CHCS II

COMPOSITE HEALTH CARE SYSTEM II

CHCS II PROVIDER
Advanced Skills Student Guide

PLEASE DO NOT REMOVE FROM CLASSROOM

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CHANGE HISTORY			
Date	**Name**	**Change Description**	**Source**
5/12/2005	Elizabeth Burrows	New Release	837.4 Release
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Lesson 1: Setup/Patient Questionnaires

Lesson Goal

The goal of this lesson is to enable the user to set up and run patient questionnaires in CHCS II.

Learning Objectives

Upon completion of this lesson, the user will be able to:

- ✓ Create and release a questionnaire.
- ✓ Edit an existing questionnaire.
- ✓ Change the status of a questionnaire.
- ✓ Select and use a questionnaire in a patient interview.
- ✓ Set viewing options for administering a questionnaire.
- ✓ Add a comment to a questionnaire as it is being administered.
- ✓ Edit a response in a saved questionnaire.
- ✓ Append a completed questionnaire.
- ✓ Associate a questionnaire with an encounter.

Questionnaire Setup

The **Questionnaire Setup** module allows you to create and modify questionnaires. Once you create a questionnaire you can modify, copy, delete, or mark it as obsolete.

Note the following exceptions in deleting a questionnaire or attempting to use a questionnaire that has been marked obsolete:

- ❒ When a questionnaire is marked as obsolete, it cannot be used.

- When a questionnaire has been used, it is tied to a patient record and cannot be deleted.

The status of the questionnaire indicates level of development or use of a questionnaire. You can choose from three questionnaire types when setting up a questionnaire:

In Development

The new questionnaire is being created.

Ready for Use

Questionnaire is ready for use.

Obsolete

Questionnaire has been removed from circulation.

Questionnaire setup:

- Allows you to create and modify questionnaires.
- Once created, you can modify, copy, delete, and mark Questionnaires obsolete.
- An open encounter is not required for Questionnaires to be created or modified.
- As you add each question, you also specify the format of the answers and enter the answers you want for each question.

With this module, you can format your answers as multiple choice (patient can only select one of the provided answers), multi-select (patient can select more than one of the provided answers), yes or no, number, and date.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

The Family Practice Clinic has just been brought up on CHCS II. The clinic has the patients complete the ***Adult Patient Questionnaire – 18 years and older*** each year and places the completed questionnaire in the out patient medical record. You have been asked to add this form as a Questionnaire in CHCS II for the clinic.

1. In the *Folder List* under the Tools folder, click the **Questionnaire Setup** icon.
2. On the Action Bar, click the **New** icon to create a new questionnaire.
3. In the Name field, enter: **Adult Patient Questionnaire > 18 years**.
4. In the Instructions to Display field, enter these instructions:

   PLEASE COMPLETE ALL QUESTIONS BY CLICKING IN THE APPROPRIATE BOX/CIRCLE. YOUR ANSWERS CAN HELP US WITH YOUR MEDICAL CARE. WE WILL DISCUSS YOUR ANSWERS WITH YOU OR SCHEDULE ANOTHER APPOINTMENT TO DISCUSS THESE.

5. Click the drop-down arrow next to the Level field and select **Clinic**.
6. Click the drop-down arrow next to the Owner field and select **CHCS II Test Clinic**.
7. Click **Add**.
8. In the **Question Test** field, add each question below.
9. Click the **Answer Type** field drop-down arrow to select the answer type, and enter each possible answer in the space provided.

Note: *Do not hit **Enter** after the last answer selection. Click **Add** for next questions. Do not click **Add** after last question/answer.*

