identify services routinely used, and determine the appropriate level of medical expertise/care required for each patient. PKC Couplers are patient-specific. Accordingly, a patient's record must be loaded to the Military Clinical Desktop before the PKC Couplers module is available. The functions available upon accessing the PKC Couplers module depends on security access roles. A user, normally with clerk privileges, is permitted to generate and print a patient password to be used by the patient to access a questionnaire at a kiosk. A user, normally with provider privileges, is permitted to display, run, and update completed questionnaires.

27.2 HEAR Questionnaire

The Health Evaluation, Assessment, and Review (HEAR) questionnaire automates the collection of individual demographic and health data. It couples (hence the term Coupler) with a healthcare knowledge network and produces reports for the patient and the patient's primary care manager. HEAR uses a COTS product developed by PKC. The application is used by clinical staff to generate passwords for patients who are completing the HEAR and other questionnaires. In addition, providers use the application to view, and if necessary, update the patient's completed questionnaire and to view related reports.

Note: As a result of the extensive reworking of the question set, sessions created in the HEAR 2.1 will not reload in the HEAR 3.0. It is recommended that new HEAR Coupler sessions be run on all personnel in this case.

Note: Data collected using earlier versions of the HEAR will continue to be available for population health studies, but it cannot be viewed as a single HEAR session.

27.3 Running a New Coupler

Two types of questionnaires can be administered: Military and All Others.

Follow the steps below to run a new coupler:

1. On the Couplers module, click either the **Military** or **All Others** tab.

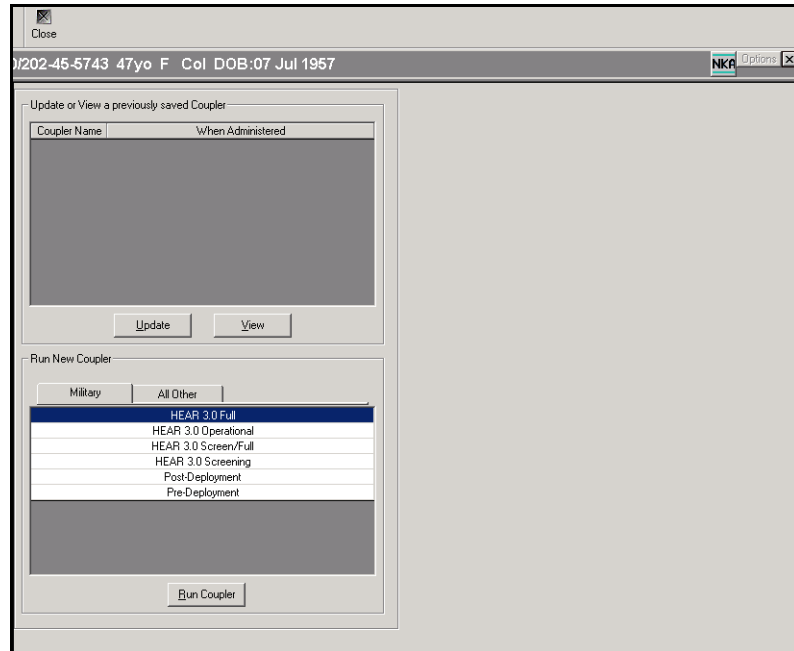


Figure 27–1: Military and All Others Tabs

2. Select the desired questionnaire.
3. Click **Run Coupler** to access the PKC Couplers application.

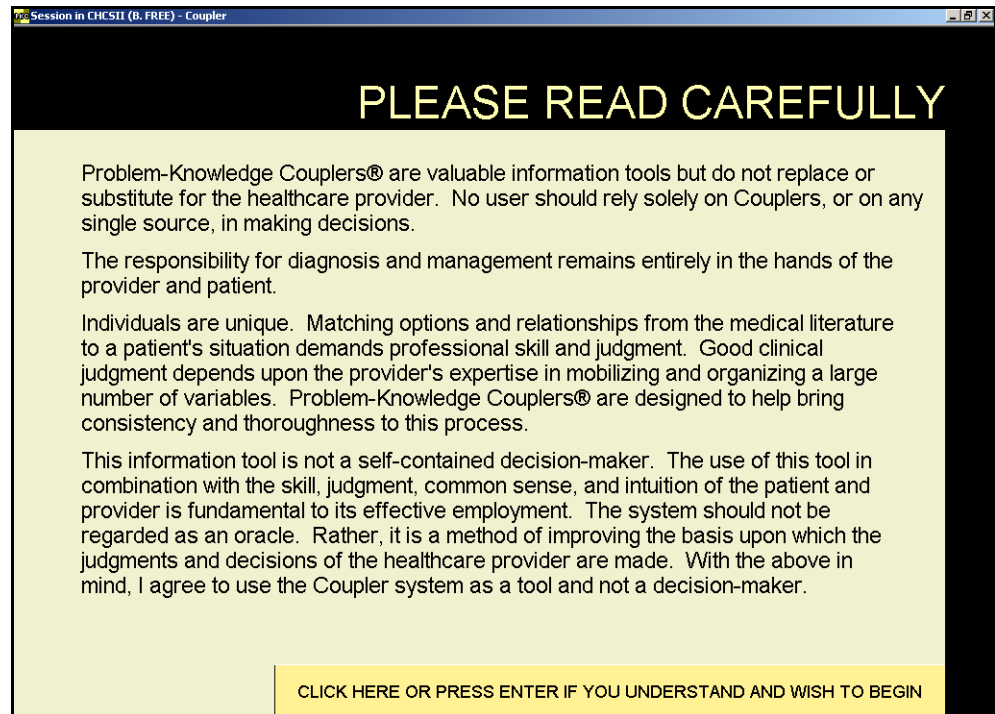


Figure 27–2: PKC Couplers Application

4. Read the medical disclosure statement and press **Enter** on your keyboard to indicate understanding of the statement.

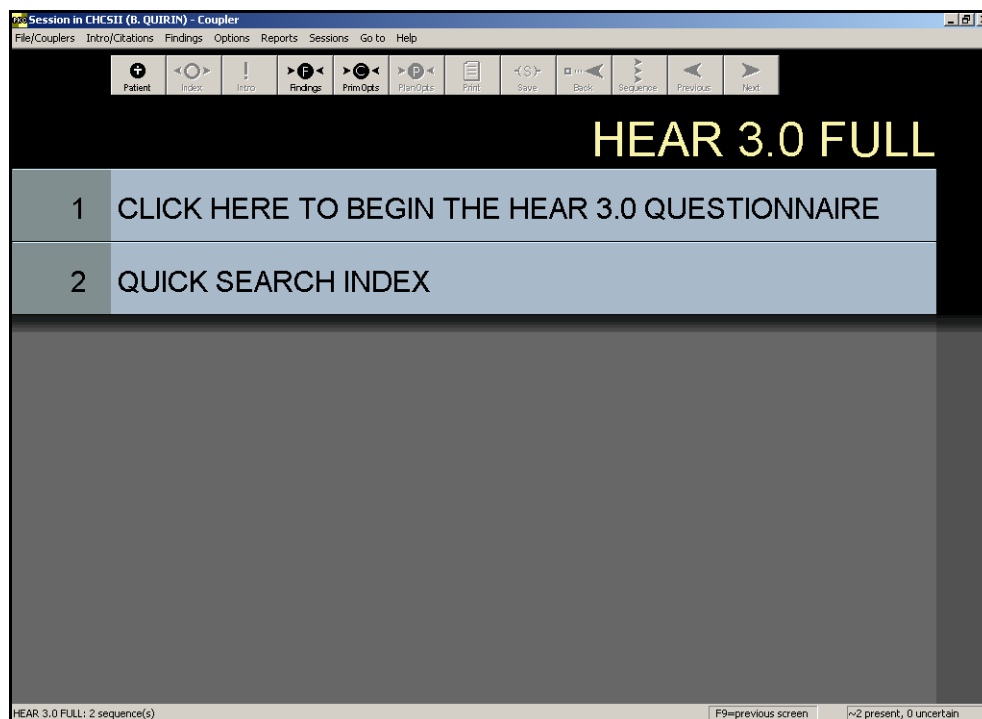


Figure 27-3: PKC Couplers Application

5. Do one of the following:
 - If the questionnaire is from the Military tab, the questionnaire begins with an opening sequence that presents options for running the questionnaire. To start the questionnaire:
 - a. Click **Click Here to Begin the HEAR 3.0 Questionnaire**.
 - b. Answer the survey questions.

Note: If answers are missing or are invalid, an error message appears. To correct the error, click **Yes**; click **No** to continue.

- If the questionnaire is from the All Others tab, the system begins with an overview of the subject areas presented in the questionnaire. To start the questionnaire:
 - a. Click the applicable area.
 - b. Select a response to answer a question. Click twice to mark a question as uncertain. Click a third time to clear the question.
 - c. On the toolbar, click the **Next Arrow** button to move to the next window to respond to the next question.

6. At the end of the questionnaire, on the File/Couplers menu, click **Exit & Return to CHCS II**.
7. Click **Yes** to save the findings and exit the questionnaire.

27.4 Viewing a Completed Coupler

The Coupler module displays completed questionnaires and a list of questionnaires that can be administered. Each completed questionnaire can be viewed and updated.

Follow the steps below to view a completed coupler:

1. Select the desired questionnaire to be viewed on the Couplers module.

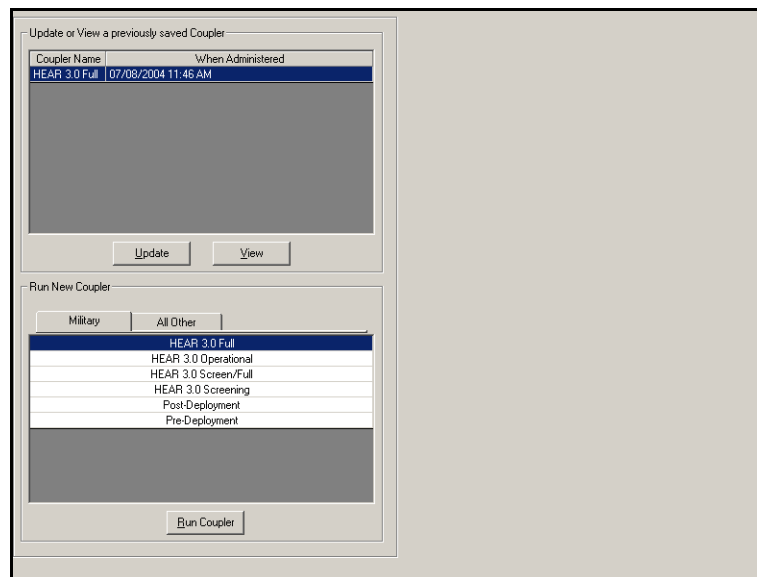


Figure 27-4: Couplers Module

2. Click **View**. The PKC application begins and the completed questionnaire is available to review.

27.5 Updating a Completed Coupler

Completed questionnaires can be updated if they have not been completed or if there are errors that need to be resolved.

Follow the steps below to update a completed coupler:

1. Select the questionnaire to be updated.
2. Click **Update**. The PKC application opens to the completed questionnaire.
3. Update the questionnaire.
4. Save the questionnaire.

- On the File/Couplers menu, click **Exit & Return to CHCS II**. The updated questionnaire is saved as a separate questionnaire. It does not replace the original questionnaire.

27.6 Starting the HEAR Questionnaire

The HEAR questionnaire can be completed through a stand-alone kiosk. A Clinical Team Member generates a password for the patient to enter when using the kiosk. The password is linked to that specific patient and is active for 24 hours. The ability to access the Generate Password window is a separate role within CHCS II and must be assigned before performing the following tasks.

Follow the steps below to start the HEAR Questionnaire:

- Access the Coupler module. The Coupler Utility Application window opens.

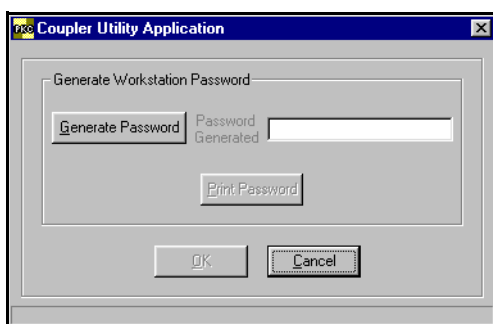


Figure 27-5: Coupler Utility Application Window

- Click **Generate Password** to create a password for the patient.
- Click **Print Password** to print the password for the patient.
- Direct the patient to the kiosk. The patient only has access to the Coupler module to complete the questionnaire.
- The patient clicks **PKC/HEAR** to view the HEAR Questionnaire Login window.

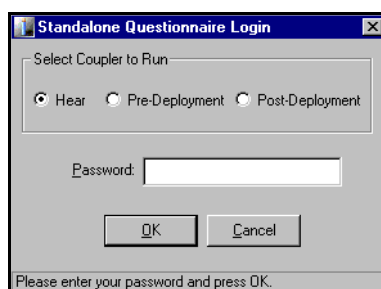


Figure 27-6: Kiosk Questionnaire Login Window

- The patient types the given password and clicks **OK** to launch the questionnaire.
- The system begins with an opening sequence that presents three options for running the questionnaire. Click **Begin Questionnaire** to start.

8. After answering a survey question, advance through screens in one of the following ways:
 - Select the box marked **Press <F10>** or **Click Here** to continue.
 - Press **<F10>**.
 - On the toolbar, click the **Next Arrow** button.

Note: Press **<F9>** or click **Previous** on the tool bar to see the previous screen.

- If answers are missing or are invalid, an error message appears. Click **Yes** to correct the error, **No** to continue.
-

9. At the end of questionnaire, click **Exit & Return to CHCS II** on File/Couplers on the menu bar.
10. Click **Yes** to save the findings and exit the questionnaire.
11. The patient informs the Clinical Team Member that the questionnaire is complete. The Clinical Team Member returns to the Coupler module and views the Coupler Utility Application window.
12. Enter the name of the stand-alone workstation in the **Workstation Name** field.
13. Click **Import to CDR** to import the results. When a Clinical Team Member views the Coupler module, the imported questionnaire is available for review.

27.7 Finding Summary Report

This option allows the proctor or provider to access and review the Finding Summary report, which displays the patient's responses under specific headings, after the questionnaire is completed in the PKC application.

Follow the steps below to find the summary report:

1. On the Findings menu, click **Finding Summary**. The Finding Summary report opens.

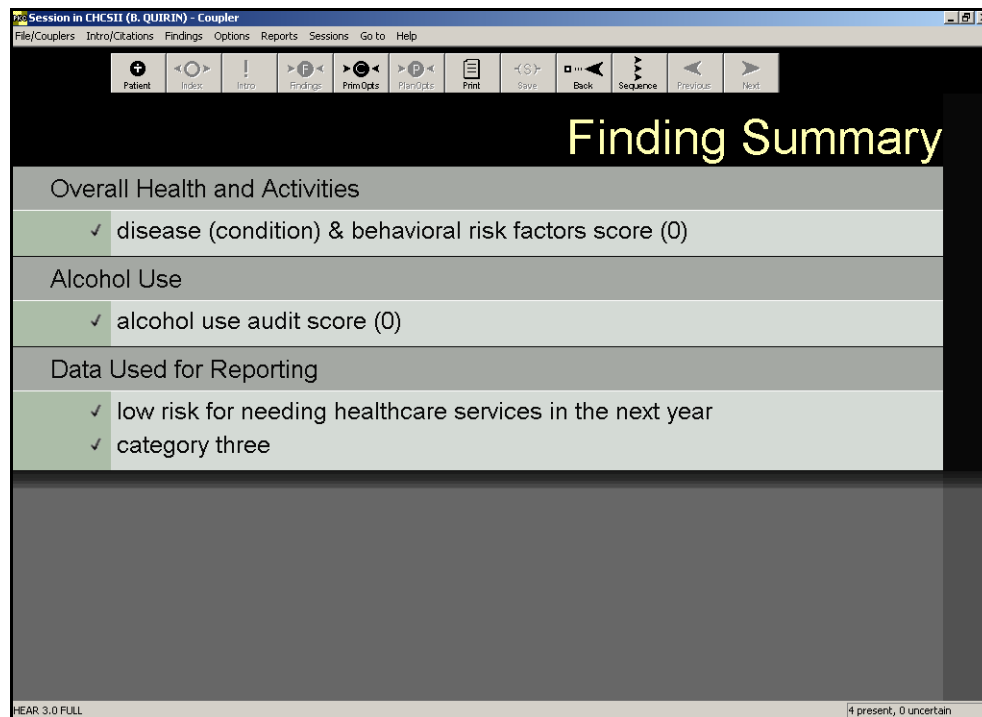


Figure 27–7: Couplers Finding Summary Report

2. View the answers that the patient entered. A checkmark indicates that the question has been answered, a question mark indicates an uncertain answer.
3. Double-click an uncertain finding to return to the question in order to answer it completely and correctly.

27.8 Reviewing and Resolving the Finding Error Summary

This option allows the proctor or provider to access and review the Finding Error Summary Report. An error message is displayed whenever the rules of a question have been violated. The patient has the option of either correcting the error by answering the question, or moving forward without making the suggested corrections. All error messages that are not corrected are displayed in the Finding Error Summary Report. From this report, the error can be corrected.

Follow the steps below to review and resolve the finding error summary report:

1. When the questionnaire is completed, click **Finding Error Summary** on the Findings menu. The Finding Error Summary Report opens.

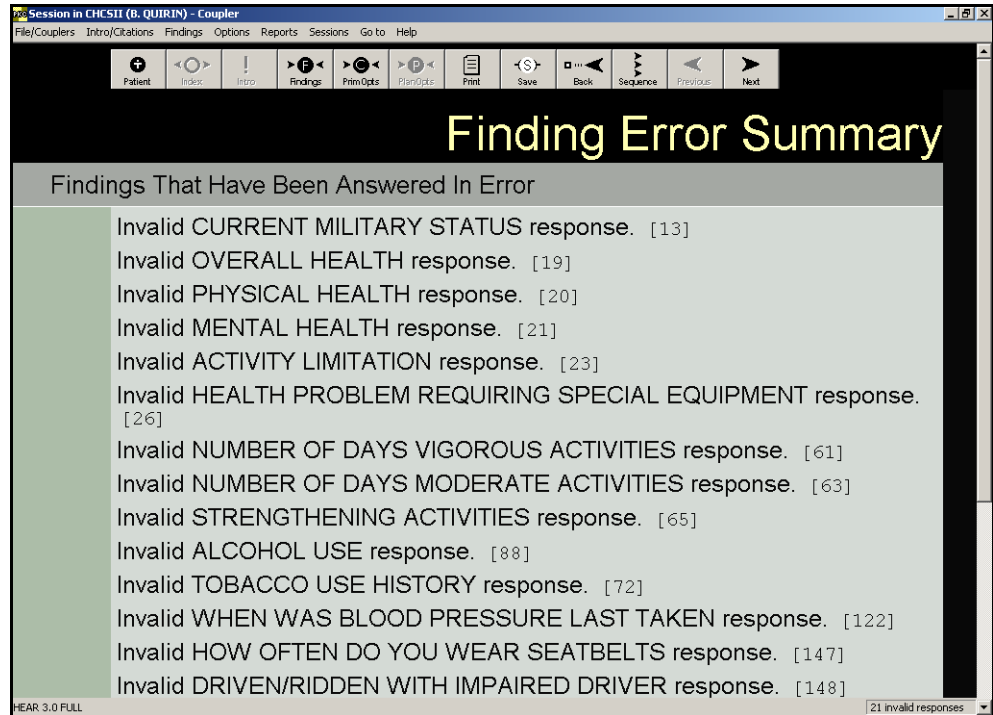


Figure 27–8: Couplers Finding Error Summary Report

2. To resolve any error messages:
 - a. At the end of the error message, click the number in brackets (e.g., [13]).
 - b. Correct the error.
 - c. Repeat steps until all error messages are resolved.
3. At the end of questionnaire, click **File/Couplers** on the menu bar.
4. Click **Exit**.
5. Click **Yes** to save findings and exit the questionnaire.

27.9 Printing or Previewing a Report

Follow the steps below to print or preview a report:

1. Access the Reports pull-down menu and select **Print Any Reports** to view the Print Any Reports window.
2. Select the report to be printed by clicking in the check box next to the desired report.
3. Enter a *Report Comment* if necessary. If the comment needs to be saved, click **Save as Session Comment**.
4. Select necessary **Details for Primary Options** to be printed if Details for Primary Options is selected. Highlight the desired **Primary Options for Plan Option** if Primary Option Index is selected.

5. Click **OK** to print.
6. Click **Reset** to clear any changes made to the form.

Note: The Help button is not functional at this time.

28.0 PREVIOUS ENCOUNTERS

28.1 Previous Encounters Overview

The Previous Encounter module displays a list of a patient's completed encounters. Select a previous encounter to view the details in the bottom of the window. You must select a patient record to view previous encounters. You can append a narrative, amend an encounter, create a new Template from a completed encounter and “copy forward” the results of a previous encounter to the current encounter, easing effort and saving time in documenting follow-up visits.

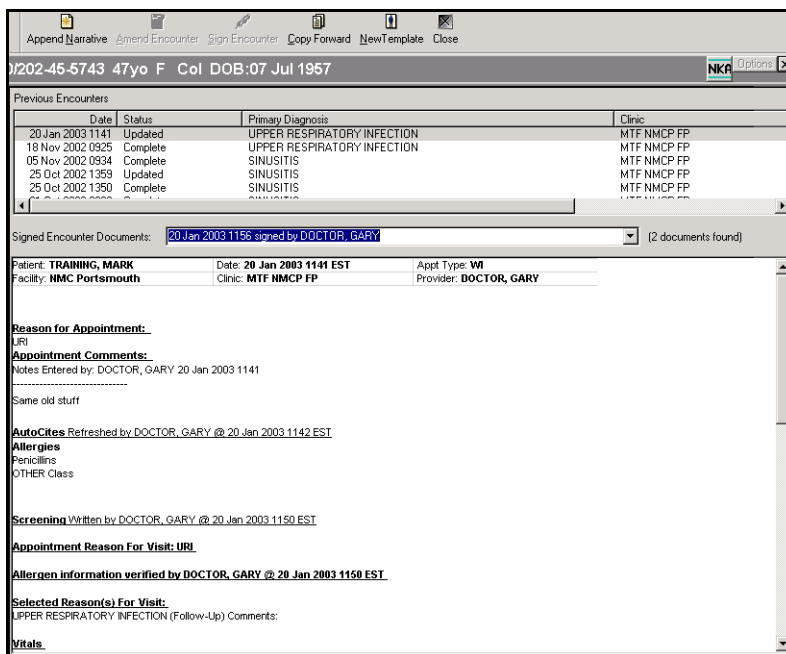


Figure 28–1: Military Clinical Desktop—Previous Encounters Module

28.2 Appending a Narrative

The Append Narrative function enables you to attach text or a graphic file to an encounter. Graphics that are imported cannot be greater than 500K. The narrative appears at the bottom of the encounter, stamped with the time, date, and author's name. After appending a narrative, the note must still be co-signed.

Follow the steps below to append a narrative:

1. Select an encounter.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens.

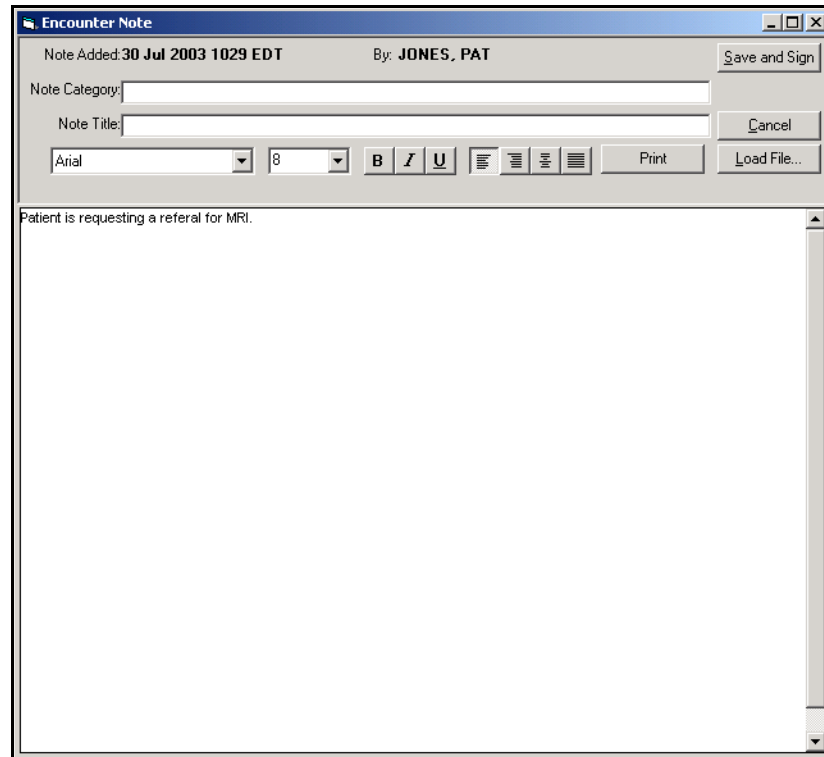


Figure 28-2: Encounter Note Window

3. Enter a note category, if appropriate.
4. Enter a note title, if appropriate.
5. Enter the note in the text box.
6. Do one of the following:
 - If you want to insert a file into the note:
 - a. Click **Load File**. The Select Destination File window opens.

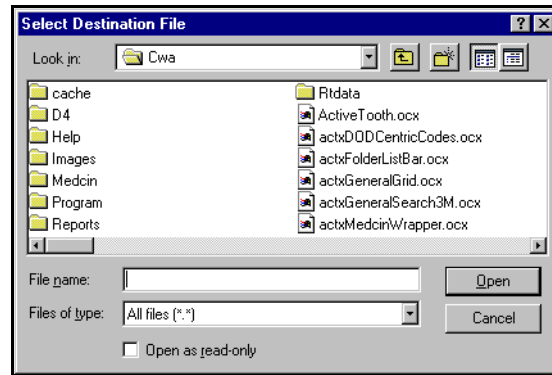


Figure 28–3: Select Destination File Window

- b. Select the desired file to be added.
- c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.
7. Click **Save and Sign**. The Sign Appended Note window opens, so you can review the narrative before signing.

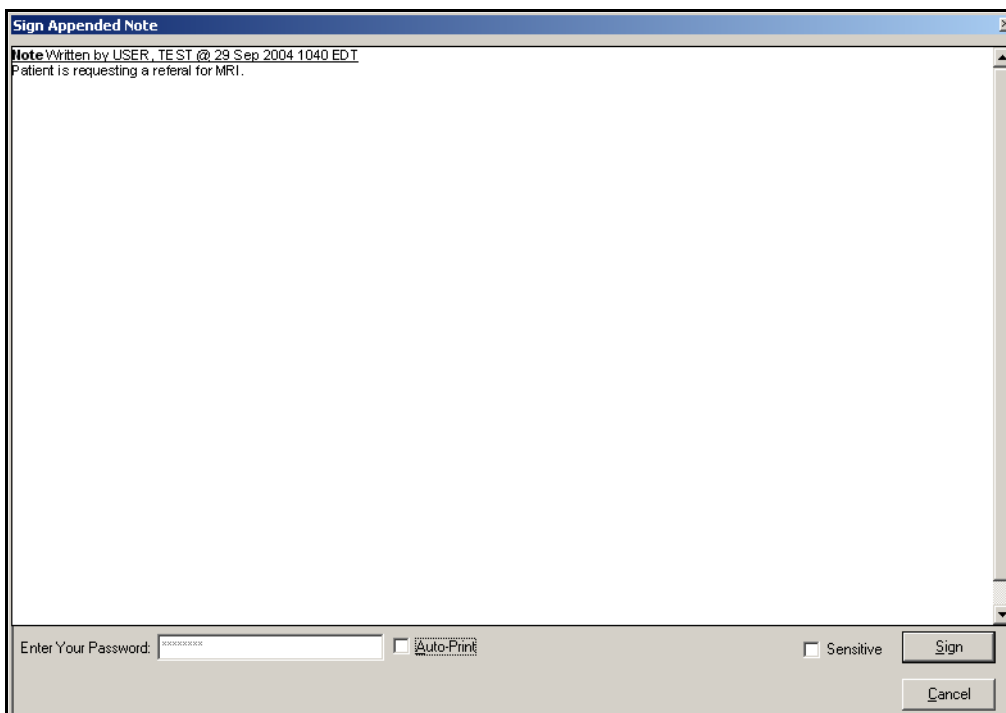


Figure 28–4: Sign Appended Note Window

8. In the **Enter Your Password** field, enter your password.

- Click **Sign**. The narrative appears at the bottom of the encounter summary with the Time, Date, and Provider name next to the narration.

28.3 Amending a Previous Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. The amended encounter document must be signed.

Follow the steps below to amend an encounter:

- Select the previous encounter you want to amend.
- Click **Amend Encounter** on the Action bar. The Patient Encounters module opens for the selected encounter.

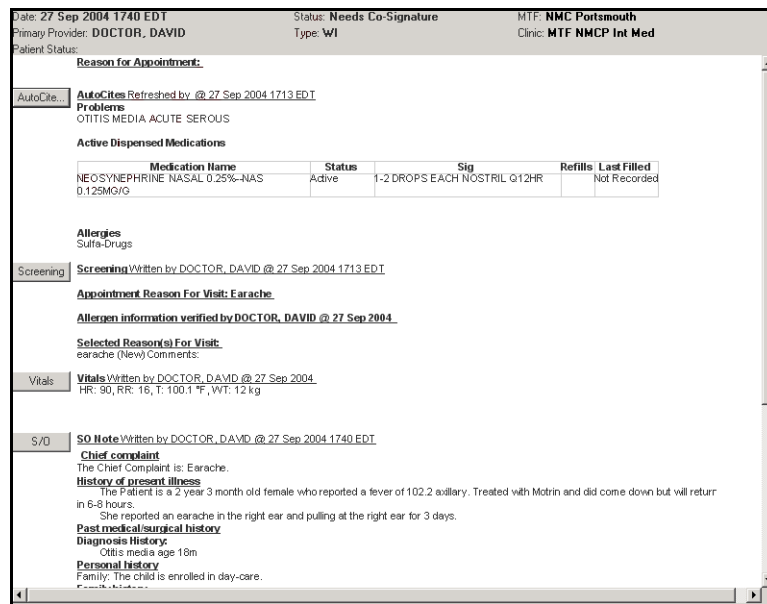


Figure 28–5: Encounter Summary

- Update applicable sections of the encounter.
- Once the changes have been made, the amended encounter document must be signed. Click **Sign** on the Action bar. The Sign Encounter window opens.

Sign Encounter

Patient: **ALEX, E D** Date: **09 Mar 2004 0953 EST** Appt Type: **ACUT**
 Facility: **4th Medical Group** Clinic: **Silver MTF** Provider: **SMITH, JACOB**
 Patient Status: **Outpatient**

Reason for Appointment: uri

AutoCites Refreshed by SMITH, JACOB @ 09 Mar 2004 0955 EST

Problems • ACHILLES TENDON ADHESIONS LEFT LEG • visit for: neonatal observ for suspect neurologic condition • CONJUNCTIVITIS - BOTH EYES • DIABETES MELLITUS • ACUTE POST-TRAUMATIC STRESS DISORDER	Allergies • PENE TRATING RELIEF (MENTHOL): Rash
---	---

Active Medications
No Active Medications Found.

Screening Written by SMITH, JACOB @ 09 Mar 2004 0954 EST
Reason For Appointment: uri
Reason(s) For Visit (Chief Complaint): UPPER RESPIRATORY INFECTION (New);

Vitals
Vitals Written by SMITH, JACOB @ 09 Mar 2004 0956 EST
 BP: 130/70,

SO Note Written by SMITH, JACOB @ 09 Mar 2004 0956 EST
History of present illness
 The Patient is a 54 year old male.
 • Nasal discharge.
 • Feeling congested in the chest and wheezing.

Past medical/surgical history

Enter Your Password: Auto-Print Sensitive **Sign**

Cosigner Required **Search** **Cancel**

Figure 28–6: Sign Encounter Window

5. In the **Enter Your Password** field, enter your password.
 - If you do not want to Auto-Print the signed encounter, click the **Auto-Print** checkbox to deselect this option.
 - If a co-signer is required, select the **Cosigner Required** checkbox.
 - If you want to mark the amended encounter as sensitive, select the **Sensitive** checkbox. Sensitive data is displayed with asterisks. Providers other than the primary and co-signing must have “break the glass” privileges to view the sensitive data.
6. Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments.

Disposition	Disposition Written by PROVIDER, DYLAN @ 02 Jul 2001 1429 EDT Released Without Limitations E&M Code: 99212: Estab Outpatient Focused H&P - Straightforward Decisions
Add Note	
Change History	<p>CHANGE HISTORY</p> <p><i>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PROVIDER, DYLAN @ 18 Jul 2001 1115 EDT.</i> Signed@ 02 Jul 2001 1429 PROVIDER, DYLAN Physician NMC PORTSMOUTH</p> <p><i>The following Signature(s) No Longer Applies because this Encounter Was Opened for Amendment by PROVIDER, DYLAN @ 18 Jul 2001 1124 EDT.</i> Signed@ 18 Jul 2001 1124 PROVIDER, DYLAN Physician NMC PORTSMOUTH</p>

Figure 28–7: Change History Section of an Encounter

28.4 Creating a New Encounter Template

After you document an encounter, you can use the structure of the current encounter to create a new encounter template. No patient-specific information is saved in the encounter template.

Follow the steps below to create a new encounter template:

1. Click **New Template** on the Action bar. The Template Management module opens with details populated in the Template Details tab.

The screenshot displays the 'Template Details' tab of the Template Management module. It features several sections for configuring a new template:

- Template Name:** Created from Encounter 105950
- Owner Type:** Personal
- User:** JONES, PAT
- Specialty:** (Empty dropdown)
- EM Code Category:** (Empty dropdown)
- Associated Reasons for Visit:** nasal discharge, a cough 786.2
- Associated Problems:** ACUTE BRONCHITIS 466.0
- Diagnoses:** ACUTE BRONCHITIS 466.0
- Notes Templates:** (List) Created from Encounter 105950
- Other Therapies:** Oral Fluids, Return To Clinic If Worse Or New Symptoms
- Associated Appointment Types:** w/
- Items to Autocite into Note:** (Empty)
- Procedures:** Pulmonary Function Tests Peak Flow 94150
- Orders:** (Med)ALBUTEROL ORAL (PROVENTIL)-INH 90MCG AE, (Lab)CBC w/AUTO DIFF

Figure 28–8: Template Management module—Template Details Tab

2. Select an **Owner Type** from the drop-down list, if necessary.
3. Select a **Specialty** from the drop-down list, if necessary.

4. Select an **E&M Code Category** from the drop-down list, if necessary.
5. Add or remove information from the following areas:
 - **Associated Reasons for Visit:** In the **Search Term** field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Associated Problems:** In the **Search Term** field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Diagnoses:** In the **Search Term** field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Notes Templates:** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note template and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Other Therapies:** In the **Search Term** field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Associated Appointment Types:** In the **Search Term** field, enter the first few letters of the appointment type and click **Search**. Select the appointment type from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Items to AutoCite into Note:** Select an AutoCite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Procedures:** In the **Search Term** field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
6. Click **Save As** on the Action bar. The Save Encounter Template window opens.
7. Select the template type from the Save in drop-down list.
8. In the **Template Name** field, enter the name of the template.
9. Select a specialty from the drop-down list.
10. Select the checkboxes to denote whether the template should be added to the favorites list or shared with other clinical team members.
11. Click **Save**.

28.5 Copy Forward

Users can “Copy Forward” a previous encounter document for use in the current encounter. This enables users to quickly and efficiently copy work from previous encounter(s) to the current encounter. This feature saves charting steps when seeing a follow-up visit or when the patient has many complicated problems and the user does

not have the templates to recreate this visit/physical exam findings. The S/O and A/P sections of the previous encounter copy forward as if they were an Encounter Template.

Follow the steps below to Copy Forward a previous encounter:

1. With a current encounter summary open, click **Previous Encounters** in the patient's Folder List. The Previous Encounter module displays.

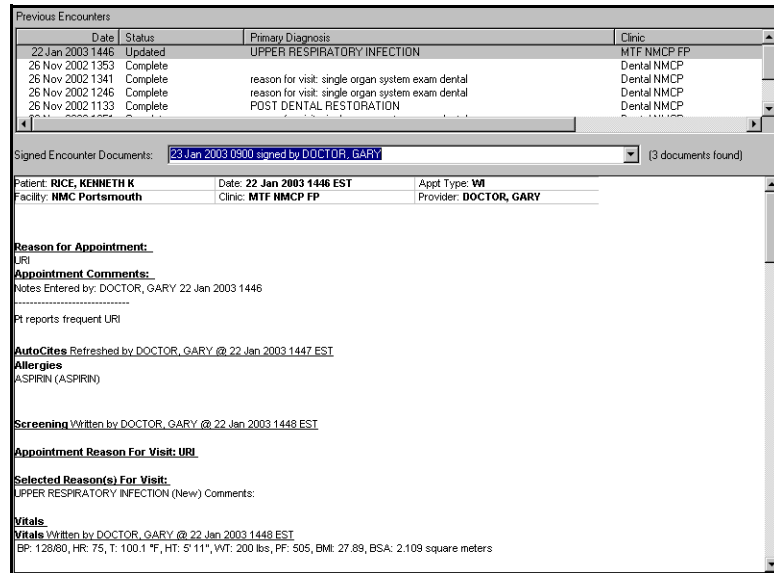


Figure 28–9: Previous Encounter Module

2. Right click on the previous encounter to be copied forward, and select **Copy Forward**. You are returned to the Current Encounter Summary.

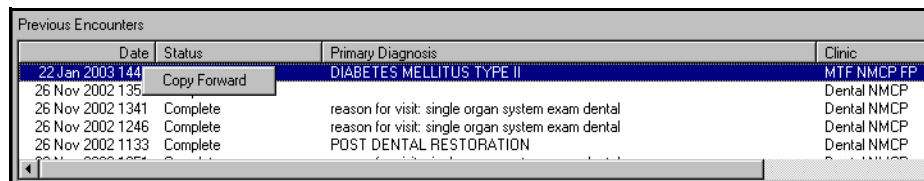


Figure 28–10: Copy Forward Selected

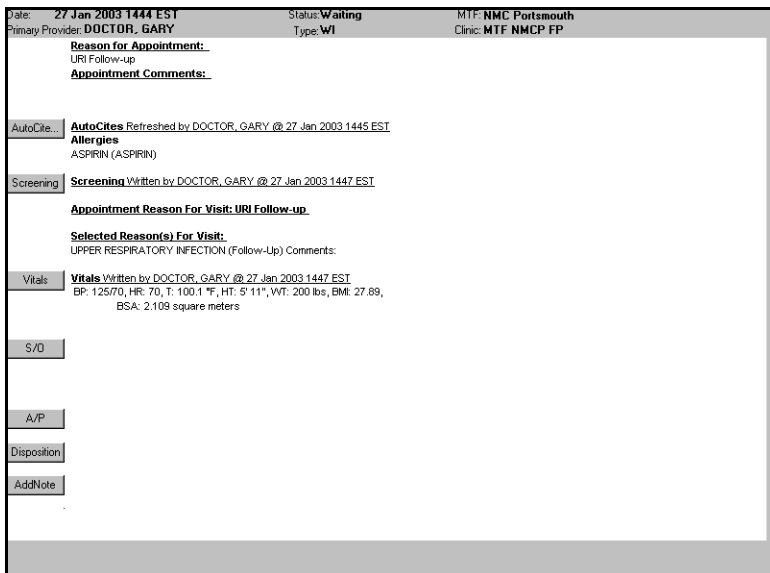


Figure 28–11: Current Encounter Summary

3. Click **S/O**. The S/O module opens.

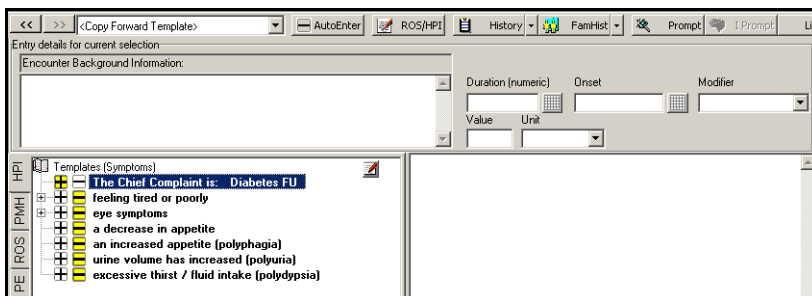


Figure 28–12: Copy Forward Items Highlighted

Note: Items copied forward are marked in yellow. Click the copied forward items to insert them into the current encounter note. Click **AutoEnter** on the S/O dashboard to insert all items copied forward.

28.6 Printing Previous Encounter Documents

Follow the steps below to print selected previous encounters:

1. Select the previous encounter you want to print.
2. On the File menu bar, point to Print.
3. Do one of the following:
 - If you want to print the previous encounter in a DD2766, click **DD2766**.
 - If you want to print the previous encounter in a SF600, click **SF600**.

Tip:
To print multiple encounters, press the **Ctrl** key on your keyboard and select each encounter.

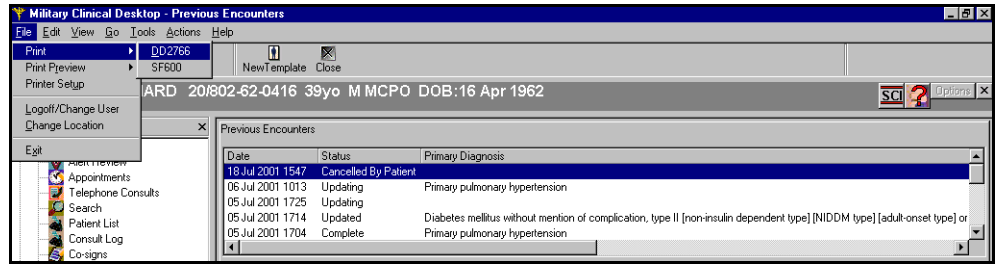


Figure 28–13: Print Previous Encounter

29.0 PROBLEMS

29.1 Problems Overview

The Problems module displays a problem list, Healthcare maintenance, Dental Readiness Classification, Historical Procedures, and Family History information for the selected patient in the top portion. Dental Readiness Classification information is populated by the Dental module and is read only. Problems (diagnoses) and Family History data added during an encounter automatically update the Problems module when the encounter is signed.

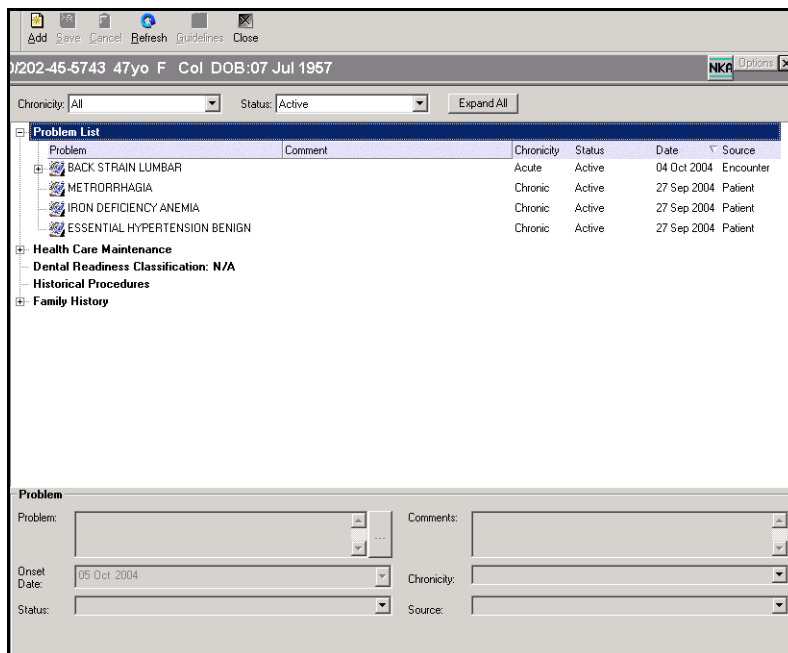


Figure 29-1: Military Clinical Desktop—Problems Module

29.2 Viewing the Problem List

Use the two filter options to view selected problems on the list. The two filter criteria are Chronicity and Status.

Follow the steps below to view the problem list:

1. Select a **Chronicity** filter from the drop-down list. The default is Chronic.
2. Select a **Status** filter from the drop-down list. The default is Active.

Tip:
Click the *Expand All* checkbox to view the associated encounters and orders for all problems.

Note: Details about any associated encounters, procedures, medications, labs, and radiology procedures associated with the selected problem can be displayed by clicking the plus sign to the left of the item. Double-click the associated encounter to view the encounter details in the Previous Encounter module.

Double-click the radiology or lab results to view the details in the respective modules.

29.3 Adding a Problem

New problems are automatically added to the problem list every time an encounter is signed. The diagnosis from each encounter becomes a problem. Use the following procedure to add a problem that was not documented through an encounter.

Follow the steps below to add a problem:

1. Select the **Problem List** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.

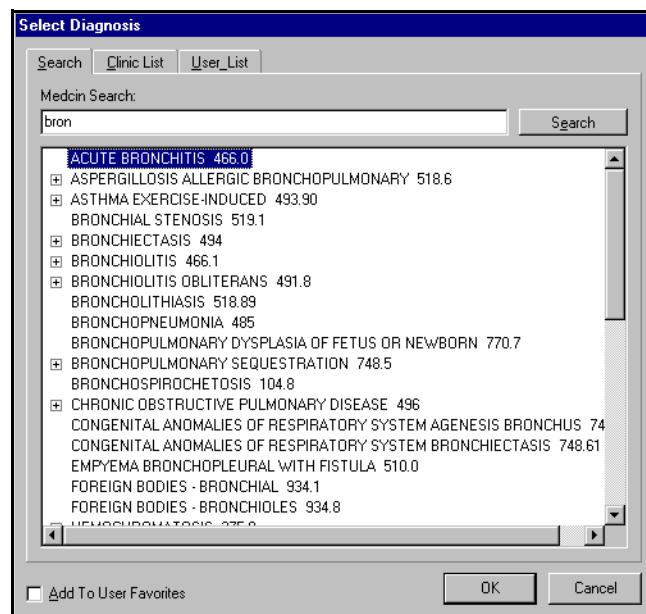


Figure 29-2: Problems—Select Diagnosis Window

3. Select the diagnosis you want to add. The selected problem appears in the New Problem pane on the Problems module.

Note: The Select Diagnosis window contains three tabs:

- **Search:** Click the Search tab and enter the first few letters of the diagnosis in the **MEDCIN Search** field and click **Search**. Select the diagnosis and click **OK**.
- **Clinic List:** Click the Clinic List tab and enter the first few letters of the diagnosis in the **Find** field and click **Find**. Select the diagnosis from the Clinic List results and click **OK**.

- **User List:** Click the User List tab and enter the first few letters of the diagnosis in the **Find** field and click **Find**. Select the diagnosis from the **User List** results and click **OK**.

Note: If the Add to Favorites checkbox is selected, the selected diagnosis and ICD-9 code are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the User List tab of the Problems module. You cannot change the items in the Clinic List tab.

Figure 29–3: New Problem Pane

4. Complete the appropriate fields.
 - **Onset Date:** Click the drop-down arrow to select the correct date the problem began.
 - **Chronicity:** Select **Acute** or **Chronic** from the drop-down list.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Comments:** Add a note for a selected problem or procedure.
 - **Source:** The manner in which you received the problem information:
 - Patient
 - Encounter
 - HEAR
5. Click **Save** on the Action bar.

29.4 Adding an Historical Procedure

Historical procedures can be followed as problems. These procedures are not automatically populated from the A/P module when an encounter is signed, in the way diagnoses are. The procedures are added directly from the Problems module.

Follow the steps below to add an historical procedure:

1. Click the **Historical Procedures** header.
2. Click **Add** on the Action bar. The Select Procedure window opens.

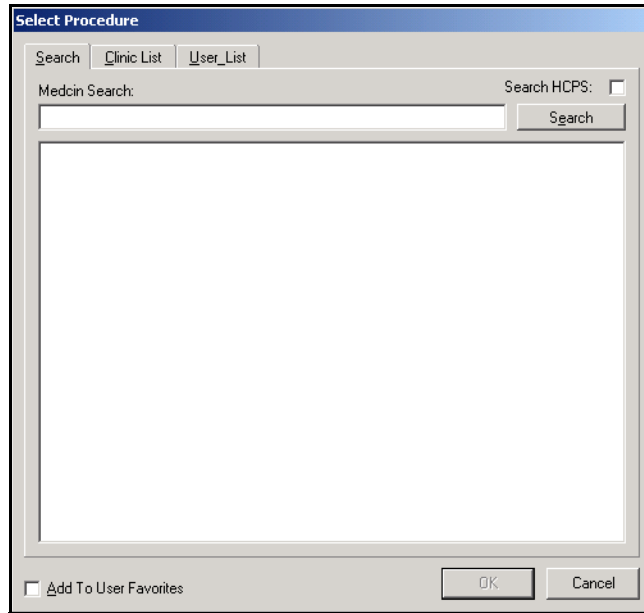


Figure 29-4: Problems—Select Procedure Window

3. Select the procedure you want to add. The selected procedure displays in the New Procedure pane on the Problems module.

Note: The Select Procedure window contains three tabs:

- **Search:** Click the Search tab and enter the first few letters of the procedure in the **MEDCIN Search** field and click **Search**. Select the procedure and click **OK**.
- **Clinic List:** Click the Clinic List tab and enter the first few letters of the procedure in the **Find** field and click **Find**. Select the procedure from the Clinic List results and click **OK**.
- **User List:** Click the User List tab and enter the first few letters of the procedure in the **Find** field and click **Find**. Select the procedure from the **User List** results and click **OK**.

Note: If the **Add to Favorites** checkbox is checked, the selected Procedure and CPT-4 codes are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the User List tab of the Problems module. The items in the clinic list cannot be changed by the user.

Figure 29–5: New Procedure Pane

4. Complete the appropriate fields:
 - **Procedure Date:** Click the drop-down arrow to select the date the procedure was performed.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Comments:** Add a note for a selected problem or procedure.
5. Click **Save** on the Action bar.

29.5 Adding Family History Problems

The Problems module allows you to document specific problems in a patient's family history. Positive and negative family history documentation from the S/O module is displayed in the Family History area in the Problems module.

Follow the steps below to add family history problems:

1. Select the **Family History** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.
3. Select the diagnosis you want to add. The selected problem appears in the New Family History pane on the Problems module.

Figure 29–6: New Family History Pane

4. Complete the appropriate fields:
 - **Onset Date:** Click the drop-down arrow to select the date of the onset of the problem.
 - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
 - **Sensitivity:** Click the checkbox to mark the family history problem as sensitive.
 - **Comments:** Add a note for the family history problem.
 - **Relationship:** Select the family member from the drop-down list.

- **Source:** The manner in which you received the family past medical history problem.
5. Click **Save** on the Action bar.

29.6 Updating a Problem or Procedure

Problems and procedures can be updated from the Problem List, Historical Procedures, and Family History areas.

Follow the steps below to update a problem or procedure:

1. Select a problem or procedure. The Update Problem or Procedure pane displays on the Problems module.

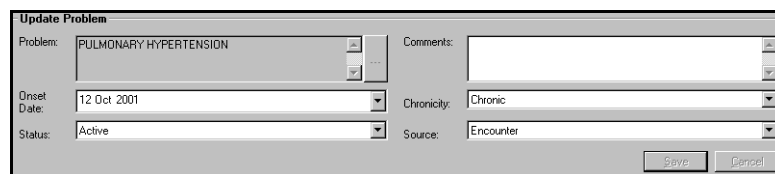


Figure 29–7: Update Problem Pane

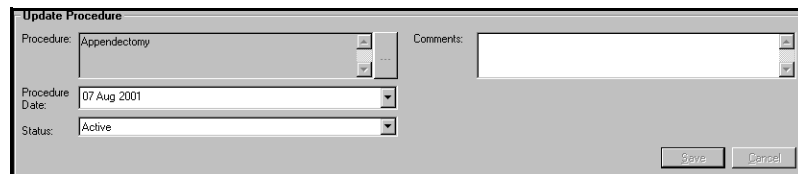


Figure 29–8: Update Procedure Pane

2. Do one of the following:
 - If you are updating a problem, update the following fields, as necessary:
 - Onset Date
 - Status
 - Comments
 - Chronicity
 - Source
 - If you are updating a procedure, update the following fields, as necessary:
 - Procedure Date
 - Status
 - Comments
 - If you are updating a patient's family history, update the following fields, as necessary:
 - Onset Date
 - Status

- Comments
- Relationship

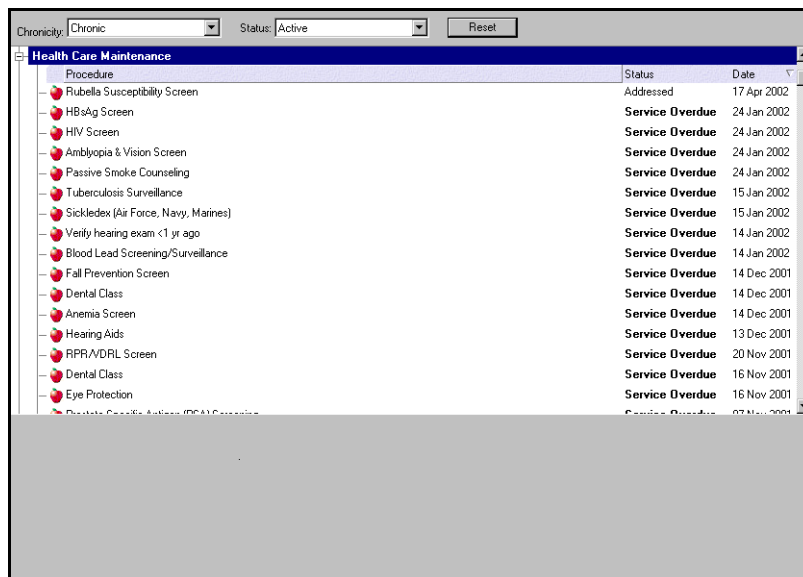
3. Click **Save**.

Note: Active problems added to the patient’s problem list auto-age to **Acute-Inactive** after 180 days.

29.7 Accessing Healthcare Maintenance

Health Care Maintenance items are the same wellness reminders found in the Wellness module, and the Reminders tab of the A/P module. Any expired medications for the patient also display as Healthcare Maintenance items.

Healthcare Maintenance can be accessed by clicking the **plus sign** next to Healthcare Maintenance. A list of the wellness reminders is displayed.



Procedure	Status	Date
Rubella Susceptibility Screen	Addressed	17 Apr 2002
HBsAg Screen	Service Overdue	24 Jan 2002
HIV Screen	Service Overdue	24 Jan 2002
Amblyopia & Vision Screen	Service Overdue	24 Jan 2002
Passive Smoke Counseling	Service Overdue	24 Jan 2002
Tuberculosis Surveillance	Service Overdue	15 Jan 2002
Sicklelex (Air Force, Navy, Marines)	Service Overdue	15 Jan 2002
Verify hearing exam < 1 yr ago	Service Overdue	14 Jan 2002
Blood Lead Screening/Surveillance	Service Overdue	14 Jan 2002
Fall Prevention Screen	Service Overdue	14 Dec 2001
Dental Class	Service Overdue	14 Dec 2001
Anemia Screen	Service Overdue	14 Dec 2001
Hearing Aids	Service Overdue	13 Dec 2001
RPR/VDRL Screen	Service Overdue	20 Nov 2001
Dental Class	Service Overdue	16 Nov 2001
Eye Protection	Service Overdue	16 Nov 2001
Diabetes Specific Asthma (DCA) Counseling	Service Overdue	07 Nov 2001

Figure 29–9: Healthcare Maintenance

Note: Click **Guidelines** to view a description of the Healthcare Maintenance item.

Tip:
 Select a Healthcare Maintenance Item and press **F1** to view the clinical guidelines associated with the item.

30.0 QUESTIONNAIRE SETUP

30.1 Questionnaire Setup Overview

The Questionnaire Setup module allows you to create and modify questionnaires. Once created, you can modify, copy, delete, and mark obsolete these questionnaires. An open encounter is not required for questionnaires to be created or modified. The Questionnaire Setup module can be accessed from the Folder List by expanding Tools.

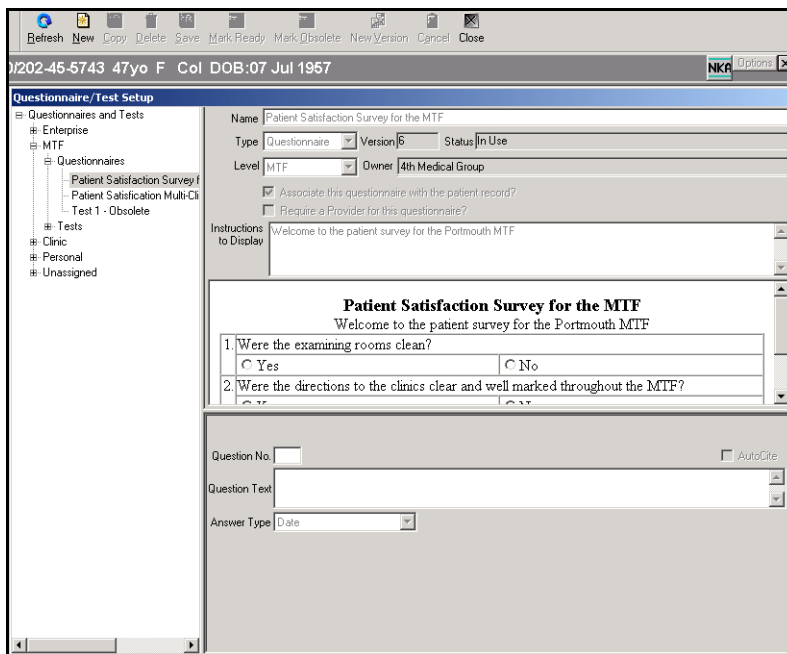


Figure 30–1: Questionnaire Setup Module

30.1.1 In More Depth

The Questionnaire Setup module allows you to create and modify questionnaires. Once created, these questionnaires can be modified, copied, deleted, or marked as obsolete these. An open encounter is not required for questionnaires to be created or modified.

The Status section of each questionnaire denotes the level of development or use of a questionnaire. A new questionnaire always starts out as In Development.

- Mark as Ready means the questionnaire is ready for use. A questionnaire must be marked Ready for Use before it can be used in the Patient Questionnaires module. Once marked, the status changes from In Development to Ready for Use.
- Mark as Obsolete means a questionnaire has been removed from circulation. A questionnaire that is marked obsolete can be made active again by selecting Ready For Use. New Version means a questionnaire can be modified and saved as different version of a specific questionnaire.

A questionnaire can be copied and saved as another questionnaire so that questions can be reused.

Only questionnaires that have never been used can be deleted. Deleted questionnaires do not appear on the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup modules.

30.2 Creating a New Questionnaire

Follow the steps below to create a new questionnaire:

1. Click **New** on the Action bar. The New Questionnaire pane opens.

Figure 30–2: Questionnaire Setup — New Questionnaire

2. In the **Name** field, enter the name for the new questionnaire.
3. Select **Questionnaire** or **Test** from the Type drop-down list.

Note: The Status is *In Development* until you save the questionnaire.

4. Select the Level from the drop-down list.
5. Select the Owner from the drop-down list.
6. In the **Instructions to Display** field, enter any instructions related to the questionnaire for the patient.

7. Click **Add** to create a new question.

Note: The **Question No.** field is pre-populated in numerical order.

8. In the **Question Text** field, enter the question.

9. Select an answer type from the drop-down list. The **Answer Type** field allows different answer format styles to be assigned to the question.

- **Date:** This field is used for questions requiring a specified date to be entered as the answer.
- **Multiple Choice:** This field is used for questions where a single choice is available for selection.
- **Multi-Select:** This is used for questions where more than one answer can be selected.
- **Number:** This is used for questions requiring a number to be entered. A minimum or maximum amount can be specified.
- **Yes/No:** This is used for questions requiring a yes or no response.

The screenshot displays the 'Questionnaire/Test Setup' window. On the left is a tree view showing the hierarchy: Questionnaires and Tests > Enterprise > MTF > Clinic > Questionnaires > GOLD MTF > Eds Latest Questionnaire Version 1 > Eds Latest Questionnaire (Version 2). The main area shows the configuration for 'Eds Latest Questionnaire'. Fields include: Name (Eds Latest Questionnaire), Type (Questionnaire), Version (2), Status (In Development), Level (Clinic), and Owner (GOLD MTF). There are checkboxes for 'Associate this questionnaire with the patient record?' (checked) and 'Require a Provider for this questionnaire?' (unchecked). The 'Instructions to Display' field contains 'Answer each question as honestly as possible'. Below this is a preview of the questionnaire titled 'Eds Latest Questionnaire' with the instruction 'Answer each question as honestly as possible'. It contains three questions: 1. 'When was you last cholestereol check?' with an 'Answer:' text box; 2. 'How much do you think you eat?' with radio buttons for 'Too much', 'Too little', 'Not enough', and 'The right amount'; 3. 'When do you eat foods that are high in fat?' with checkboxes for 'Breakfast', 'Lunch', 'Dinner', and 'Snacks'. At the bottom, there are 'Import' and 'Add' buttons, and a section for 'Question No.' (with an 'AutoSite' checkbox), 'Question Text' (with a text box), and 'Answer Type' (set to 'Date').

Figure 30-3: Questionnaire Answer Format Styles

10. When you have finished adding questions, click **Save** on the Action bar to save the questionnaire as completed.

11. Click **Mark as Ready** on the Action bar.

Note: The status changes from **In Development** to **Ready for Use**. The questionnaire must be marked **Ready for Use** before it can be used in the Patient Questionnaires module.

30.3 Copying a Questionnaire

A questionnaire can be copied and saved as another questionnaire so that questions can be reused.

Follow the steps below to copy a questionnaire:

1. Select the questionnaire you want to copy from the **Questionnaire** list.
2. Click **Copy** on the Action bar. The Copied Questionnaire displays.
3. In the **Name** field, enter the name of the questionnaire.
4. Select the question you want to modify, if necessary.
5. Click **Save** on the Action bar.
6. Click **Mark as Ready** to mark the test as ready for use.

30.4 Deleting a Questionnaire

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup.

Follow the steps below to delete a questionnaire:

1. Select the questionnaire you want to delete from the **Questionnaire** list.
2. Click **Delete** on the Action bar.
3. Click **Yes** at the delete confirmation prompt.

30.5 Importing a Questionnaire or Question into a Questionnaire

Entire questionnaires or selected questions can be imported into questionnaires.

Follow the steps below to import a questionnaire or question into a questionnaire:

1. Select the questionnaire into which you want to import.
2. Click **Import**.
3. Click **OK** at the import questionnaire prompt.

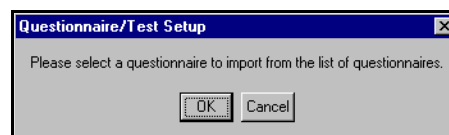


Figure 30-4: Import Questionnaire Prompt

4. Select the questionnaire you want to import from the Questionnaire list. The Import Questionnaire window opens.

The screenshot shows a window titled "Questionnaire -- Import Question". Inside, the questionnaire is titled "Eating Habits" and includes the instruction "Answer each question as honestly as possible." The questions are as follows:

1. When was your last cholesterol check?
Answer:
2. How much do you think you eat?
 Too much Too little Not enough The right amount
3. How many times a week do you eat after 8 pm?
 1-2 3-4 5-6 0
4. How many meals do you eat a day?
Answer:
5. Do you snack between meals?
 Yes No

At the bottom right of the window, there are two buttons: "Import" and "Cancel".

Figure 30–5: Import Question Window

5. Click the question(s) you want to import.
6. Click **Import**. The questions are imported after the last question in the questionnaire.
7. Click **Save**.

30.6 Maintaining Questionnaires

The Status section of each questionnaire denotes the level of development or use of a questionnaire. A new questionnaire always starts out as *In Development*.

- **Mark as Ready:** This marks the questionnaire as ready for use.
- **Mark as Obsolete:** This allows a questionnaire to be removed from circulation.
- **New Version:** This allows a questionnaire to be modified into another version of a specific questionnaire.

Follow the steps below to mark a questionnaire as ready:

1. From the questionnaires listed in the side bar, select the questionnaire to be marked Ready for Use.
2. From the Questionnaire Set Up module, access the Actions pull-down menu and select **Mark Ready** to mark the questionnaire as ready. Once marked as ready, the questionnaire is available for use. The Status bar reflects the questionnaire as Ready for Use.

Follow the steps below to mark a questionnaire as obsolete:

1. From the questionnaires listed in the side bar, select the questionnaire to be marked obsolete.
2. From the Questionnaire Set Up module, access the Actions pull-down menu and select **Mark Obsolete** to mark the questionnaire as Obsolete. Once marked Obso-

lete, the questionnaire is not available for use. The Status bar reflects the questionnaire as Obsolete.

Note: A questionnaire that is marked obsolete can be made active again by selecting **Ready For Use**.

Follow the steps below to mark a questionnaire as a new version:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked New Version.
2. From the Questionnaire Set Up module, access the Actions pull-down menu and select **New Version** to mark the questionnaire as a New Version. Once marked New Version, the questionnaire is available for use. The Status bar reflects the questionnaire as New Version.

Follow the steps below to delete a questionnaire:

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup. A questionnaire cannot be deleted if it has been used.

31.0 RADIOLOGY

31.1 Radiology Overview

The Radiology (Rad) module enables you to view radiology test result data for desired patients. Results are viewed, not ordered from this module. Radiology results are pulled from CHCS. An alert is triggered when new results are received. Use the A/P module to order radiology tests.

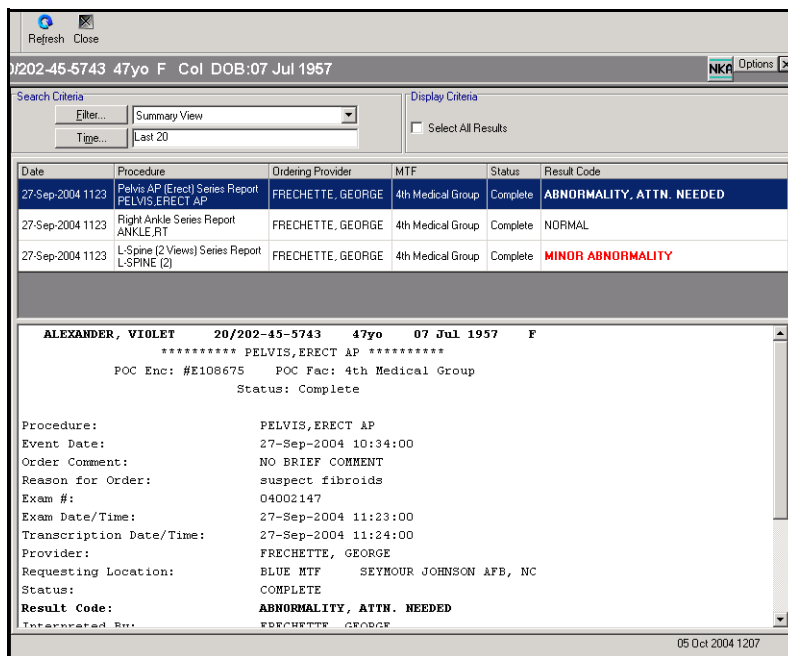


Figure 31-1: Military Clinical Desktop—Radiology Module

31.2 Creating a Filter in the Radiology Module

The Filter tab on the Properties window enables you to view radiology results by selecting a previously saved filter from the drop-down list or creating a new filter.

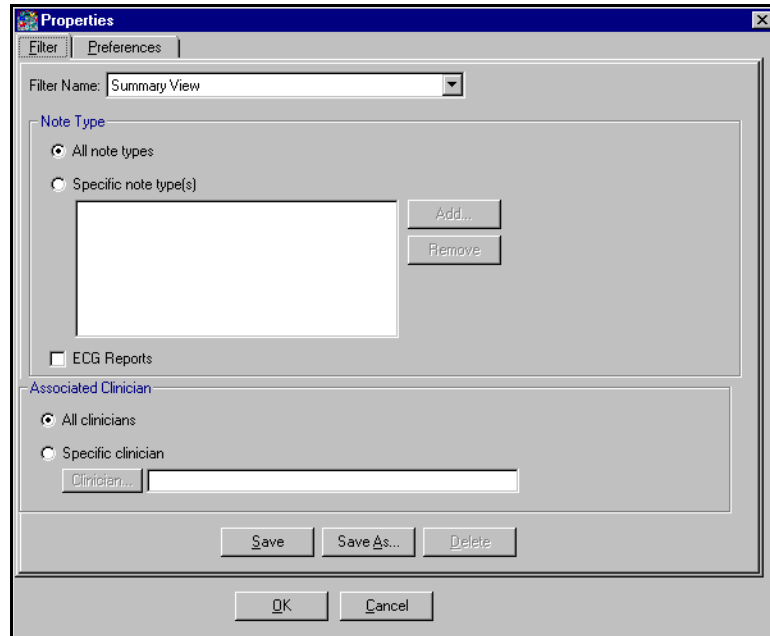


Figure 31-2: Radiology Properties Window – Filter Tab

Follow the steps below to create a new filter:

1. Click the applicable radio button for the Note Type.

Note: If **All Note Types** is selected, all of the listed note types are displayed.

Note: If **Specific Note Type(s)** is selected, click **Add** to open the Healthcare Data Dictionary Search window to search and add specific clinical note(s).

2. Click the applicable radio button for the Associated Clinician.

Note: If **All Clinicians** is selected, all of the listed clinicians are displayed.

Note: If **Specific Clinician** is selected, click **Clinician** to locate and select the specific clinician(s).

3. Click **Save As**.

Note: If this is a change to a pre-existing filter, click **Save**.

4. Enter the name for the filter.
5. Click **Save**.

Tip:

To delete a filter, select the filter from the drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.

- Click **OK** on the Properties window.

31.3 Setting Time Preferences in the Radiology Module

The Preferences tab on the Properties window allows you to customize the default times within the Radiology module.

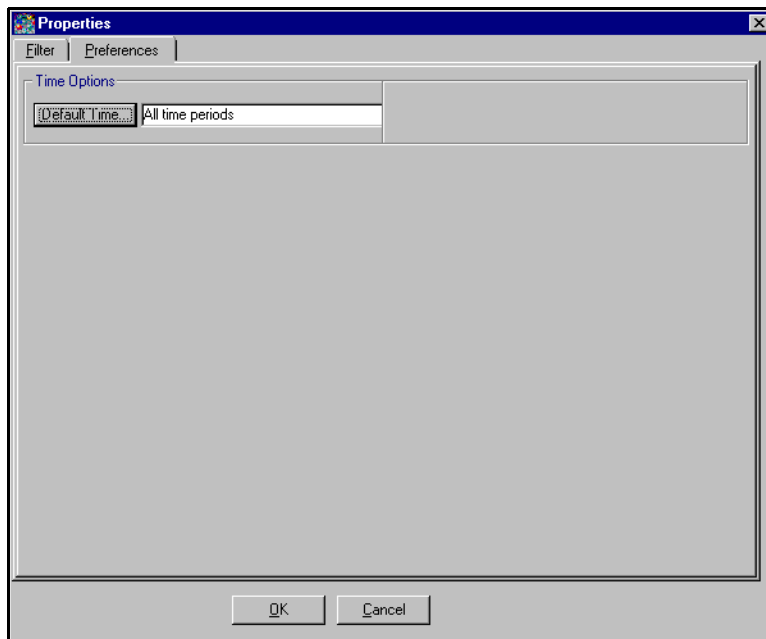


Figure 31–3: Radiology Properties Window—Preferences Tab

Follow the steps below to set time preferences:

- Click **Default Time**. The Time Search window opens.

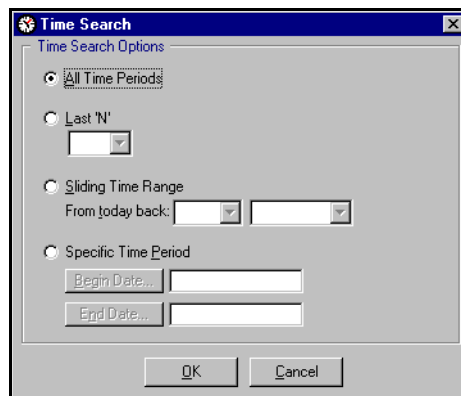


Figure 31–4: Time Search Window

- Click the radio button for the applicable Time Search Option.
- Click **OK** on the Properties window.

31.4 Viewing Radiology Results

Once the search criteria have been defined, the radiology results are displayed.

Select the desired test data to be viewed by selecting the test name (i.e., mammogram). The data is displayed in the bottom of the Radiology Results window.

Note: When mammogram results are ready, a letter is sent to the patient notifying her that her results are ready. A copy of this letter can be found in the Clinical Notes module.

31.5 Printing Radiology Results

Follow the steps below to print the radiology results:

1. Select the test(s) you want to print.
2. On the File menu, point to Print and click **DD2766**.

31.6 Copying Radiology Results to a Note

Once the radiology result is displayed, the result can be copied for use in other modules or can be copied directly into the Note area of the Patient Encounter module.

Follow the steps below to copy the details of a radiology result:

1. Select the desired result so the details display in the bottom of the Radiology module.

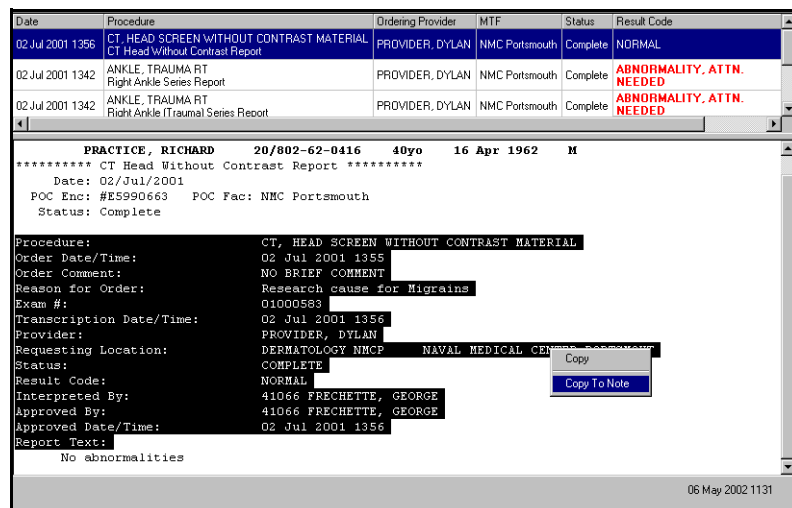


Figure 31-5: Radiology Results Module (Copy Radiology Results)

2. Select the portion of the result to be copied.
3. Right click your mouse, then select either:

- **Copy:** Copies the selection on the clipboard so it can be used in another location.
- **Copy to Note:** Copies the details directly into the S/O area of the current patient encounter summary.

Note: An encounter must be open to utilize the **Copy to Note** function. The result is pasted directly into the patient encounter. Once copied, the result cannot be deleted from the note, so ensure that you only select the **Copy to Note** option once, to avoid duplicate entries in the note.

32.0 READINESS

32.1 Readiness Overview

The Readiness module displays information to determine whether the patient is ready for deployment. Most of the data displayed on the Readiness module is received from other sources. Data edited in the Readiness module does not update data in its original source.

The screenshot shows a software window titled "NKR Options" with a patient ID of "1202-45-5743 47yo F Col DOB:07 Jul 1957". The window contains several sections of data entry fields:

- Lab Tests:** HIV Done, G6PD, Sickle Cell, and Blood Type, each with a Date and Result field.
- Screening Exams:** Hearing Exam, Last Dental Exam, and Medical Assessment (PE), each with a Date field. Hearing Exam also includes Hearing Aid Required, Issued, and Date Issued fields. Last Dental Exam includes Dental Readiness Classification and Date fields.
- Profiles:** Temporary Profile, Start Date, End Date, Diagnosis, and Limitation fields.
- Vision Readiness:** Last Visual Acuity, Protective Insert, and Date Issued fields. Vision Readiness also includes fields for Uncorrected and Corrected vision (OD 20/, OS 20/, OU 20/).

Figure 32–1: Military Clinical Desktop—Readiness Module

32.2 Modifying Readiness Information

Most of the data displayed in the Readiness module are downloaded from other sources. Editing data in the Readiness module does not update data in its original source.

Follow the steps below to modify readiness information:

1. Click **Edit** on the Action bar.
2. Complete the following areas, as necessary:
 - Lab Tests
 - Screening Exams
 - Profiles
 - Vision Readiness

Tip:
The fields in the module are not active until you click **Edit**.

3. Click **Save**.

Note: If changes were made, the Save option must be completed before closing the module; otherwise, changes are not saved.

33.0 REMINDER MAPPING

33.1 Reminder Mapping Overview

The Reminder Mapping module enables authorized users to set and modify default orders and other actions for Wellness Reminders. The default actions occur when the individual reminder is addressed. Users who do not have the appropriate roles assigned to them are able to view the Wellness Reminders and associated defaults, but cannot perform any other actions.

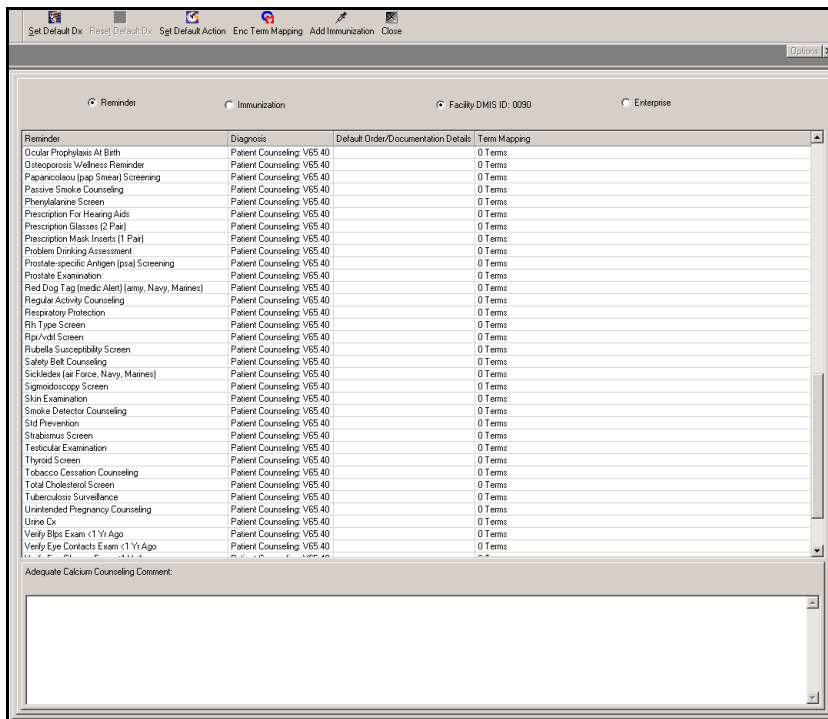


Figure 33–1: Military Clinical Desktop—Reminder Mapping Module

33.1.1 In More Depth

Upon opening the Reminder Mapping module, a list of all Wellness Reminders is displayed, along with default diagnoses, orders, and documentation details. Each of these defaults can be changed by Clinical Team Members with the appropriate privileges.

The default actions set up in the Reminder Mapping module allow for a more streamlined documentation of the Wellness reminders. Wellness Reminders can be met with the documentation of vital signs, the ordering of a lab or radiology procedure, the documentation of a MEDCIN term, or the documentation that counseling was completed.

The default actions set within the Reminder Mapping module are seen within the A/P module. The Reminders tab contains the active wellness reminders for a given patient as well as the default settings for each reminder. The A/P module is where a clinical

team member documents completed reminders; the Reminder Mapping module sets up the default actions that are completed when a reminder is addressed in the A/P module.

Note: A list of active Wellness reminders for the selected patient is displayed in the Reminders Mapping window (bottom left of the desktop) and in the A/P module on the Reminders tab.

33.1.2 Setting a Default Diagnosis

When a reminder is addressed for an individual patient, through the A/P module, the associated default diagnosis is added to the encounter automatically. The default diagnosis for Wellness Reminders is Patient Counseling V65.40, but this can be changed.

Follow the steps below to change the default diagnosis for a Reminder:

1. Select the Reminder and click **Set Default Dx** on the Action bar. The Default Diagnosis Search window opens.
2. Enter a search string in the Search field and click **Search**. The search results display.

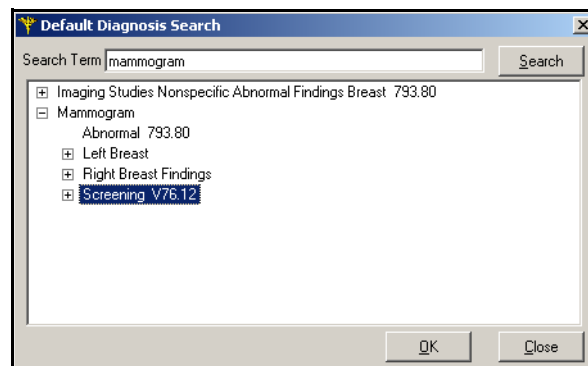


Figure 33–2: Default Diagnosis Search Window—Search Results

3. Select a Diagnosis and click **OK**. The selected diagnosis replaces the default diagnosis.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Hemoglobinopathy Screen	Patient Counseling: V65.40		0 Terms
Hiv Screen	Patient Counseling: V65.40		0 Terms
Hormonal Replacement Therapy Counseling	Patient Counseling: V65.40		0 Terms
Hot Water Counseling	Patient Counseling: V65.40		0 Terms
Mammogram Screening	Mammogram Screening V76.12 (MTF)		0 Terms
Maternal Serum Alpha-fetoprotein Counseling	Patient Counseling: V65.40		0 Terms
Multivitamin With Folate	Patient Counseling: V65.40		0 Terms

Figure 33–3: Default Diagnosis Changed

33.1.3 Resetting a Diagnosis to the Default Diagnosis

Select the Reminder with the diagnosis you want to reset and click **Reset Default Dx** on the Action bar to reset a diagnosis to the default diagnosis (Patient Counseling V65.40). The diagnosis is reset to the default diagnosis.

33.2 Setting a Default Action

Along with a default diagnosis, each reminder can have a default action. The action can be the placement of a lab, radiology or medication order, or the documentation of patient instructions, vital signs, or simply that the reminder was completed or ordered. When the reminder is addressed in the A/P module, the default action occurs automatically.

Follow the steps below to set a default action for a reminder:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.

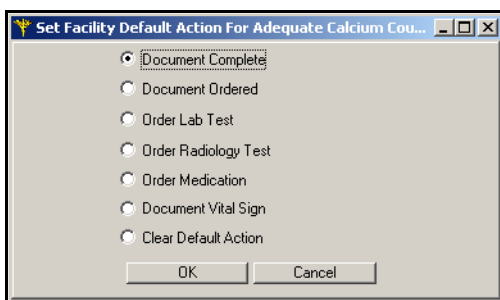


Figure 33–4: Set Facility Default Action Menu

You have multiple options from which to select.

33.2.1 Setting Document as the Default Action

If Document is the default action, CHCS II documents the reminder as complete or ordered in the comments section of the default diagnosis in the A/P module. For example, if the Nutrition Counseling reminder had a default diagnosis of Patient Counseling and a default action of Document Complete, the result in A/P would look like the figure below.

Priority	ICD	Diagnosis
1	V65.40	Patient Counseling:
	Comment	Nutrition Counseling Completed

Figure 33–5: Example of A/P Documentation

Follow the steps below to set the default action to Document (Completed, Ordered):

1. Click the appropriate radio button.
2. Click **OK**. Document (Complete, Ordered) is the default action for the reminder.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Multivitamin With Folate	Patient Counseling: V65.40		0 Terms
Nutrition Counseling	Patient Counseling: V65.40	Document Nutrition Counseling Complete (MTF)	0 Terms
Ocular Prophylaxis At Birth	Patient Counseling: V65.40		0 Terms
Osteoporosis Wellness Reminder	Patient Counseling: V65.40		0 Terms

Figure 33–6: Reminder Set to Document Complete

33.2.2 Setting a Lab Order as the Default Action

Set the default action to automatically order a lab test when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default lab test is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Lab Test:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Lab Test and click **OK**. The Lab order window displays.
3. Enter a search string in the Search field and click **Search**. The search results opens.

Figure 33–7: Order Lab Test Search Results

4. Select the lab order, fill in other fields as necessary, and click **OK**. The ordering of the lab test is the default action.

Reminder	Diagnosis	Default Order/Documentation Details
Adequate Calcium Counseling	Patient Counseling: V65.40	
Amblyopia & Vision Screen	Patient Counseling: V65.40	Document Amblyopia & Vision Scree
Anemia Screen	Patient Counseling: V65.40	Order: Cholesterol (MTF)
Anti-tobacco Counseling	Patient Counseling: V65.40	ORDER: (CHEST)

Figure 33–8: Lab Order Default Added

Note: The lab test is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

33.2.3 Setting a Radiology Order as the Default Action

Set the default action to automatically order a radiology test when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default radiology test is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Radiology Test:

1. Select the Wellness Reminder, and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Radiology Test and click **OK**. The Order Rad window opens.
3. Enter a search string in the Search field and click **Search**. The search results display.

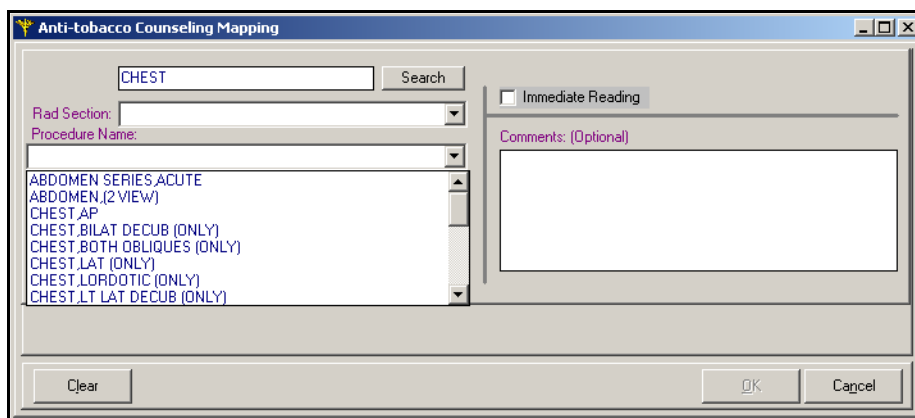


Figure 33–9: Rad Order Window—Search Results

4. Select the radiology test, fill in other fields as necessary, and click **OK**. The ordering of the radiology test is the default action.

Note: The radiology test is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

33.2.4 Setting a Medication Order as the Default Action

Set the default action to automatically order a medication when a reminder is addressed through the Reminders tab in the A/P module. In this case, the default diagnosis is documented and the default medication is ordered and associated to the default diagnosis.

Follow the steps below to set the default action to Order a Medication:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Order Medication and click **OK**. The Order Medication window opens.

3. Enter a search string in the Search field and click **Search**. The search results display.

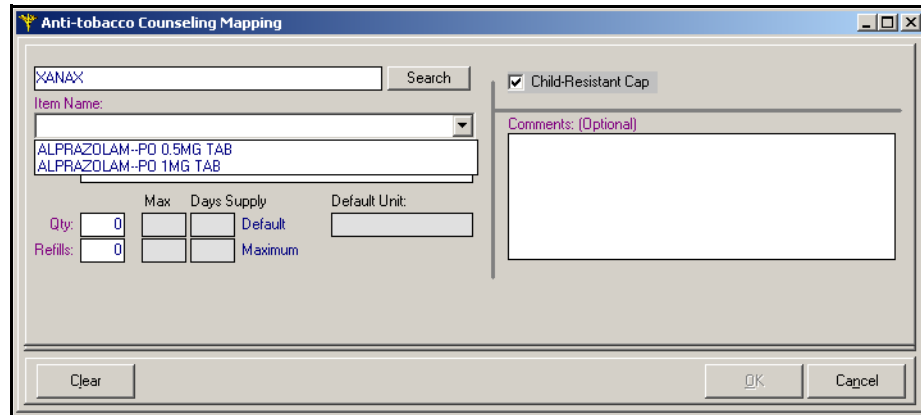


Figure 33–10: Order Med Window— Search Results

4. Select the medication, fill in other fields as necessary, and click **OK**. Ordering medication is the default action.

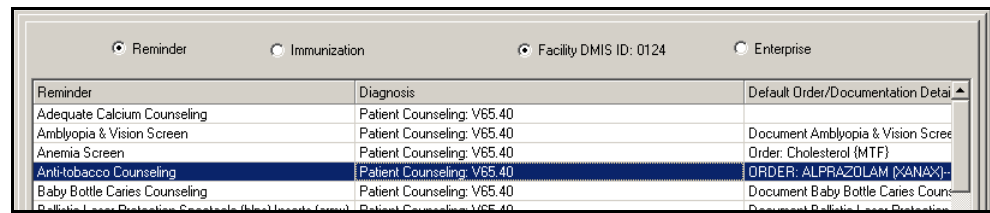


Figure 33–11: Medication Order Default Added

Note: The medication order is not ordered until the provider addresses the Wellness Reminder in the A/P module during a patient encounter.

33.2.5 Clearing a Default Action

Follow the steps below to clear a default action for a Wellness Reminder:

1. Select the Wellness Reminder and click **Set Default Action** on the Action bar. The Set Facility Default pop-up menu opens.
2. Select Clear Default Action and click **OK**. The Clear Reminder Option message displays.

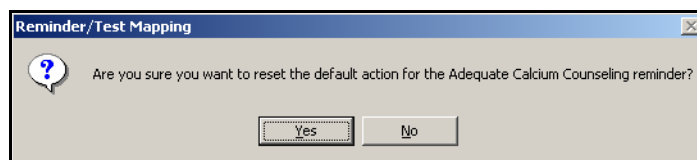


Figure 33–12: Clear Reminder Option Message

3. Click **Yes**. The default action is cleared.

33.3 Mapping Encounter Terms

Follow the steps below to map encounter terms:

1. Click **Enc Term Mapping** on the Action bar. The Enc Term Search window opens.
2. Select the radio button next to the type of term to be mapped:
 - Other Therapies (patient instructions)
 - Procedure
 - Diagnosis
 - S/O Item
3. Enter a search string and click **Search**. The search results display.
4. Select a term and click **Add**. Your selection is added in the lower pane of the window.