Question	Answer Type	Possible Answers	Action
1. Do you have any problems or trouble with the following:	Multi Select	Vision Hearing Walking Eating Preparing meals Cleaning yourself	Add
2. Do you feel sad or depressed much of the time?	Yes/No	Yes No	Add
3. Are you experiencing emotional, physical or sexual abuse?	Yes/No	Yes No	Add
4. Do you have a problem with alcohol or drug use?	Multiple Choice	Yes No Not sure (Do not hit enter)	Add
5. Have you lost or gained more than 10 lbs without any reason in the past 6 months?	Yes/No	Yes No	Add
6. Do you have pain that affects your daily activities?	Yes/No	Yes No	Add
7. Rate the level of pain with 0 = Pain Free and 10 = Totally Disabling	Number	0,1,2,3,4,5,6,7,8,9, 10	Add
8. Is it hard to understand instructions from your doctor or nurse?	Yes/No	Yes No	Add
9. Do you have any social, religious, cultural or ethnic concerns that may affect the medical treatment we give you?	Yes/No	Yes No	Add
10. Do you have a living will or advance medical	Yes/No	Yes No	Add

directive?			
11. What is the date on your living will or advance medical directive? (Do not click Add.)	Date	Date	Do not click Add.

10. Click the **Save** icon on the Action Bar.
11. Highlight the Questionnaire just saved and click the **Mark Ready** icon.
12. Close the **Questionnaires Setup** module.

Scenario 2

The Diabetic Clinic has requested a change in their Diabetes – Each Visit questionnaire. They would like the first question to read: How well do you feel you are managing your diabetes? You will now edit this questionnaire and make the change.

1. Click **+** next to Tools folder in the Folder List.
2. Click **Questionnaire Setup**.
3. Click **+** next to Personal.
4. Click **+** next to Questionnaires.
5. Highlight **Diabetes – Each Visit**.
6. Click **New Version** icon on the Action Bar.
7. Change first question to read: **How well do you feel you are managing your diabetes?**
8. Click **Save** on the Action Bar.

Scenario 3

The Diabetic Clinic has told you that they no longer use their Diabetes Follow-up questionnaire. You will now inactivate the questionnaire.

1. Click **+** next to Personal.
2. Click **+** next to Questionnaires.
3. Highlight **Diabetes Follow-up**.
4. Click **Mark Obsolete** on the Action Bar.
5. Click **Close** on the Action Bar.

Patient Questionnaires

The **Patient Questionnaires** module allows the user to administer questionnaires created in the Questionnaire Setup module. Questionnaires can be administered in a single question view or multiple question view. Once completed the user can view, modify and/or associate the questionnaire to a patient encounter.

If the questionnaire is associated with an encounter, you must select Questionnaires as part of their AutoCite preferences in order to have the questionnaire as part of the patient's eSF600. Once AutoCited, the questionnaire will populate to the S/O portion of the eSF600.

There are two options for how you use it to collect patient information:

Patient Interview

The user enters the patient's responses into the questionnaire.

Patient Takes the Questionnaire at a Kiosk in the Clinic

The patient completes the questionnaire at a workstation in the clinic.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

We will set the properties for the Patient Questionnaire module and administer a questionnaire to CAPT Clayton Williams.

1. Single-click on CAPT Williams' appointment.
2. Click **Patient Questionnaires** icon under Health History.
3. Click **Options** on the Action Bar.
4. Review the two options in the drop-down menu.
5. Select **Multiple Question View** for the default.
6. Click **OK**.
7. Single-click on CAPT Williams' appointment.
8. Click **+** next to Health History folder.
9. Click **Patient Questionnaires** icon.
10. Click **Interview** icon on the Action Bar.
11. Click **+** next to Clinic.
12. Click **+** next to Questionnaires.
13. Click **+** next to CHCS II Test Clinic.
14. Highlight **Adult Patient Questionnaire 18 + yrs**.
15. Ask patient each question and document answer.
16. Add the following comment to question number 5: **GAINED 6 LBS.**
17. Click **Save** on Action Bar.

Note: *Do not close Patient Questionnaire module.*

Scenario 2

We just finished the questionnaire and CAPT Williams tells you he made a mistake on the date of his living will. It was actually revised last month. You now will edit the response on the questionnaire. Note that you can only edit a questionnaire that has a status of Incomplete.

1. Review the **Status/Score** of the questionnaire.
2. Highlight **Adult Patient Questionnaire 18 + yrs**.
3. Click **Edit** on the Action Bar.
4. Modify the date on **Question number 11**.

5. Click **Done** on the Action Bar.

Note: *Do not close Patient Questionnaire module.*

Scenario 3

CAPT Williams now tells you that he is getting a hearing aid next week and forgot to tell you during the questionnaire interview. You need to add this information to the questionnaire. Since the status of the questionnaire is now complete, you can only append the questionnaire.