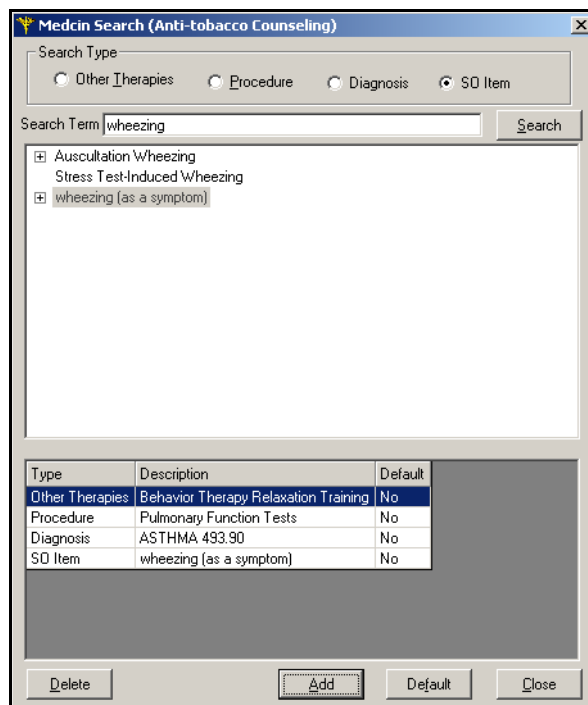


Figure 33–13: Selected Encounter Terms

33.3.1 Setting an Encounter Term as the Default

Follow the steps below to set one of the terms as the Default:

1. Select one of the terms.
2. Click **Default**. The terms Default column changes to Yes.

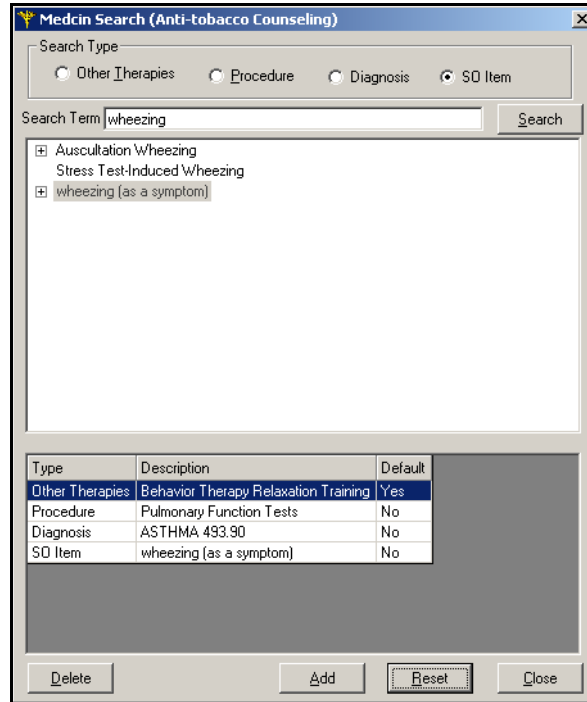


Figure 33–14: Term Item Set as Default

3. Click **Close**. Your Enc Terms selections have been added to the Reminder.

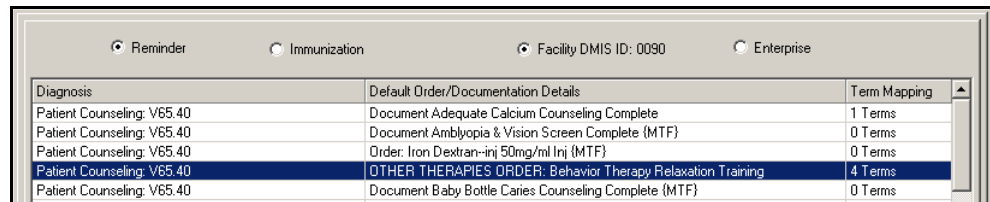


Figure 33–15: Defaults Set

Note: The default term is displayed and the Term Mapping column shows the total number of terms that you added (4).

33.4 Managing Immunization Reminders

33.4.1 Adding an Immunization

Immunizations must be added to the list before changing the default diagnosis or adding a default action.

Follow the steps below to locate and add an immunization to the list:

1. Click the **Immunization** radio button on the Reminder Mapping module. The Immunizations window opens.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered (MTF)	0 Terms
MmrV	Patient Counseling: V65.40	Document MmrV Ordered (MTF)	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete (MTF)	0 Terms

Figure 33–16: Immunizations Window

- Click **Add Immunization** on the Action bar. The Immunization Search window opens.
- Enter a search string in the Search field and click **Search**. The search results display.

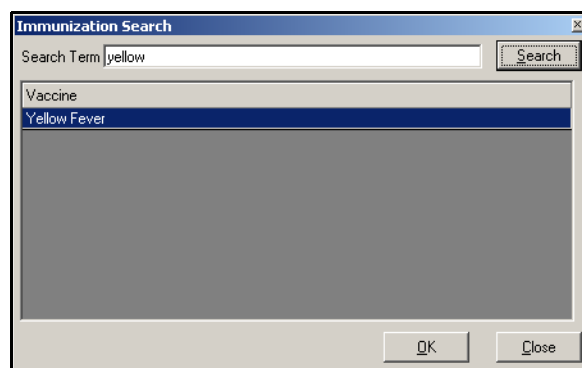


Figure 33–17: Immunizations Search Results

- Select the Immunization and click **OK**. The Immunization is added to the list.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered (MTF)	0 Terms
MmrV	Patient Counseling: V65.40	Document MmrV Ordered (MTF)	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete (MTF)	0 Terms
Yellow Fever	Patient Counseling: V65.40		0 Terms

Figure 33–18: Immunization Added

33.4.2 Setting the Default Diagnosis for an Immunization

Follow the steps below to change the default diagnosis for a Reminder:

- Select the Reminder and click **Set Default Dx** on the Action bar. The Default Diagnosis Search window opens.
- Enter a search string in the Search field and click **Search**. The search results display.

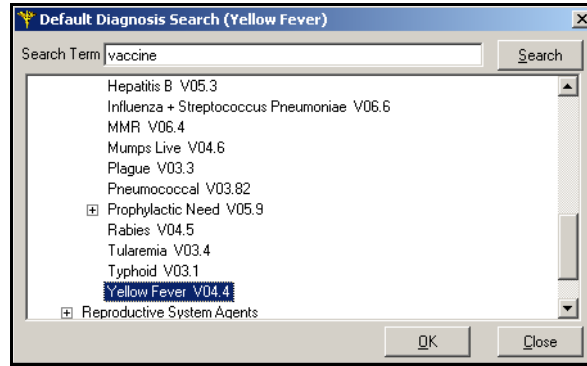


Figure 33–19: Default Diagnosis Search Window – Search Results – Immunization

3. Select a Diagnosis and click **OK**. The selected diagnosis replaces the default diagnosis.

The screenshot shows a window with three radio buttons at the top: "Reminder", "Immunization" (which is selected), and "Facility DMIS ID: 0090". Below the radio buttons is a table with four columns: "Reminder", "Diagnosis", "Default Order/Documentation Details", and "Term Mapping". The table contains the following data:

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
	Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)
	Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40	0 Terms
	Mmr	Patient Counseling: V65.40	Document Mmr Ordered
	Mmrv	Patient Counseling: V65.40	Document Mmrv Ordered
	Varicella	Patient Counseling: V65.40	Document Varicella Ordered
	Yellow Fever	Need For Vaccination Yellow Fever V04.4 (MTF)	0 Terms

Figure 33–20: Immunizations Window

33.4.3 Setting the Default Action for an Immunization

Follow the steps below to set the default action to Document (Completed, Ordered):

1. Select the immunization and click **Set Default Action** on the Action bar. The Set Immunizations Default Action window opens.

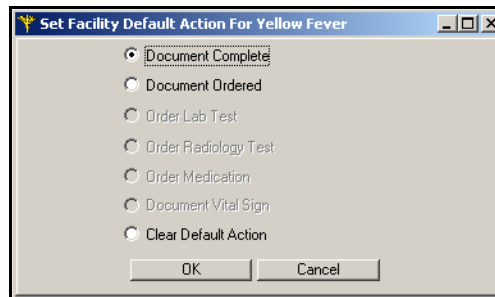


Figure 33–21: Set Immunizations Default Action Window

- Click the appropriate radio button.

Note: Only Document Complete or Document Ordered are available as default actions.

- Click **OK**. Document (Complete, Ordered) is the default action for the immunization.

Reminder	Diagnosis	Default Order/Documentation Details	Term Mapping
Anthrax	Patient Counseling: V65.40	Document Anthrax Complete (MTF)	0 Terms
Hep A Ped/adol, 2 Dose	Patient Counseling: V65.40		0 Terms
Mmr	Patient Counseling: V65.40	Document Mmr Ordered (MTF)	0 Terms
Mmriv	Patient Counseling: V65.40	Document Mmriv Ordered (MTF)	0 Terms
Varicella	Patient Counseling: V65.40	Document Varicella Complete (MTF)	0 Terms
Yellow Fever	Patient Counseling: V65.40	Document Yellow Fever Complete	0 Terms

Figure 33–22: Immunization Default Action Set

Note: The Immunization is not documented until the Reminder is addressed in the A/P module during a patient encounter. The documentation of an administered vaccine must be done in the Immunizations module.

34.0 REPORTS

34.1 Reports Overview

The Reports module consists of four different types of predefined reports used to collect statistical data to determine the needs of MTFs, Clinics, or Providers.

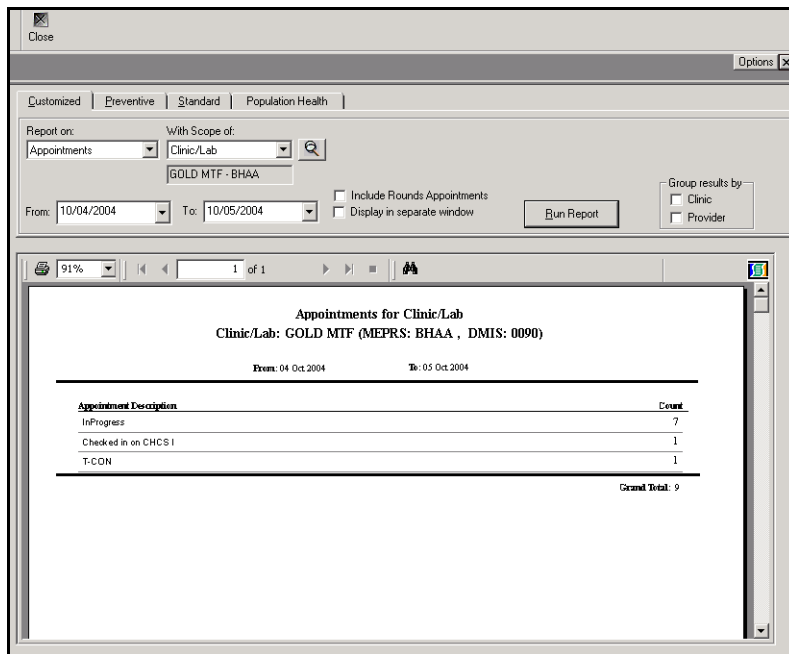


Figure 34-1: Military Clinical Desktop—Reports Module

34.1.1 In More Depth

The Reports module consists of three different types of predefined reports—Customized, Preventive, Standard, and Population Health—used to collect statistical data.

Customized Reports enable the user to run different types of reports for a desired patient. Current pre-defined customized reports include:

- Allergy Verified (Audit)
- Appointments
- Consults
- Diagnoses
- Disposition
- E&M
- Lab Tests Ordered
- Medications Ordered

- Primary Diagnoses
- Procedures
- Radiology Tests

There are 21 different Preventive Reports that can be run for a desired patient. Available reports include:

- 2 Year Olds, DTP/OPV/MMR Immunizations
- 2 Year Olds, Hepatitis B Immunizations
- 2 Year Olds, Varicella Immunization
- Cholesterol Screening Aggregate
- CPS Services Due
- CPS Summary
- Discontinued Services Risk
- High Cholesterol Follow-Up Counseling
- High Cholesterol Follow-Up Repeat
- High Cholesterol HDL/LDL Follow-Up
- Immunizations Active Duty Hepatitis A-1 Dose
- Immunizations Active Duty Hepatitis A-2 Dose
- Mammography, Have Not
- Mammography, Query for
- MMR #2, HBV #3, Varicella and TD Immunizations for 13 year old

There are 13 different predefined Standard Reports that can be run. Available reports include:

- Alphabetic Patient List for Encounters
- Appointment by Status for Encounters
- Diagnoses
- Inpatient Workload
- Insurance Change
- Insurance Indicator
- Insurance Indicator Not Marked
- Outpatient Workload, for Clinic/Lab
- Patient Categories by Disposition
- Patient Categories by Provider
- Patient Encounter
- Procedures
- Readiness

There are different predefined Population Health reports that can be run. In order to run Population Health Reports, special user privileges are required. If you do not have these privileges and wish to run these reports, please contact your system administrator. Depending on the selected report, the user can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient.

34.2 Running Customized Reports

Customized Reports enable you to run different types of reports for a desired patient.

Current pre-defined customized reports include:

- Allergy Verified (Audit)
- Appointments
- Consults
- Diagnosis
- Disposition
- E&M
- Laboratory Tests
- Medication
- Primary Diagnosis
- Procedure
- Radiology Tests

Follow the steps below to run customized reports:

1. Select the report from the Report on drop-down list on the Customized tab.
2. Select a scope from the With Scope of drop-down list. Depending on the selection, a default MTF, clinic/lab, or provider displays.

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays.

Tip:

*If you select Clinic/Lab or Provider from the drop-down list, click the **Lookup** icon to search for the desired clinic or provider.*

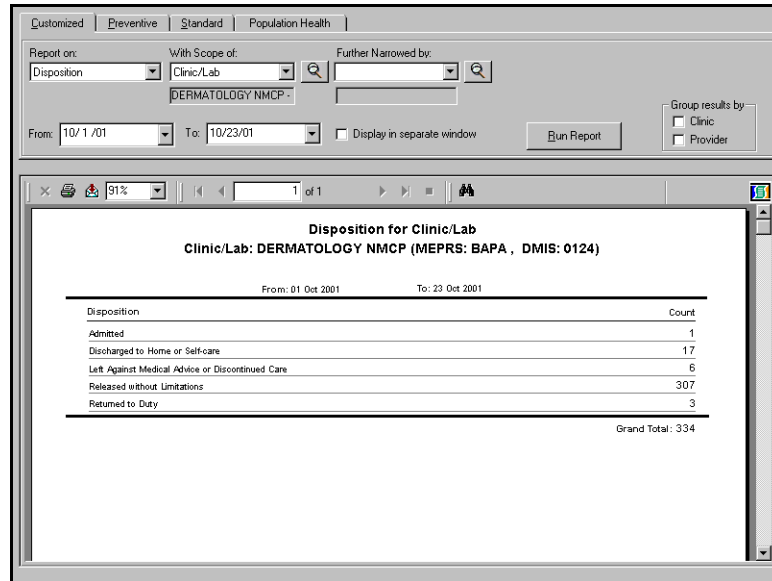


Figure 34–2: Customized Report

7. Click **Print Reports** to send the report to your local printer.

34.3 Running Preventive Reports

There are 22 different Preventive Reports that can be run for a desired patient.

Available reports include:

- 2 Year Olds, DTP/OPV/MMR Immunizations
- 2 Year Olds, Hepatitis B Immunizations
- 2 Year Olds, Varicella Immunization
- Cholesterol Screening Aggregate
- CPS Services Due
- CPS Summary
- Discontinued Services Risk
- High Cholesterol Follow-Up Counseling
- High Cholesterol Follow-Up Repeat
- High Cholesterol HDL/LDL Follow-Up
- Immunizations Active Duty Hepatitis A-1 Dose
- Immunizations Active Duty Hepatitis A-2 Dose
- Mammography, Have Not
- Mammography, Query for
- MMR #2, HBV #3, Varicella and TD Immunizations for 13 year old
- PAP Smear, Have Not

- Prevention Report Card
- Query for Potential Heavy Alcohol Use
- Safe Sex Counseling
- Tobacco Use Screening
- Tobacco, Advising Users to Quit

Follow the steps below to run preventive reports:

1. Select the report from the Report on drop-down list on the Preventive tab.
2. Select a scope from the With Scope of drop-down list.

Tip:
 If you select **PCM**, the default PCM displays. If you select **Patient**, click the **Lookup** icon to search for the desired patient. You can also search for a different PCM.

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click **Run Report**. The customized report displays.

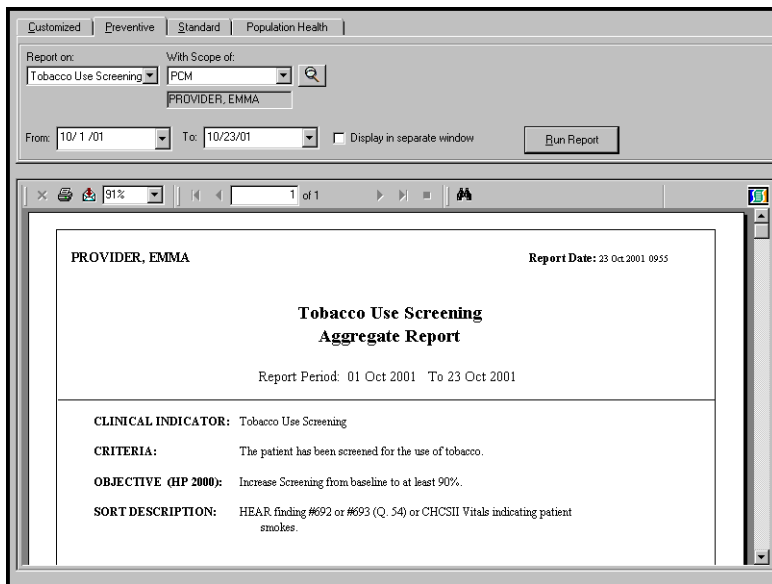


Figure 34–3: Preventive Report

6. Click **Print Reports** to send the report to your local printer.

34.4 Running Standard Reports

There are 13 different predefined Standard Reports that can be run.

Available reports include:

- Alphabetic Patient List for Encounters
- Appointment by Status for Encounters
- Diagnosis
- Inpatient Workload
- Insurance Change
- Insurance Indicator
- Insurance Indicator Not Marked
- Outpatient Workload
- Patient Categories by Disposition
- Patient Categories by Provider
- Patient Encounter
- Procedures
- Readiness

Tip:

*Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the **Lookup** icon to search for the desired scope option. Additional scopes are available depending on the selected scopes.*

Follow the steps below to run standard reports:

1. Select the report from the Report on drop-down list on the Standard tab.
2. Select a scope from the With Scope of drop-down list.
3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays.

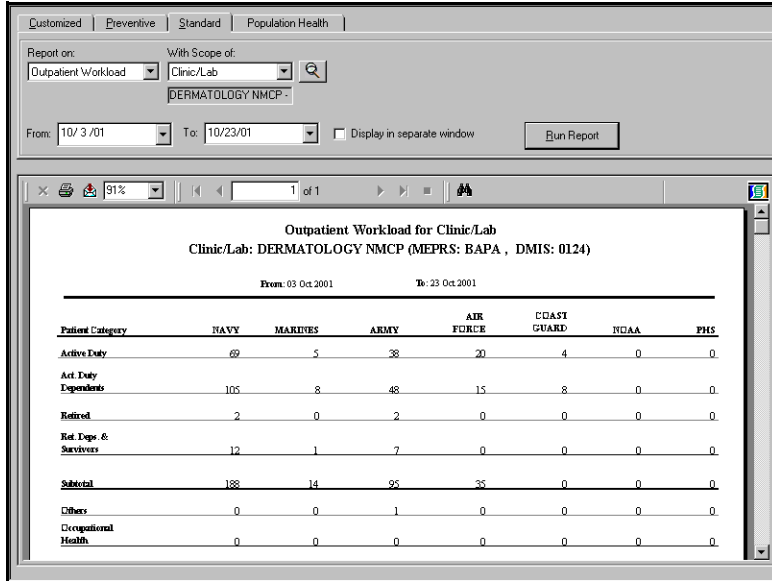


Figure 34–4: Standard Report

7. Click **Print** to send the report to your local printer.

34.5 Running Population Health Reports

There are different pre-defined Population Health reports that can be run.

Note: In order to run Population Health Reports, special user privileges are required. If you do not have these privileges and wish to run these reports, please contact your system administrator.

Follow the steps below to run a Population Health report:

1. Select the report from the Report on drop-down list on the Population Health tab.
2. Select a scope from the With Scope of drop-down list.

Note: Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the **Look up** icon to search for the desired scope option. Additional scopes are available depending on selected scopes.

3. Select a date range in the **From** and **To** fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click **Run Report** to run the customized report.

6. Click **Print** to send the report to your local printer.

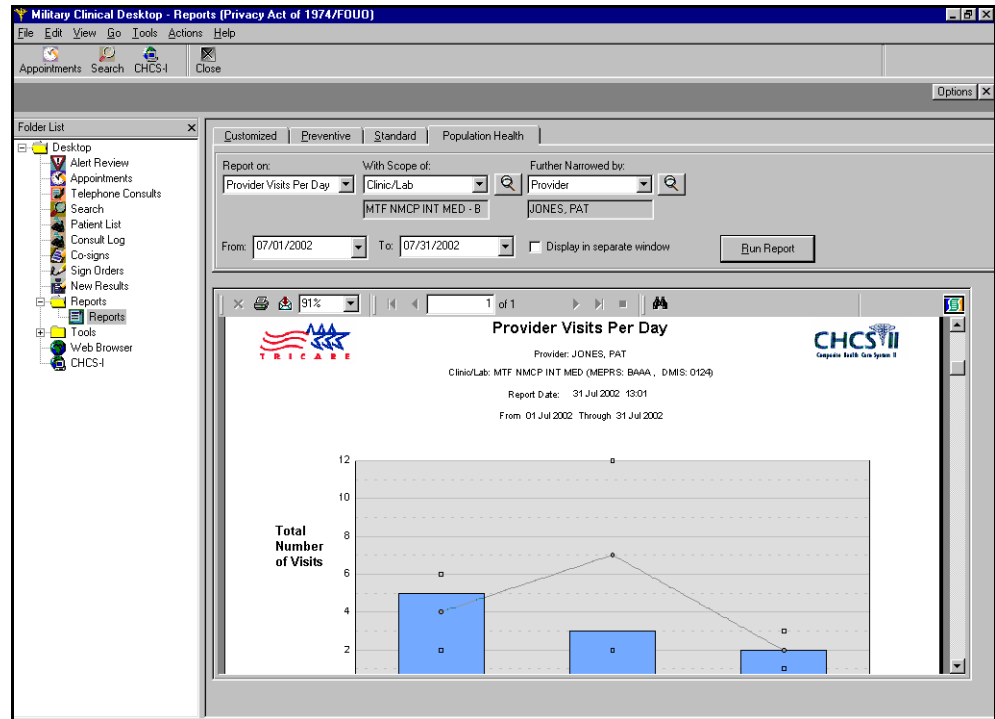



Figure 34–5: Population Health Tab

34.6 Exporting a Report

Follow the steps below to export a report:

1. Run the selected report.
2. Click the **Export Report**  icon. The Export window opens.
3. Select a **Format** from the drop-down list.
4. Select a **Destination** from the drop-down list.
5. Click **OK**.

35.0 RX ALTERNATIVES

35.1 Drug (RX) Alternatives Overview

The RX Alternatives module allows you to track the cost of primary and alternative medications. When you add the cost associated with a medication in this module, the information is used in populating population health medication cost reporting data.

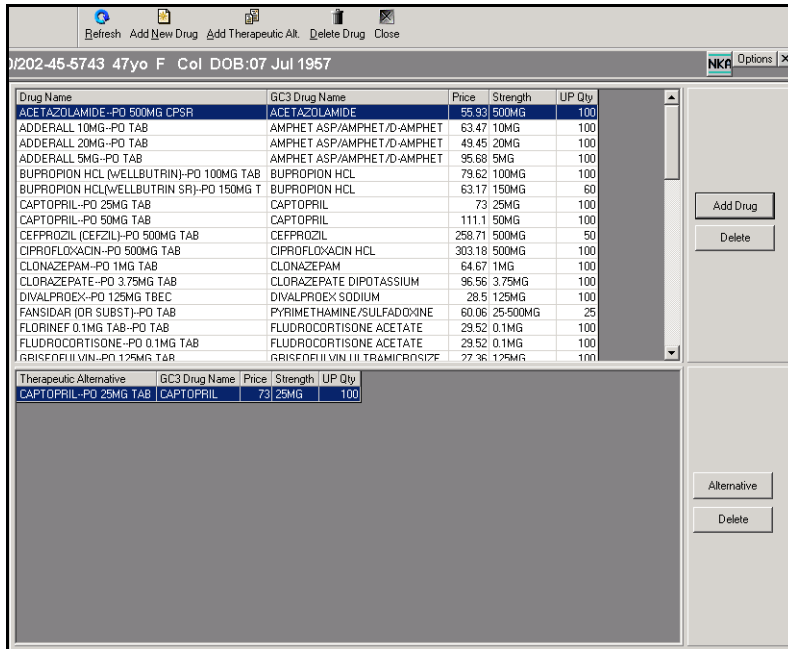


Figure 35–1: Military Clinical Desktop—RX Alternatives Module

35.2 Setting Drug Display Options

The Drug Display Options window lets you establish the type of data that displays when primary and alternative medications are added to the RX Alternatives module.

Follow the steps below to set the drug display options:

1. On the RX Alternatives module, click **Options** to open the Drug Display Options window.

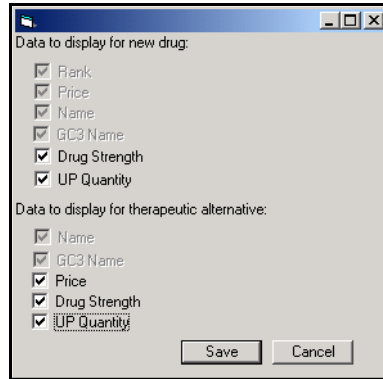


Figure 35–2: Drug Display Options Window

2. Select data options to display for the new drug:
 - Price
 - Name
 - Drug Strength
 - UP Quantity
3. Select data options to display for therapeutic alternative drugs:
 - Name
 - Price
 - Drug Strength
 - UP Quantity
4. Click **Save**.

35.3 Adding a New Drug

The Select Drugs window allows you to add new drug cost information to the RX Alternatives module. You can add drugs according to their name or description.

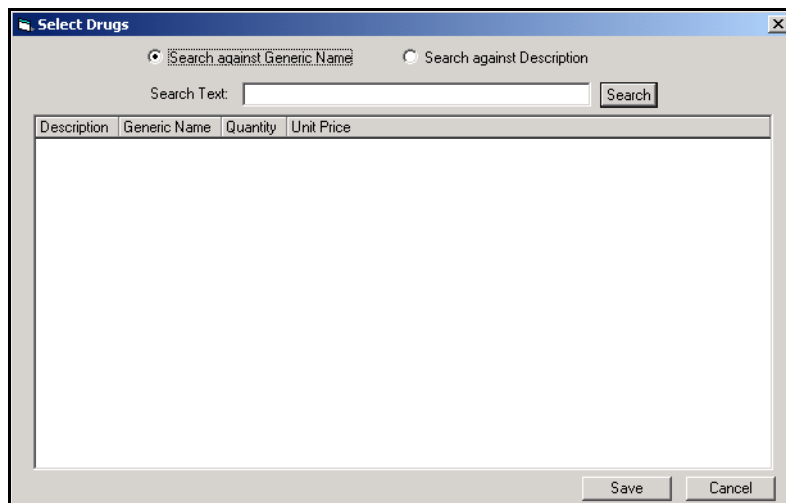


Figure 35-3: Select Drugs Window

Follow the steps below to add a new drug:

1. On the RX Alternatives module, click **Add New Drug** to open the Select Drugs window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the **Search Text** field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.

Note: Press the **Ctrl** key on the keyboard while you are selecting each medication to select more than one medication.

7. Click **Save**. You are returned to the RX Alternatives module.

Tip:
*If you do not see the added medication(s), on the RX Alternatives module, click **Refresh**.*

35.4 Adding Therapeutic Alternatives

The Select Therapeutic Alternative window allows you to add therapeutic alternative drug cost information to the RX Alternatives module for selected primary drugs. You can add therapeutic alternatives according to their name or description.

Note: You must have a primary drug selected before you can add a therapeutic alternative.

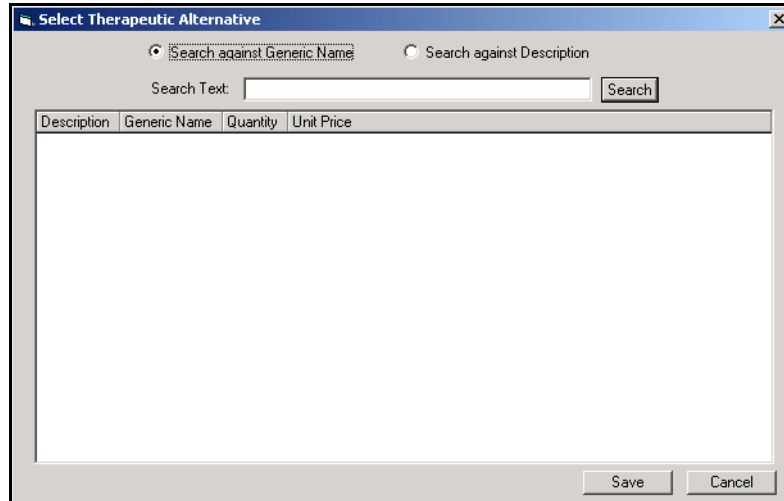


Figure 35-4: Select Therapeutic Alternative Window

Follow the steps below to add therapeutic alternatives:

1. On the RX Alternatives module, click **Add Therapeutic Alt** to open the Select Therapeutic Alternative window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the Search Text field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.
7. Click **Save**. You are returned to the RX Alternatives module.

Tip:

*If you do not see the added medication(s), on the RX Alternatives module, click **Refresh**.*

35.5 Deleting a Drug

Follow the steps below to delete a drug from the RX Alternatives module:

1. In the RX Alternatives module select the primary or alternative drug you want to delete.
2. On the action bar, click **Delete Drug**.
3. At the Delete Drug Ranking confirmation prompt, click **Yes**.

Tip:

*If you want to delete the therapeutic alternative but keep the primary drug, in the Therapeutic Alternative area, select the alternative and click **Delete**.*

36.0 SCREENING (REASON FOR VISIT)

36.1 Screening Overview

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

The Screening module is made up of two tabs:

- **Reason for Visit:** Allows you to document why the patient has an appointment and other screening information.
- **Due Reminders:** Displays due reminders from the Wellness module as health maintenance items for the patient.

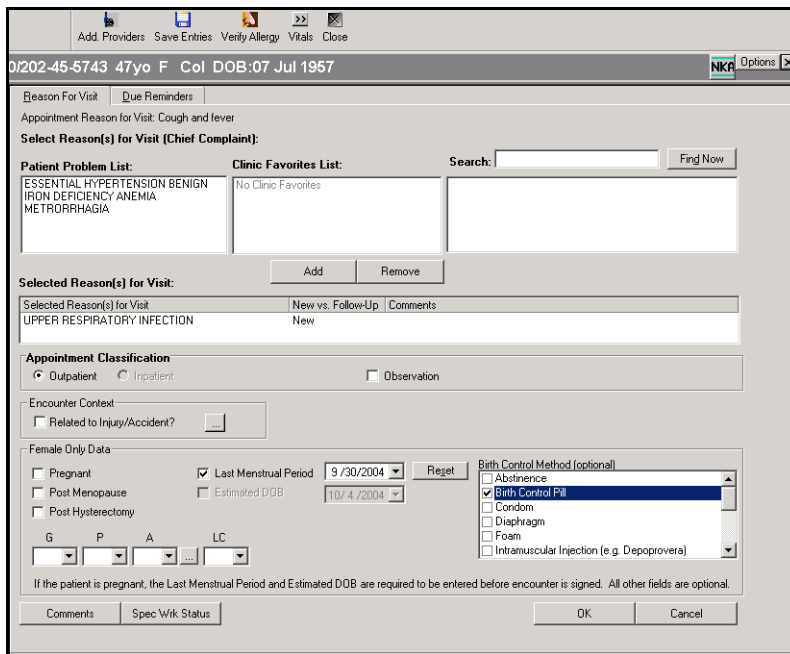


Figure 36-1: Military Clinical Desktop—Screening Module—Reason for Visit Tab

36.2 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work performed on a patient.

Follow the steps below to add an additional provider:

1. On the Action bar, click **Add Providers**. The Provider and Roles window is displayed.

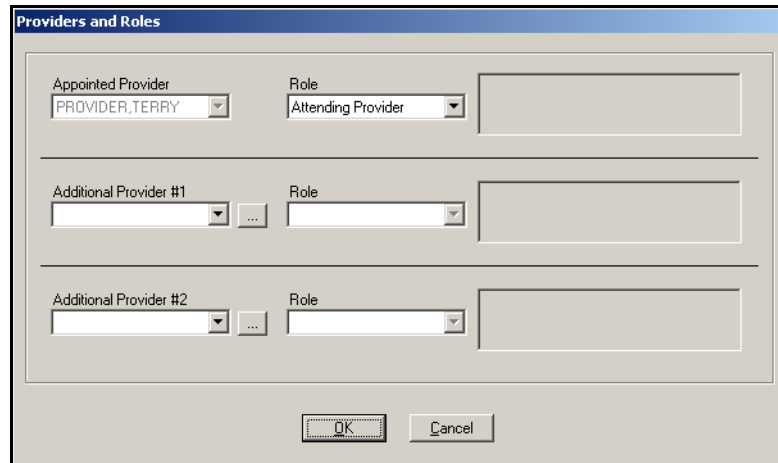


Figure 36–2: Providers and Roles Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click the **ellipsis** button to search for a provider. The Clinician Search window opens.

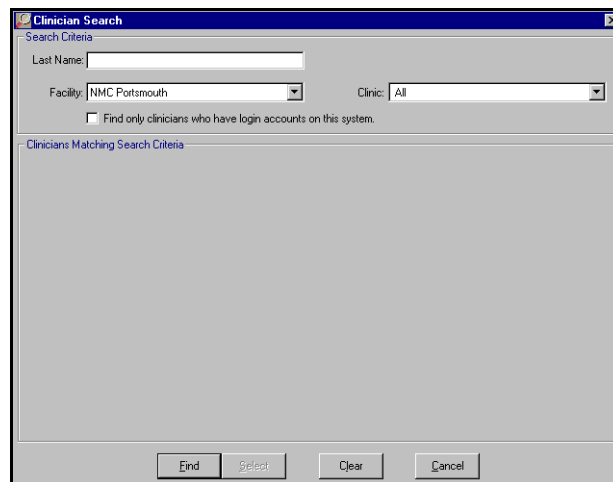


Figure 36–3: Clinician Search Window

4. In the **Last Name** field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the **Find only clinicians who have login accounts on this system** to view only providers associated with CHCS II.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the **Additional Provider** field on the Provider and Roles window.

11. Click the Role drop-down list to select the additional provider's role.

Note: Repeat steps 2-11 if you want to add a second additional clinician.

12. Click **OK**. The clinician(s) is(are) added to the appointment.

36.3 Documenting the Reason for Visit

Follow the steps below to document the reason for visit:

- On the Reason For Visit tab, select a reason for the visit from one of the following areas:
 - Patient Problem List:** Displays entire history of the patient's past problems.
 - Clinic Favorites List:** Displays a list of reasons specific to the clinic.
 - Search:** Allows you to select a reason not listed in the Patient Problem List or the Clinic Favorites List. Enter the desired reason (a minimum of two letters must be typed) in the search field and click **Find Now** to conduct a search. The search results appear in the third column.
- Click **Add**. The selected reason displays in the Selected Reason(s) for Visit area.

Figure 36–4: Reason for Visit Tab

Note: Reasons from the patient's problem list are marked as Follow-Up and reasons from the other lists are marked as New. Select the reason for visit and click in the **New vs. Follow-up** column to change the status. A drop-down list displays, allowing a new selection.

- Click inside the Comments field next to the reason for visit to enter additional comments for the selected reason for visit.

Note: You can also add general comments at the bottom of the module.

- Complete the following:

- Appointment Classification:** This is determined by CHCS and cannot be changed.
- Special Work Status:** Click **Spec Wrk Status** to view the Special Work Status window. Click the checkbox next to the applicable work status and click **Save**.
- Related to Injury/Accident?:** If the appointment is related to an injury or an accident, select this checkbox. The Date and Related Cause Code Window appears.

Tip:
For CHCS scheduled appointments, this information can be captured in the A/P and Disposition modules.

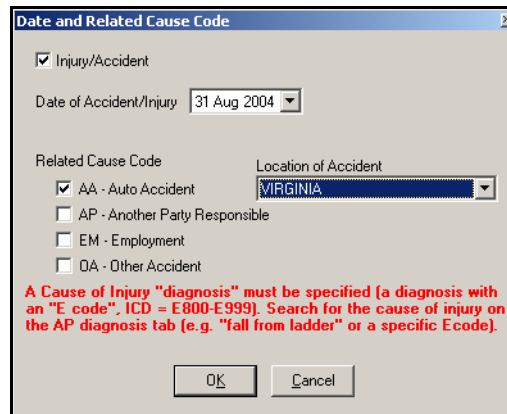


Figure 36-5: Date and Related Cause Code Window

- Complete all fields and click **OK**. Notice the checkbox indicating that the date and Related Cause Code have been entered.

Note: An encounter marked as related to an injury or accident is required to contain an e-code as one of the diagnoses. A notification will appear when you attempt to close the A/P module or sign the encounter if the encounter is marked as related to an injury or accident and no E-code (diagnosis) was selected.

- Click **OK**.

36.4 Adding Female Only Data

The fields associated with Female Only Data display for female patients 12 years of age or older.

Follow the steps below to add female only data:

1. In the Female Only Data area, select the checkboxes to all the fields that apply.

- **Pregnant**
-

Note: If the patient is pregnant, the Last Menstrual Period and the Estimated DOB are required fields.

- **Post Menopause**
 - **Post Hysterectomy**
 - **Last Menstrual Period:** Select this checkbox to activate the date drop-down field. Select the appropriate date.
 - **Estimated DOB:** Select this checkbox to activate the date drop-down field. Select the appropriate date.
-

Note: On the electronic SF600, the estimated DOB is written as the EDC (Estimated Date of Confinement).

- **Birth Control Method:** Click the checkbox next to the appropriate birth control method.
- **G, P, A, LC:** Click the drop-down list and select the appropriate value.

36.5 Verifying Allergies

In every encounter, it is important to verify the patient's current allergies. The Screening module is the only module in the workflow where you can document patient allergies in the encounter note.

Follow the steps below to verify a patient's allergies during the screening process:

1. Click **Verify Allergy** on the Action bar. You are transferred to the Allergy module.
2. Verify the patient's allergies in the Allergy module and click the **Verified this Encounter** checkbox. This documents that the allergies have been verified on the Patient Encounter.
3. Close the Allergy module to return to the Screening module.

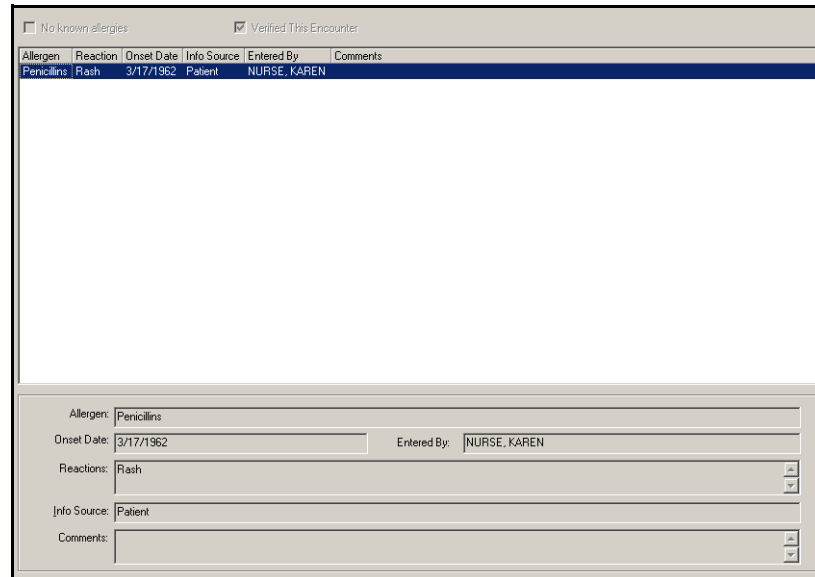


Figure 36–6: Verifying Allergies

36.6 Managing the Wellness Reminders

Wellness Reminders can be reviewed and addressed through the Screening module.

Follow the steps below to manage the wellness reminders:

1. Click the Due Reminders tab in the Screening module. A list of Healthcare Maintenance items display in the tab.

Tip:
These are the same reminders found under Healthcare Maintenance in the Reminders pan and below the Folder List on the Due Reminders tab in the Wellness module.

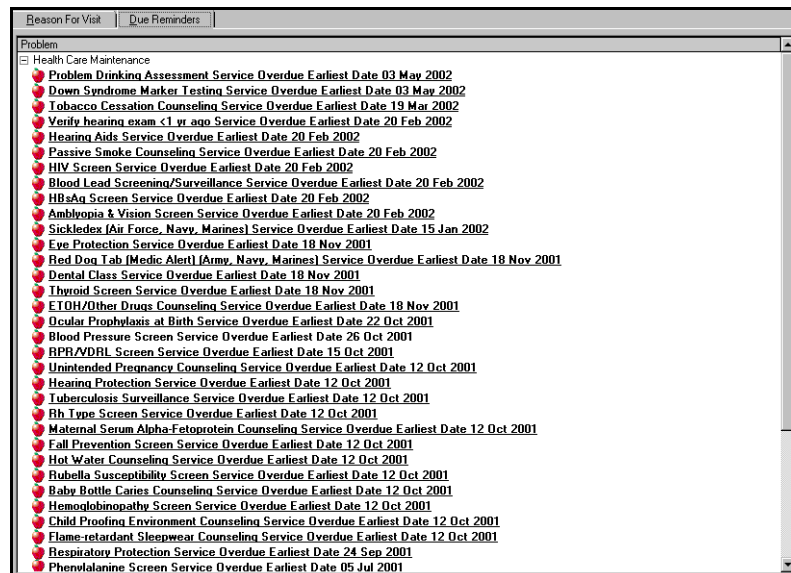


Figure 36–7: Due Reminders Tab (Screening Module)

2. Double-click a reminder. The Due Reminders tab in the Wellness module opens.

Type	Status	Earliest Date	Recommended Date	Comment
Screening				
Ambyopia & Vision Screen	Service Overdue		20 Feb 2002	
Anemia Screen	Service Overdue		02 Jul 2001	
Blood Lead Screening/Surveillance	Service Overdue		20 Feb 2002	
Blood Pressure Screen	Service Overdue		26 Oct 2001	
Down Syndrome Marker Testing	Service Overdue		03 May 2002	
Fall Prevention Screen	Service Overdue		12 Oct 2001	
HBsAg Screen	Service Overdue		20 Feb 2002	
Hemoglobinopathy Screen	Service Overdue		12 Oct 2001	
HIV Screen	Service Overdue		20 Feb 2002	
Ocular Prophylaxis at Birth	Service Overdue		22 Oct 2001	
Phenylalanine Screen	Service Overdue		05 Jul 2001	
Problem Drinking Assessment	Service Overdue		03 May 2002	
Rh Type Screen	Service Overdue		12 Oct 2001	
RPR/VDRL Screen	Service Overdue		15 Oct 2001	
Rubella Susceptibility Screen	Service Overdue		12 Oct 2001	
Thyroid Screen	Service Overdue		18 Nov 2001	
Tuberculosis Surveillance	Service Overdue		12 Oct 2001	
Counseling				
Readiness				

Figure 36–8: Due Reminders Tab (Wellness Module)

3. Document the selected due reminder.
4. When you have completed documenting the due reminder in the Wellness module, close the Wellness module to return to the Due Reminders tab in the Screening module.

37.0 SCREENING NOTIFICATION

37.1 Screening Notification Overview

The Screening Notification module allows you to notify patients via e-mail or letter when a wellness reminder is scheduled. The Screening Notification module interfaces with the Wellness module in tracking wellness reminders.

The Screening Notification module allows you to search for patients by Defense Medical Information System ID (DMIS ID) or Primary Care Manager (PCM).

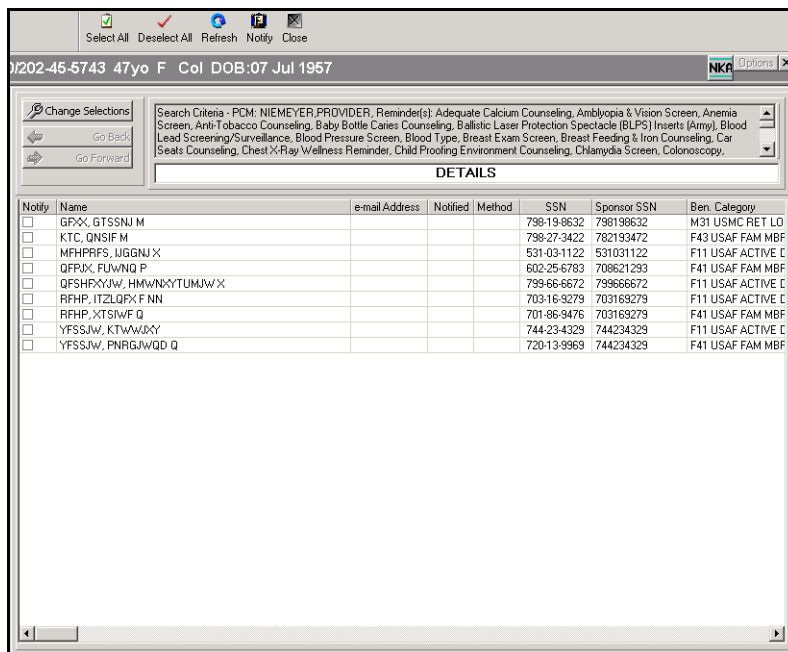


Figure 37-1: Military Clinical Desktop—Screening Notification Module

37.1.1 In More Depth

The Screening Notification module allows the user to notify patients via e-mail or letter when a wellness reminder is scheduled. The Screening Notification module interfaces with the Wellness module in tracking wellness reminders. Patients listed in the Screening Notification module have a date in the corresponding wellness reminder column that determines when they need to be notified. Patients can be searched for by DMIS ID or PCM. The user can notify patients by e-mail or letter. The Properties dialog box is used to determine how the patient is notified. The properties selected become the user's default settings.

Screening service results depend on the selected wellness reminder and the number of patients scheduled to be notified for the reminder. Viewing results for an entire DMIS ID may produce extensive feedback and take an extended amount of time; therefore, it may be more beneficial to view results for a specific PCM.

37.2 Selecting Screening Notification Reminder Search Options

Screening service results depend on the selected wellness reminder and the number of patient(s) scheduled to be notified for the reminder. Viewing results for an entire DMIS ID may produce extensive feedback and take an extended amount of time; therefore, it may be more beneficial to view results for a specific PCM.

Follow the steps below to select Screening Notification reminder search options:

1. Click **Change Selections**, the Screening Notification Reminder Search Options window opens.

Screening Notification Reminder Search Options

Select reminder types for which you want to notify the patient if they are overdue or coming due.

Available Reminder(s)

- Adequate Calcium Counseling
- Amblyopia & Vision Screen
- Anemia Screen
- Anti-Tobacco Counseling
- Baby Bottle Caries Counseling

Selected Reminder(s)

Define Source

DMIS ID

PCM

Narrow Result(s) By Due Date

Include Patients Who Have Been Previously Notified

Method

Narrow Result(s) By Date Notified

Figure 37–2: Screening Notification Reminder Search Options Window

2. In the **Available Reminder(s)** list, select the reminder(s).

-
3. Click the **Associate Down Arrow** button to move the reminder to the **Selected Reminder(s)** list.

Note: Select the available reminders while pressing the **Ctrl** key on your keyboard to select multiple reminders.

Note: Clicking the **Associate All Down Arrow** button moves all the Available Reminders to the Selected Reminders list.

Note: Selected reminders can be removed from the Selected Reminders list by selecting the selected reminders and clicking the **Unassociate Up Arrow** button.

4. Do one of the following:
 - If you want to search by DMIS ID, select the DMIS ID radio button and click **Search**.
 - If you want to search for patients associated with a primary care manager, select the **PCM** radio button and click **Search** to search for the provider.

Note: Performing a search for patients associated with a DMIS ID may take an extended period of time.

5. If you want to filter reminders by reminder date, select the **Narrow Result(s) By Due Date** checkbox and select the applicable date range.
6. If you want to include patients who have already been notified, select the **Include Patients Who Have Been Previously Notified** checkbox.
7. Select a **Method** of notification from the drop-down list.
8. If you want to filter reminders by notification date, select the **Narrow Result(s) By Date Notified** checkbox and select the applicable date range.
9. Click **OK**.

Notify	Name	e-mail Address	Notified	Method	SSN
<input type="checkbox"/>	ALEXANDER, EDWARD P				213-55-423
<input type="checkbox"/>	ALEXANDER, EVELYN L				647-09-762
<input type="checkbox"/>	ALEXANDER, MARIE D				213-56-421
<input type="checkbox"/>	ALEXANDER, SAMANTHA R				000-00-003
<input type="checkbox"/>	ALEXANDER, VIOLET W	violet@chcsii.com			202-45-574
<input type="checkbox"/>	BERG, LEE T				000-00-002
<input type="checkbox"/>	BERG, OLAF V	OLAF@CHCSII.COM			245-63-694
<input type="checkbox"/>	CHANG, ESTER M				788-27-904
<input type="checkbox"/>	CHANG, INDIRA L				000-00-002
<input type="checkbox"/>	CHANG, JON S	jon@chcsii.com			732-67-923
<input type="checkbox"/>	CHANG, MAMDOUH R				789-56-557
<input type="checkbox"/>	CLOUD, APRIL				000-00-002
<input type="checkbox"/>	CLOUD, HEATHER	heather@chcsii.com			645-21-005
<input type="checkbox"/>	CLOUD, LANCE				877-32-811
<input type="checkbox"/>	CLOUD, ROSE				536-65-211
<input type="checkbox"/>	MARCOS, FREDERICK B				532-97-362
<input type="checkbox"/>	MARCOS, RAMONA D	ramona@chcsii.com			013-97-987
<input type="checkbox"/>	SUAREZ, BONITA S	bonita@chcsii.com			000-00-002
<input type="checkbox"/>	SUAREZ, EDUARDO A	eduardo@chcsii.com			454-72-321
<input type="checkbox"/>	SUAREZ, JOSE Q				000-00-003
<input type="checkbox"/>	SUAREZ, MARIA E				626-78-443
<input type="checkbox"/>	SUAREZ, MIGUEL E				444-34-978
<input type="checkbox"/>	SUGARMAN, REGINALD T	reginald@chcsii.com			575-34-216
<input type="checkbox"/>	WILLIAMS, BERNICE K	bernice@chcsii.com			645-92-004
<input type="checkbox"/>	WILLIAMS, CLAYTON U	clayton@chcsii.com			967-62-886
<input type="checkbox"/>	WUNDERLICH, ANNA W	anna@chcsii.com			223-76-089
<input type="checkbox"/>	WUNDERLICH, GERTHA M				000-00-002

Figure 37-3: Screening Notifications

37.2.1 Setting the Options for Notifying Patients

You can notify patients by e-mail or letter. The Notification Options window lets you establish how you are going to notify patients. The options you select are your default properties each time you access the Screening Notification module.

Follow the steps below to set the options for the Screening Notification module:

1. On the Screening Notification module, select a patient from the list and click **Notify** to open the Notification Options window.

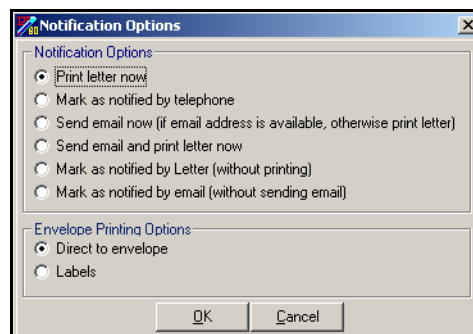


Figure 37-4: Screening Notification Options Window

2. Select a Notification option.

Note: If you select E-mail, the Envelope option remains selected but does not affect e-mails. All other options require you to select the Envelope or Label option for mailing letters.

3. Click **OK**.

37.3 Notifying Patients about Screening Services

Patients listed in the Screening Notification module have a date in the corresponding wellness reminder column that determines when they need to be notified, either by e-mail, letter, or both.

Follow the steps below to notify patients about future screening services:

1. Select a patient or patients and double-click the **Notify** checkbox.
2. Click **Notify** to open the Notification Options window.
3. Select a notification option and click **OK**.
 - If you are notifying the patient by letter, the Print Preview window opens displaying a form letter for the patient you are notifying.

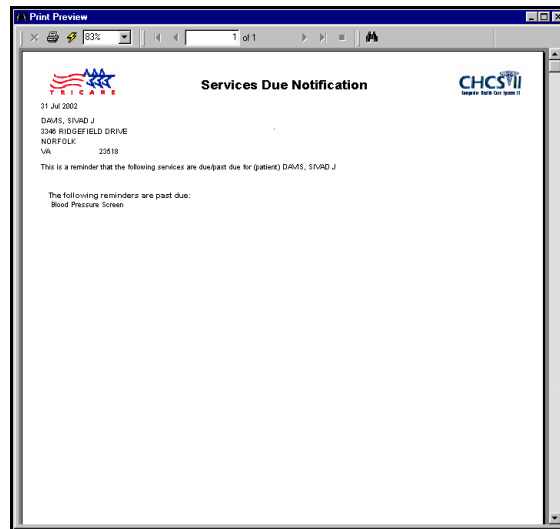


Figure 37-5: Print Preview Window

- Click the **Print** icon.
- On the Print window, click **OK**. The letter(s) is sent to your designated printer.
- If you are printing labels, a Notification Reminders window opens. Click **Yes** when you have manually loaded the printer with label-specific paper. Click **No** if you are not printing envelope labels.

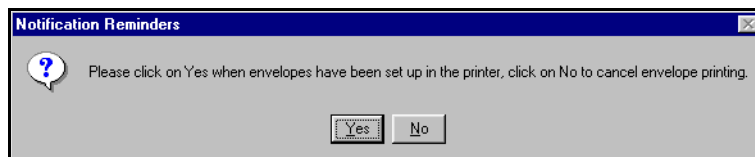


Figure 37-6: Notification Reminders Window

Tip:
 The patient's postal and e-mail addresses are maintained in the Demographics module and can be modified, if necessary.

- If you are notifying the patient by e-mail, the E-Mail Notifications window opens. Click **Yes** to send the patient a form e-mail notifying him/her of the due screening service(s).

Note: The letter and e-mail notifications contain the same information, they are just sent using different methods.

38.0 SUBJECTIVE/OBJECTIVE (S/O)

38.1 Subjective/Objective Overview

The S/O module is used to document the S/O portion of the note. Terms to describe the exam findings are available to select into the note. Each term is coded and those codes are one of the elements used to determine the E&M code in the Disposition module. Templates are used to rapidly document the patient visit. Once the exam is documented and saved, the notes appear in the Encounter module.

The S/O module provides you with two different ways to document the encounter: with an S/O template or with an S/O Form. Each of these means enables you to document your findings with structured terms for a patient encounter and enables you to produce accurate and complete coding. Templates can be either user-created or provided with the system, while the forms are provided to each clinic and MTF by the appropriate service. In this chapter we cover using both templates and forms to document the S/O portion of an encounter.

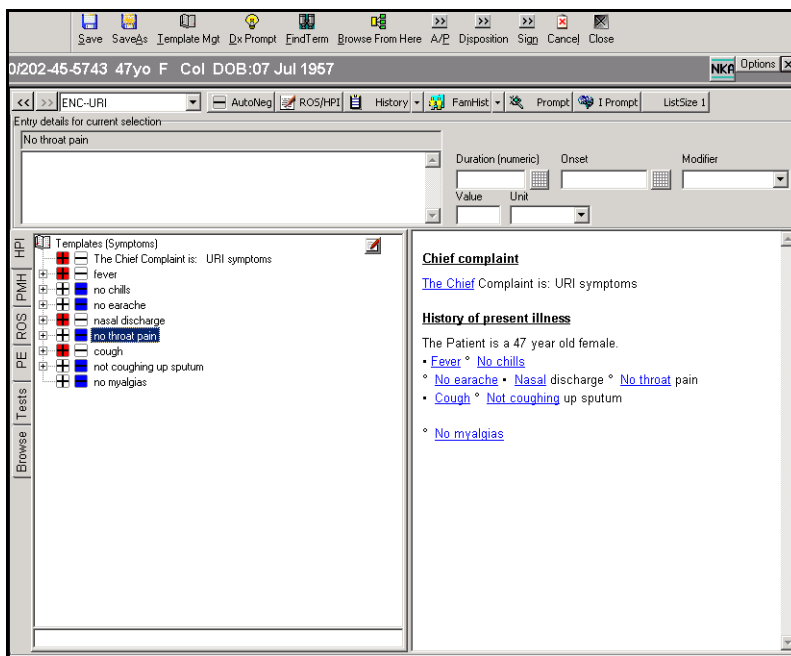


Figure 38–1: Military Clinical Desktop—Subjective/Objective Module

Note: The use of this software is not intended to suggest or replace any professional medical judgment, decisions, or actions with respect to a patient's medical care. The user of this software must monitor and verify the input to the software and determine the accuracy, completeness, or appropriateness of any diagnostic, clinical, or medical information, or other output provided by the software.

38.1.1 In More Depth: Navigating and Using S/O

To navigate and use the S/O module, you need to be comfortable with several key concepts.

38.1.1.1 Navigating within the Module

To navigate within the module, simply use the S/O module tabs located along the left margin of the workspace. These tabs correspond to the basic functional areas of S/O and the sections in the encounter document and note.

38.1.1.2 Adding Terms

To add a term to the note, simply select the large plus or minus sign. When selected, this sign becomes red (+) or blue (-). There are exceptions for more advanced users, but generally, adding a term as positive means that it is an abnormal finding and adding a term as a negative denotes a normal finding.

38.1.1.3 Using the S/O Toolbar (Dashboard)

The S/O toolbar is a sophisticated and essential component of S/O documentation. It enables you to add a range of detailed and explanatory information to any term you add. As you'll see in this lesson, selecting a term in the MEDCIN hierarchy populates the term in the dashboard.

This means that the dashboard is focused on that term. The various elements of the dashboard represent different functions for adding to or modifying the selected term.

We use this dashboard to add free-text to a note, document the duration of a condition, and specify a term as a family history term. And perhaps most importantly, in this lesson you learn how to use **AutoNeg** to rapidly document normal findings.

38.1.1.4 Using the Narrative Pane

To the right of the S/O module is the narrative pane, which displays the narrative for this encounter based on the terms selected and the modifiers added to these terms. The narrative as it appears in this pane, is identical to the narrative that appears in the encounter note.

In terms of an S/O workflow, these four key concepts work together to create an effective tool that is easy to use:

1. Use the tabs to get where you need to be.
2. Use the MEDCIN terms to document the patient visit.
3. Use the toolbar to add detailed and specific information to a selected term.
4. Use the narrative pane to see how your documentation is read in the encounter note.

38.1.2 S/O Templates Overview

Use of a template to document a patient visit is a key feature of CHCS II. Template use greatly streamlines the documentation process and ensures that coding is accurate and complete when the encounter is done.

A template pre-positions clinical terms for rapid entry and reflects how providers typically document encounters. If a template is created correctly, a provider should be able to, with minimal clicks, document a normal exam. Personal templates should be built and utilized to use the S/O module efficiently. Templates should match the common visit types you see and include terms from each of the following:

- **Physical Exam (PE) Templates:** A good PE template includes items that are typically reviewed for each physical exam.
- **Review of Systems (ROS) Templates:** Each provider has a list of questions that is asked of every patient in regards to the ROS. Therefore, the template should reflect those questions. One comprehensive ROS template can be built with every possible finding included or several focused ROS templates can be built to deal with “oh, by the way” situations.
- **Past Medical History (PMH) Templates:** The PMH templates deal with common questions concerning previous hospitalizations and family and social history. Again, findings should be selected that reflect what you normally ask the patient. A good set of PMH templates should include generic adult, generic pediatric, generic adult male, and generic adult female.
- **Procedure (PROC) Templates:** Procedure templates are blocks of free-text that cover routine procedure, education, and informed consent notes. These can be added using the free-text icon from the PE tab or by typing the free-text to an actual term (e.g., attaching a procedure note to the term *skin biopsy*).
- **Visit Templates:** These templates are built for the most common types of diagnoses of the clinic. They are the most comprehensive of the five types and are made up of a PE, ROS, PMH, and PROC template. Also included is the history of present illness (HPI) and chief complaint.

38.1.3 Putting It into Practice

When a patient has a common reason for an appointment, for example, asthma follow-up, the provider simply loads the Asthma Visit Template that contains the appropriate component templates (PE, ROS, PHM, PROC). If in the process of the exam, the patient complains of a sore throat, the provider can load just the Sore Throat, ROS-focused template to document the “oh, by the way” symptom.

38.1.4 Selecting an S/O Template

The most efficient way to document the S/O note is to use an S/O visit template that you have customized. Once a template is loaded, there are various approaches to document findings from certain tabs. Generally, positive or abnormal findings are documented first in order to capitalize on the AutoNeg function. This can be done on the HPI, ROS, and PE tabs. Care needs to be taken when documenting from the ROS tab

if using a comprehensive ROS. You should not use AutoNeg because of the large size and improbability of asking about all the terms.

Follow the steps below to select an S/O template:

1. Click **Template Mgt.** from the Action bar to view the S/O Template Management module.

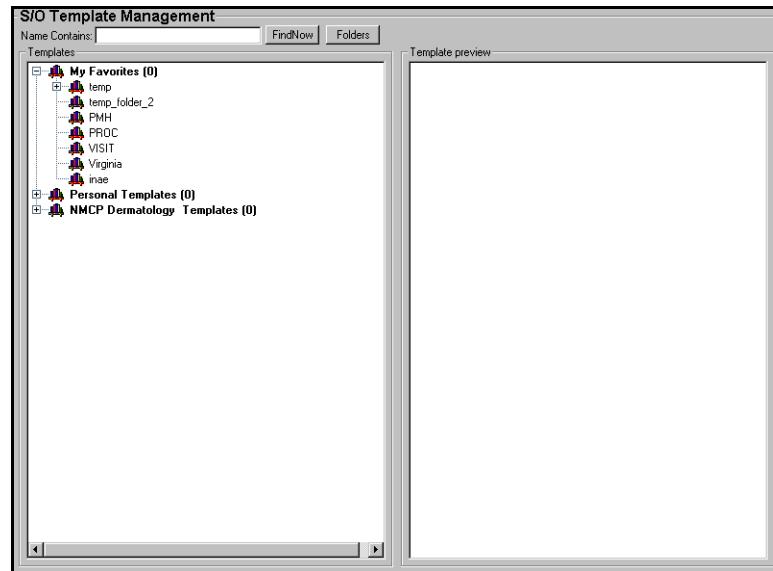




Figure 38–2: S/O Template Management Module

2. Search for the desired template by typing in the name or type of the template (URI, visit).
3. Click **Find Now** to view the templates that meet the search criteria.
4. Select the template and click **Load** on the Action bar.

Note: S/O templates are displayed with the  icon. The  icon delineates an S/O Form.

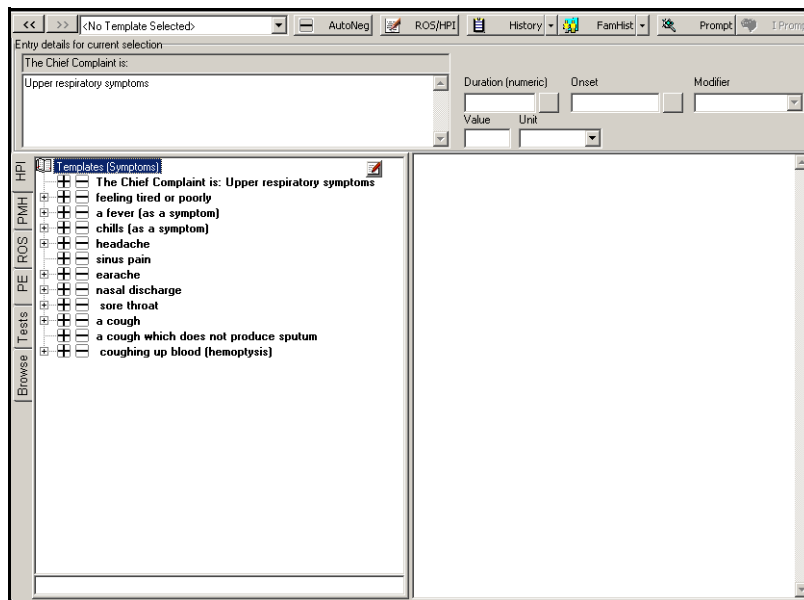


Figure 38–3: Loaded Template

- After a template is loaded, terms from the template are displayed on the appropriate tabs. If there is a small plus sign next to a parent term, click it to expand the list and view the associated children terms. A small minus sign indicates the term has been expanded completely.

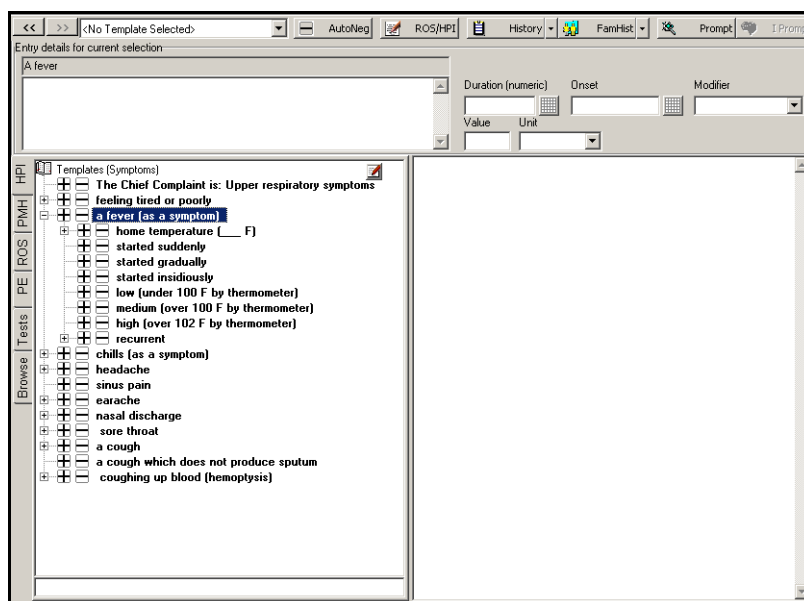


Figure 38–4: Parent/Child Relationship

38.1.5 Documenting from the HPI Tab

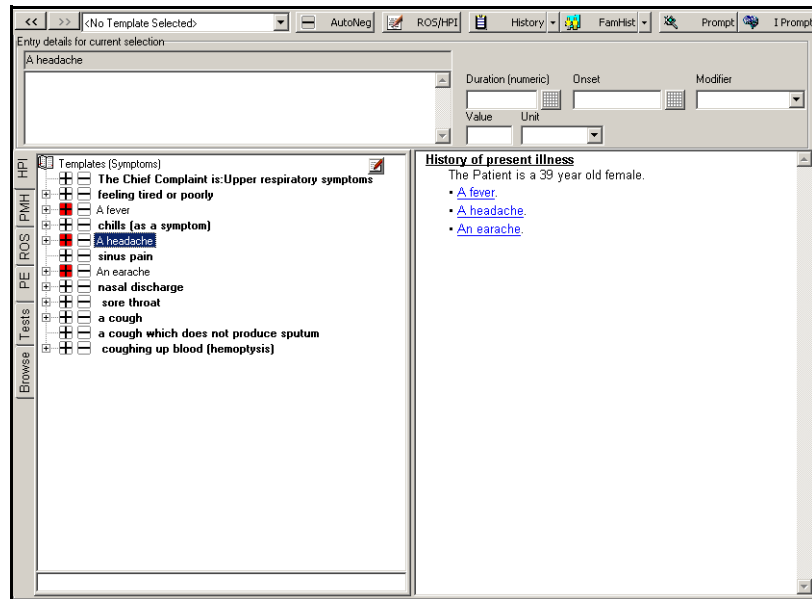


Figure 38–5: HPI Tab

Follow the steps below to document from the HPI tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term. The selected terms are added to the Narrative pane under the History of Present Illness (HPI) heading.
2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal findings.

Note: One can document rapidly and accurately using the AutoNeg function. This is active only for the Symptoms, Review of Systems, and Physical Exam tabs. Clicking **AutoNeg** enters all the top-level, parent findings in the list as negative or normal. This is extremely helpful for physical exams and review of systems.

3. Click the opposite sign to change a finding. Click the sign that was selected to delete it.
4. If desired terms are not present on the template or the HPI needs to be characterized, a subjective free-text note can be added. Click the **Notepad** icon in the upper right corner of the findings list.
5. Enter the note.

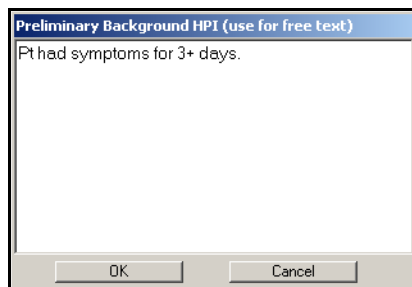


Figure 38–6: S/O Notepad

- Click **OK** to add the note to the encounter.

38.1.6 Documenting from the PMH Tab

In order to document from the History (PMH) tab, simply add positive or negative responses to the terms by clicking the large plus or minus sign.

Note: The AutoNeg function cannot be used on the PMH tab.

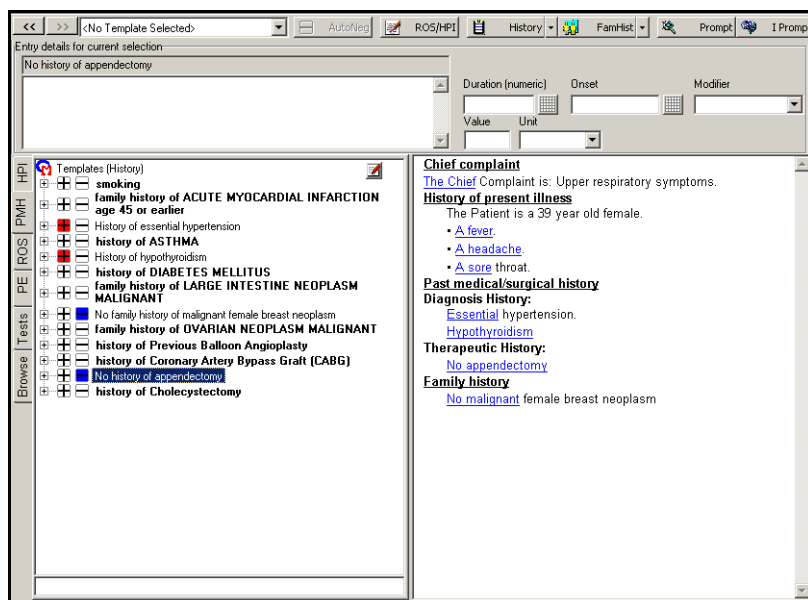


Figure 38–7: PMH Tab

38.1.7 Documenting from the ROS Tab

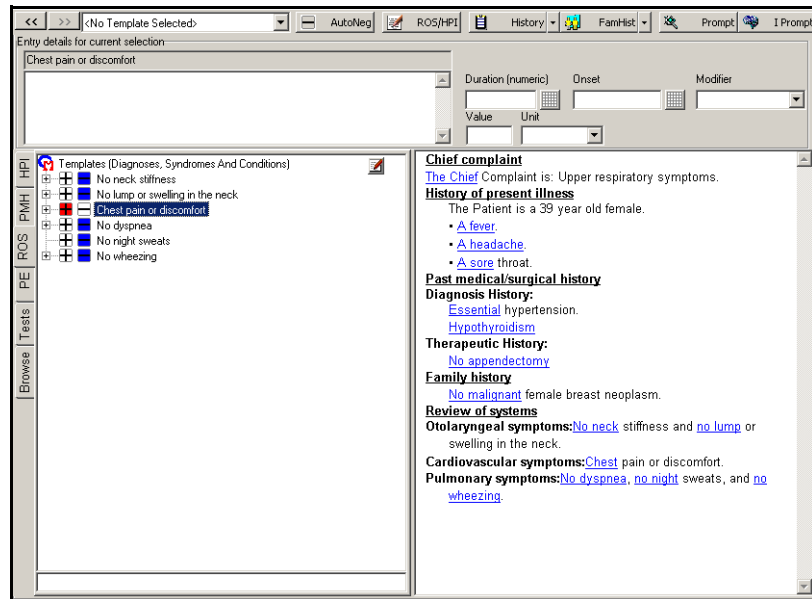


Figure 38–8: ROS Tab

Tip:

Flipping can be used with the ROS. Highlight a term and then click **ROS/HPI** from the Dashboard. This moves the term from the Review of Systems heading to the History of Present Illness heading and back again.

Follow the steps below to document from the ROS tab:

1. If using a focused ROS template, document the positive or abnormal findings first by clicking the large plus sign next to the term. Click **AutoNeg** to document the rest of the findings as normal.
2. If using a comprehensive ROS template, document both the positive and normal findings. Never use AutoNeg with a comprehensive ROS because all of the terms are not addressed in the course of an encounter.

38.1.8 Documenting from the PE Tab

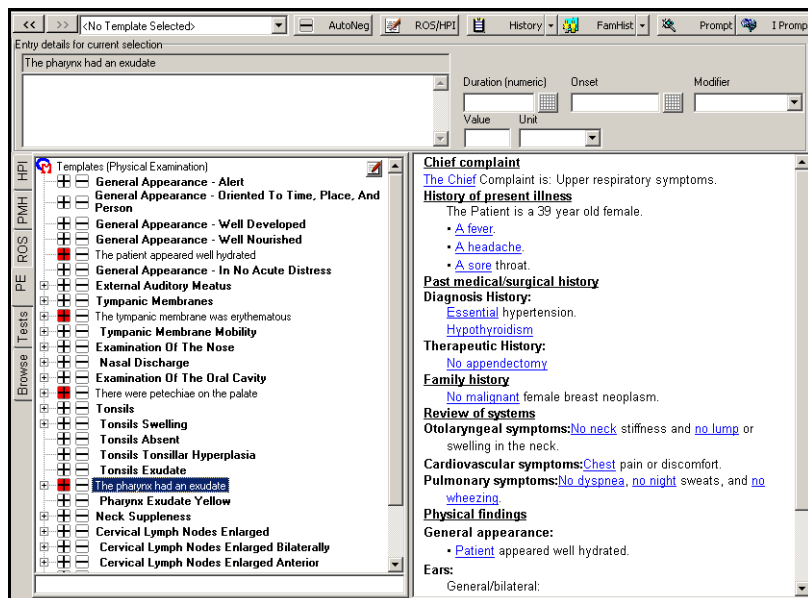


Figure 38–9: PE Tab

Follow the steps below to document from the PE tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term.
2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal.

Note: The use of the AutoNeg function assumes the template has been customized to fit your workflow. If you own the template, the narration for normal findings is already known and can be added with confidence.

3. Once all findings are documented, click **Close** to save the note and return to the Encounter.

38.1.9 Adding Details to a Finding

Once a term has been selected from the findings list, it is displayed in the **Entry details for Current Selections** field and in the Narrative pane. Use the S/O Tool bar or the Dashboard to further explain the finding.

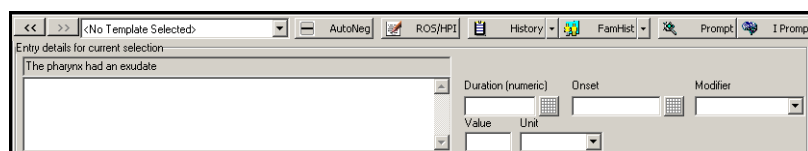


Figure 38–10: Toolbar and Dashboard

Tip:

If the button is not appropriate for the selected finding, it is grayed out.

Follow the steps below to add details to a finding:

1. Select the term in the **Findings** list.
2. Select the desired detail or modifier:
 - **ROS (Review of Systems):** Flips the highlighted finding between the Review of Systems and History of Present Illness headings.
 - **History:** Sets the prefix to **History of**, then adds the current finding to the documentation.
 - **Family History:** Sets the prefix to **Family History of** then adds the current finding to the documentation.
 - **Entry Details for Current Selection Free-Text Field:** Enter in any additional information in the free-text field next to the **Entry Details For Current Selection** field and press **Enter**. The ellipse button displays the entire free-text field.
 - **Duration and Onset:** Click the **grid** to enter the associated date.
 - **Modifier and Unit:** Access the pull-down menus to add the adjective to the finding.
 - **Value:** Enter in the appropriate value.

38.1.10 Using the Search Capabilities

Use one of the following tools to search for specific terms or to dynamically build a Visit template. Each tool is found on the Action bar.

38.1.10.1 Find Term

This feature searches for a term in the MEDCIN terminology. This conceptual search returns terms relevant to the search text regardless of spelling. Abbreviations such as HTN (hypertension) or CHF (congestive heart failure) are recognized.

1. Click **Find Term** from the Action bar to view the Search String window.

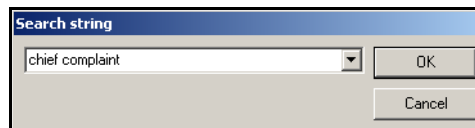


Figure 38–11: Find Term Search String

2. Enter the desired term and click **Search**.

38.1.10.2 Dx Prompt

This feature creates a list of findings based on one or more selected diagnoses. This is helpful when adding the history of present illness to a visit template or when building a visit template on the fly.

1. Click **Dx Prompt** from the Action bar to view the Search String window.

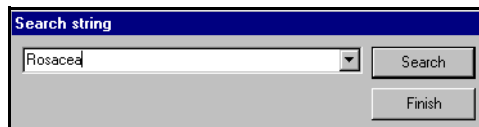


Figure 38-12: Dx Prompt Search String

2. In the Search String window, enter the diagnosis and click **Search**.
3. In the Select Diseases for Consideration window, select the appropriate disease and click **OK**. A template relevant to the term selected is displayed. Use the **List Size** button to control the number of terms on each tab.

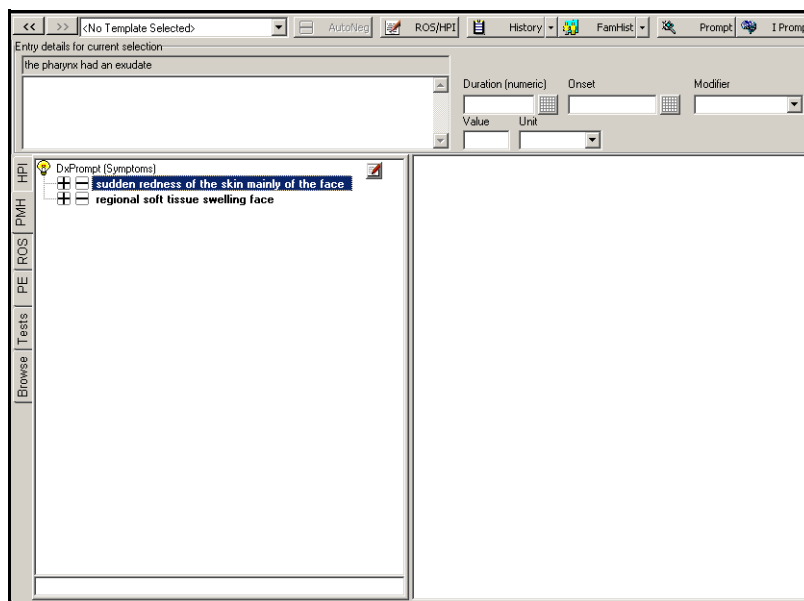


Figure 38-13: Select Diseases for Consideration

38.1.10.3 Prompt

This feature builds a finding list based on a single highlighted term.

1. Highlight a term from the Findings list.
2. Click **Prompt** on the S/O Tool bar.

38.1.10.4I-Prompt (Intelligence Prompt)

This feature builds a list of terms based on the documentation in the Narrative pane. Once terms have been documented, click **I Prompt** on the S/O Tool bar to view a list of additional terms that might also be considered.

Tip:
This tool is helpful for multi-symptom patients. You may want to see a list of relevant terms for consideration to help document the note.

38.1.10.5List Size

This feature creates a broader or narrower list of findings. Three levels exist: short (List Size 1), medium (List Size 2), and long (List Size 3). Use List Size after conducting a Find Term, Prompt, Dx Prompt or I Prompt.

38.1.10.6 Browse from Here

This feature displays the highlighted finding as it appears within the MEDCIN terminology. Related Findings can be seen and selected.

Tip:
The *Browse from Here* function is helpful when locating PE terms.

1. From the Findings list, select the term to be located.
2. Click **Browse from Here** on the Action bar.

38.1.11 Importing/Exporting an S/O Template

An S/O template can be imported or exported from other facilities using CHCS II.

Follow the steps below to export an S/O template:

1. From the S/O Template Management module, select the template to export.
2. Click **Export** from the Action bar to view the Export S/O List Template window.

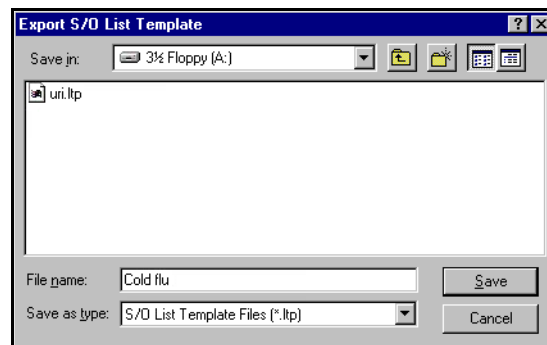


Figure 38–14: Export S/O List Template Window

3. Select the desired location for the template, type in the name of the template, and click **Save**.

Follow the steps below to export multiple templates:

1. Select the templates to export by holding down the **Ctrl** key.
2. Click **Export** from the Action bar to view the Select Export Path window.

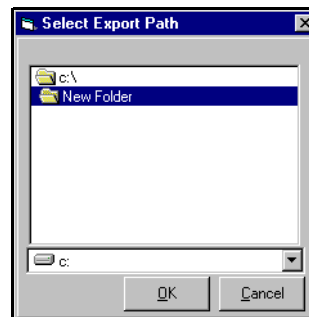


Figure 38–15: Select Export Path Window

3. Select the location for the exported templates and click **OK**.

Follow the steps below to import a template:

1. From the S/O Template Management module, click **Import** from the Action bar to view the Import MEDCIN Template window.

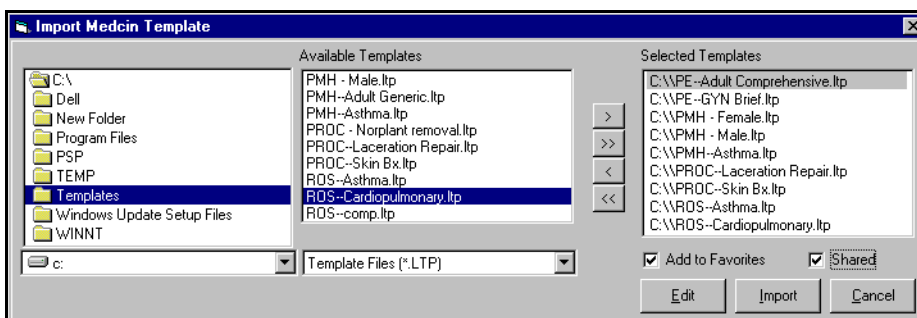


Figure 38–16: Import MEDCIN Template Window

2. In the left pane, navigate to the location of the template(s). Once the location is determined, the available templates are displayed.
3. Select the template(s) to be imported and use the arrow keys to move the templates to the Selected Templates column.
4. Click **Import** to save the template(s) as is. Click **Edit** to open the template in Template Edit mode to add or remove terms prior to saving.

Note: If a template currently exists with the same name as a template being imported, a message is displayed asking whether or not to override the existing template.

38.2 S/O Template Creation Overview

CHCS II contains a list of common templates as a starting point. Though these are helpful, clinicians need to customize their own templates to optimize the use of the application in clinical practice. Templates are the key to rapid documentation and accurate coding.

The first step to creating a useful set of templates is to create a template for the physical exams that are commonly used. One can build any type of physical exam template. The most important factor in template creation is to build exams that reflect what you do.

Once you build your common physical exam templates, you can move on to ROS, PMH and Free Text templates. These are then combined to create Visit Templates. These are created for common visit types and chronic diseases seen in the clinic. They typically use the physical exam templates previously created as building blocks. It is important also to create ROS templates.

38.2.1 Creating a Physical Exam Template

When building a PE template, keep in mind the AutoNeg function. If a template is built correctly, documentation of a normal PE can be done by clicking **AutoNeg**.

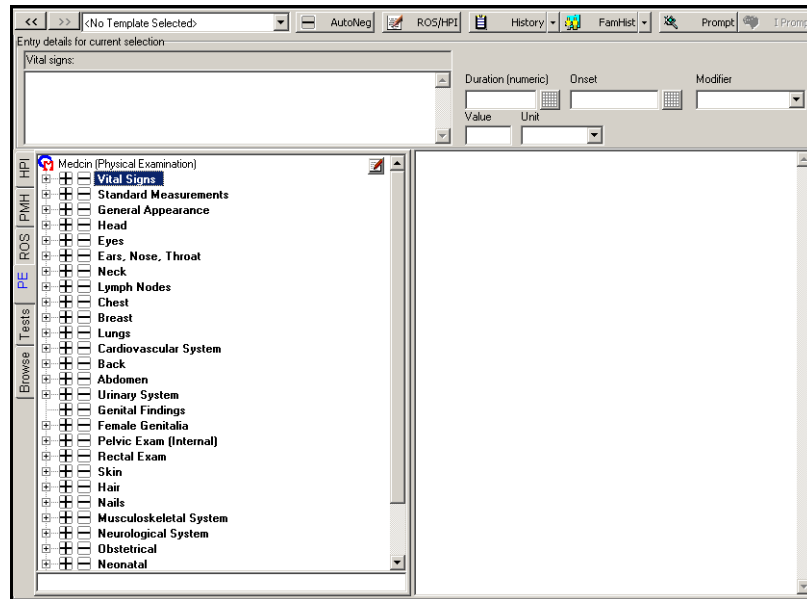


Figure 38–17: Physical Exam Template

Follow the steps below to build a Physical Exam template:

1. Load an appropriate PE template from the Starter Kit.
2. Click the PE tab to view the list of physical exam findings.
3. Add terms from the Starter Template that match your documentation style. Only the terms in the Narrative pane are saved as the template. It does not matter which sign (+ or -) is selected. Both options are available when using the template.

Tip:

To load a template, click **Templates** from the Action bar. Search for the desired template by typing in the type of the template (PE). Click **Find Now** and then double-click the desired template to load it.

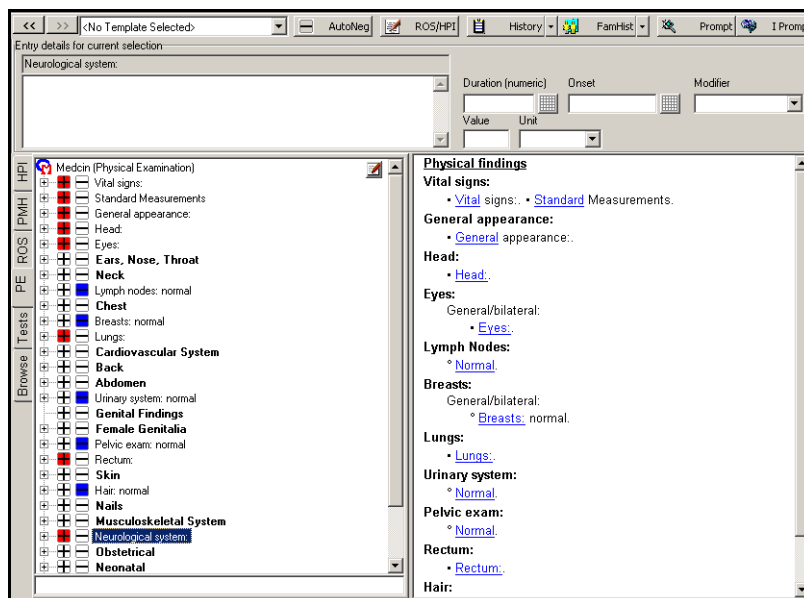


Figure 38–18: Starter Template Terms

4. When adding findings to a template, keep in mind the following hints:
 - **Browse from Here:** Use the **Browse from Here** icon from the Action bar to quickly locate terms for the PE. Highlight a term from the Starter Template and click **Browse from Here**. The highlighted term is displayed as it appears in the MEDCIN hierarchy. This enables access to other terms related to the highlighted term.
 - **Bilateral Structures:** When adding terms to document bilateral structures, drill down to the right-left level of the hierarchy. This enables you to document on either the right or left side.

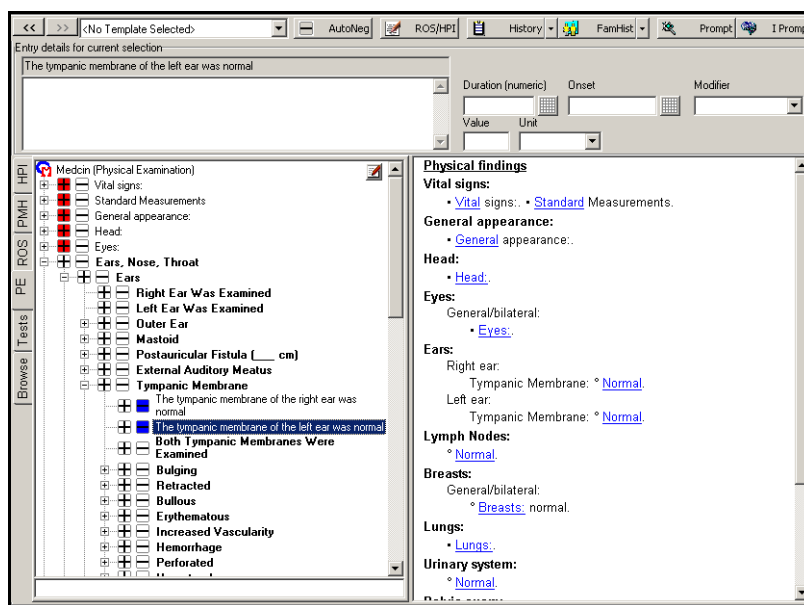


Figure 38–19: Bilateral Structures

- **Common Positives:** Common positives are findings that are frequently abnormal in a provider's exam. In order to add these terms to a template to allow for easy selection, add the parent findings as normal (click the large plus sign) and select the children findings as abnormal (click the large minus sign). In the template, the children findings are the common positives.
 - **Free-text added to a Term:** Free-text can be added to an individual finding for clarification. For example, if the finding 'Lymph Node: Normal' needs to be clarified to state there are no nodules present, highlight the finding Lymph Nodes: Normal and enter the desired text in the free-text field in the dashboard. Press **Enter** to add the note to the Narrative pane.
5. For hard to find terms, use the Find Term function from the Action bar. Click **Find Term**, enter the desired term, and click **Search**.
 6. When all findings used for a typical physical exam are selected, click **Save As** from the Action bar to view the Save List Note Template window.

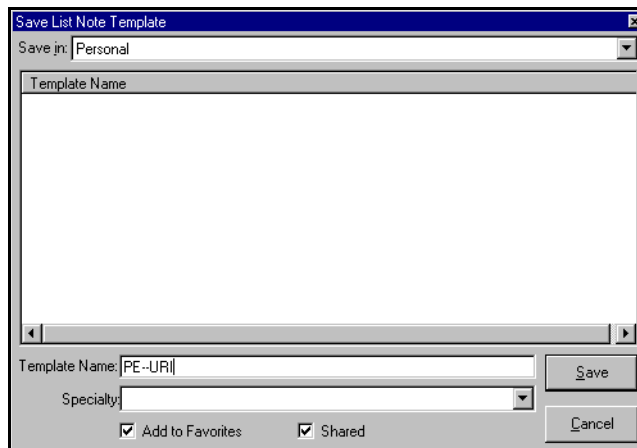


Figure 38–20: Save List Note Template Window

7. On the Save List Note Template window, enter the name of the template using the convention 'PE--[name].' This groups the component templates together so they can be easily found.
8. The template is automatically added to your Favorites List (unless the checkbox is deselected). Select the **Shared** checkbox to make your template available to other clinical team members.
9. Click **Save** to save the template. **Cancel** closes the module without saving the template.
10. In order to test the template, load it into the encounter, click the PE tab, and click **AutoNeg**. The resulting note should display an accurate narrative for a normal exam. Those findings that are not selected should be the findings that are used to document any abnormalities. When using this template to see patients, document the abnormalities first and then click **AutoNeg** to denote all other findings as normal.