1. Review the **Status/Score** of the questionnaire.
2. Highlight **Adult Patient Questionnaire 18 + yrs**.
3. Click **Append** on the Action Bar.
4. Click **Append Comment** on question number 1.
5. Type ***PATIENT STATES HE IS GETTING A HEARING AID FOR HIS RIGHT EAR NEXT WEEK****.*
6. Click **Save** on the Action Bar.
7. Click **Close** on the Action Bar.

Scenario 4

Now that the questionnaire has been completed, we will check-in CAPT William's for his appointment today and then associate the questionnaire to today's encounter. We will then set the options for the results to AutoCite into the encounter note.

1. Click CAPT Williams on the appointment screen.
2. Click **Check-In** icon on the Action Bar.
3. Scroll to the right to view the Encounter column.
4. Write down or remember the **encounter number**.
5. Click **Patient Questionnaires** under Health History.
6. Highlight **Adult Patient Questionnaire 18 + yrs**.

7. Click **Encounter** on the Action Bar.
8. Select Encounter **# XXXX**.
9. Click **OK**. Note the questionnaire display now shows the encounter number.
10. Click **Close**.
11. Click **Open Appt** on the Action Bar.
12. Click **Options** on the Action bar.
13. Click check box next to Questionnaires under AutoCite preferences.
14. Click **OK**.
15. Click **AutoCite** at top of encounter note.
16. View questionnaire responses.
17. Click **Close** on the Action Bar.
18. Clear **Patient**.

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises below.

Scenario 1

The Headache Clinic has just been brought up on CHCS II. When screening patients for the first time, the clinic has a form they ask the patients to complete prior to being seen by a user. The clinic would like to name the questionnaire Headache Initial Visit. The following questions need to be part of the questionnaire.

In the Instructions to Display field, enter these instructions:

PLEASE COMPLETE ALL QUESTIONS BY CLICKING IN THE APPROPRIATE BOX/CIRCLE. YOUR ANSWERS CAN HELP US WITH YOUR MEDICAL CARE. WE WILL DISCUSS YOUR ANSWERS WITH YOU OR SCHEDULE ANOTHER APPOINTMENT TO DISCUSS THESE.

Question	Answer Type	Possible Answers
1. Do you have a headache right now?	Yes/No	
2. When was the last time you had a headache?	Date	
3. How long have you been having headaches?	Multiple Choice	Less than 1 month 1-6 months 7-12 months Greater than 1 year
4. How often do you have a headache?	Multiple Choice	1 per day More than 1 per day 1 per week More than 1 per week 1 per month More than 1 per month
5. Are you taking any medication for the headaches? (If No, skip to question 7.)	Yes/No	
6. What medications do you take?	Multi Select	Advil Tylenol Excedrin Codiene Imitrex Other
7. Does the medication help the headaches?	Multi Select	Yes No Sometimes
8. Have you seen a medical user regarding these headaches within the last year?	Yes/No	
9. Does anyone else in your family suffer from headaches? Multiple Choice (If No, skip to question 10.)	Yes/No	
10. If so, who suffers from headaches?	Multi Select	Mother Father Siblings Grandparents No One

11. Is there a lot of stress in your normal day?	Yes/No	

Scenario 2

Reginald Sugarman has arrived for today's appointment. You will now complete the Headache questionnaire with Mr. Sugarman using the interview technique. Answer each question as if you were recording the answers for Mr. Sugarman. You will use the multiple question view. You want to review the questionnaire but do not want to AutoCite the responses into the encounter.

Scenario 3

The Mental Health Clinic has just been brought up on CHCS II. The clinic has the patients complete a ***Depression Visit*** and a ***Depression Scale*** questionnaire and then places the completed questionnaire in the mental health medical record. You have been asked to add these forms as a Questionnaire in CHCS II for the clinic.