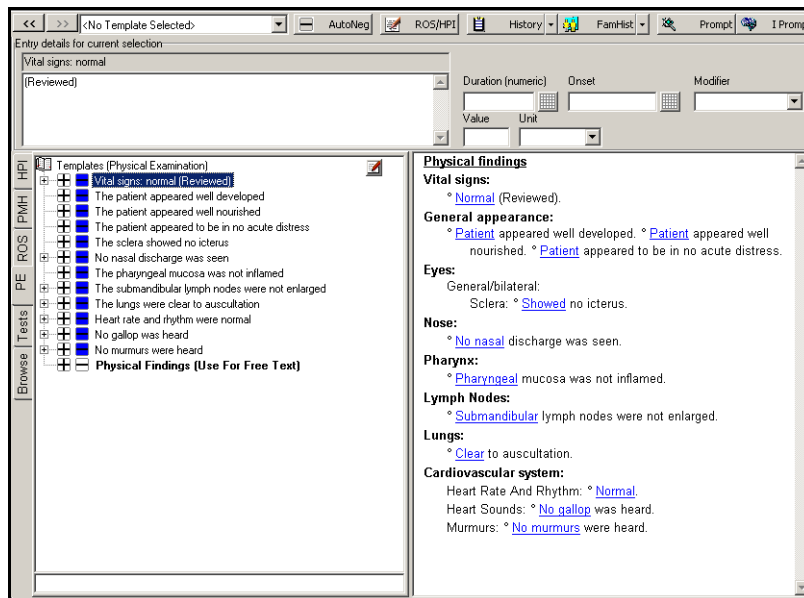


Figure 38–21: PE Note

38.2.2 Creating a Focused ROS Template

Focused ROS templates are used for specific visits, complaints, or organ systems, including depression, headache, and cardiopulmonary. Due to the short, focused nature of these templates, the AutoNeg function is especially useful.

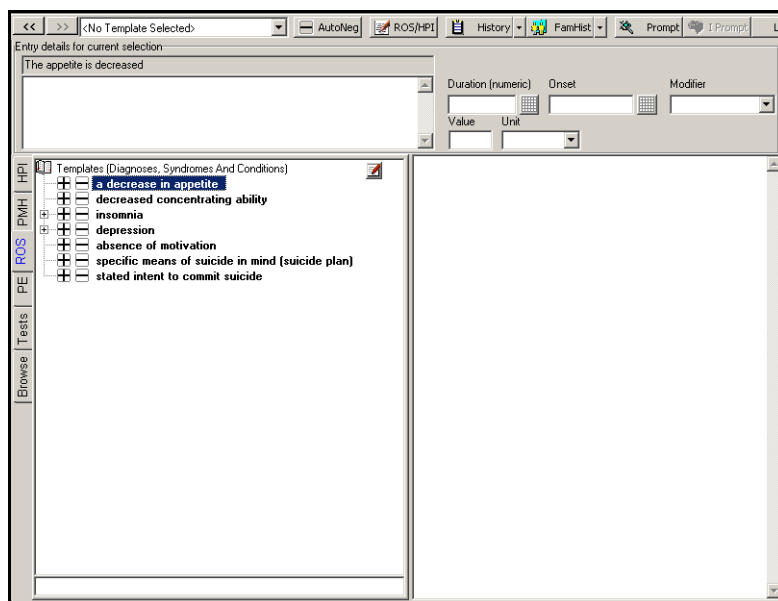


Figure 38–22: Focused ROS Template

Follow the steps below to build a focused ROS template:

1. Load an ROS template from the Starter Kit or start from scratch.
2. Use one of the following techniques to add terms to the template:

- If building the template around an organ system, select terms from the ROS tab (e.g., Pulmonary).
 - If building the template around a complaint or a disease, use the **Find Term** function and the **Single Prompt**.
 - **Find Term:** Click **Find Term**, enter the desired term, and click **Search**.
 - **Single Prompt:** Builds a finding list based on a single highlighted term (e.g., dizziness). Highlight the term and click **Prompt** from the Dashboard.
3. Be sure the terms emit into the Narrative pane under the Review of Systems heading. Each time a Find Term or Single Prompt is completed, the HPI tab becomes the default. Click the ROS tab prior to making the selection of a term to ensure the correct heading. If a term does fall under the HPI heading, highlight the term in the Narrative pane and click **ROS/HPI** from the dashboard to flip the term down into the ROS.
 4. Click **Save As** from the Action bar to save the template. Name the template 'ROS-[name].'
 5. Test the template by loading it into a clean note and clicking **AutoNeg**. The result should be a normal ROS.

38.2.3 Creating a Comprehensive ROS Template

Comprehensive ROS templates are a large repository of symptoms that can be used in the HPI or ROS. AutoNeg should not be used with the Comprehensive ROS due to the size of the list. The ROS—Comprehensive component is used in the Generic Visit template to act as a starting point for both the HPI and ROS.

Follow the steps below to build a comprehensive ROS template:

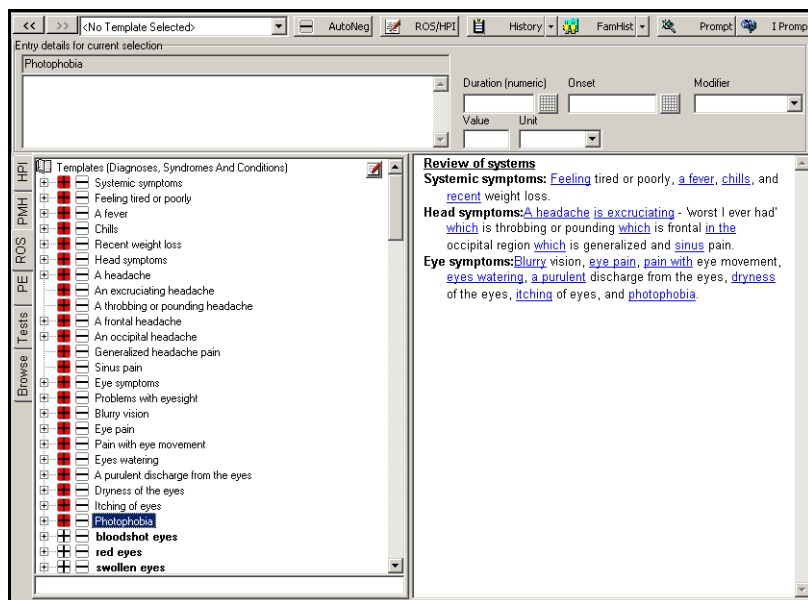


Figure 38–23: Comprehensive ROS Template

1. Load the **ROS--Comprehensive** template from the Starter Kit.
2. Starting at the top of the ROS tab, review each term and either add it to the template or ignore it. Remember, this is a repository of symptoms that are used to document “oh, by the way” complaints.
3. Load any focused ROS templates that have been built and add all the terms to the current template. The terms on the focused templates have already been selected and should also appear on the comprehensive ROS. Duplicate terms are not allowed in one template so terms are not added twice if found on both the comprehensive and focused template.
4. Use **Find Term** to locate any additional terms for the template.
5. Click **Save As** from the Action bar and name the template 'ROS--[comprehensive or complete].'
6. Test the use of the template by loading it into an encounter. Once loaded, practice adding terms to the Narrative pane and flipping terms up into the HPI.

Tip:

To load an additional template, click **Templates** from the Action bar, enter **ROS** in the search field and click **Find Now**. Multi-select any focused ROS templates by holding down the **Ctrl** key while clicking on individual templates. Click **Load** from the Action bar.

Tip:

To flip a term from the ROS heading to the HPI, select the term and click **ROS/HPI** from the Dashboard.

38.2.4 Creating a PMH Template

PMH templates include the patient's past history, social history, and family history. Typical PMH templates are adult generic, adult female, adult male, and pediatric.

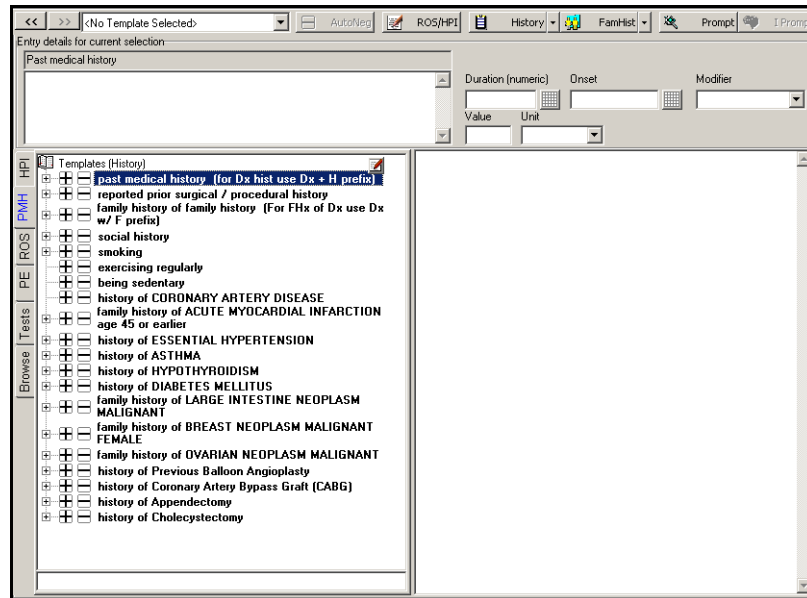


Figure 38–24: PMH Template

Tip:

Remember to click the **PMH** tab after completing a **Find Term**. Look under the **History of Diagnoses, Syndromes, and Conditions** and **History of Therapy** nodes for the desired terms.

Follow the steps below to build a PMH template:

1. Load an appropriate PMH template from the Starter Kit.
2. Add terms to the template by using the Find Term functionality.

Note: Sometimes the search returns a message stating that “no items have been found.” Click **OK**, click the **PMH** tab, and expand either the **History of Diagnoses, Syndromes, and Conditions** or the **History of Therapy** node to locate the term.

3. Add the Family History prefix when needed. Highlight the term and click **Family History** from the Dashboard.
4. Click **Save As** from the Action bar and name the template 'PMH--[name].'
5. Test the use of the template by loading it into an encounter. Once loaded, you cannot AutoNeg when documenting from the **PMH** tab.

38.2.5 Creating a Free Text Template

A free text template can be used for routine procedure, education, and informed consent notes.

Follow the steps below to build a free text template:

1. Click the **PE** tab and click **Notepad** to open the free text window.

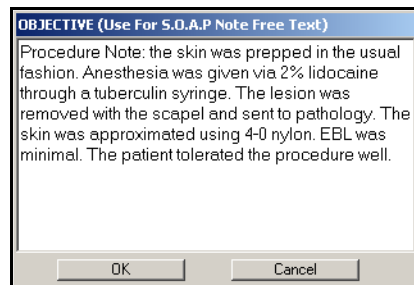


Figure 38–25: Free-Text Window

2. Enter the first words of the note the category of the template (e.g., “Procedure Note:” or “Education Note:”).
3. Enter the rest of the free text.
4. Click **Save and Close**. The note is added to the Narrative pane.
5. Click **Save As** from the Action bar and name the template “PROC--[name]” or “EDU--[name]” as appropriate.

Note: A free text note can also be attached to a structured test term. Highlight the desired term (e.g., Skin biopsy) and add the procedure in the free-text field in the Dashboard. Press **Enter**, then save the template.

6. Test the use of this template by loading it into an encounter. Remember to look on the PE tab for the procedure note.

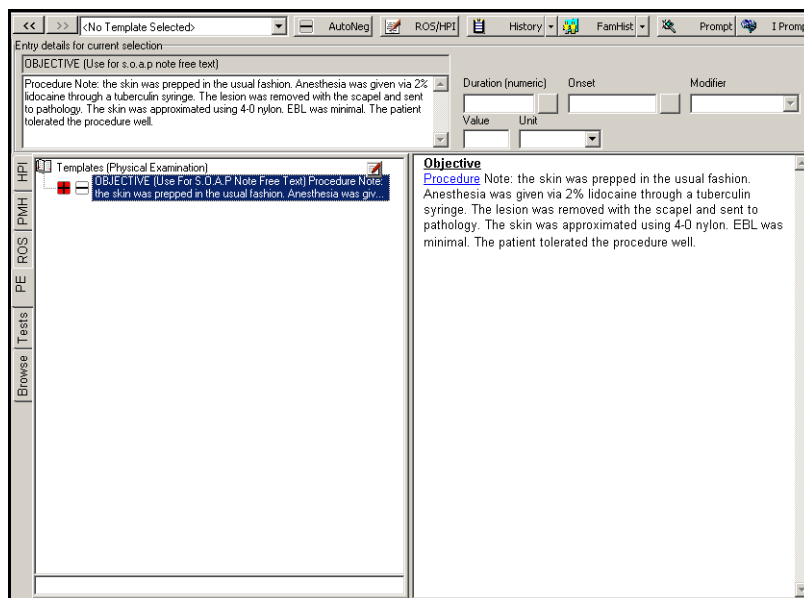


Figure 38–26: Procedure Note

38.2.6 Visit Templates

Building Visit templates is the final step in building templates. It is the Visit template that is used when seeing patients. Visit templates are built by combining the appropriate component templates into one template, thus allowing an entire encounter to be documented with one template. The Chief Complaint is added to every Visit template to characterize the note. Without the Chief Complaint, the purpose of the visit is lost in the note.

When building either Visit template (Generic or Standard), the Template Edit mode is used instead of the Documentation mode. The Template Edit mode allows for easy merging and editing of component templates. When in this mode, terms are selected using a single large plus sign and the template is shown in outline form in the Narrative pane.

38.2.7 Creating a Generic Visit Template

A Generic Visit template consists of a chief complaint, PMH, comprehensive ROS, PE, and PROC templates. It is used when no Standard Visit template exists for that type of patient encounter. The comprehensive ROS is key because this is where terms are selected and then *flipped* up into the HPI. This template is heavily used initially until an adequate repository of templates is built.

Follow the steps below to build a Generic Visit template:

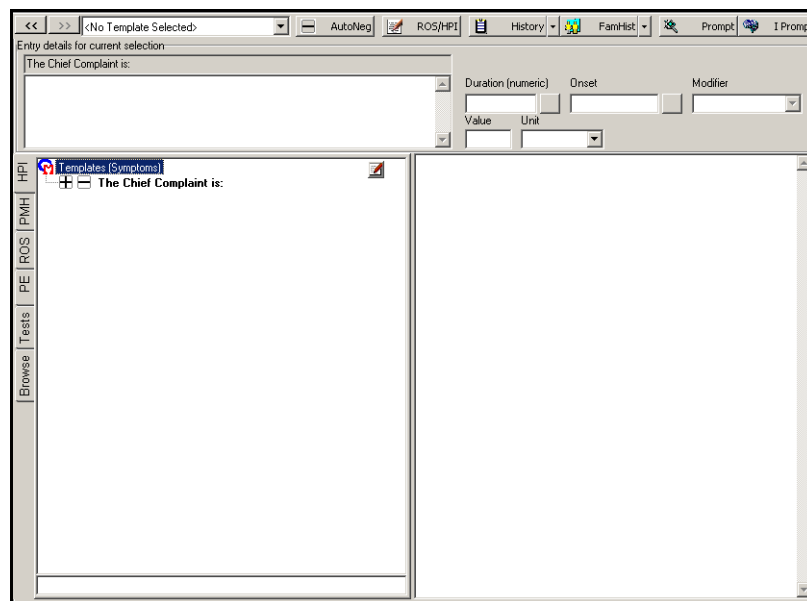


Figure 38–27: Generic Visit Template

1. Click **Template Mgt.** on the Action bar to enter S/O Template Management.
2. Click **New** from the Action bar to enter Template Edit mode.

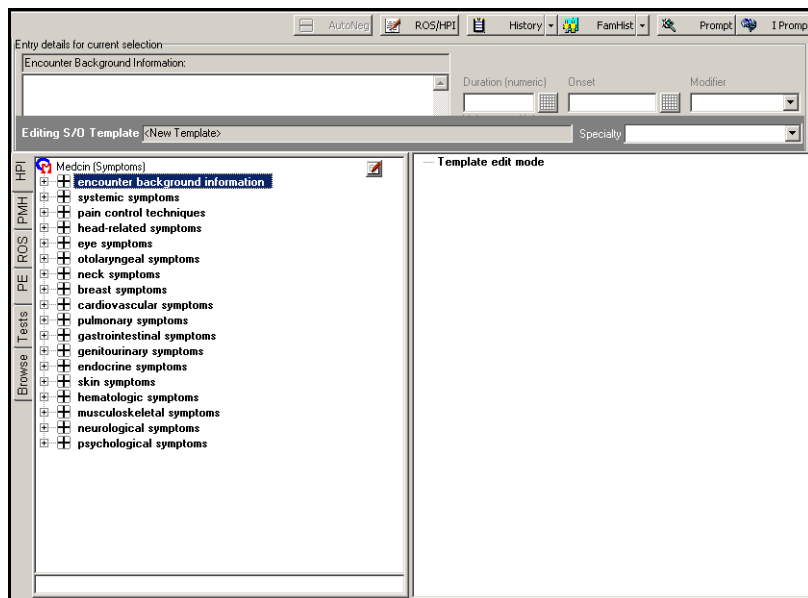


Figure 38–28: Template Edit Mode

- Click **Find Term** from the Action bar and type Chief Complaint in the Search String window.

Tip:
Entering CC pulls up the term Chief Complaint.

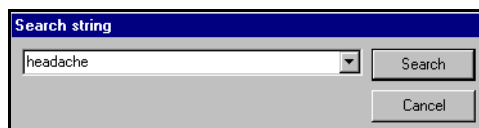


Figure 38–29: Find Term Search String

- Click **Search** to view the Chief Complaint finding on the HPI tab. Click the large plus sign next to the term Chief Complaint to add it to the template. The Chief Complaint is left blank to the generic nature of this template. It is filled out when using this template to document a visit.
- The component templates that have already been built need to be added. Click **Add In Template** from the Action bar to return to S/O Template Management.
- Select a generic PE, comprehensive ROS, and PMH template. Multiple templates can be selected by holding down the **Ctrl** key.

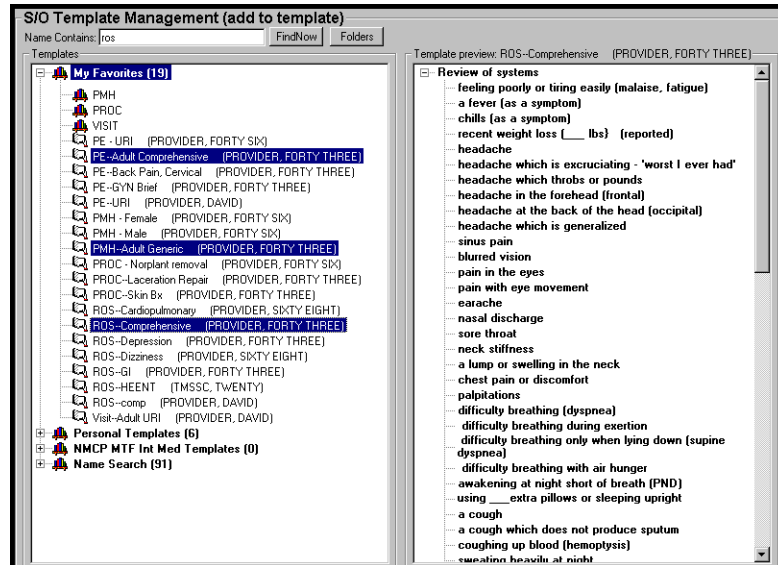


Figure 38–30: Selecting Multiple Templates

- Click **Add** from the Action bar to load the selected templates into the Template Edit mode. Notice the component templates are shown in the Narrative pane and are now one template.

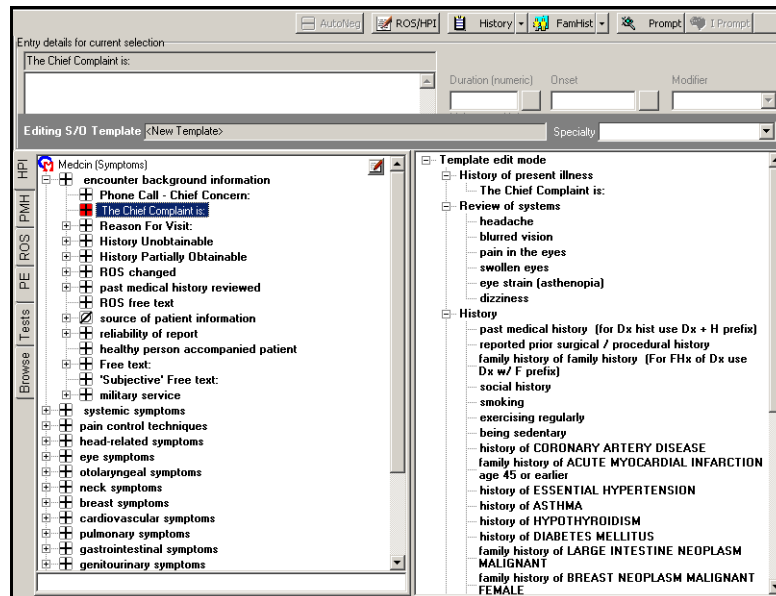


Figure 38–31: Generic Visit Component Templates

- Click **Save As** from the Action bar and save the template as 'VISIT—Generic.'

- Test the use of this template by loading it into an encounter. When using the Generic Visit Template, click the large plus next to Chief Complaint and add the reason for the visit in the free-text field in the Dashboard.

Note: Use the ROS tab to locate terms relative to the chief complaint and HPI. Highlight these terms and flip them into the HPI by clicking **ROS** from the Dashboard. Use the PMH and PE components in the normal fashion.

38.2.8 Creating a Standard Visit Template

A Standard Visit template is used for common clinical visits and consists of a chief complaint, HPI terms, and relevant PMH, ROS, PE, and PROC templates. Examples are asthma follow-up or school physicals.

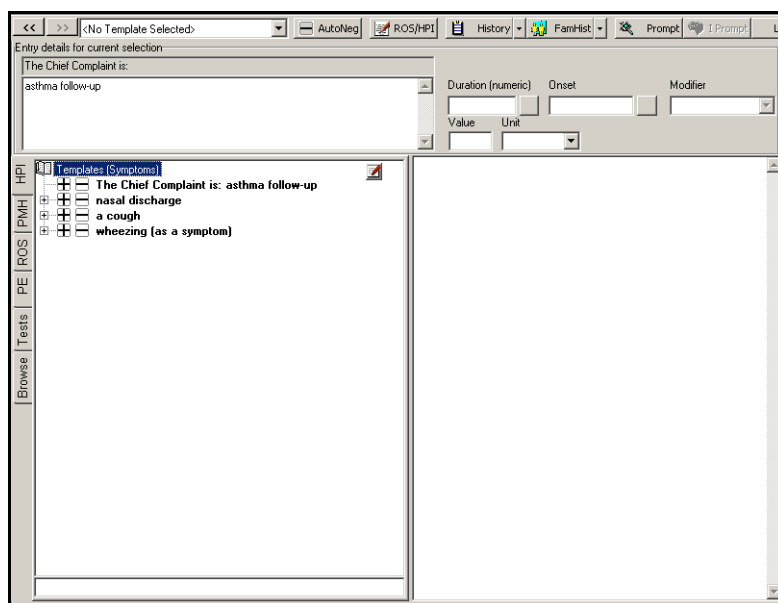


Figure 38–32: Standard Visit Template

Follow the steps below to build a Standard Visit template:

- Click **Template Mgt.** on the Action bar to enter S/O Template Management.
- Click **New** from the Action bar to enter Template Edit mode.
- Click **Find Term** from the Action bar and enter Chief Complaint in the Search String window.
- Click **Search** to view the Chief Complaint finding on the HPI tab. Click the large plus sign next to the term **Chief Complaint** to add it to the template. Enter the reason for the specific visit in the free-text field in the Dashboard (e.g., Asthma follow-up).

Tip:
Entering CC pulls up the term Chief Complaint.

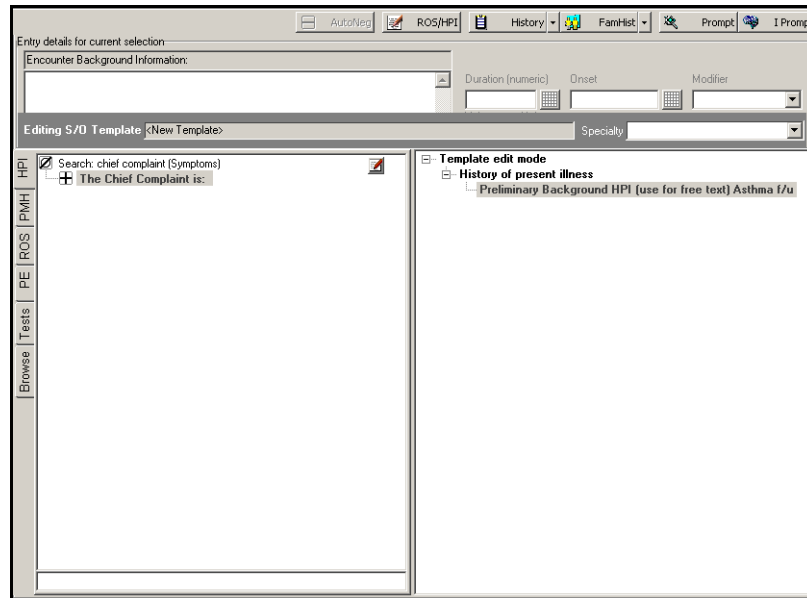


Figure 38–33: Chief Complaint

5. Since this is a template for a specific type of visit, HPI terms can be added. Use the **Dx Prompt** functionality to create a list of terms for possible selection. Click **Dx Prompt** from the Action bar, type in the specific diagnosis and click **Search**. Select the diagnosis, click **OK**, and then **Finish**.
6. Add terms to the template from the search results or use **Find Term** to locate additional items.
7. The component templates that have already been built need to be added. Click **Add In Template** from the Action bar to return to S/O Template Management.
8. Select the appropriate PE, ROS, PMH, and PROC templates. Multiple templates can be selected by holding down the **Ctrl** key.

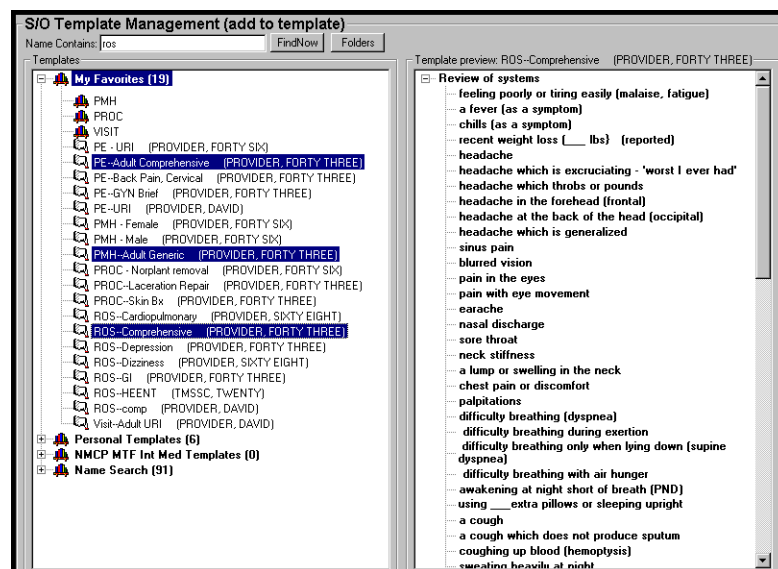


Figure 38–34: Selecting Multiple Templates

- Click **Add** from the Action bar to load the selected templates into the Template Edit mode. Notice the component templates are shown in the Narrative pane and are now one template.

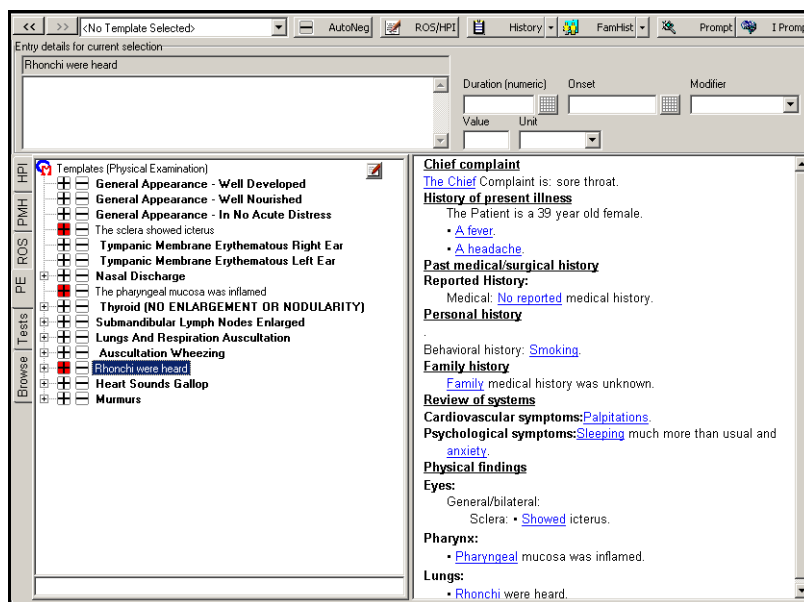


Figure 38–35: Standard Visit Component Templates

- Click **Save As** from the Action bar and save the template as 'VISIT--[name].'
- Test the use of this template by loading it into an encounter and documenting a typical encounter.

38.2.9 Editing a Template

A template can be edited using Template Edit mode. It allows for quick addition or removal of terms as well as easy merging of component templates.

Follow the steps below to edit a template:

- From the S/O Template Management module, highlight the template and click **Edit** from the Action bar to view the template in Edit Mode.

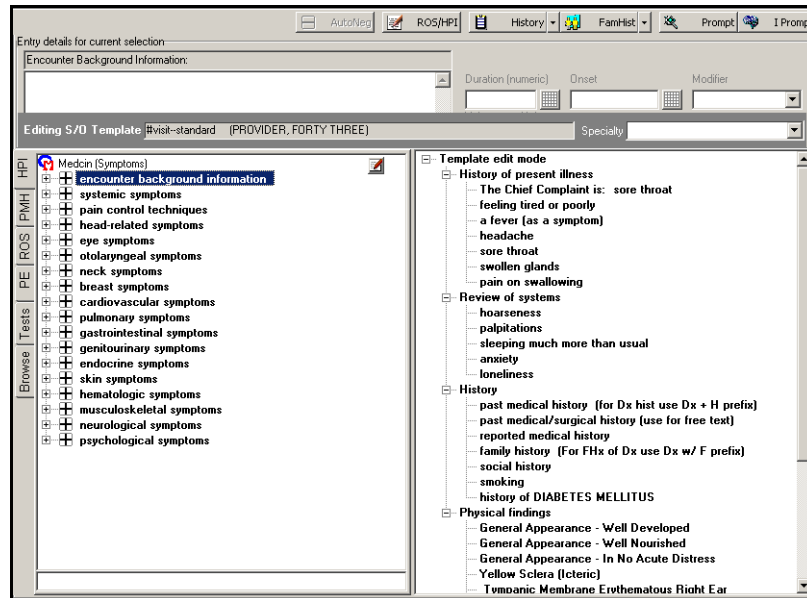


Figure 38–36: Template Edit Mode

2. Locate and click the finding in the outline on the right to remove a finding. The finding is displayed in the findings list on the left.
3. Select the current sign (plus or minus) to remove the finding.
4. New findings can be added by using one of the search capabilities to locate and select the finding. Once selected, the new term is added to the outline on the right.
5. When finished editing, click **Save As** from the Action bar to save the modified template.

38.3 MEDCIN Forms Overview

The MEDCIN Forms provide you with easy-to-use tools and a library of service-provided forms that enable you to document the S/O section of the patient encounter. MEDCIN has over 250,000 clinical terms, subsets of which are grouped together in a form. Each form is built around a theme, a diagnosis or a symptom.

These forms were created and approved by Tri-service clinical consultants. These consultants are collaborating to create a standard library of forms to be used DoD-wide. MEDCIN Forms are an easy, streamlined way to complete the S/O documentation for an encounter. You can think of MEDCIN Forms as an electronic version of paper-based overprints, helping to ease the transition from paper-based medical records to electronic medical records.

Although in many ways forms and templates are simply two alternative ways of documenting S/O, there is a major difference that can help you determine which means to use. The forms provided by the system cannot be edited or modified, which means you are unable to customize a form to reflect your documentation style. If your style matches the form provided, forms can be a very easy, streamlined way to complete the S/O documentation for an encounter.

The screenshot displays the MEDCIN Forms Tool interface. At the top, the patient information is shown: '202-45-5743 47yo F Col DOB:07 Jul 1957'. Below this, there are navigation buttons like '<<', '>>', and 'AutoNeg'. The main content area is organized into several columns and sections:

- Chief Complaint / Purpose of Visit:** Includes checkboxes for 'Women's Health Visit' and 'Reason for Visit is Deployment Related'.
- History of Present Illness:** Contains fields for 'Age at Menarche: (years old)', 'Age at Menopause', 'Date of Last Menstrual Period: Onset', 'Menstrual Bleeding Lasts: (days)', and several checkboxes for symptoms like 'Severe Menstrual Pain', 'Less Menstrual Bleeding', 'Excessive Menstrual Bleeding', 'Bleeding Between Periods', and 'Vaginal Discharge'. There is also a text area for 'Additional History of Present Illness'.
- Past Medical/Surgical History (Continued):** Lists various medical and surgical conditions with checkboxes, including Risk Factors?, Exposure Hx, DES Exposure, STD Exposure, Trauma Hx, Surgical Hx, Pregnancy Hx, Dietary Hx, Hypertension, Thrombus, Liver Ds, Gallbladder Ds, Vaginitis, Diabetes, Migraine HA, Epilepsy, Fibromyalgia, Depression, PID, and Cancer.
- Previous Therapies:** Lists treatments like Breast Surgery, GYN Surgery, Hysterectomy, Tubal Ligation, and OB Surgery.
- Personal History:** Includes checkboxes for Caffeine Use, Tobacco Use, Alcohol Use, Herbs, Reg. Exercise, and Birth Control?
- Family History:** Lists 'Breast Ca', 'Ovarian Ca', and 'Uterine Ca'.
- Review of Systems:** Includes checkboxes for 'Pain During Urination (Dysuria)' and 'Pain During Intercourse', along with a text area for 'Additional Review of Systems'.
- Past Medical/Surgical History (Bottom):** Includes checkboxes for 'Prior Tests', 'Medication Hx', 'Admissions', 'ER Visits', and 'Medical Hx'.

Figure 38–37: Military Clinical Desktop—MEDCIN Forms Tool

38.3.1 Loading a Form

To use a form to document the S/O portion of an encounter, you can either load the form from the Quick-Load list or you can click **Template Mgt.** on the Action bar and load the form there.

Follow the steps below to load with the Quick-Load menu:

1. In the encounter document, click **S/O**. The S/O module opens.
2. Display the Quick-Load menu by clicking the small **down-arrow**. The menu appears.
3. Scroll through the menu to the form you want, then select it. The form populates the workspace.

Note: All forms in the Quick-Load menu begin with AIM; Alternative Input Method.

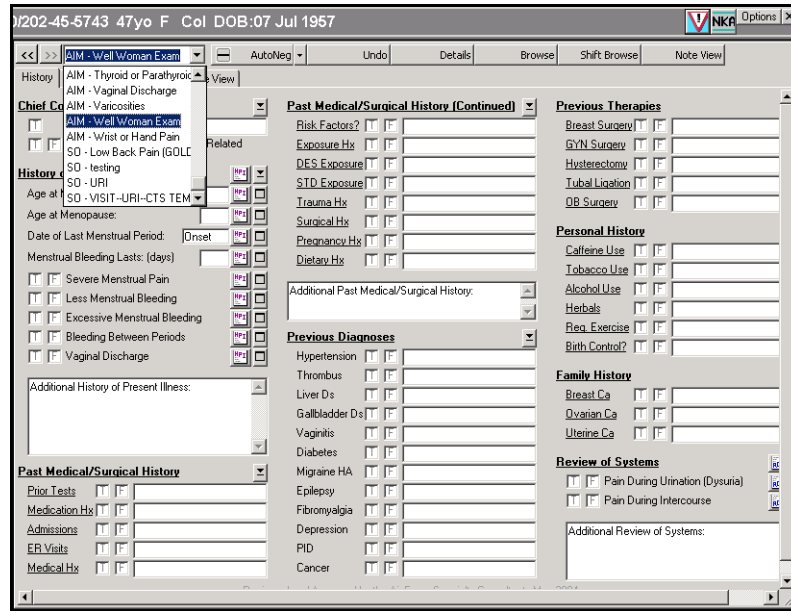


Figure 38–38: Military Clinical Desktop—Quick-Load List

Follow the steps below to load a form from S/O Template Management:

1. Click **Template Mgt** from the Action bar to open the S/O Template Management module.

Note: Forms are represented by the  icon.

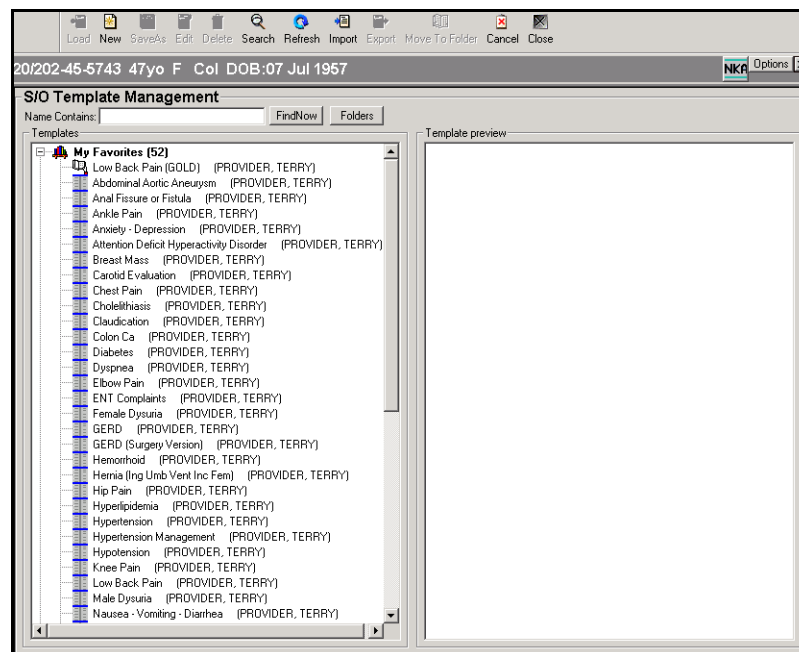


Figure 38–39: S/O Template Management Module

2. Enter the name of the form in the Search field.
3. Click **Find Now** to view the forms that meet the search criteria.
4. Select the form and click **Load** on the Action bar.
5. After a form is loaded, it populates the S/O module.

38.3.2 Navigating a Form

Navigation in MEDCIN Forms is similar to the other modules in CHCS II. Use the Action bar to perform basic actions in the MEDCIN Forms workspace. In addition to the Action bar, you can also use the Forms Toolbar and Tabs to navigate within the workspace.

38.3.2.1 Forms Toolbar

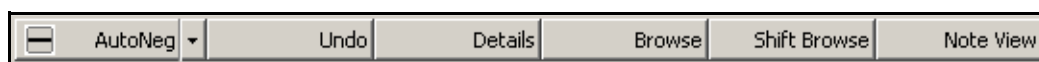


Figure 38–40: Forms Toolbar

The Forms Toolbar is located at the top of the workspace and provides you with form-specific functionality. This toolbar only appears when you have loaded a form and the form populates the workspace. The toolbar contains six options.

These options are as follows:

- **AutoNeg:** AutoNeg enables you to document all currently undocumented HPI or ROS findings as False or to document that the patient denied the symptoms. On the PE tab, it documents the statements as True or clinically normal. It is also a dual-purpose option that enables you to automatically select all positive or all negative values for a displayed form page. In order use this option, simply click the **arrow** to the right of the option, then select either **AutoPos** or **AutoNeg**. Selecting one of the options populates the form with the type of value you chose.
- **Undo:** This option enables you to undo your last actions. If you just selected a single item, clicking this option undoes that single action. If you have just clicked **AutoNeg** or **AutoPos**, this option undoes that action completely, returning the form to the previous state.
- **Details:** Clicking this button displays the Details pane in the bottom of the workspace. In this pane you can add more detailed information for the finding selected in the forms. In order to select a finding, single-click the finding you want, then click **Details**.

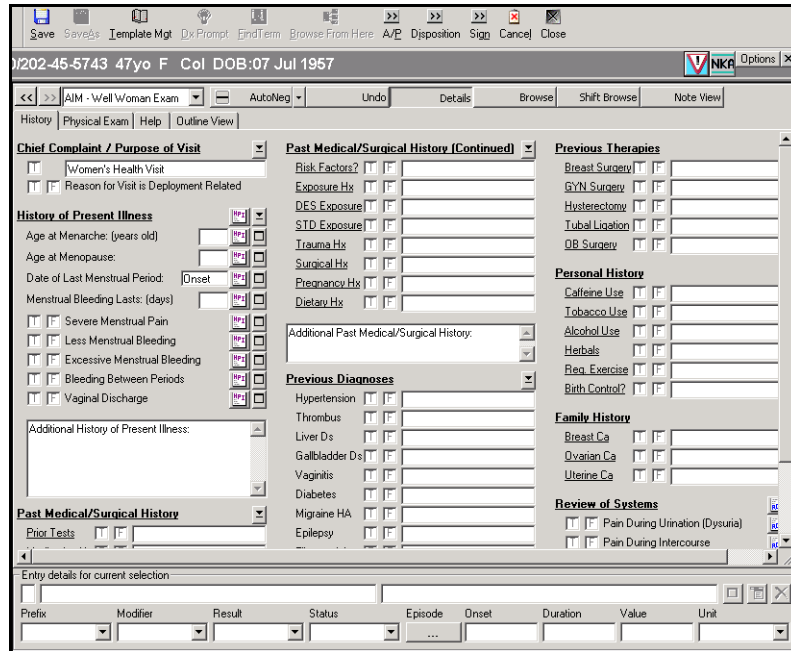


Figure 38–41: Details

- Browse:** This option enables you to display the Browse pane in the workspace. This pane populates one-third of the form. The Browse pane displays the child term of a selected parent term. On the form, parent terms cause the cursor to change to a question mark. Perform a right mouse click to view the child terms in the Browse pane. Click **Browse** to remove the Browse pane after you have selected the appropriate terms.

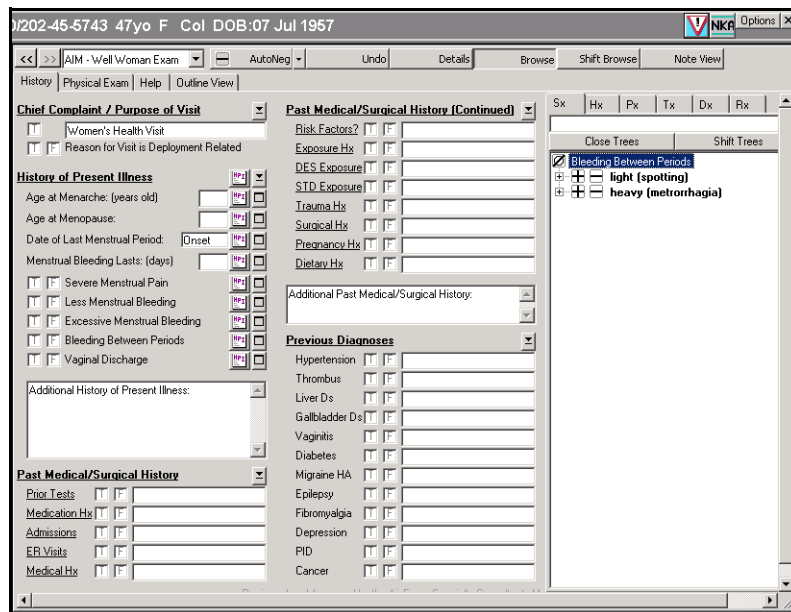


Figure 38–42: Browse

- **Shift Browse:** Use this option to shift where the Browse pane appears. If it currently populates the right-third of the form, clicking this button moves the pane to the left-third. You can use this option if you want to keep the Browse pane always available as you move through the columns in a form.
- **Note View:** This option enables you to navigate from the Forms tool to the traditional S/O layout, where you can see how your documentation is progressing based on what you have selected in the form. Click **Form View** on the Toolbar to return to the form view.

Figure 38-43: Note View

38.3.2.2 MEDCIN Forms Tabs

All of the forms included with the system use tabs to enable navigation from section to section: History, Physical Exam, Help, and Outline view.

Click the tabs to navigate to different sections within the form.

Figure 38–44: Physical Exam Tab

38.3.2.3 MEDCIN Forms Workspace

The workspace uses three columns, with findings and terms and related options included in each column. This is the basic view of a form, and the form is fully displayed.

The second view of a form is the Details view. You access this view by selecting a term of finding in the form, then clicking Details in the toolbar. In the Details view, you can add more detailed information to the term you selected, including a prefix, modifier, onset date, or status.

38.3.3 Documenting S/O with a Form

Because of the number and diversity of the forms provided with the system, there are different ways you can use each form to document the S/O for an encounter. In this section we cover some of the basics of using a form.

38.3.3.1 Adding Terms

You should always view each finding as a statement that is either True or False. On the History tab, the statements always describe an abnormal condition; the patient has severe menstrual bleeding. On the History tab, True responses always imply a clinical abnormality.

On the PE tab, the statement always describes a clinically normal condition (i.e., the heart is of regular rate and rhythm, the abdomen is soft without masses). True responses always imply a clinically normal condition on the PE tab.

Tip:

On the History tab, True = abnormal. On the PE tab, True = normal.

Figure 38–45: MEDCIN Form

38.3.3.2 Changing the Stats of a Term

If you accidentally clicked the wrong box (clicked the true box instead of false), you can simply click the opposite box to change the response.

38.3.3.3 Removing a Term

If you want to deselect a term and remove it from the note entirely, simply deselect the box that is currently marked. A warning window appears, asking if you want to remove the term. Click **OK** to remove the term, or **Cancel** to keep it.

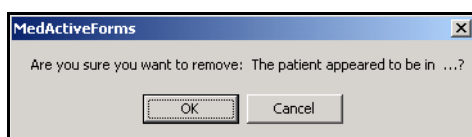


Figure 38–46: MedActiveForms Window

38.3.3.4 Using the Free Text Icon

Click the free text icon next to a term to add more details to that term. A free text window opens, allowing you to add text. After you enter your free text, click **Close The Note Dialog** to close the window and add your free text. Notice that the icon changes once free text is added to a term.

Note: There is a 2,000 character restriction for each free text area.

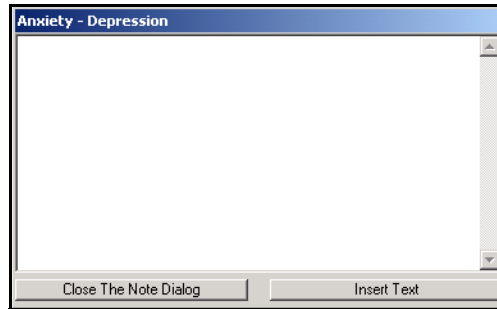


Figure 38–47: Free Text Field

38.3.3.5 Using the Free Text Fields

There are multiple free text fields located throughout the forms. Use these fields to add additional information that pertains to the specific section of the note. Click in the free text field and enter your note. Double-clicking in the free text field opens the free text field in a separate window where text can be added, using either the virtual keyboard or your regular keyboard. Virtual keyboard letters are added by clicking them with your mouse.

Note: There is a 2,000 character restriction for each free text area.

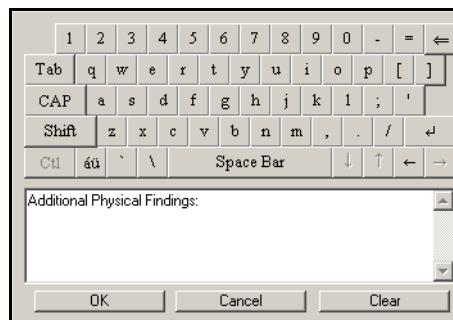


Figure 38–48: Free Text Field Window

38.3.3.6 Using Numeric/Date Entry

Some of the answers to the questions on the forms will be numbers or dates. In these cases, either click in the field and enter the value or double-click in the field to open the Numeric/Date Entry window. The Numeric/Date Entry window displays either the Interval view tab or Calendar view tab, depending on the field. Click the value(s), then click **OK**.

Figure 38-49: Interval View Tab

Figure 38-49: Interval View Tab

Figure 38-50: Calendar View Tab

Figure 38-50: Calendar View Tab

38.3.3.7 Using AutoNeg

The “Neg” in AutoNeg is “clinically negative,” which means clinically normal. Use AutoNeg to document all undocumented findings as clinically normal. Use this feature by manually selecting your true findings, then click **AutoNeg** to document the remaining terms. This is called documentation by exception.

AutoNeg also is a dual-purpose option that enables you to automatically select all positive or all negative values for a displayed form page. In order use this option, simply click the **arrow** to the right of the option, then select either **AutoPos** or **AutoNeg**. Selecting one of the options populates the form with the type of value you chose.

The screenshot displays the MEDCIN Form interface for a patient named '202-45-5743 47yo F Col DOB:07 Jul 1957'. The interface is organized into several columns of findings, each with a 'T' (True) or 'F' (False) checkbox and a 'Flip' button. The categories include:

- General Appearance:** Current Vital Signs Reviewed, Alert, Well Developed, Well Nourished, No Acute Distress.
- Examination of the Neck:** Thyroid Not Diffusely Enlarged.
- Examination of the Lymph Nodes:** Cervical Lymph Nodes Not Enlarged, Lymph Nodes of Normal Consistency.
- Examination of the Breasts:** Breasts Without Palpable Mass.
- Examination of the Abdomen:** Abdomen Normal to Visual Inspection, Bowel Sounds Normal, Abdomen Soft, No Abdominal Muscle Guarding, No Abdominal Rigidity, No Direct Abdominal Tenderness, No Abdominal Rebound Tenderness, No Abdominal Mass.
- Liver and Spleen:** Liver Normal to Palpation, Spleen Normal to Palpation.
- Examination of the Female Genitalia:** External Genitalia Without Abnormalities, Normal Vaginal Mucosa, Without Vaginal Discharge, Without Vaginal Vesicle(s), Without Vaginal Tenderness, Without Vaginal Cystocele, Without Vaginal Rectocele.
- Female Pelvic Examination:** No Cervical Discharge, No Cervical Lesion, No Cervical Pain Elicited By Motion, Pap Smear NDT Done, Uterus Position Normal, Without Uterine Enlargement, Uterus Not Surgically Absent, Uterus Non-tender, Adnexae Non-tender, Adnexae Not Surgically Absent, Without Ovarian Mass.
- Examination of the Rectum:** Anal Sphincter Tone Normal, No Hemorrhoids Noted, Without Rectal Mass.
- Test Results:** Negative for Fecal Occult Blood, Normal Vaginal Wet Mount Smear, Negative Vaginal KOH Prep.

Figure 38–51: MEDCIN Form

38.3.3.8 Flipping Terms between the HPI and ROS Headings

In the HPI section, you have the option to flip an HPI finding to ROS. Click the **HPI** button provided next to each term. The term is flipped into the ROS. The ROS section includes similar buttons, but these enable you to flip a term found in the ROS to the HPI. Click the **ROS** button to flip the ROS terms into the HPI.

This close-up shows a list of findings with 'ROS' and 'HPI' buttons next to them:

- Severe Menstrual Pain (ROS, HPI)
- Less Menstrual Bleeding (ROS, HPI)
- Excessive Menstrual Bleeding (ROS, HPI)
- Bleeding Between Periods (ROS, HPI)
- Vaginal Discharge (ROS, HPI)

Figure 38–52: ROS/HIP Flip

38.3.3.9 Adding Details to an Individual Term

The Details section is hidden on the Forms workspace until you want to view it. To access the Details section, click **Details** on the Toolbar. The Details pane appears at the bottom of the workspace. When the Details section is visible, any time you click on an item in the Form, details about that item appear in the details section. In the details view, you can add more detailed information to the term you selected, including a prefix, a modifier, an onset date or a status. You can also see how the finding is worded in the encounter note.

The screenshot shows a medical software window titled 'V202-46-5743 47yo F Col DOB:07 Jul 1957'. The window contains several panels for data entry:

- Chief Complaint / Purpose of Visit:** Includes checkboxes for 'Women's Health Visit' and 'Reason for Visit is Deployment Related'.
- History of Present Illness:** Includes fields for 'Age at Menarche', 'Age at Menopause', 'Date of Last Menstrual Period', 'Menstrual Bleeding Lasts', and checkboxes for 'Severe Menstrual Pain', 'Less Menstrual Bleeding', 'Excessive Menstrual Bleeding', 'Bleeding Between Periods', and 'Vaginal Discharge'.
- Past Medical/Surgical History (Continued):** Includes checkboxes for 'Risk Factors?', 'Exposure Hx', 'DES Exposure', 'STD Exposure', 'Trauma Hx', 'Surgical Hx', 'Pregnancy Hx', and 'Dietary Hx'.
- Previous Diagnoses:** Includes checkboxes for 'Hypertension', 'Thrombus', 'Liver Ds', 'Gallbladder Ds', 'Vaginitis', 'Diabetes', 'Migraine HA', and 'Epilepsy'.
- Previous Therapies:** Includes checkboxes for 'Breast Surgery', 'GYN Surgery', 'Hysterectomy', 'Tubal Ligation', and 'OB Surgery'.
- Personal History:** Includes checkboxes for 'Caffeine Use', 'Tobacco Use', 'Alcohol Use', 'Herbals', 'Reg. Exercise', and 'Birth Control?'.
- Family History:** Includes checkboxes for 'Breast Ca', 'Ovarian Ca', and 'Uterine Ca'.
- Review of Systems:** Includes checkboxes for 'Pain During Urination (Dysuria)' and 'Pain During Intercourse'.
- Past Medical/Surgical History (Bottom):** Includes a 'Prior Tests' section and a table for 'Menorrhagia' with columns for Prefix, Modifier, Result, Status, Episode, Onset, Duration, Value, and Unit.

Figure 38–53: Details

38.3.3.10 Browsing the MEDCIN Hierarchy

MEDCIN is organized as an hierarchical tree of clinical findings. A high level finding, such as the abdominal exam (Parent), has subordinate or children findings, such as inspection, auscultation, percussion and so forth. Children findings may have their own children as well. MEDCIN has many levels in this parent/child hierarchy. When you add terms to the S/O, you must pay careful attention because MEDCIN allows a negative response on a parent term, while allowing a positive response on a child term. This would be clinically incorrect.

A form includes many of these parent terms. These terms have children in the MEDCIN hierarchy, but the child terms are not present on the form. Roll your cursor over an item on the form to determine whether that item has associated children. If the item has children, the cursor will change to a cursor-question mark.



Figure 38–54: Cursor-Question Mark

Right-click the term to display the children. A Browse pane displays, either on the right-third or left-third of the form, showing the additional terms. Select either the large plus (+) or large minus (-) sign next to the terms you want. You can close the Browse pane by clicking **Close Trees** on the Browse pane or by clicking **Browse** on the Toolbar. You can shift the Browse pane to the left-third or right-third of the form by clicking **Shift Trees** on the Browse pane, or by clicking **Shift Browse** on the Toolbar.

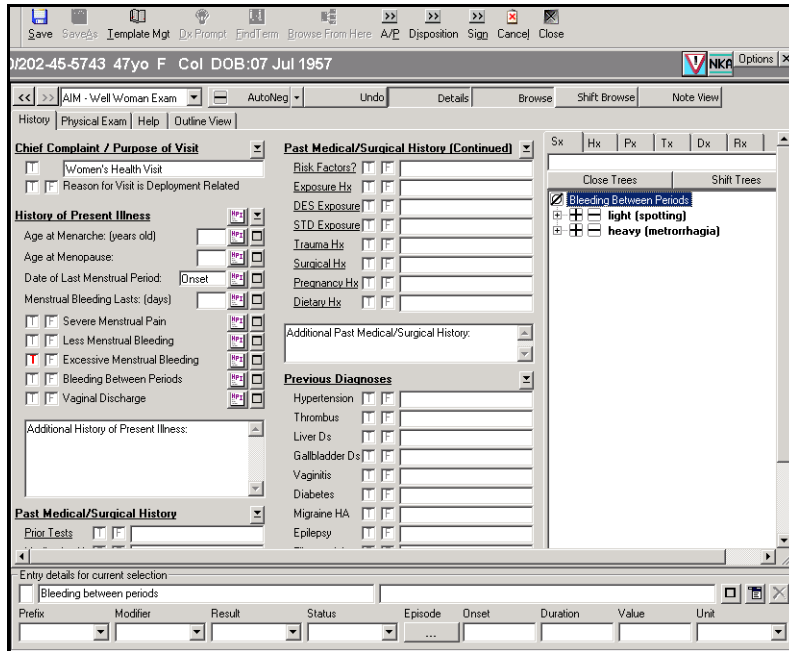
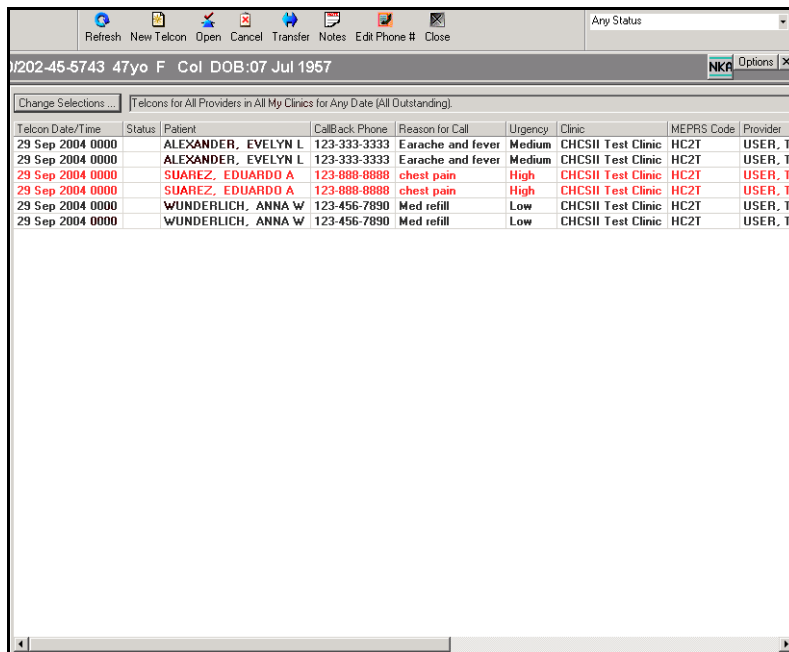


Figure 38–55: Browse Pane

39.0 TELEPHONE CONSULTS

39.1 Telephone Consults Overview

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (telcons) module displays telephone consults for specified clinics, providers, dates, and statuses. From the Telephone Consults module, telcons can be created, viewed, transferred to another provider, and canceled. Phone numbers can be edited, notes viewed, and an encounter can be opened for that appointment.



The screenshot shows a software interface for the Telephone Consults Module. At the top, there is a menu bar with options: Refresh, New Telcon, Open, Cancel, Transfer, Notes, Edit Phone #, and Close. Below the menu bar, there is a patient information header: //202-46-5743 47yo F Col DOB:07 Jul 1957. A search filter is set to 'Any Status'. The main area contains a table titled 'Telcons for All Providers in All My Clinics for Any Date (All Outstanding)'. The table has columns for Telcon Date/Time, Status, Patient, CallBack Phone, Reason for Call, Urgency, Clinic, MEPRS Code, and Provider. The data rows are as follows:

Telcon Date/Time	Status	Patient	CallBack Phone	Reason for Call	Urgency	Clinic	MEPRS Code	Provider
29 Sep 2004 0000		ALEXANDER, EVELYN I	123-333-3333	Earache and fever	Medium	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		ALEXANDER, EVELYN I	123-333-3333	Earache and fever	Medium	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		SUAREZ, EDUARDO A	123-888-8888	chest pain	High	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		SUAREZ, EDUARDO A	123-888-8888	chest pain	High	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		WUNDERLICH, ANNA W	123-456-7890	Med refill	Low	CHCSII Test Clinic	HC2T	USER, TI
29 Sep 2004 0000		WUNDERLICH, ANNA W	123-456-7890	Med refill	Low	CHCSII Test Clinic	HC2T	USER, TI

Figure 39–1: Military Clinical Desktop—Telephone Consults Module

39.1.1 In More Depth

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (telcons) module displays telephone consults for specified clinics, providers, dates, and statuses. From the Telephone Consults module, telcons can be created, viewed, transferred to another provider, and cancelled. Phone numbers can be edited, notes viewed, and an SF600 can be created for that appointment.

Similar to the Appointments function telcons can be filtered for the following:

- **Set as Default:** Customized default settings from the Telephone Consult Search Selections dialog box.
- **All Outstanding:** Telephone consults with the status 'outstanding.'
- **Today Only:** Today's telephone consults.

- **Today Plus Incomplete:** Today's telephone consults that have a status of incomplete.
- **Any Status:** Telephone consults that meet any status and meet the date criteria set in the Telephone Consult Log Selections window.
- **Pending:** Telephone Consults that have a status of pending and meet the date criteria set in the Telephone Consult Log Selections dialog box. No note has been initiated.
- **InProgress:** Telephone Consults that have a status of In Progress and meet the date criteria set in the Telephone Consult Log Selections window. The note has been initiated.
- **Complete:** Telephone consults that have a status of complete and meet the date criteria set in the Telephone Consult Log Selections dialog box. The encounter document has been signed.
- **Updated:** Telephone consults that have a status of updated and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been completed and then amended. Use this function to filter the telephone consult list for the current session. Use the Change Selections function to select a filter to use as the default. To filter the list of telephone consults, select a filter from the drop-down list in the top, right corner on the Telephone Consults module.
- **Transfer:** The Telcon Transfer option enables an individual telcon or a group of telcons to be transferred to a different provider within the same clinic.
- **Notes:** Allows notes associated with the telephone consult to be viewed.
- **Edit Phone #:** Allows the call back number to be changed. The system defaults to the home number.
- **Close:** Closes the Telephone Consult module.

Note: If the column headings have been re-ordered on the Telephone Consults module, click **Set Column Order as Defaults** to keep this heading order each time the Telephone Consults module is opened. Click **Restore Column Order Defaults** to return the column heading order to the system default.

39.2 Setting the Properties of the Telephone Consults Module

Follow the steps below to set the properties of the Telephone Consults module:

1. On the Telephone Consults module, click **Change Selections**. The Telephone Consult Search Selections window opens.

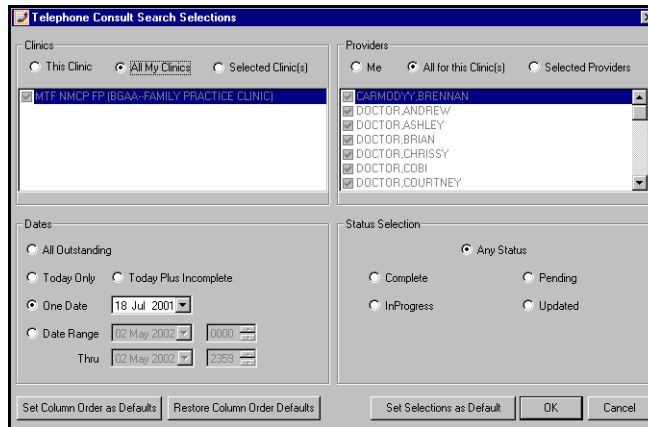


Figure 39–2: Telephone Consult Search Selections Window

2. Select the applicable option in the Clinics area.
 - **This Clinic:** Telephone consults for this clinic only.
 - **All My Clinics:** Telephone consults for all of the provider’s clinics.
 - **Selected Clinic(s):** Only telephone consults for the selected clinics.
3. Select the applicable option in the Providers area.
 - **Me:** Telephone consults for the current provider only.
 - **All for this Clinic(s):** All telephone consults for the current clinic(s).
 - **Selected Providers:** Only telephone consults for the selected providers.
4. Select the applicable option in the Dates area.
 - **All Outstanding:** Telephone consults with the status of outstanding.
 - **Today Only:** Only today's telephone consults.
 - **Today Plus Incomplete:** Today's telephone consults that have a status of incomplete.
 - **One Date:** Only telephone consults for a selected date.
 - **Date Range:** All telephone consults that fall within a specified date range.
5. Select the applicable option in the Status Selection area.
 - **Any Status:** Telephone consults that meet any status and meet the date criteria set in the Telephone Consult Log Selections window.
 - **Pending:** Telephone Consults that have a status of pending and meet the date criteria set in the Telephone Consult Log Selections window. No note has been initiated.
 - **InProgress:** Telephone Consults that have a status of In Progress and meet the date criteria set in the Telephone Consult Log Selections window. The note has been initiated.

- **Complete:** Telephone consults that have a status of complete and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been signed.
 - **Updated:** Telephone consults that have a status of updated and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been completed and then amended.
6. Click **Set Selections as Default** or click **OK** to set the selected search criteria as the default criteria. The telephone consults that meet the required criteria displays.

Note: If the column headings have been re-ordered on the Telephone Consults module, click **Set Column Order as Defaults** to keep this heading order each time the Telephone Consults module is opened. Click **Restore Column Order Defaults** to return the column heading order to the system default.

39.3 Canceling a Telephone Consult

Follow the steps below to cancel a telephone consult:

1. Select the telephone consult to be canceled.
2. On the Action bar, click **Cancel**. The Cancel Telcon window opens.

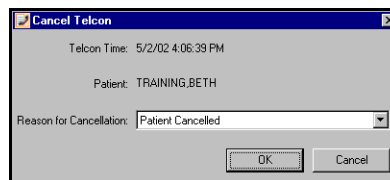


Figure 39–3: Cancel Telcon Window

3. Select a reason for the cancellation from the drop-down list.
4. Click **OK**.

39.4 Editing the Callback Phone Number

Follow the steps below to edit the callback phone number:

1. Select the telephone consult to be modified.
2. On the Action bar, click **Edit Phone #**. The Change Callback Number window opens.

Tip:

This does not change the patient's home phone number in the Demographics module.

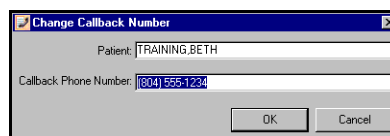


Figure 39–4: Change Callback Number Window

3. In the **Callback Phone Number** field, enter the new phone number.
4. Click **OK**.

39.5 Opening an Encounter

Follow the steps below to open an encounter:

1. Select the telephone consult on the Telephone Consult module.
2. On the Action bar, click **Open**. The Telcon Quick Entry window opens.
3. Click **Cancel**. The Telcon Quick Entry window closes and the patient encounter is displayed.

39.6 Creating a New Telephone Consult

Follow the steps below to create a new telephone consult:

1. On the Action bar, click **New Telcon**. The New Unscheduled Appointment/Telcon Visit window opens, immediately overlaid by the Patient Search window.
2. Search for the patient you want to schedule a telephone consult for, or if the patient is already loaded, click **Cancel**. The New Unscheduled Appointment/Telcon Visit window displays.

Figure 39-5: New Unscheduled Appointment/Telcon Visit Window

3. Complete the following fields:

- **Assigned Clinic:** Select the assigned clinic from the drop-down list.
- **Provider:** Use the drop-down list to select the desired provider.
- **Appointment Type:** The only Appointment Type choice is **TELEPHONE CONSULT (T-CON*) 20**.

Note: Appointment types with a \$ or * annotate those types of appointments that can only be created by the clinic.

- **Appointment Classification:** This defaults based on the patient's appointment classification.
- **Meets Outpt Visit Criteria (Workload?):** Defaults to Yes, but if the patient does not meet outpatient visit criteria, select No.
- **Related to Injury/Accident:** Select the checkbox to indicate that the telcon is related to an injury/accident.
- **Call Back Number:** Enter the phone number where the patient can be reached. The default number is the patient's home phone.
- **Reason for Telephone Consult:** Enter a short description of the problem for the patient called.
- **Urgency:** Select either **High**, **Medium**, or **Low**.
- **Notes:** Enter any comments pertaining to the telephone consult.

4. Click **OK** to save the appointment.

Note: Click **Change Patient** to search for a new patient. The Patient Search window opens. If you click **Change Patient** before clicking **OK**, the telephone consult for the patient cannot be created.

Note: If you have privileges to view encounter information, the Telcon Quick Entry window opens, allowing for continued documentation.

39.7 Completing the Telcon Quick Entry Screen

Follow the steps below to complete the Telcon Quick Entry screen:

1. Double-click the desired telephone consult from the list. The Telcon Quick Entry window opens.

Figure 39–6: Telcon Quick Entry Window

2. Complete the applicable fields:
 - **Provider Note:** Enter free-text to document the S/O portion of the encounter.
 - **Diagnoses:** The diagnoses can be selected from the Template List, Problem List (Acute or Chronic), or Clinic and User Favorite Lists. You can also search for the diagnosis by entering the diagnosis in the **Search** field and clicking **Find Now**. Select the diagnosis and click **Add** to add the diagnosis to the Selected Diagnosis list.
 - **E&M:** Select an **E&M code** from the drop-down list.
3. Select the desired **Save** option:
 - **Save and Sign:** Saves the information and opens the Sign Encounter window.
 - **Save and Open A/P:** Saves the information, writes it into the Patient Encounter module, and opens the Assessment and Plan module.
 - **Save and Return to Encounter:** Saves the information and returns you to the encounter document.

4. Click **OK**.

Note: Once information has been entered and saved via the Quick Entry Screen, the Quick Entry Screen is not available to document additional data.

39.8 Transferring a Telephone Consult

The Telcon Transfer window enables an individual telcon or a group of telcons to be transferred to a different provider within the same clinic.

Follow the steps below to transfer a telephone consult:

1. Select the telephone consults to be transferred.
2. On the Action bar, click **Transfer**. The Telcon Transfer window opens.

Tip:

If transferring multiple telcons, the patients must be from the same clinic.

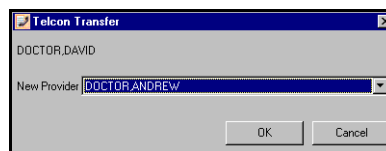


Figure 39–7: Telcon Transfer Window

3. Select a new provider from the New Provider drop-down list. Only providers assigned to the specific clinic are available.
4. Click **OK** to execute the transfer. The telephone consult is added to the new provider's telephone consults list.

39.9 Viewing a Telcon Note

If a comment was added on the New Telcon window, the full text of the comment cannot be seen on the Telephone Consults module.

Follow the steps below to view a telcon note:

1. Select the telephone consult on the Telephone Consult module.
2. On the Action bar, click **Notes**. The Appointment Note window opens containing the comment.

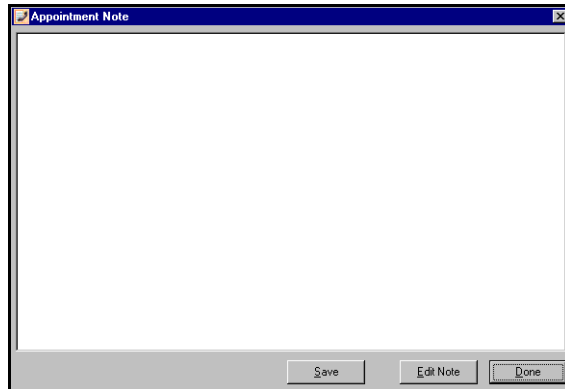


Figure 39–8: Appointment Note Window

3. Click **Done** to close the window and return to the Telephone Consults module.

Note: Click **Edit Note** to edit information in the note. When all edits have been made, click **Save**.

40.0 TEMPLATE MANAGEMENT

40.1 Template Management Overview

Templates are used to streamline the encounter documentation process. Each encounter template contains placeholders for diagnoses, procedures, orders, S/O Notes templates, AutoCited items, and the associated reason for visit. Once an encounter template has been selected and loaded into the encounter, the pre-positioned lists are available within S/O and A/P. The Template Management module is generally accessed while in an encounter after the screening process and before any charting is completed. The Encounter templates can be viewed and edited without an open encounter.

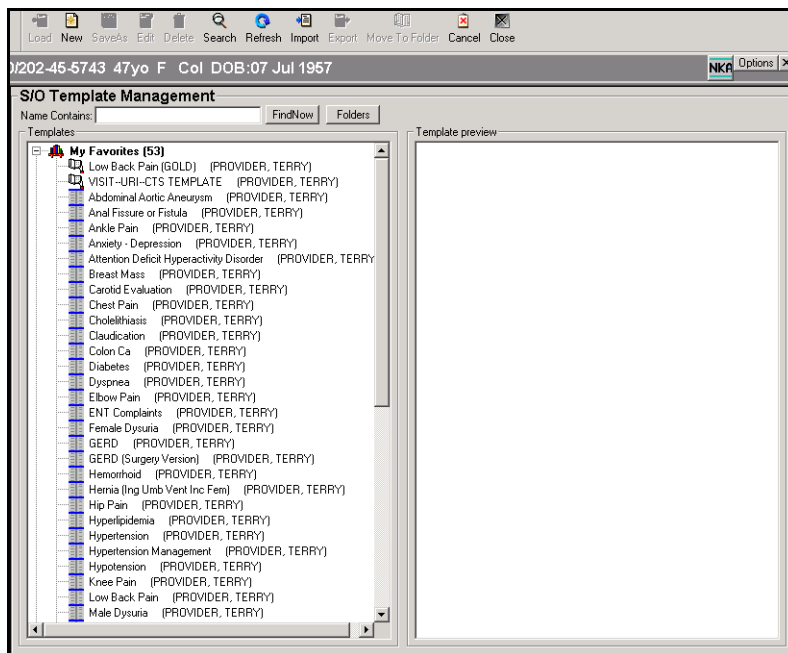


Figure 40-1: Military Clinical Desktop—Template Management Module

40.1.1 In More Depth

Templates are used to streamline the encounter documentation process. Each encounter template contains placeholders for diagnoses, procedures, orders, S/O Notes templates, AutoCited items, and the associated reason for visit. Once an encounter template has been selected and loaded into the encounter, the pre-positioned lists are available within S/O and A/P. The Template Management module is generally accessed while in an encounter after the screening process and before any charting is completed. The Encounter templates can be viewed and edited without an open encounter.

The Encounter template contains details of the encounter in terms of AutoCite items, diagnoses, procedures, S/O templates, orders, and patient instructions. The system

provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, the provider selects an encounter template from the Patient Encounter module before documenting the exam.

The top portion of the workspace shows the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are displayed in the applicable folder.

Templates can be added to the Favorites List to be seen as suggested templates for every encounter. A template search can also be conducted with only the Favorites List. Templates can be added to or removed from the Favorites List from either the Template Selections or Search/Browse tab.

A template can be imported to or exported from another location. All of the details of the template are included when it is imported or exported. Since the template contains all details, the order sets included are specific to the originating clinic. If the template is imported/exported to another clinic, the receiving locations for the orders are updated upon import. You can import/export a template from the Template Selections or Search/Browse tab.

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Current Encounter and Previous Encounter modules.

40.2 Organizing Templates

The Template Selections tab allows you to organize templates in the Template Management module. The Template Selections tab lets you add, edit and delete folders to manage encounter templates.

Note: You must have a current encounter open to access the Template Selections tab.

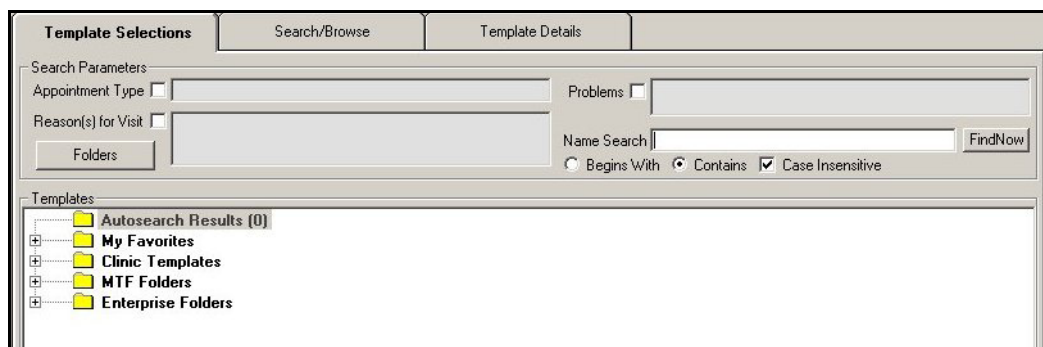


Figure 40–2: Template Folders

Follow the steps below to organize encounter templates:

1. In the Template Management module, Template Selections tab, click **Folders** to open the Template Folder Management window.

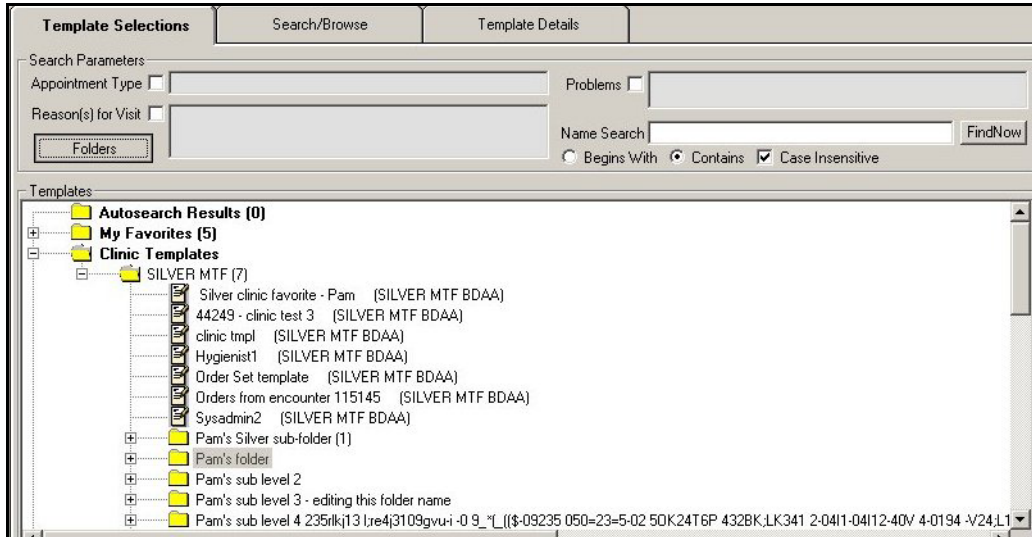


Figure 40–3: Clinic Templates Sub Folders

2. Click **New** to create a new folder for encounter templates.

Note: If there is a folder you want to modify, click **Edit**. If there is a folder you want to delete, click **Delete**.

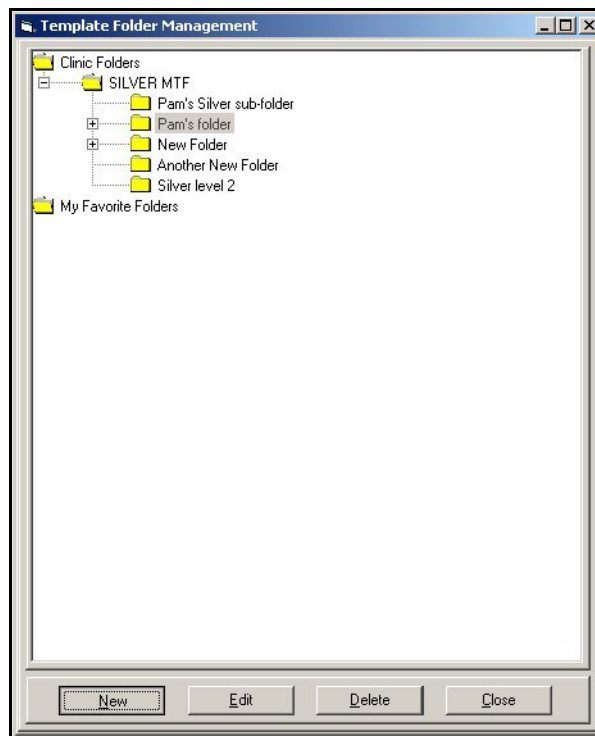


Figure 40–4: Template Folder Management Window

3. In the New Folder window, enter the name of the folder you are using to organize your templates.
4. Click **OK** to add the folder to the Template Management module. You are returned to the Template Folder Management window.

Note: In the Template Folder Management window, select the top-level folder and click **New** to add a sub-folder. Enter the name of the sub-level folder and click **OK**.

5. Repeat steps 3 and 4 for each template management folder you want to add. When you are finished adding the folders, click **Close** to return to the Template Management module Template Selections tab.

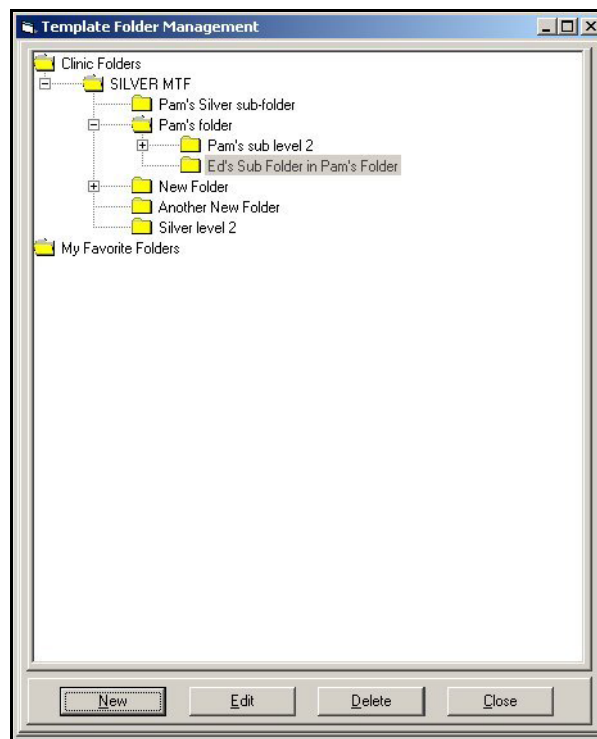


Figure 40-5: Template Folder Management Window—Complete

40.3 Moving Templates to Folders

The Template Management module lets you easily move templates from one folder to another. This enables templates to be categorized into proper folders allowing you to access and use templates more efficiently.

Note: Moving templates from one folder to another does not create a copy of the template. Therefore, it is not recommended that you move templates out of shared folders into personal folders without commanding officer consent.

Follow the steps below to move templates to a specific folder:

1. In the Template Management module, select the template you want to move.
2. Perform a right mouse click and select **Move to Folder**.
3. In the Template Folder Management module, select the folder where you want to move the template.
4. Click **Move**. The template is moved from the original (folder) location to the new location.

40.4 Selecting an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter template contains details of the encounter in terms of AutoCite items, diagnoses, procedures, S/O templates, orders, and patient instructions. The system provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, the provider selects an encounter template from the Patient Encounter module before documenting the exam.

Follow the steps below to select an encounter template from the Patient Encounter module:

1. Click **Templates** on the Action bar. The Template Management module opens with the Template Selections tab defaulted.

Note: The top portion of the workspace shows the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. Click the checkboxes to remove them. If changes are made to the criteria, the system displays an updated list.

Note: The Template Selection tab auto-refreshes when a template is imported, displaying the imported template in the template list.

Note: The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are displayed in the applicable folder.

Tip:

*If the desired template is not listed in any of the folders a search can be conducted. In the top portion of the workspace type in the name of the template in the Name Search field. Click **Find Now** to view the results in the Name Search Results folder.*

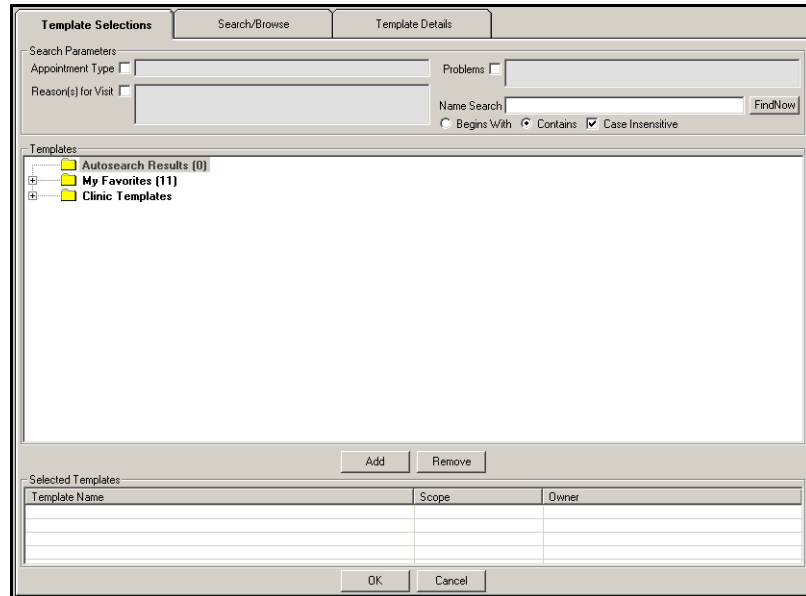


Figure 40-6: Template Management Module—Template Selections Tab

2. Select the **Folders** button to add, edit or delete a folder. The Template Folder Management window opens.
 - In the Template Folder Management window, click **New**. The New Folder window opens.
 - In the New Folder window, enter the name of the new folder and click **OK**. The new folder is added to the Template Folder Management window.
 - Highlight the folder and click **New** to add a sub-folder. The New Folder window opens.
 - Enter the name of the sub-folder and click **OK**. The sub-folder is added in the Template Folder Management window.
 - Add additional sub-folders in the same manner. When finished, click **Close**. The new folders and sub-folders are added to the Template Selections tab of the Templates Management module.
3. Select the template to be used in the encounter from one of the folders or through a template search.
4. Click **Add** to move the template into the Selected Templates area. More than one template can be added to an encounter.
5. Click **OK** to load the template(s) into the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the Patient Encounter (AutoCite), S/O (notes template), and A/P (diagnoses, procedures, orders, and patient instructions) modules.

Follow the steps below to set an Encounter Template as a default that automatically loads for each subsequent new encounter:

1. Highlight the desired template in the Encounter Template list.
2. Right-click on the highlighted template and select **Default Encounter Template** from the right-click pop-up menu.

40.5 Setting an Encounter Template as a Default

Any encounter template may be designated to load for every encounter. This eliminates the need to open the Template Management module to load a template. Typically, the most common diagnoses, procedures, and orders are included in this default encounter template. Once an encounter template is designated as the default template, it can be reset so that no encounter template is automatically loaded.

Follow the steps below to set an Encounter Template as a default:

1. On the Search/Browse tab or the Template Selections tab, highlight the desired template in the Encounter Template list.
2. Right click on the highlighted template and select **Default Encounter Template** from the right-click pop-up menu.

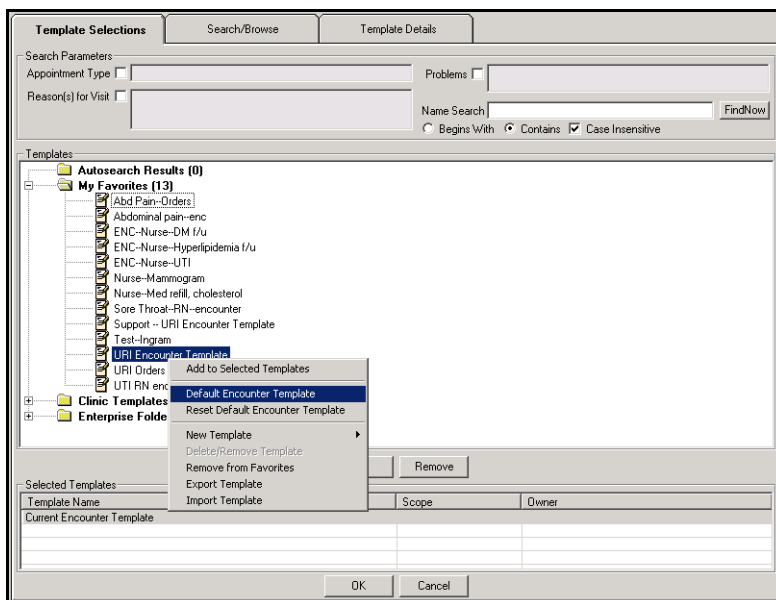


Figure 40-7: Setting the Default Encounter Template

3. The highlighted template is now followed with the indication of Default Encounter Template.

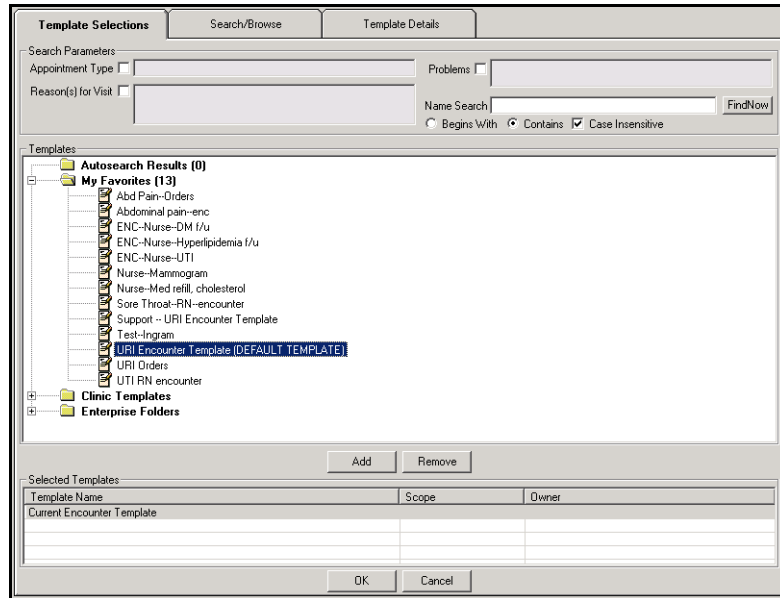


Figure 40–8: Default Encounter Template Set

Follow the steps below to reset the default encounter template:

1. On the Search/Browse tab or the Template Selections tab, highlight the current default encounter template.
2. Right click on the highlighted template and select **Reset Default Encounter Template**.
3. The default template designation is removed from the template.

40.6 Creating a New Template

Follow the steps below to create a new template, begin on the Template Selections or Search/Browse tabs.

1. Click **New** on the Action bar. The Template Details tab displays.

Figure 40–9: Template Management Module—Template Details Tab

2. Complete the following fields on the Template Details tab:
 - **Owner Type:** Select the desired owner type from the drop-down list. Options include Personal, Clinic, MTF, or Enterprise. The user's role determines whether the template can be saved as clinic, MTF, or enterprise.
 - **Shared:** Click this checkbox to allow other providers to copy the template.
 - **Specialty:** Select the specialty to which the template belongs from the drop-down list. This is a required field.
 - **E&M Code Category:** Select the desired codes for the template from the drop-down list.

Note: The template name is added upon saving and the **User** field is read-only. Templates can only be shared between providers in the same clinic.

3. Click **Add** to add details to the template in the following areas, where applicable:
 - **Associated Reasons for Visit:** In the **Search Term** field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Associated Problems:** In the **Search Term** field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Diagnoses:** In the **Search Term** field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

Tip:
The Associated Reasons for Visit, the Associated Problems, Associated Appointment Types and Items to Autocite into Note areas lend limited support in the creation and use of an encounter template.

- **Notes Templates:** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note template and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Other Therapies:** In the **Search Term** field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Associated Appointment Types:** In the **Search Term** field, enter the first few letters of the appointment type and click **Search**. Select the appointment type from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Items to AutoCite into Note:** Select an AutoCite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
 - **Procedures:** In the **Search Term** field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
4. Click **Save As**. The Save Encounter Template window opens.

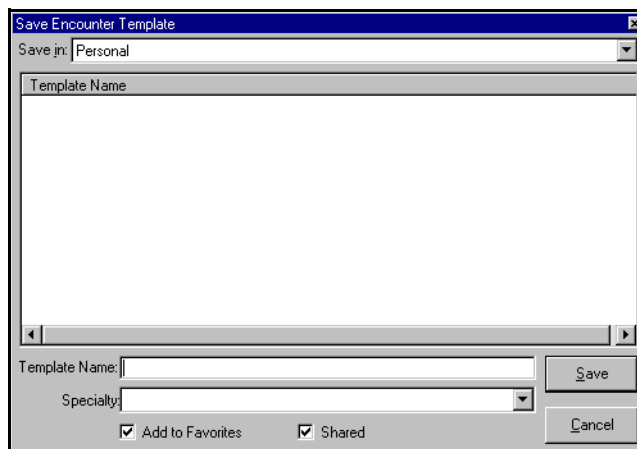


Figure 40–10: Save Encounter Template Window

5. Select a **template type** from the Save in drop-down list.
6. In the **Template Name** field, enter the template name.
7. Select a **Specialty** from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites List to be shared with other Clinical Team members.

8. Click **Save**.

40.7 Searching for a Template

In order to do any work with a template, you must select a template with the Template Selections or Search/Browse tabs.