Question	Answer Type	Possible Answers
Depression Visit		
Instructions: ANSWER ALL QUESTIONS COMPLETELY AND HONESTLY.		
1. Have you ever been diagnosed with depression? If No skip to question 4	Yes/No	
2. When were you diagnosed with Depression?	Date	
3. What type of depression were you diagnosed with?	Multiple Choice	Dysthymia Bipolar Disorder Unipolar Disorder Manic Depressive Major Depression Mania
4. Have you ever experienced any of the following:	Multi-Select	Anxious mood Fatigue Restlessness

		Thought of ending your life Loss of interest in hobbies or activities Feelings of guilt, or helplessness
5. Number of episodes of depression you experience in a month.	Number	Minimum 0 – Maximum 10
6. Has anyone in your family been diagnosed with Depression?	Yes/No	
7. If yes to question 6, who has been diagnosed?	Multi-Select	Father Mother Brother Sister Paternal Grandfather Paternal Grandmother Maternal Grandfather Maternal Grandmother Aunt Uncle Cousin Other

Question	Answer Type	Possible Answers
Depression Scale		
Instructions: In the Instructions to Display field, enter these instructions: BELOW IS A LIST OF COMMON SYMPTOMS OF ANXIETY. PLEASE CAREFULLY READ EACH QUESTION AND CLICK ON THE ANSWER THAT BEST DESCRIBES HOW MUCH YOU HAVE BEEN BOTHERED BY EACH SYMPTOM DURING THE PAST WEEK, INCLUDING TODAY.		
1. Numbness or tingling.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
2. Feeling hot.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much.

		MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
3. Wobbliness in legs.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
4. Unable to relax.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
5. Fear of the worst happening.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
6. Dizzy or lightheaded.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
7. Heart pounding or racing.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
8. Unsteady.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it.

		SEVERELY. I could barely stand it.
9. Terrified.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
10. Nervous.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
11. Feelings of choking.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
12. Hands trembling.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
13. Shaky.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
14. Fear of losing control.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.

15. Difficulty breathing.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
16. Fear of dying.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
17. Scared.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
18. Indigestion or discomfort in abdomen.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
19. Faint.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
20. Face flushed.	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.
21. Sweating (not due to heat).	Multiple Choice	NOT AT ALL. MILDLY. It did not bother me

		much. MODERATELY. It was very unpleasant, but I could stand it. SEVERELY. I could barely stand it.

Scenario 4

COL Violet Alexander has arrived for today's appointment. You will now complete the Depression Visit and Depression Scale questionnaires with COL Alexander using the interview technique. You will use the multiple question view. After you are finished answering the questions, you want to review the questionnaire and associate it to her current encounter. The provider would like to AutoCite the responses into the encounter.

Lesson 2: Immunizations

The **Patient 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.

When immunizations are due, but have not been given, the column under Next Due displays in red. The column changes to green when all required immunizations have been issued through the “Give Vacc” function.

The **Individual Immunization** tab displays all immunizations the patient is required to have based on the vaccination groups to which the patient is assigned.

There is an option to print the worksheet and the DD Form 2766C from the Individual Immunization window. The report prints to your default printer.

Lesson Goal

The goal of this lesson is to enable the user to view a patient’s immunization record in CHCS II.

Learning Objectives

Upon completion of this lesson, the user will be able to:

- ✓ View a patient’s immunization history.
- ✓ Add an immunization to a patient’s history.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

Setting the Scene: Mr. Clayton Williams tells the user two months ago he was on vacation and stepped on a rusty nail. He was treated in a civilian emergency room and received a tetanus shot. The user asks you to assist in documenting this vaccine.

1. Click the **Vaccine History** tab.
2. Click **Add.**
3. Select the **List All Immunizations** check box.
4. Select **Tetanus toxoid** in the listing.
5. Click **Select**.
6. Click the **[...]** (ellipsis) button next to **Vacc Date** field.
7. Click the **[<]** button next to the month and year twice to select a date two months ago.
8. Click **OK**.
9. Click **Update.**
10. Select the **Individual Immunizations** tab.

> ***Note:*** *If connected to a printer, user can print a copy of the patient's immunization record.*

11. Select **Print Preview** from the *File->Print Preview->DD2766* menu.
12. Click **>** twice at the top of the Print Preview screen to view the Immunization Record.
13. Click the **Red X** at the top of the Print Preview screen.
14. Click **Close** on the Action Bar to close the Immunizations module.
15. Click **Close** on the Action Bar to close the eSF600.

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises.

Scenario 1

The user has kept Rose Cloud's paper medical record in the clinic and today wants to enter her past vaccine history into her electronic medical record. The user asked you to assist with the fastest way to accomplish this.

1. Click the **Vaccine History** tab.
2. Click the **Rapid Pediatric Immunization** button.
3. Click the **DTP/DtaP/DTP-Hib** tab.
4. Double-click in the **Vaccine** field and then the **Vacc Date** field and enter the following data.

DTaP	05/25/1992	Series 1
DTaP	07/25/1992	2
DTaP	09/25/1992	3
DTaP	09/25/1993	4
DTaP	03/21/1998	5

5. Click the **Hep B** tab.
6. Click **Yes** to "Do you want to save?"
7. Double-click in the **Vaccine** field and then the **Vacc Date** field and enter the following data.

Hep B Child	05/25/1992	Series 1
Hep B Child	07/25/1992	2
Hep B Child	09/25/1992	3

8. Click **Save**.
9. Click the **Vaccine History** tab.
10. Click **Close**.

Scenario 2

The user just finished interviewing Master Chief Petty Officer Susan Cruz. MCPO Cruz reports that she was exposed to a shipmate with TBC and had an IPPD while deployed. The test was positive and she had a localized skin reaction in addition to the positive result. The provider told her to make sure her CHCS II record reflected a permanent exemption. The user has asked you to assist. The user reviews her vaccine history and sees that it does not reflect the IPPD so first it must be added and then marked as a permanent exemption.

1. Open MCPO Cruz's electronic record.
2. Click the **Vaccine History** tab.
3. Select **IPPD**.
4. Change the **Vacc Date** to 2 months ago.
5. Select **Left Arm** as the Site.
6. Select **ID** as the Route.
7. Select **Medical (Perm)** as the Exempt.
8. Click **Update**.
9. Click **Close**.

Scenario 3

The 1st Bn, 7th Marines is being deployed. Create a group of required immunizations for the battalion. The required immunizations are Anthrax, Hep B, Influenza and Yellow Fever. Define/name the group using your full name. Ensure the following vaccines are in stock and contain the following information:

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Anthrax	Bioport	OD13570	0.5 ml	SC
Hep B	Smith Kline	9197472	1.0 ml	IM
Influenza	Aventis Pasteur Inc.	9284728	0.5 ml	IM
Yellow Fever	Connaught	C726443	0.5 ml	SC

Scenario 4

LCDR Eduardo Suarez presents to you for his pre-deployment immunizations. He informs you he is exempt from the Hep B because he received it six months ago. Document the temporary exemption and the remainder of the required immunizations.

Lesson 3: Documenting & Managing the S/O

CHCS II gives the user numerous options to search for and find terms within the database. These options include Find Term, Dx Prompt, Browse From Here, Prompt, IPrompt, and List Size.

Dx Prompt

Creates a list of findings based on a diagnosis. This is helpful in selecting terms for a template built around diagnosis.

Find Term

Searches for a specific term within the MEDCIN® tree.

List Size

Creates a broader or narrower list of findings—in up to three levels.

Browse From Here

Displays the highlighted finding as it appears within the MEDCIN tree. Related findings can be viewed and selected.

IPrompt

Builds a list of terms based on the documentation in the Narrative pane. Once terms are documented, simply click IPrompt on the Action Bar to view a list of additional terms.

Lesson Goal

The goal of this lesson is to enable the user to document the S/O portion of the patient's eSF600 utilizing advance search options.

Learning Objectives

Upon completion of this lesson, the user will be able to:

- ✓ Save S/O documentation as an S/O Template

✓ Use Browse From Here for MEDCIN® terminology.

✓ Use IPrompt.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

The user is now ready to examine CAPT Clayton Williams and complete the Visit or S/O note. The user will start with a visit template and add additional items using the Prompt, Browse From Hear and IPrompt functions. The user will then choose to save the note as an S/O template.