Follow the steps below to search for a template:

1. Click **Search**. The Encounter Template Search window opens.

Figure 40–11: Encounter Template Search Window

2. Complete the following search criteria fields, as necessary:
 - **Template Name:** Enter the name or the first word of the template. Select the applicable radio button to denote if the template name begins with or contains entered text. The search is case-insensitive by default. Deselect the checkbox to make the search case-sensitive.
 - **Select from My Favorites Only:** Select the checkbox to search Favorite templates only.
 - **Owner Type:** Use the drop-down list to select the desired type. Options include:
 - Personal
 - Clinic, MTF
 - Enterprise
 - **Owners:** Click **Add** to open the Template Owner Lookup window and select another provider. This enables you to search another provider's templates.
 - **Specialty:** Select the specialty to which the template belongs from the drop-down list.
 - **Associated Reason for Visit:** Click **Add** to add a reason for visit by which to search.

- **Associated Appointment Type:** Click **Add** to add an appointment type by which to search.
 - **Associated Problem:** Click **Add** to add problems by which to search.
 - **Replace Search Results or Add to Search Results:** Click a radio button to either show results from the current search (Replace) or add the current results to the list of templates (Add).
3. Click **Search** to view the templates that match the criteria. The templates are displayed on the Search/Browse tab.

Note: Once a template has been found and selected, the following actions can be taken:

- View and edit the template
 - Merge templates (more than one template must be selected)
 - Copy a template
 - Remove or add to the Favorites List
 - Export a template
 - Delete a template
 - Select an Encounter template
-

40.8 Editing a Template

Follow the steps below to edit a template:

1. Search for the template you want to edit using the Template Selections or Search/Browse tab.
2. Select the desired template.
3. Click **View/Edit** on the Action bar. The Template Details tab displays.

Figure 40–12: Template Management Module— Template Details Tab

4. Add or remove information in the following fields, as necessary:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures
5. Click **Save** on the Action bar.

Tip:
Click **Save As** to save the template under a new name.

40.9 Merging Templates

Templates can be combined to create a completely new template.

Follow the steps below to merge templates:

1. Search for the templates you want to merge. The templates appear in the Search/Browse tab.

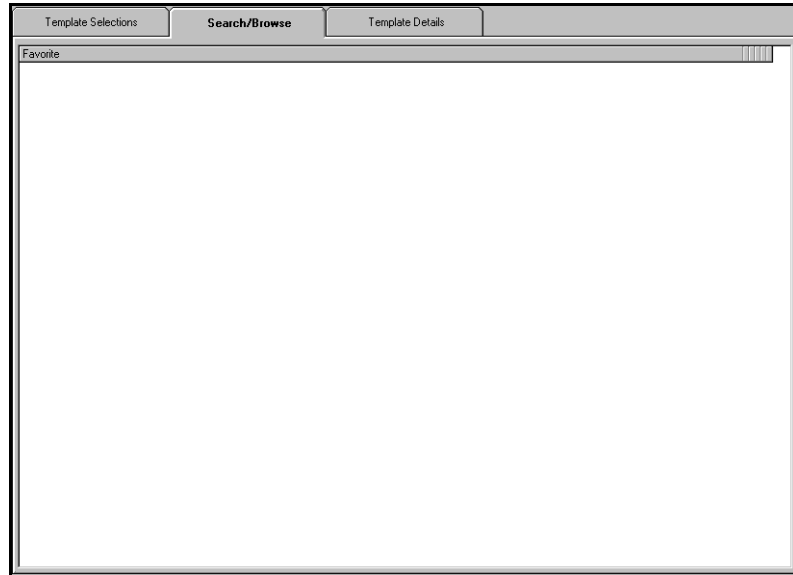


Figure 40–13: Template Management Module – Search/Browse Tab

2. Select the templates by pressing the **Ctrl** key on your keyboard and clicking on each template you want to merge.
3. Click **Merge** on the Actions menu. The Template Details tab displays the details from the selected templates.
4. Edit the template if necessary.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.

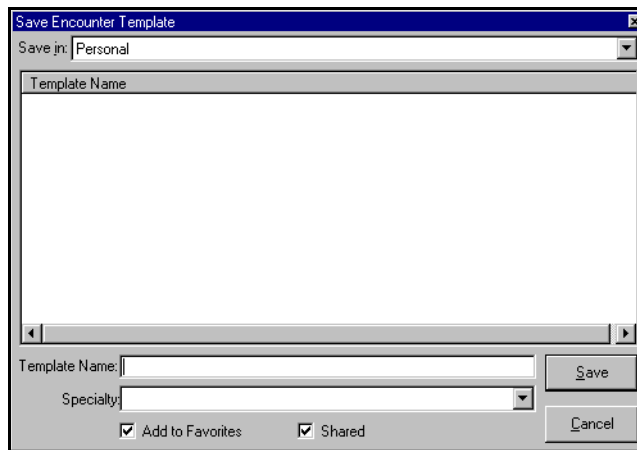


Figure 40–14: Save Encounter Template Window

6. Select a template type from the Save in drop-down list.
7. In the **Template Name** field, enter the template name.
8. Select a Specialty from the drop-down list.
9. Select the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.

10. Click **Save** to save the template.

40.10 Copying a Template

A current template can be copied, edited, and renamed to create a new template.

Follow the steps below to copy a template:

1. Search for the template you want to copy.
2. Select the template in the Search/Browse tab.
3. Right click and point to **New Template** and then click **Copy from Selection**. The Template Details tab displays with the selected template details.
4. Edit the template if necessary.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
6. Select a template type from the Save in drop-down list.
7. In the **Template Name** field, enter the template name.
8. Select a Specialty from the drop-down list.
9. Click the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
10. Click **Save** to save the template.

Tip:

The title of the template changes to Copy of ... (selected template).

40.11 Removing/Adding to Favorites

Templates can be added to the Favorites List to be seen as suggested templates for every encounter. A template search can also be conducted with only the Favorites List. Templates can be added to or removed from the Favorites List from either the Template Selections or Search/Browse tab.

Follow the steps below to add a template to the Favorites List:

1. Search for the template you want to add.
2. Select the template in the Search/Browse tab.
3. Click **Add Favorite** on the Action bar. The Favorite column on the Search/Browse tab changes from No to Yes and the template is added to My Favorites folder on the Template Selections tab.

Follow the steps below to remove a template from the Favorite List:

1. Search for the template you want to remove.
2. Select the template in the Search/Browse tab.
3. Click **Remove Favorite** on the Action menu.
4. At the confirmation prompt, click **Yes**.

40.12 Importing/Exporting a Template

A template can be imported from or exported to an electronic storage device for use at another location. All of the details of the template are included when it is imported or exported. Since the template contains all details, the order sets included are specific to the originating clinic. If the template is imported/exported to another clinic, the receiving locations for the orders are updated upon import. You can import/export a template from the Template Selections or Search/Browse tab.

Follow the steps below to import a template:

1. Click **Import** on the Action bar. The Import Encounter Template window opens.

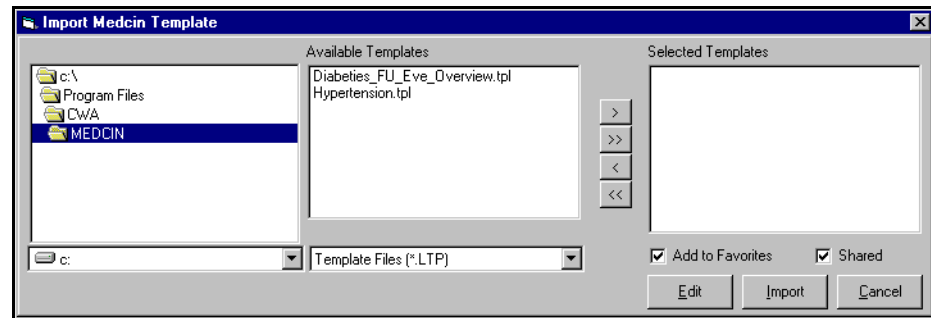


Figure 40–15: Import Encounter Template Window

2. Select a template from the Available Templates list.

Note: If the template is not in the defaulted folder, browse to the folder where the templates are located.

3. Click the **arrow buttons** to move the selections to the Selected Templates list.
4. Do one of the following:
 - If you want to edit the selected template before you save it:
 - a. Click **Edit**. The Template Details tab displays with the details of the imported template.
 - b. Add or remove information in the following fields:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures

- If you want to import the template as is, click **Import**. The Template Details tab displays with the details for the imported template.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
 6. Select a template type from the Save in drop-down list.
 7. In the **Template Name** field, enter the template name.
 8. Select a Specialty from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites list to be shared with other Clinical Team members.

9. Click **Save**.

Follow the steps below to export a template:

1. Search for the template you want to export.
2. Select the template from the Search/Browse tab.
3. Click **Export**. The Export Encounter Template window opens.

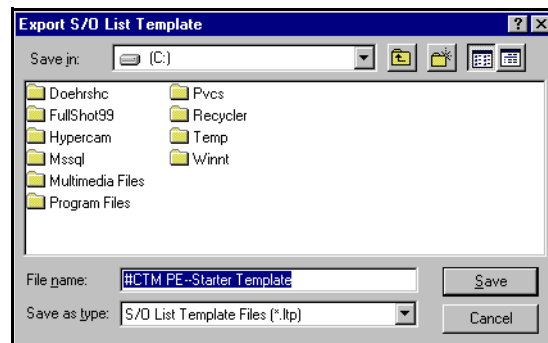


Figure 40–16: Export Encounter Template Window

4. Browse to the folder location where you want to export the template.
5. Click **Save**.

40.13 Deleting a Template

A template can be deleted from the Search/Browse tab.

Follow the steps below to delete a template:

1. Search for the template you want to delete.
2. Select the template from the Search/Browse tab.
3. Click **Delete** on the Action menu.
4. At the delete confirmation prompt, click **Yes**.

40.14 Saving an Encounter as a Template

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

Follow the steps below to save an encounter as a template:

1. Document the encounter.
2. On the Actions menu, click **Save As Template**. The Template Details tab on the Template Management module opens.

Figure 40–17: Template Management module—Template Details Tab

3. Select an owner type from the drop-down list, if necessary.
4. Select a specialty from the drop-down list, if necessary.
5. Select an E&M code category from the drop-down list, if necessary.
6. Add or remove information from the following areas:
 - Associated Reasons for Visit
 - Associated Problems
 - Diagnoses
 - Notes Templates
 - Other Therapies
 - Associated Appointment Types
 - Items to AutoCite into Note
 - Procedures
7. Click **Save As** on the Action bar. The Save Encounter Template window opens.

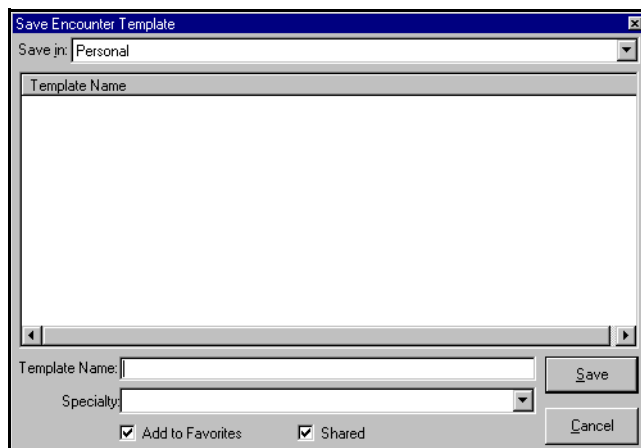


Figure 40-18: Save Encounter Template Window

8. Select the template type from the Save-in drop-down list.
9. In the **Template Name** field, enter the template name.
10. Select the specialty from the drop-down list.
11. Select the checkboxes to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
12. Click **Save**.

41.0 CHCS II TRAINING SYSTEM

41.1 CHCS II Training System Overview

The CHCS II Training System is a stand-alone training application. The goal of this tool is to enable you to participate in the CHCS II courses that teach you the skills you need to perform your assigned duties as well as practice on your own. The Training System contains staged data to help you through your course and assist you in understanding CHCS II functionality.

The CHCS II Training System contains the same core functionality available in CHCS II; however, interface capabilities between CHCS II and components (e.g., CHCS) are simulated to produce a realistic data exchange process. The Training System is not role based—users, regardless of their clinic roles and responsibilities, have access to the same functionality.

41.2 Logging into the Training System

The Training System is built with an automatic login.

Follow the steps below to login to the Training System:

1. Double-click the CTS icon on your desktop.



Figure 41–1: Training System Icon

2. First, you are asked to choose a training clinic (Medical, Dental, SRTS II). This specifies which portion of the training database will be available to you. Select the appropriate clinic from the list and click **OK**.

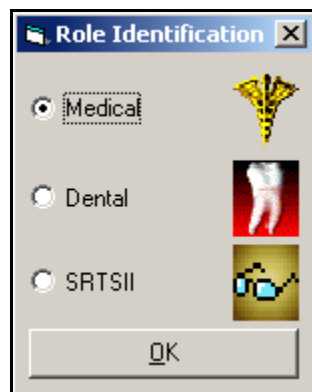


Figure 41–2: Role Identification Selection Window

3. Read the purpose statement on the first splash screen and click the small **x** in the top, right corner or press **Esc** on your keyboard.

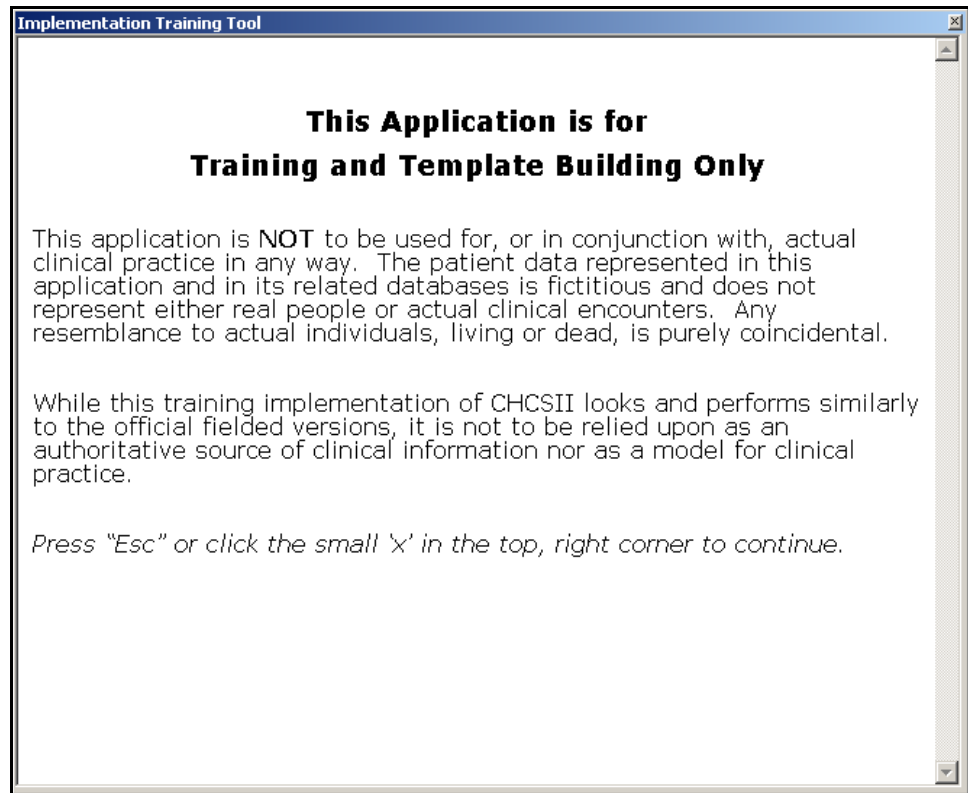


Figure 41-3: Purpose Statement

4. The second splash screen highlights the functionality of the Training System. Again, click the small **x** in the top, right corner or press **Esc** on your keyboard.

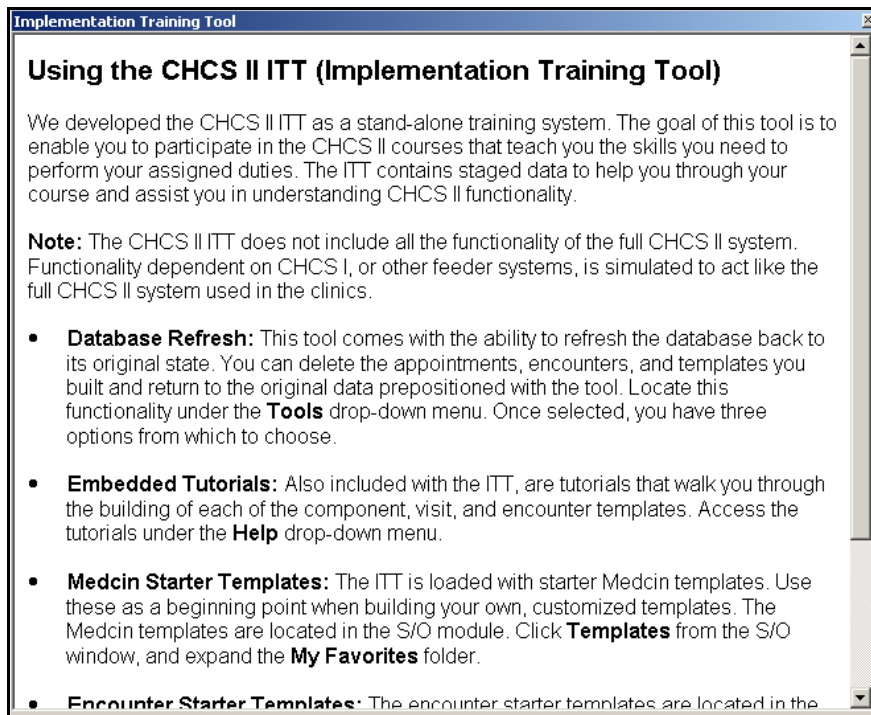


Figure 41-4: Training System Functionality

5. The Training System moves through the automatic logon.



Figure 41-5: Automatic Logon

6. Once complete, the application opens to the Appointments module.

Note: You can differentiate between CHCS II and the Training System by the Patient ID bar and the “Training Use Only” watermark. The Training System uses a green Patient ID bar and CHCS II uses a gray Patient ID bar.

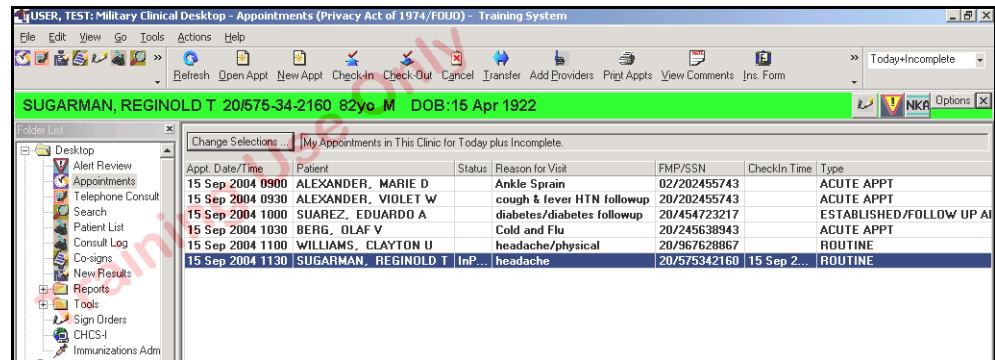


Figure 41-6: Appointments Module

The Training System allows you to access only one clinic at a time. Therefore, if you need to use the Training System for a different clinic, you need to log out of the application, then logon again, choosing the appropriate clinic as in step #2 above. You should also reset the Training System database before proceeding.

41.3 Using the Training System

Once logged in, the Training System works similarly to the CHCS II application. The sections below highlight some of the features of the Training System.

41.3.1 Training System Database

The Training System comes with two databases. One database houses all the prepositioned information relative to the appointments, patients, templates, and encounters. The first time you log into the Training System, this information is available and ready for use.

The second database is used as you navigate through the application and make changes or additions to the original baseline database. Information you add or modify (appointments, templates, or patient information), is stored within this database.

41.3.2 Database Reset

The Training System comes with the ability to reset the database to the original baseline. You can delete the appointments, encounters, and templates you created and return to the original baseline data prepositioned with the system. After you install the Training System, you should reset the database as shown in the steps below.

Follow the steps below to reset the database:

1. Select the **Tools** menu.
2. Select **Training System Database Reset**.
3. You have three options from which to choose. Click **Templates**, **Encounter Data**, or **Entire Database**.

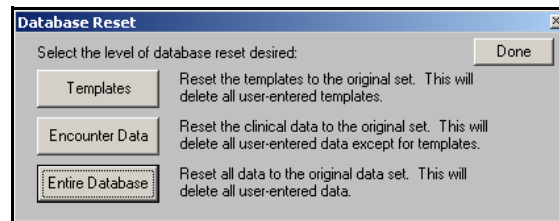


Figure 41-7: Reset Options

4. Upon completion, click **Done**. The Training System closes and returns to the desktop.

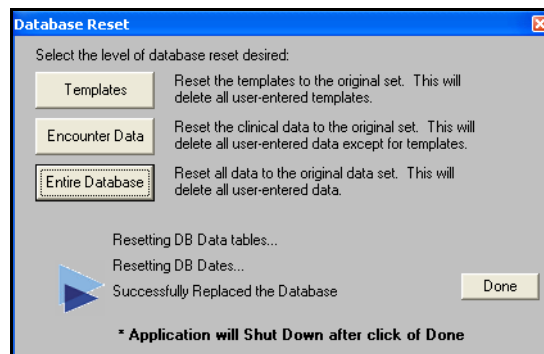


Figure 41-8: Reset Complete

5. Log back in to the Training System to begin using the application.

41.3.3 Locking the Training System

If you want to leave the workstation you may lock your session by pressing **Ctrl + Z** on your keyboard. Your session remains locked until you click **OK**.

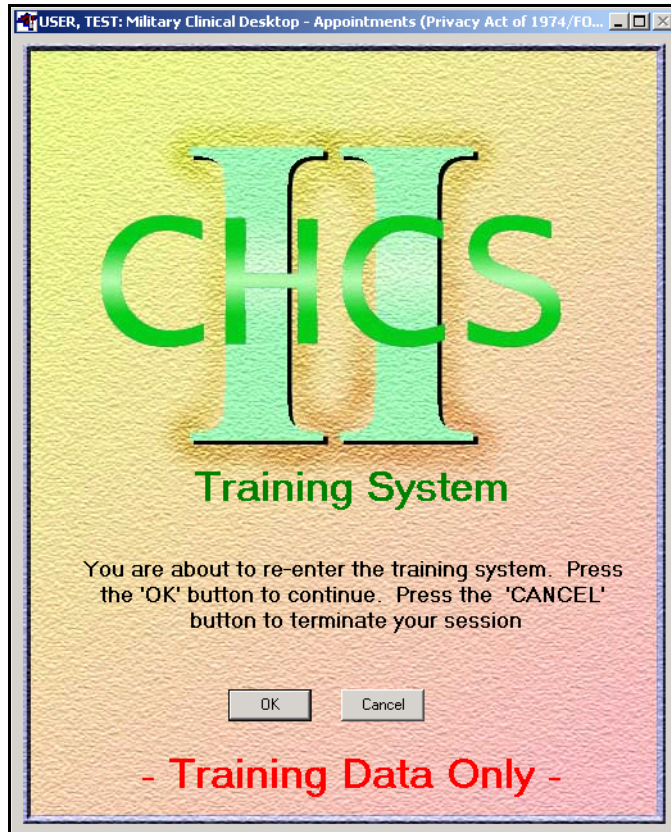


Figure 41-9: CTS Lock Out Screen

Note: The CTS lock out screen is visually different from the CHCS II lock out screen. Notice also that unlike the CHCS II lock out screen, a password does not need to be entered to unlock the session.

41.3.4 Appointments

The Appointments module is the default module to be viewed upon login. Prepositioned appointments, located in the baseline database, are immediately available for medical, dental and SRTS II training. The default date of the appointments is the date of installation or reset. So, if the Training System is installed on March 1, the prepositioned appointments is not visible on March 2nd unless the filter is changed.

41.3.5 MEDCIN (S/O) Starter Templates

The Training System is loaded with starter MEDCIN (S/O) templates. Use these as a beginning point when building your own, customized templates.

Follow the steps below to access the MEDCIN starter templates:

1. Open a patient encounter.

2. Click **S/O** from the Patient Encounter module.
3. Click **Template Mgt.** in the Action bar.
4. Expand the **My Favorites** folder to view the available templates.

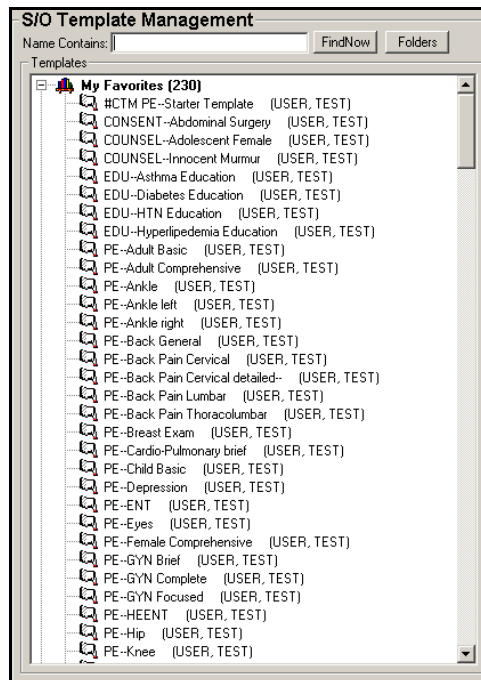


Figure 41–10: MEDCIN Templates

The starter templates are organized by component and type (ex: Well Child templates). Load and use any of the starter templates as a beginning point when building your own templates.

41.3.6 Encounter Starter Templates

The encounter starter templates are located in the Template Management module. From the Search/Browse tab, perform a search for templates that include the words *starter kit*.

Follow the steps below to access the Encounter Starter Kit Templates:

1. Click on the + next to the Tools folder in the Folder List.
2. Click **Template Management** from the Folder List.
3. On the Search/Browse tab, click **Search** from the Action bar.
4. In the Template Name field, enter *starter kit*.

Figure 41–11: Encounter Template Search

5. Click **Search** to view all of the Encounter Starter Kit Templates.

Template Name	ID	Scope	Owner	Shared	Favorite
Abd Pain_starter kit	1139	Clinic	CHCSII ITT HC2T	Yes	No
Abnormal Vaginal Bleeding_starter kit	1140	Clinic	CHCSII ITT HC2T	Yes	No
Allergic Rhinitis_starter kit	1141	Clinic	CHCSII ITT HC2T	Yes	No
Ankle Sprain Left_starter kit	1142	Clinic	CHCSII ITT HC2T	Yes	No
Ankle Sprain Right_starter kit	1143	Clinic	CHCSII ITT HC2T	Yes	No
Asthma_starter kit	1144	Clinic	CHCSII ITT HC2T	Yes	No
Breast Mass_starter kit	1145	Clinic	CHCSII ITT HC2T	Yes	No
Depression_starter Kit	1146	Clinic	CHCSII ITT HC2T	Yes	No
Diabetes_starter kit	1147	Clinic	CHCSII ITT HC2T	Yes	No
HTN_starter kit	1148	Clinic	CHCSII ITT HC2T	Yes	No

Figure 41–12: Encounter Starter Kit Templates

41.4 Patient Information

The Training System contains patients of various ages and ailments. The system is populated with a male and a female patient from age 24 hours to age 80, which matches the critical stages of development.

Certain patients have associated encounter data (lab and rad results, problems, medications).

41.4.1 Patient Search–Training System Functionality

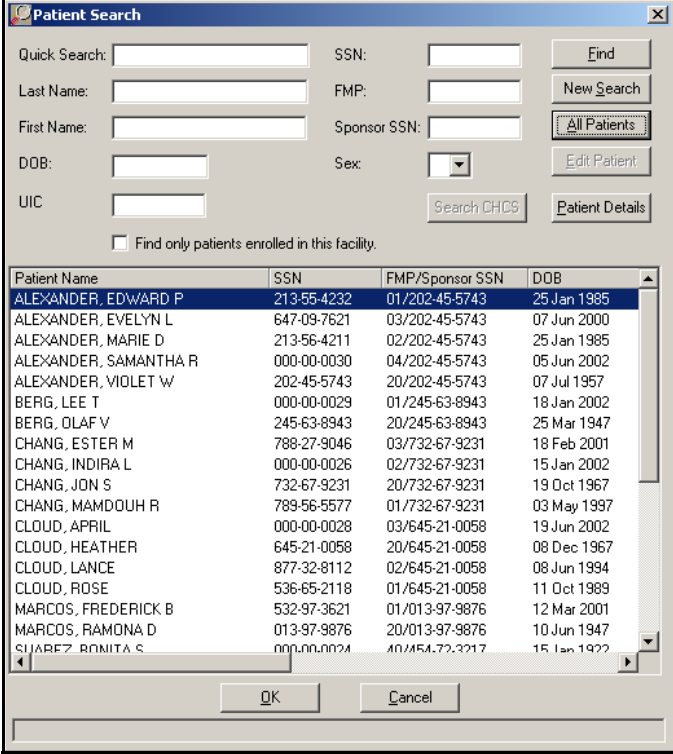
The Patient Search module contains two features that are not part of CHCS II. One is the All Patients feature and the other is Patient Details.

- All Patients: Allows you to view all the patients in the Training System database

- Patient Details: Allows you to view all the patient-specific information (age, associated clinical data)

Follow the steps below to locate patients in the Training System database:

1. Click **Search** from the Folder List to view the Patient Search window.
2. Click **All Patients** to view all the patients in the database.



The screenshot shows a 'Patient Search' dialog box with several search criteria fields and a list of patients. The search criteria include Quick Search, Last Name, First Name, DOB, UIC, SSN, FMP, Sponsor SSN, and Sex. There are buttons for 'Find', 'New Search', 'All Patients', 'Edit Patient', 'Search CHCS', and 'Patient Details'. A checkbox at the bottom left is labeled 'Find only patients enrolled in this facility.' The patient list is as follows:

Patient Name	SSN	FMP/Sponsor SSN	DOB
ALEXANDER, EDWARD P	213-55-4232	01/202-45-5743	25 Jan 1985
ALEXANDER, EVELYN L	647-09-7621	03/202-45-5743	07 Jun 2000
ALEXANDER, MARIE D	213-56-4211	02/202-45-5743	25 Jan 1985
ALEXANDER, SAMANTHA R	000-00-0030	04/202-45-5743	05 Jun 2002
ALEXANDER, VIOLET W	202-45-5743	20/202-45-5743	07 Jul 1957
BERG, LEE T	000-00-0029	01/245-63-8943	18 Jan 2002
BERG, OLAF V	245-63-8943	20/245-63-8943	25 Mar 1947
CHANG, ESTER M	788-27-9046	03/732-67-9231	18 Feb 2001
CHANG, INDIRA L	000-00-0026	02/732-67-9231	15 Jan 2002
CHANG, JON S	732-67-9231	20/732-67-9231	19 Oct 1967
CHANG, MAMDOUH R	789-56-5577	01/732-67-9231	03 May 1997
CLOUD, APRIL	000-00-0028	03/645-21-0058	19 Jun 2002
CLOUD, HEATHER	645-21-0058	20/645-21-0058	08 Dec 1967
CLOUD, LANCE	877-32-8112	02/645-21-0058	08 Jun 1994
CLOUD, ROSE	536-65-2118	01/645-21-0058	11 Oct 1989
MARCOS, FREDERICK B	532-97-3621	01/013-97-9876	12 Mar 2001
MARCOS, RAMONA D	013-97-9876	20/013-97-9876	10 Jun 1947
SUAREZ, BONITA S	000-00-0024	00/054-72-3217	15 Jan 1922

Figure 41-13: All Patients

3. Follow the steps below to view patient-specific information, click **Patient Details**.

The screenshot shows a 'Patient Search' dialog box with the following search criteria:

- Quick Search: []
- SSN: []
- Last Name: []
- FMP: []
- First Name: []
- Sponsor SSN: []
- DOB: []
- Sex: []
- UIC: []

Buttons include: Find, New Search, All Patients, Edit Patient, Search CHCS, Patient Details, and a checkbox for 'Find only patients enrolled in this facility.' Below the search fields is a table with the following data:

	A	B	C	D	E	
1	Name	SSN	Sponsor SSN	Race	Age	S
2						
3	Wunderlich, Gertha M.	000-00-0023	818-11-8118	Caucasian	< 24 hours	F
4	Cloud, April	000-00-0028	645-21-0058	Native American	< 24 hours	M
5						
6	Alexander, Samantha R	000-00-0030	202-45-5743	Black	2 weeks	F
7	Suarez, Jose Q	000-00-0031	454-72-3217	Hispanic	2 weeks	M
8						
9	Chang, Indira L	000-00-0026	732-67-9231	SE Asian	6 months	F
10	Berg, Lee T	000-00-0029	245-63-8943	Asian	6 months	M
11						
12	Chang, Ester M	788-27-9046	732-67-9231	Black, Hispanic	1 year	F
	Marrons	532-97-3621	013-97-9876	White	1 year	M

Buttons at the bottom: OK, Cancel.

Figure 41-14: Patient Details

41.5 Removing the Training System

You cannot remove the Training System without removing CHCS II. When removing CHCS II and the Training System from your workstation, use the standard Windows Add/Remove function.

Follow the steps below to remove CHCS II and the Training System:

1. On your workstation desktop, select **Start**, point to **Settings**, and then click **Control Panel**.
2. Double-click **Add/Remove Programs**.
3. Click the **CHCS II** listing and then click **Remove**.
4. Click **Yes** at the prompt.
5. The InstallShield Wizard removes CHCS II and the Training System from your computer. Click **Finish** when the task is complete.

42.0 VITAL SIGNS

42.1 Vital Signs Overview

The Vitals Sign module enables you to view, edit, delete, and add vital signs information for a patient in the CDR. The Vital Signs module can be accessed in two different areas on the Folder List, under Health History and under Current Encounter. If the Vital Signs module is accessed under Health History, only past vitals can be reviewed. If accessed through the current encounter, vital signs may be reviewed, entered, edited, or deleted.

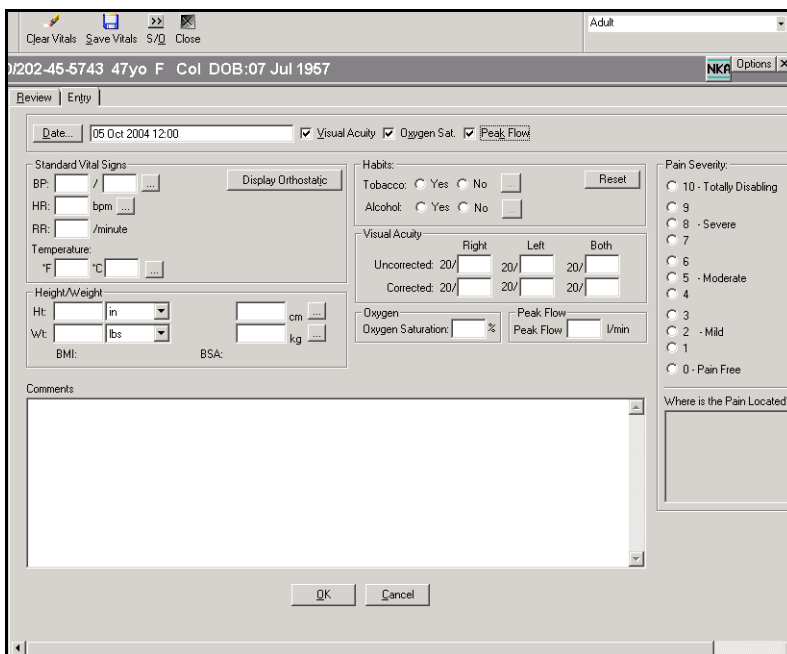


Figure 42–1: Military Clinical Desktop— Vital Signs Module— Entry Tab

42.2 Setting the Properties of the Vital Signs Module

When accessing the Vital Signs module from the Health History folder in the Folder List or a current encounter, you can customize the default settings for both the Entry and Review tabs.

Follow the steps below to set the properties of the Vital Signs module:

1. On the Vital Signs window, click **Options** in the upper-right corner. The Properties window opens.

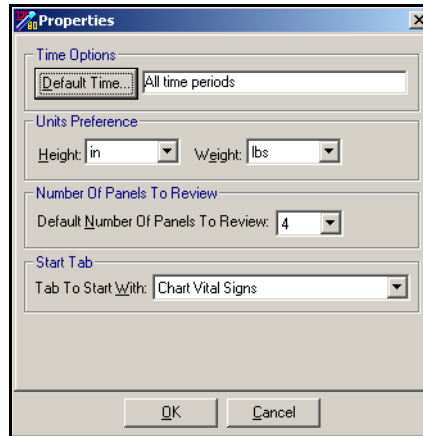


Figure 42-2: Vital Signs – Properties Window

2. Set the following preferences:
 - **Default Time:** Click **Default Time** to view the Time Search window. Select the desired option for the date range of the records to be viewed on the Review tab.
 - **Temperature, Height, and Weight:** Using the drop-down lists, select the Temperature, Height, and Weight units displayed on the Entry tab.
 - **Default Number of Panels to Review:** Use the drop-down list to select the desired number of panels to be reviewed on the Review tab.
 - **Tab to Start With:** Use the drop-down list to select the tab (Review or Entry) that appears when you open the Vital Signs module.
3. Click **OK** to save the selected settings as the default settings.

42.3 Entering New Vital Signs

The Entry tab allows vital signs to be entered under three different categories:

- Adult
- Obstetric (Female Patients)
- Pediatric

The default view is Adult, which displays Standard Vital Signs, Height/Weight, and Tobacco Use. Selecting either **Obstetric** or **Pediatric** brings up additional panels specific to their respective category. Vital signs must be entered in the Current Encounter Vital Signs module in an open encounter.

Follow the steps below to enter new vital signs:

1. Open a patient encounter.
2. On the Patient Encounters module, click **Vitals**. The Vitals module opens and the Entry tab is displayed by default.

Tip:

*You can also access the Vitals module by opening the Current Encounter folder and clicking **Vital Signs** on the Folder list.*

Review | Entry

Date: 12 Aug 2004 09:52 Visual Acuity Oxygen Sat. Peak Flow

Standard Vital Signs: BP: / ... HR: bpm ... RR: /minute Temperature: °F °C ...

Height/Weight: Ht: in cm ... Wt: lbs kg ... BMI: BSA:

Habits: Tobacco: Yes No ... Alcohol: Yes No ...

Pain Severity: 10 - Totally Disabling 9 8 - Severe 7 6 5 - Moderate 4 3 2 - Mild 1 0 - Pain Free

Comments:

Where is the Pain Located?

Figure 42-3: Vital Signs Entry Module—Entry Tab

3. Select the category for which you are entering vitals from the drop-down list to the right, on the Action bar.

Note: The default is Adult. The Obstetric option, if the patient is female, includes the adult panels plus the Urine Dip Stick panel. The Pediatric option includes the adult panels plus the Head Circumference panel.

4. Select the checkbox for any of the following to display additional vital sign input fields, if necessary:
 - Visual Acuity
 - Oxygen Saturation
 - Peak Flow

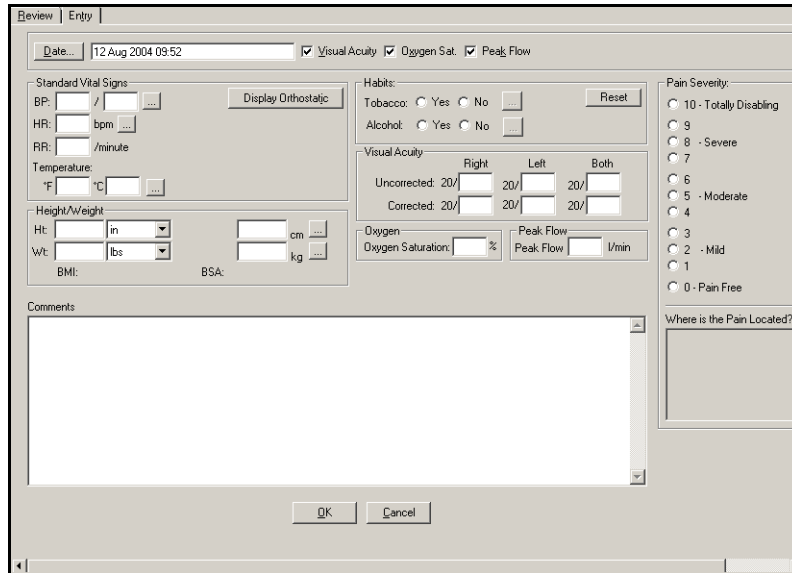


Figure 42–4: Vitals Module—Entry Tab

5. Enter the correct data in the following fields and tab to the next field.
 - **Standard Vital Signs:** Enter blood pressure, heart rate, respiratory rate (how many breaths the person takes in a minute), and temperature (in Celsius or Fahrenheit). The **Blood Pressure**, **Heart Rate**, and **Temperature** fields allow you to add modifiers. Click **Display Orthostatic** if you want to enter orthostatic vital signs for the patient.
 - **Habits:** Select the radio button to denote the usage of tobacco and/or alcohol. Clicking the **Yes** radio button activates the Ellipsis button. Click the **Ellipsis** button to document the frequency/duration.

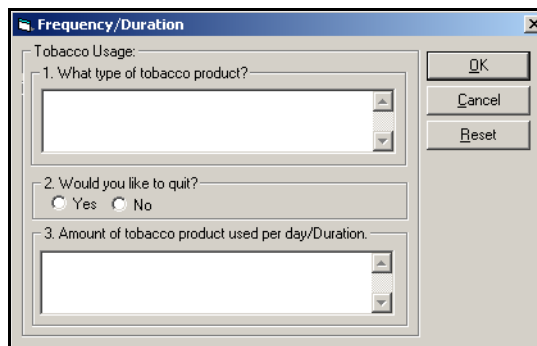


Figure 42–5: Tobacco Frequency/Duration Window

Figure 42–6: Alcohol Frequency/Duration Window

- **Height/Weight:** Enter patient height information in inches, feet, or centimeters and weight in pounds, ounces, grams, or kilograms. The height and weight can be entered using decimals (e.g., 75.6) or fractions (e.g., 175 ½). You can add modifiers to both the height and weight categories. The system automatically calculates the Body Mass Index (BMI) and the Body Surface Area (BSA).
- **Comments:** Enter any comments.

Note: If the data is abnormal, a Vital Sign Range Warning appears. Click **Yes** to continue with the entered data. Click **No** to go back and re-enter the data.

Note: Click the **Ellipsis** button to add modifier information to the associated vital sign.

6. Click **OK** to save the vitals or click **Save Vitals** on the Action bar.

42.4 Editing Vital Signs

You can only edit vital signs for the current encounter.

Follow the steps below to edit vital signs:

1. On the Review tab, select the vital signs you want to edit.
2. Click **Edit Vitals** on the Action bar. The Entry tab automatically opens.

Note: The Edit Vitals option is not available if you access the Vital Signs module from the Health History folder on the Folder List.

3. Enter any additional comments or add any values in the following areas:

- Standard Vital Signs
 - Habits
 - Height/Weight
 - Comments
 - Visual Acuity
 - Oxygen Saturation
 - Peak Flow
 - Pain Scale
4. Click **OK** to save the information. The edits are documented in the Change History portion of the Encounter Document.

42.5 Deleting Vital Signs

You can only delete vital signs for the current encounter.

Follow the steps below to delete vital signs:

1. On the Review tab, select the vital signs you want to delete.

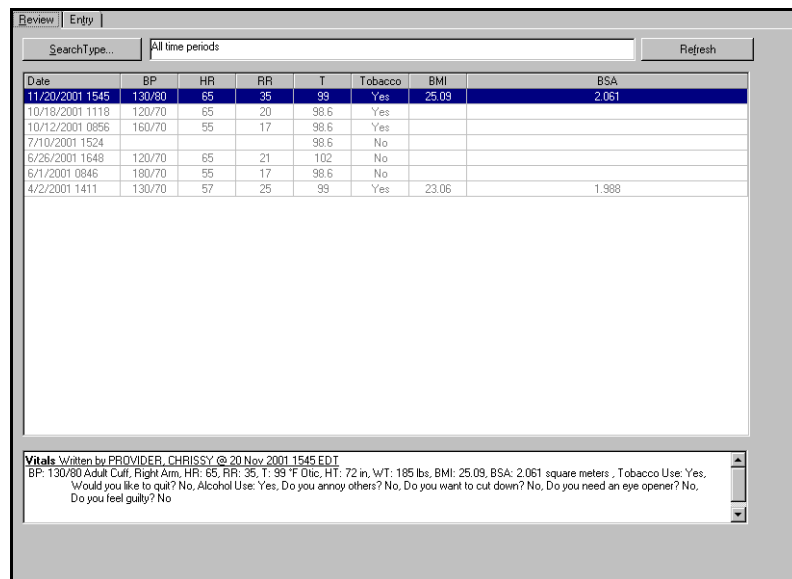


Figure 42-7: Vital Signs Entry Module—Review Tab

2. Click **Delete Vitals** on the Action bar. A confirmation message appears.
3. Click **Yes**. The deletion is documented in the Change History portion of the encounter document.

42.6 Graphing Vital Signs

You can only graph vital signs for a current encounter.

Tip:
 The **Delete Vitals** option is not available if you access the **Vitals** module from the **Health History** folder on the **Folder List**.

Follow the steps below to graph vital signs:

1. On the Review tab, select the set of vitals you want to graph.
2. Click **Graph Vitals** on the Action bar. The Graph Vitals window opens.

Tip:
More than one set of vital signs must be selected to generate the graph.