1. Highlight CAPT Clayton Williams' appointment.
2. Click **Open Appt** on the Action Bar.
3. Click **S/O** .
4. Click **Template Mgt**.
5. Type ***ADULT*** in Name Contains: box.
6. Click **Find Now**.
7. Select **Visit-Generic Adult**.
8. Click **Load** on the Action Bar.
9. Confirm **HPI** tab is selected.
10. Click **+** next to **The Chief Complaint**.
11. Type ***HEADACHE*** in the free text field.
12. Select the **Notepad** icon in upper right corner of the MEDCIN pane.
13. Type ***PHYSICAL EXAM***.
14. Click **OK**.
15. Click the **ROS** tab.
16. Select **Headache**.
17. Flip to **HPI**.
18. Select the **Prompt** on dashboard.
19. Select **ROS**.

20. Click **+** next to **chronic/recurring headache**.
21. Click **+** next to **tired eyes**.
22. Click the **PMH** tab.
23. Click **History of SINUSITIS**.
24. Click **Go back >>**.
25. Click the **PE** tab.
26. Click **Vital Signs Reviewed**, **Nasal Discharge**, and **Pharynx Inflammation**.
27. Negate **Submandibular Lymph Nodes Enlarged** and **Axillary Lymph Nodes Enlarged**.
28. Click **Browse From Here** icon on the Action Bar.
29. Scroll down to **Ears, Nose, Throat** and expand.
30. Expand **Pharynx**.
31. Expand **Tonsils**.
32. Click **Swelling**, **Erythema**, **Inflammation**.
33. Negate **Exudate**.
34. Click the **IPrompt** button on the dashboard.
35. Expand **Nasal Discharge Rhinorrhea**.
36. Click **Bilaterally**.
37. Click the **Save As** icon on the Action Bar.
38. Save in **Personal**.
39. Type ***S/O –Sinusitis--XX*** as name of S/O template.
40. Select **Family Medicine** as Specialty.
41. Deselect **Shared**.
42. Select **Add to Favorites**.
43. Click **Save**.
44. Click **Close**.
45. Click **Close**.

Scenario 2

The user now wants to delete one of his personal S/O templates that is no longer used. The user will open a patient's electronic medical record and then find and delete the template.

1. Click **S/O**.
2. Click **Template Mgt**.
3. Type ***Sinusitis*** in the Name Contains: box.
4. Click **Find Now**.
5. Select **SO—SINUSITIS—XX**.
6. Click the **Delete** icon on the Action Bar.
7. Click **Yes** in confirmation window.
8. Click **Close**.
9. Click **Close**.
10. Click **Close**.

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises.

Scenario 1

You see a number of patients with lung problems and would like to personalize the starter kit template Visit—Lung Mass to the way you document. You have some terms you would like to add and remove and you would also like to have History of Lung Neoplasm say Family History of Lung Neoplasm.

Remove the following items from the template:

- **HPI**: Otolaryngeal Symptoms
- **ROS**: Gastrointestinal, Genitourinary, Endocrine, Skin, Hematological, Musculoskeletal and Neurological Symptoms
- **PMH**: Tobacco Use

- **PE**: Middle Ear Fluid
- **PE**: Tympanic Membrane Erythematous

Add the following data to the template:

- **HPI**: fatigue (Find Term), a cough (Find Term)

Use **Prompt** to find and add to **ROS**: chronic cough, wheezing, shortness of breath, (expand difficulty breathing), hemoptysis, weight loss, decrease in appetite, and weakness.

- **PMH**: smoking (from prompt on cough)
- **ROS**: hoarseness (Find Term), joint pain of shoulder, upper back pain, dysphagia
- **PMH**: history of lung cancer, history of lung lobectomy, history of pneumonia, history of pulmonary infections
- **PE**: Nail clubbing (Find Term), Rib point tenderness (Browse From Here from Lymph Nodes enlarged)(expand Chest -> Rib Abnormalities), Liver Enlargement (expand Abdomen -> Hepatic Findings) and Abdominal Tenderness

Scenario 2

You would like to personalize the conjunctivitis template that is available in the system. You would like to add the OD and OS child terms to Eyes Itch, Difficulty closing eyes, eye pain and mucous discharge from eyes. You would then like to remove the parent terms. The terms conjunctiva, murmurs and sore throat also needs to be removed.

You would like the terms eye pain with movement and swollen eyelids in the ROS and add the following terms also to ROS: burning of the eyes, blurred vision, bloodshot eyes, and matted eyelashes. The terms eye injury (trauma) and history of conjunctivitis needs to be added the PMH and slit lamp needs to be added to the Test tab.