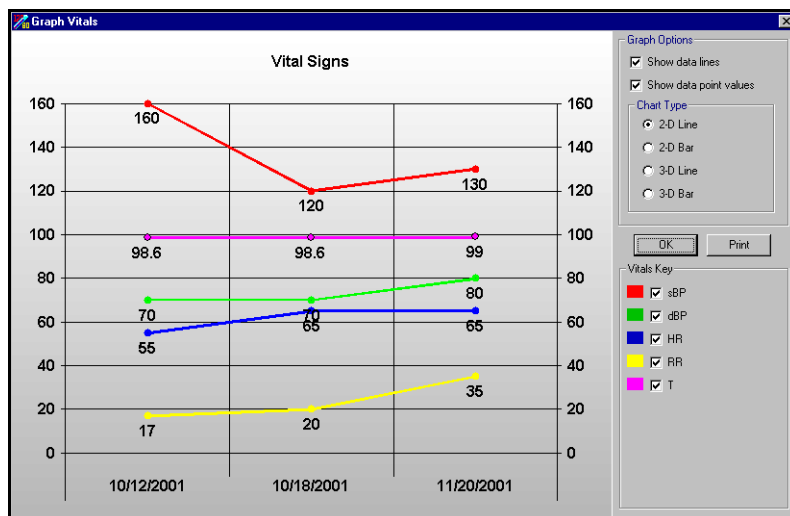


Figure 42-8: Graph Vitals Window

3. Select the checkbox(es) to change the graph options, if necessary. The default displays both data lines and data point values.
4. Select the radio buttons to change the chart type, if necessary. The default displays the chart in a 2-D line.
5. Click **Print** to print the current graph.
6. Click **OK** to close the Graph Vitals window and return to the Vital Signs window.

42.7 Reviewing Vital Signs

Follow the steps below to review past vital signs:

1. On the Review tab, view past vital sign information.
2. Do one of the following:
 - If you want to customize the number of vital sign entries listed in the tab:
 - a. Click **Search Type**. The Time Search window opens.

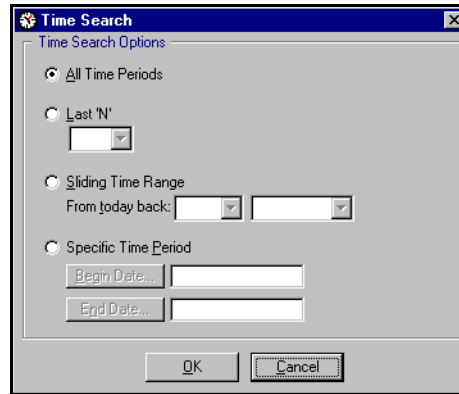


Figure 42-9: Time Search Window

- b. Select the desired time option.
 - c. Click **OK**. The entries meeting the search criteria appear in the tab.
- If you want to view details on a specific set of vital signs:
 - a. Select the set of vital signs for which you want to view detailed information.
 - b. The details populate the text field in the bottom of the tab.
- You want to change the unit of temperature values for a set of vitals:
 - a. Select the set of vital signs.
 - b. Click the **Temp** toggle button on the Action bar.

42.8 Vital Sign Ranges

The following are valid ranges for entering vital sign information in CHCS II.

Vital Signs	CHCS II Range
Blood Pressure:	
Systolic	80–200 mm Hg
Diastolic	Must be less than systolic and 40–120 mm Hg
Heart Rate	40–150 Beats per minute
Respiratory Rate	5–40 breaths per minute
Temperature	95–105° F
Height	12–84 inches
Weight	1–350 pounds
Visual Acuity	10–999
Oxygen Saturation	70–100 percent
Peak Flow	40–650 liters per min
Head Circumference (Pediatric)	10–22 inches
Pain Sensitivity	Adult: 0–10 (with 0 being pain free and 10 being totally disabling) Child: 0–5 (with 0 being no hurt and 5 being hurts worst)

Note: If you enter a vital range that is out of the ordinary, a warning window appears. Click **Yes** to accept the vital sign entry, or click **No** to re-enter the vital sign.

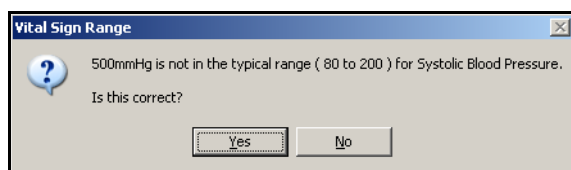


Figure 42–10: Warning Window

43.0 WEB BROWSER

43.1 Web Browser Overview

CHCS II is installed with the Internet Explorer Web Browser. This functionality enables you to access the Internet for the purpose of researching information from a variety of favorite medical sites without exiting CHCS II. Because the Web Browser is contained within CHCS II, the application does not time out while searching the Internet. Navigation in the Web Browser is done through the Action bar.



Figure 43–1: Military Clinical Desktop—Web Browser

43.2 Changing the Internet Home Page

Once the Web Browser has been accessed, the internet home page is displayed in the Workspace. The internet home page can be changed according to individual preference.

Follow the steps below to change the Internet home page:

1. On the Windows Task bar, click **Start**.
2. Point to Settings and click **Control Panel**. The Control Panel window opens.

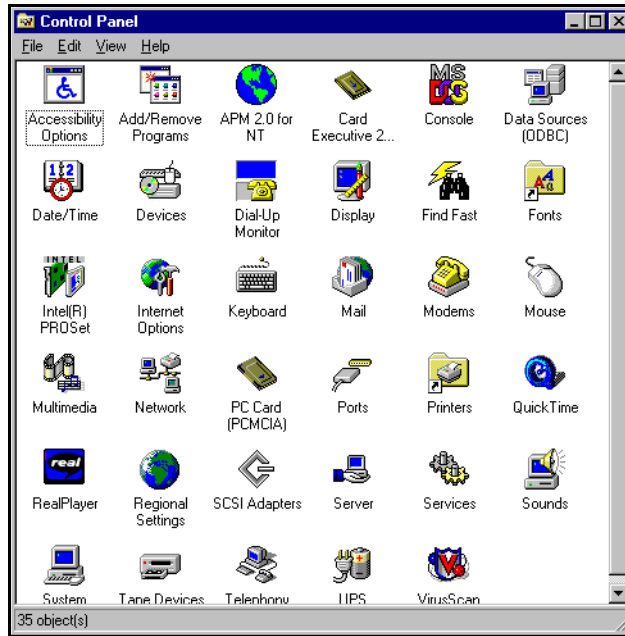


Figure 43-2: Control Panel

3. Double-click **Internet Options**. The Internet Properties window opens with the General tab defaulted.

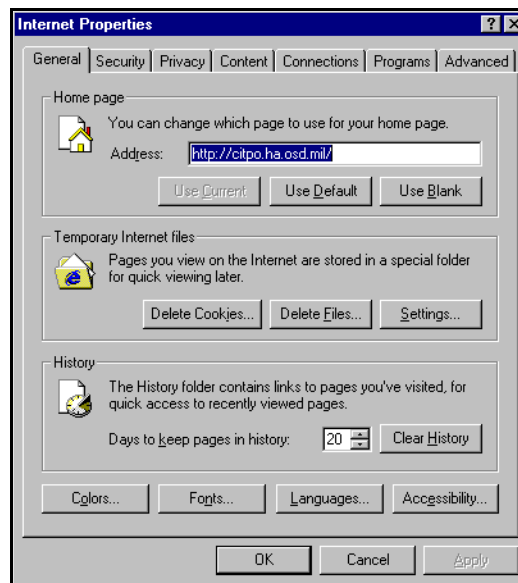


Figure 43-3: Internet Properties Window

4. In the Home Page area enter the desired URL in the Address field.
5. Click **OK**. This is the webpage that displays when you access the Web Browser. Click **Home** on the Action bar to return to the home page at any time.

43.3 Accessing the Favorites List

The Favorites list is a shortcut to Internet sites that are frequently accessed.

Follow the steps below to access the favorites list:

1. Click **Favorites** on the Action bar. The Goto Favorite window opens.

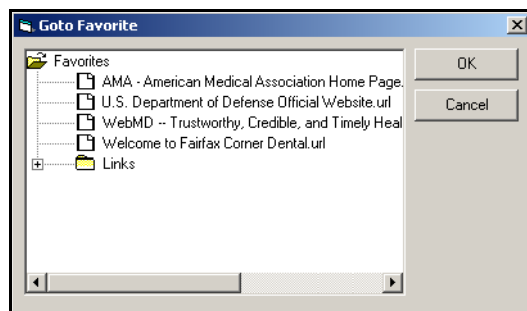


Figure 43-4: Goto Favorite Window

2. Select the desired URL and click **OK**. The site displays in the Workspace.

43.4 Adding to the Favorites List

Follow the steps below to add to the favorites list:

1. Navigate to the website you would like to add to your favorites list.
2. Click **Add** on the Action bar. The Add Favorites window opens.

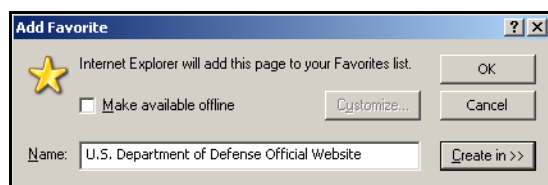


Figure 43-5: Add Favorite Window

Note: Notice that a default website name is displayed in the Name field. You can use this website name, or enter a new name in the Name field. It does not have to be the exact name for the website, but should be something that reminds you of the site.

3. Click **OK**. The website is added to your favorites list.

43.5 Organizing the Favorites List

Once Internet sites are added to your favorites list, you can organize, rename or delete them.

1. Click **Organize** on the Action bar. The Organize Favorites window opens.

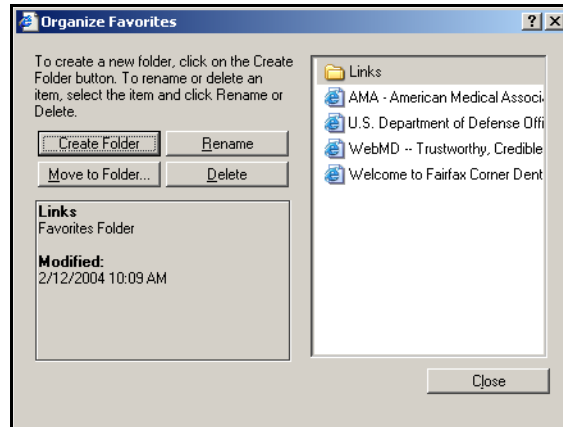


Figure 43–6: Organize Favorites Window

2. Click **Close** after you are finished organizing your favorites list.

43.5.1 Creating a New Folder

Follow the steps below to create a new folder:

1. Click **Create Folder** on the Organize Favorites window. A new folder is created at the end of your favorites list.
2. Enter the name of your new folder and press **Enter** on your keyboard.

43.5.2 Moving a Favorite into a Folder

Follow the steps below to move a favorite into a folder:

1. Select a favorite from the Organize Favorites window and click **Move to Folder**. The Browse for Folder window opens.

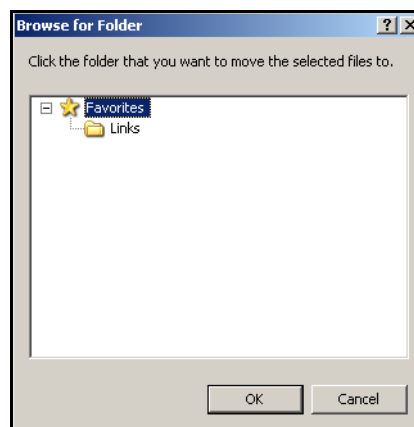


Figure 43–7: Browse for Folder Window

2. Select a folder and click **OK**. The favorite is now moved into the selected folder.

43.5.3 Renaming Favorites

Follow the steps below to rename a favorite:

1. Select a favorite from the Organize Favorites window and click **Rename**.
2. Enter the new name of the favorite and press **Enter** on your keyboard. Your favorite is now renamed.

43.5.4 Deleting Favorites

Follow the steps below to delete a favorite:

1. Select a favorite from the Organize Favorites window and click **Delete**. The Confirm File Delete window appears.
2. Click **Yes**. The favorite is now deleted from your favorites list.

43.6 Importing HTML Bookmarks

Follow the steps below to import HTML bookmarks:

1. Click **Import** on the Action bar. The Import Bookmarks HTML into Favorites window opens.
2. Navigate to where the HTML bookmark is stored.
3. Select the HTML bookmark and click **Open**. The Browse for folder window opens.
4. Double-click the favorites folder where you want to convert the bookmarks into favorites and click **OK**. The Import Favorites warning window displays.
5. Click **Yes**. The Import Favorites warning window displays notifying you that favorites were imported successfully.
6. Click **OK**. The bookmarks are now accessible through your favorites list.

43.7 Exporting HTML Bookmarks

Follow the steps below to export HTML bookmarks:

1. Click **Export** on the Action bar. The Browse for folder window opens.
2. Select the folder that contains the favorites you want to export into an HTML bookmark and click **OK**.
3. Navigate to where you want the HTML bookmark to be created.
4. Enter the name of your HTML bookmark in the File Name field and click **Save**. The WebBrowser warning window appears, notifying you that your HTML bookmark was created successfully.
5. Click **OK**.

43.8 Printing Web Pages

Follow the steps below to print a web page:

1. Click **Print WebPage** on the Action bar. The Print window opens.
2. Select your print options and click **Print**.

44.0 WELLNESS

44.1 Wellness Overview

The Wellness module generates preventive health reminders for a patient. These reminders are tied to the United States Preventive Services Task Force guidelines for the general population. Additionally, text-based reminders can be created to notify a provider of special information on a particular patient. Active wellness reminders are placed on the Patient's Problem List area in the Health Maintenance section. Reminders tied to a measurable clinic event, such as a lab test, are automatically addressed as the event is completed. Service that is performed at an outside facility can be manually addressed.

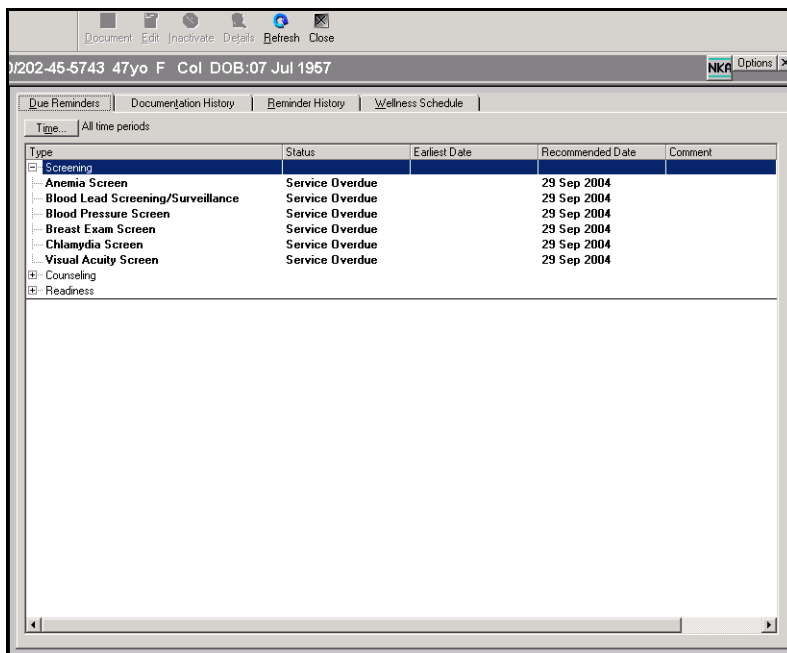


Figure 44-1: Military Clinical Desktop—Wellness Module

44.2 Setting the Filter for the Wellness Module

Click **Options** on the Wellness module or **Filter** on the Documentation History tab to open the Properties window in which display information can be customized.

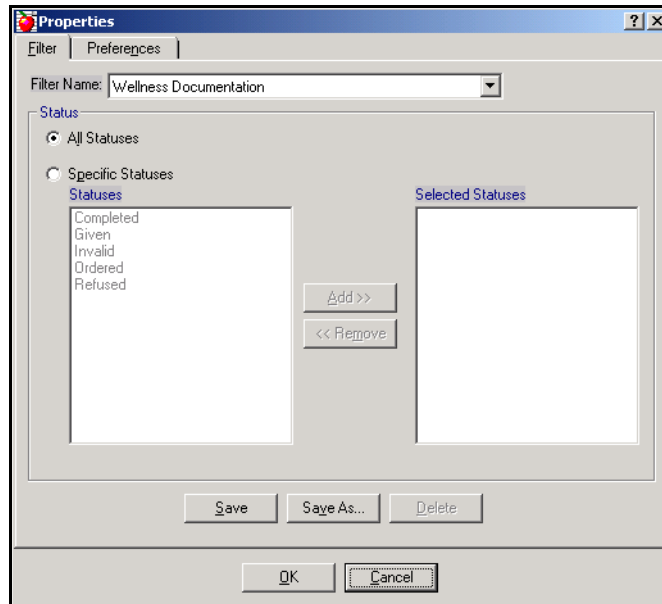


Figure 44–2: Wellness Properties Window—Filter Tab

The Filter tab provides the ability to select a previously saved filter from the drop-down list, or to create a new filter.

Follow the steps below to set the filter for the Wellness module:

1. On the Filter tab, select a **Filter Name** from the drop-down list.
2. Do one of the following:
 - If you want all of the listed statuses to display, select **All Statuses**.
 - If you want to display specific statuses:
 - Select **Specific Statuses**.
 - Select a status from the list.
 - Click **Add** to move the status to the Selected Statuses column.
3. Do one of the following:
 - If this is a new filter selection:
 - Click **Save As**.
 - Enter a new name for the filter.
 - Click **Save**.
 - If this is a change to a pre-existing filter, click **Save**.

44.3 Setting Preferences for the Wellness Module

The Preferences tab allows the time period selection to be used when displaying documented wellness items on the Documentation History tab. Once a time period is selected, it becomes the default setting.

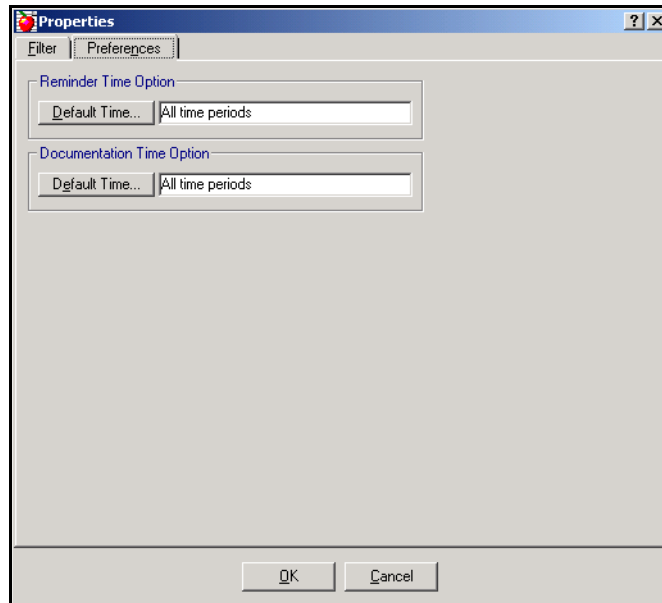


Figure 44–3: Wellness Properties Window—Preferences Tab

Follow the steps below to set preferences for the Wellness module:

1. On the Properties window, select the **Preferences** tab.
2. In the Reminder Time option, click **Default Time** to select a time option for reminders.

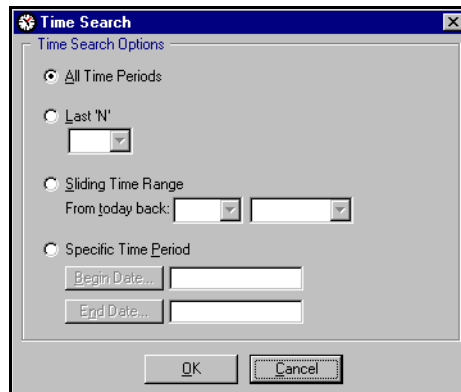


Figure 44–4: Time Search Window

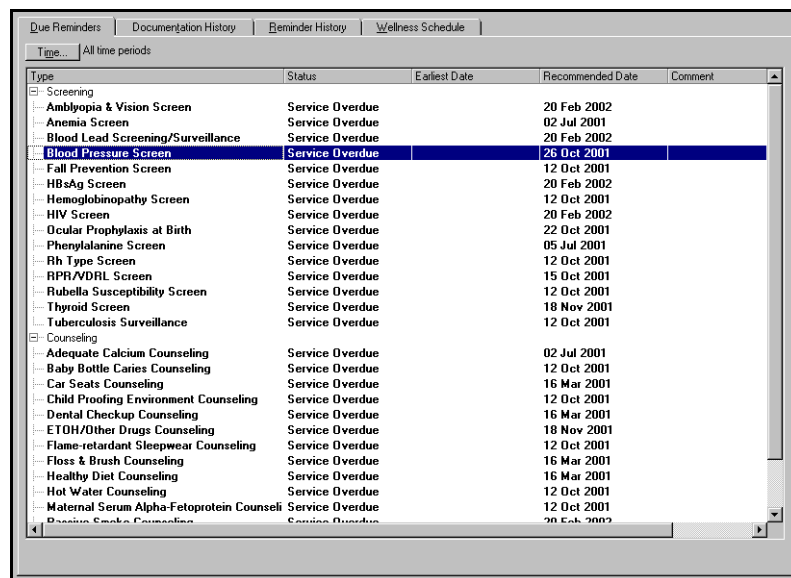
3. In the Time Search window, select time search options for reminders.
4. Click **OK**.

5. In the Documentation Time option, click **Default Time** to select a time option for documentation.
6. In the Time Search window, select time search options for documentation.
7. Click **OK**.
8. Click **OK** to set the time criteria. The data on the Documentation History window is refreshed according to the search criteria.

44.4 Due Reminders Tab

The Due Reminders tab allows you to display active reminders and documentation history (for documented reminders, either manually or automatically) for the current patient. The Due Reminders tab indicates services due in the future or due as of the current date. The tab allows you to alter the schedule of a reminder, as well as display reminders for either all patients or only the currently selected patient. The system displays the Due Reminders list grouped by wellness reminder type and then alphabetically.

Due Reminders are listed with the type of procedure, the status, the earliest date the procedure should be implemented and any comments.



Type	Status	Earliest Date	Recommended Date	Comment
Screening				
Amblyopia & Vision Screen	Service Overdue		20 Feb 2002	
Anemia Screen	Service Overdue		02 Jul 2001	
Blood Lead Screening/Surveillance	Service Overdue		20 Feb 2002	
Blood Pressure Screen	Service Overdue		26 Oct 2001	
Fall Prevention Screen	Service Overdue		12 Oct 2001	
HBsAg Screen	Service Overdue		20 Feb 2002	
Hemoglobinopathy Screen	Service Overdue		12 Oct 2001	
HIV Screen	Service Overdue		20 Feb 2002	
Ocular Prophylaxis at Birth	Service Overdue		22 Oct 2001	
Phenylalanine Screen	Service Overdue		05 Jul 2001	
Rh Type Screen	Service Overdue		12 Oct 2001	
RPR/VDRL Screen	Service Overdue		15 Oct 2001	
Rubella Susceptibility Screen	Service Overdue		12 Oct 2001	
Thyroid Screen	Service Overdue		18 Nov 2001	
Tuberculosis Surveillance	Service Overdue		12 Oct 2001	
Counseling				
Adequate Calcium Counseling	Service Overdue		02 Jul 2001	
Baby Bottle Caries Counseling	Service Overdue		12 Oct 2001	
Car Seats Counseling	Service Overdue		16 Mar 2001	
Child Proofing Environment Counseling	Service Overdue		12 Oct 2001	
Dental Checkup Counseling	Service Overdue		16 Mar 2001	
ETOH/Other Drugs Counseling	Service Overdue		18 Nov 2001	
Flame-retardant Sleepwear Counseling	Service Overdue		12 Oct 2001	
Floss & Brush Counseling	Service Overdue		16 Mar 2001	
Healthy Diet Counseling	Service Overdue		16 Mar 2001	
Hot Water Counseling	Service Overdue		12 Oct 2001	
Maternal Serum Alpha-Fetoprotein Counsel	Service Overdue		12 Oct 2001	
Positive Smoke Counseling	Service Overdue		20 Feb 2002	

Figure 44–5: Wellness Module—Due Reminders Tab

Note: All reminders appear in the Reminder Mapping window and in the A/P Reminders tab.

Note: Reminders are generated through the Wellness module for each individual patient.

44.4.1 Documenting a Due Reminder in the Due Reminders Tab

Follow the steps below to document a due reminder in the Due Reminders tab:

1. Click **Document** on the Action bar. The Document window opens.

Figure 44–6: Document Window

2. Complete the following fields to document the reminder:
 - **Status:** Refers to the status of the reminder:
 - **Completed:** The action has been taken.
 - **Ordered:** The action has been ordered.
 - **Refused:** The action has been refused by the patient.
 - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in. Click **Clinician** to search for a different clinician.
 - **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
 - **Coded:** Select a more detailed status of service from the drop-down list. For example, *Preventive Service Completed Report Reviewed*.
 - **Free-text:** Enter any additional comments in the field.
 - **Date:** Select the date the action occurred.
 - **Information Source:** Select the relationship to the patient reporting the action from the drop-down list.
 - **Admin. Location:** Enter the location where the action occurred.
3. Click **Save**.

44.4.2 Editing a Due Reminder in the Due Reminders Tab

Follow the steps below to edit a due reminder in the Due Reminders tab:

1. Select an item from the list on the Due Reminders tab.
2. Click **Edit** on the Action bar. The Edit window opens. Coded and free-text Comments are the only two fields that can be changed.

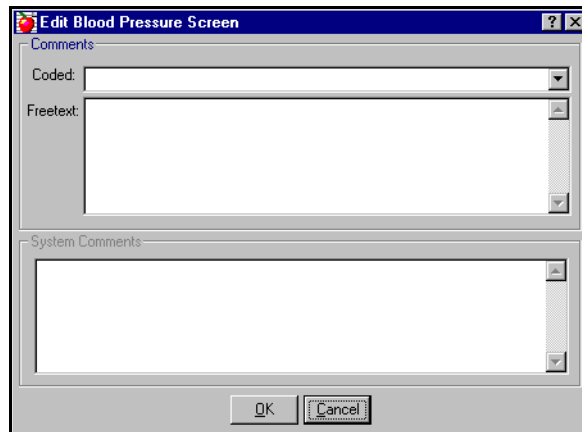


Figure 44-7: Edit Due Reminders Window

3. Select a code from the drop-down list.
4. Enter any free-text to further explain the code or in place of the code.
5. Click **OK**.

44.4.3 Inactivating a Due Reminder in the Due Reminders Tab

Inactivating a reminder prevents it from being generated.

Follow the steps below to inactivate a reminder in the Due Reminders tab:

1. Select a reminder from the Due Reminder list.
2. Click **Inactivate** on the Action bar.
3. At the Confirm Inactivation prompt, click **Yes**. The Inactivation window opens.

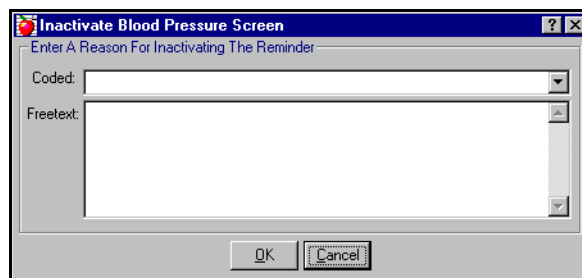


Figure 44-8: Inactivate Due Reminders Window

4. Select a code from the coded drop-down list.

Tip:

To activate an item that has been inactivated, select the Wellness Schedule tab to activate the selected reminder.

5. Enter any free-text to further explain the code or to take the place of a code.
6. Click **OK**.

44.5 Viewing Due Reminder Details in the Due Reminders Tab

Follow the steps below to view due reminder details in the Due Reminder tab:

1. Select the reminder on the Due Reminders tab.
2. Click **Details** on the Action bar. The Detail Information window opens.

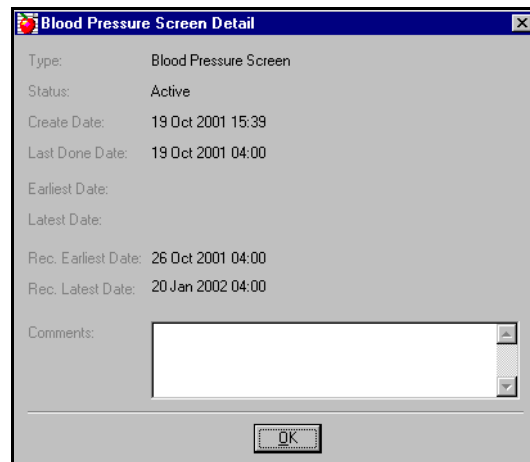


Figure 44–9: Due Reminders Detail Window

3. After viewing the due reminder information, click **OK** to close the window.

44.5.1 Adding a Wellness Schedule in the Due Reminders Tab

Follow the steps below to add a wellness schedule in the Due Reminders tab:

1. Click **Add** on the Action bar. The Add Wellness Schedule window opens.

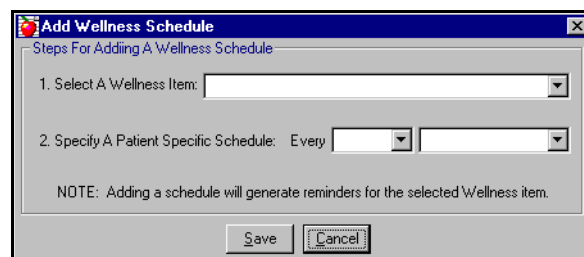


Figure 44–10: Add Wellness Schedule Window

2. Select a **Wellness Item** from the drop-down list.
3. Select a Patient Specific Schedule from the drop-down lists to document the frequency of the wellness item.

- Click **Save** to save the new schedule.

44.6 Documentation History Tab

The Documentation History tab allows you to define all Wellness-related events, including Immunizations or satisfaction of Wellness Reminders. The Documentation History tab allows you to document the appropriate service for the selected reminder. The tab also allows you to select either a coded or free-text comment to associate with a Wellness Reminder.

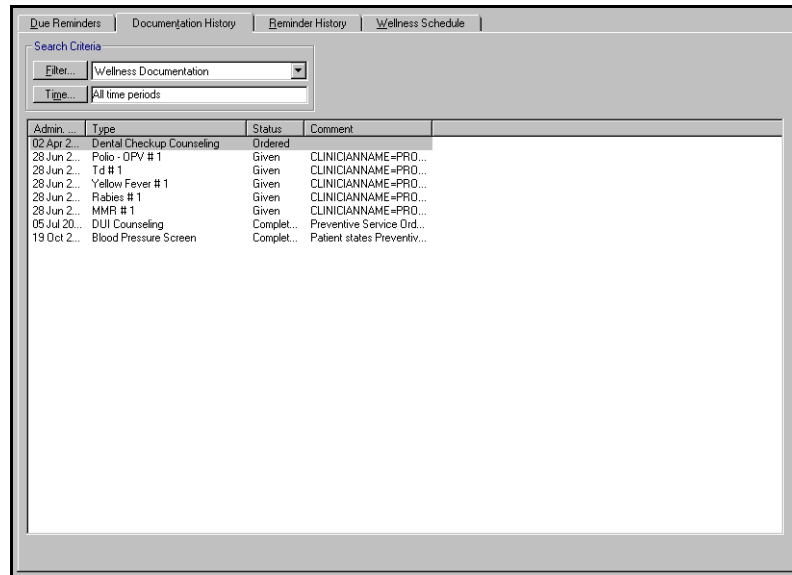


Figure 44–11: Wellness Module—Documentation History Tab

44.6.1 Adding a Reminder History in the Documentation History Tab

Follow the steps below to add a reminder history in the Documentation History tab:

- Click **Add History** on the Action bar. The Select History Type window opens.

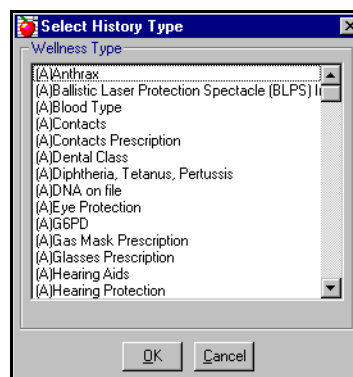


Figure 44–12: Select History Type Window

2. Select the desired procedure.
3. Click **OK**. The new History window opens with the clinician's name and type pre-filled.

Note: The **Date**, **Information Source**, and **Status** are required fields.

Figure 44-13: History Window

4. Complete the required fields.
 - **Status:** The status can be changed to Completed, Ordered, or Refused.
 - **Date:** Select the date the action occurred.
 - **Information Source:** Enter the relationship to the patient reporting the action.
5. Update information in the remaining fields, if necessary.
 - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in.
 - **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
 - **Coded:** Select a more detailed status of service by accessing the drop-down list.
 - **Free-text:** Enter any additional comments.
 - **Admin. Location:** Enter the location where the action occurred.
6. Click **Save** to add this reminder history information to the documentation history list.

44.6.2 Deleting Documentation History in the Documentation History Tab

Follow the steps below to delete documentation history in the Documentation History tab:

1. Select the item to be deleted.
2. Click **Delete** on the Action bar.
3. On the Confirm Deletion prompt, click **Yes** to delete.

44.6.3 Editing a Reminder History in the Documentation History Tab

Follow the steps below to edit a reminder history in the Documentation History tab:

1. Select the reminder to be modified.
2. Click **Edit** on the Action bar. The Documentation History Edit window opens.

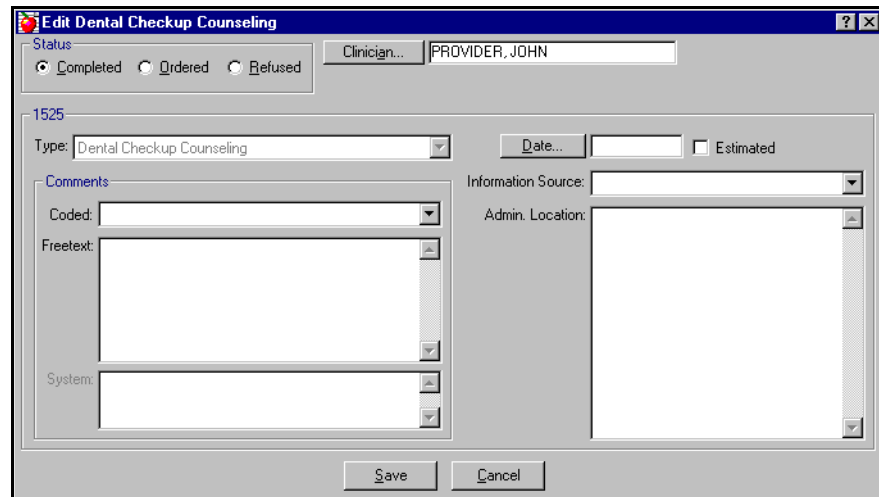


Figure 44–14: Documentation History Edit Window

3. Modify the desired data.
4. Click **Save**.

44.7 Reminder History Tab

The Reminder History tab displays a history of reminders.

Type	Status	Earliest...	Recommended...	Comment
Down Syndrome Marker Testing	Canceled	02 Jul 2001		
Verify eye mask insert exam <1 yr ago	Canceled	26 Jun 2001		
Verify eye glasses exam <1 yr ago	Canceled	16 Mar 2001		
Total Cholesterol Screen	Canceled	16 Mar 2001		
Tobacco Cessation Counseling	Canceled	16 Mar 2001		
STD Prevention	Canceled	16 Mar 2001		
Helmets Counseling	Canceled	16 Mar 2001		
Height & Weight Screen	Canceled	16 Mar 2001		
Prostate-Specific Antigen (PSA) ...	Canceled	16 Mar 2001		
Blood Pressure Screen	Documen...	16 Mar 2001		
Strabismus Screen	Canceled	16 Mar 2001		
Firearms Counseling	Canceled	16 Mar 2001		
Smoke Detector Counseling	Canceled	16 Mar 2001		
Safety Belt Counseling	Canceled	16 Mar 2001	Expired	
Problem Drinking Assessment	Canceled	16 Mar 2001		
DUI Counseling	Documen...	16 Mar 2001		
Multivitamin With Folate	Canceled	16 Mar 2001		
Urine Lx	Canceled	26 Jun 2001		
Verify HIV test <1yr ago	Canceled	26 Jun 2001		
Verify Physical exam	Canceled	05 Jul 2001		
Hearing Protection	Canceled	05 Jul 2001		

Figure 44–15: Wellness Module—Reminder History Tab

44.7.1 Setting the Time Filter in the Reminder History Tab

Follow the steps below to set the time filter in the Reminder History tab:

1. Click **Time**. The Time Search window opens.

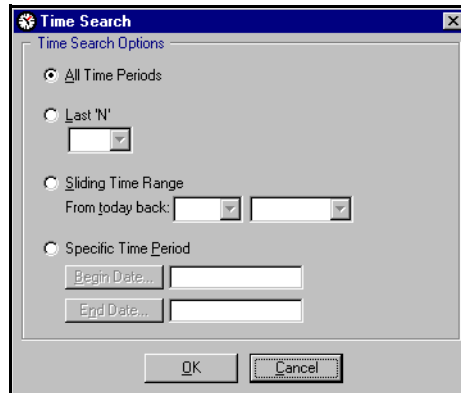


Figure 44–16: Time Search Window

2. Select **Time Search Options** for reminders.
3. Click **OK**. The data on the Reminder History List screen is refreshed according to the search criteria.

44.7.2 Editing a Reminder History in the Reminder History Tab

Follow the steps below to edit a reminder history in the Reminder History tab:

1. Select the Reminder History to be modified.
2. Click **Edit** on the Action bar. The Edit Reminder window opens.

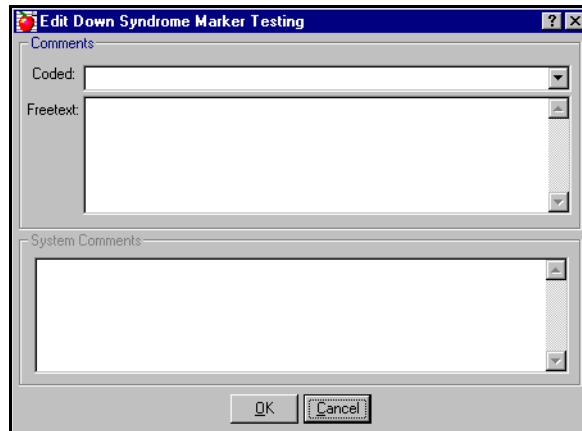


Figure 44–17: Due Reminder Edit Window

3. Select a code from the coded drop-down list.
4. Enter any necessary free-text to provide further explanation or to take the place of a code.
5. Click **OK**.

44.7.3 Activating/Inactivating a Reminder in the Reminder History Tab

The Activate/Inactivate button toggles between activate and inactivate depending on the state of the selected reminder. If the reminder is already active, the **Inactivate** button is seen. If the reminder is inactive, the **Activate** button is seen.

Follow the steps below to activate/inactivate a reminder in the Reminder History tab:

1. Select the inactive reminder.
2. Click **Activate** on the Action bar.
3. On the Confirm Reminder Activation window, click **Yes**.

Follow the steps below to inactivate a reminder:

1. Select the active reminder.
2. Click **Inactivate** on the Action bar. The Inactivation window opens.

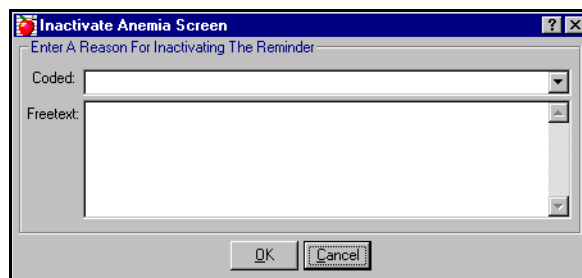


Figure 44–18: Inactivate Reminder Window

3. Enter a reason for the inactivation as a coded or free-text comment.

4. Click **OK**.
5. On the Confirm Inactivation window, click **Yes** to inactivate the reminder.

44.7.4 Viewing Reminder History Details in the Reminder History Tab

Follow the steps below to view reminder history details in the Reminder History tab:

1. Select the reminder.
2. Click **Details** on the Action bar. The Detail Information window opens.

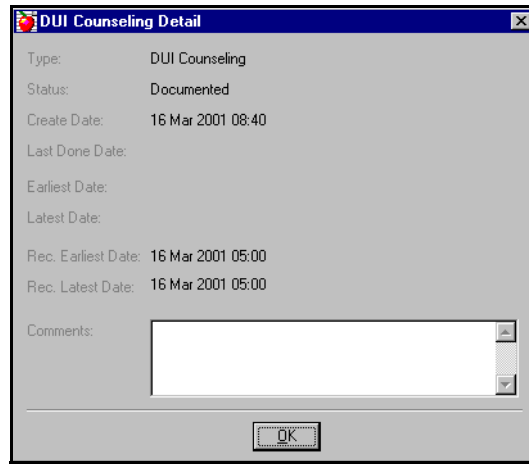


Figure 44–19: Due Reminder Detail Window

3. View the detailed reminder information in the window.
4. Click **OK**.

44.8 Wellness Schedule Tab

The Wellness Schedule tab displays the type of action, the administration schedule, the status of the reminder and a comment.

Type	Schedule	Reminder	Comments
Screening			
Amblyopia & Vision Screen	Every 5 days	Generate	
Anemia Screen	Every 4 months	Generate	
Blood Lead Screening/Surveillance	Every 2 days	Generate	
Blood Pressure Screen	Every 7 days	Generate	
Down Syndrome Marker Testing	Every 3 months	Generate	
Fall Prevention Screen	Every 2 months	Generate	
HBsAg Screen	Every 11 days	Generate	
Height & Weight Screen	Every 3 months	Do Not Generate	
Hemoglobinopathy Screen	Unavailable	Generate	
HIV Screen	Every 12 days	Generate	
Ocular Prophylaxis at Birth	Every 2 months	Generate	
Phenylalanine Screen	Every 10 days	Do Not Generate	
Problem Drinking Assessment	Every 1 years	Do Not Generate	
Prostate-Specific Antigen (PSA) Screening	Every 2 months	Generate	
Rh Type Screen	Every 1 months	Generate	
RPR/VDRL Screen	Every 5 days	Generate	
Rubella Susceptibility Screen	Every 1 months	Generate	
Strabismus Screen	Every 10 days	Do Not Generate	
Thyroid Screen	Every 3 days	Generate	
Total Cholesterol Screen	Every 1 years	Do Not Generate	
Tuberculosis Surveillance	Every 1 months	Generate	
Urine Cx	Unavailable	Do Not Generate	
Visual Acuity Screen	Every 1 months	Generate	
Counseling			
Adequate Calcium Counseling	Every 3 days	Do Not Generate	
Baby Bottle Caries Counseling	Every 1 days	Generate	
Car Seats Counseling	Every 3 months	Generate	
Child Proofing Environment Counseling	Every 1 years	Generate	
Dental Checkup Counseling	Every 1 months	Generate	
DUI Counseling	Every 1 months	Generate	

Figure 44–20: Wellness Module—Wellness Schedule Tab

44.8.1 Adding a Wellness Schedule Reminder in the Wellness Schedule Tab

Follow the steps below to add a wellness schedule reminder in the Wellness Schedule tab:

1. Click **Add** on the Action bar. The Add Wellness Schedule window opens.

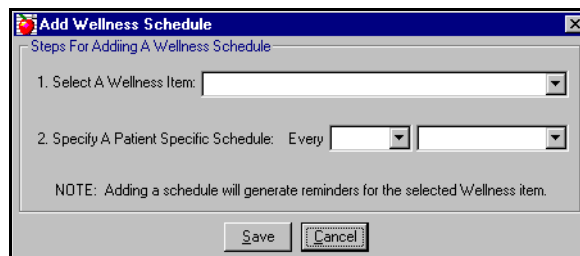


Figure 44–21: Add Wellness Schedule Window

2. Select a wellness item from the drop-down list.
3. Specify a patient schedule using the drop-down list to document the frequency of the wellness item.
4. Click **Save**.

44.8.2 Editing a Wellness Schedule Reminder in the Wellness Schedule Tab

Follow the steps below to edit a wellness schedule reminder in the Wellness Schedule tab:

1. Select the reminder to be modified.

2. Click **Edit** on the Action bar. The Reminder Schedule window opens.

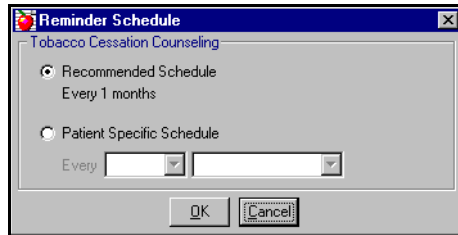


Figure 44–22: Reminder Schedule Window

3. Do one of the following:
 - If you want the wellness schedule reminder to occur once a year, select the Recommended Schedule radio button.

Note: Recommended schedule varies based on the type of test—does not automatically set reminders to one year in all cases.

- If you want to establish a patient-specific schedule:
 - Select **Patient Specific**.
 - Select a time from the drop-down list.
4. Click **OK** to set the reminder schedule.

44.8.3 Activating/Inactivating a Wellness Reminder in the Wellness Schedule Tab

The Activate/Inactivate button toggles between activate and inactivate depending on the state of the selected reminder. If the reminder is already active, the **Inactivate** button is seen. If the reminder is inactive, the **Activate** button is seen.

Follow the steps below to activate a wellness reminder in the Wellness Schedule tab:

1. Select the inactive reminder.
2. Click **Activate** on the Action bar. The Confirm Reminder Activation window opens.

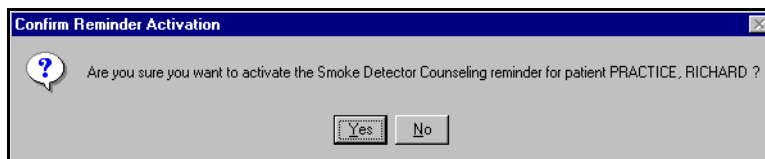


Figure 44–23: Confirm Reminder Activation Window

3. Click **Yes** to activate the reminder.

Follow the steps below to inactivate a reminder in the Wellness Schedule tab:

1. Select a reminder.

2. Click **Inactivate** on the Action bar.
3. On the Confirm Inactivation window, click **Yes**. The Inactivation window opens.

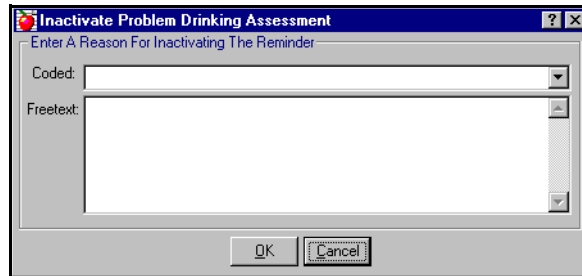


Figure 44-24: Inactivation Window

4. Select a code from the drop-down list or type free-text in place of the code.
5. Click **OK**.