Scenario 3

LCDR Eduardo Suarez has come into the clinic for his Diabetes follow-up. You would like to use the Visit--Diabetes FU template found in the S/O module. You would like to document the following symptoms and physical findings:

HPI	CC: Diabetes Follow Up
	+ Weight gain 10 lbs
	- Excessive thirst
PMH	**+** Reported home blood/sugar check of 110
	+ Cigarette smoking – 30 pack-year
	+ Alcohol – 6 bottles of beer a day
	+ Family history of diabetes
ROS	**+** Chest pain
	- Palpitations
	+ Blurry vision
PE	**+** Vital signs reviewed
	- Heart rate & rhythm
	- Murmurs
	- Radial pulses
	- Ulcer on feet
	+ Obesity
	+ Odor of breath
Add in EDU—Diabetes template	

Lesson 4: Template Management

Order sets currently in CHCS must be recreated for use in CHCS II.

Encounter templates can also be created from existing encounters and from previous encounters. Both require editing because actual patient encounters are tailored to the specific circumstances; so, they need to be generalized to be used as templates.

Lesson Goal

The goal of this lesson is to enable the user to modify encounter templates and commonly used Order Sets.

Learning Objectives

Upon completion of this lesson, the user will be able to:

- ✓ Edit an Encounter template.
- ✓ Create an Order Set in A/P.
- ✓ Customize an Order Set.
- ✓ Merge an Order Set with an Encounter template.
- ✓ Modify an Order Set.
- ✓ Import and Export Encounter templates.
- ✓ Delete an Encounter template.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

The user wants to build an encounter template for Hyperlipidemia. The template will contain an S/O template, Diagnoses, Procedures, and Other Therapies.

1. Expand **Tools** in the Folder List.
2. Click **Template Management**.
3. Click the **New** icon on the Action Bar.
4. Click **Add** in Notes Templates window.
5. Click **Search**.
6. Type ***Hyperlipidemia*** in name of template box.
7. Click **Search**.
8. Highlight **Visit—Hyperlipidemia**.
9. Click **Add Items**.
10. Click **Done**.
11. Click **Add** in Diagnoses window.
12. Type ***Hyperlipidemia*** in Search Term box.
13. Click **Search**.
14. Hold down the **CTRL** key and highlight **Hyperlipidemia**, **Familial Hypercholesterolemia**, and **Hyperlipoproteinemia**.
15. Click **Add Items**.
16. Click **Add** in Procedures window.
17. Type ***EKG*** in Search Term box.
18. Click **Search**.
19. Hold down the **CTRL** key and highlight **Echo (2-D)** and **Electrocardiogram**.
20. Click **Add Items**.
21. Click **Add** in Other Therapies window.

22. Type ***Nutrition***.
23. Highlight **Consultation with a Nutritionist**.
24. Click **Add Items**.
25. Click **Save As** icon on the Action Bar.
26. Save in **Personal**.
27. Type ***ENC—Hyperlipidemia—XX*** in the template name field.
28. Select **Family Medicine** for Specialty.
29. Deselect **Shared**.
30. Click **Save**.
31. Click **Close** icon on the Action Bar.

Scenario 2

The user would like to create/add an order set template. The user will then go back in and modify the order set template.

1. Open an encounter on a patient.
2. Click **A/P**.
3. Click the **Order Lab** tab.
4. Type ***Lipid*** in the search field.
5. Click **Search**.
6. Select **Lipid Panel Complete**.
7. Click **Save to Queue**.
8. Type ***Cholesterol*** in the search field.
9. Click **Search**.
10. Select **Cholesterol**.
11. Click **Save to Queue**.
12. Type ***Triglyceride***.
13. Click **Search**.
14. Select **Triglyceride**.
15. Click **Save to Queue**.
16. Repeat for **CBC** and **Urinalysis**.

17. Click the **Order Rad** tab.
18. Type ***Chest*** in Search.
19. Select **Chest, PA and Lateral**.
20. Type ***Hyperlipidemia*** in Clinical Impression box.
21. Click **Save to Queue**.
22. Click the **Order Med** tab.
23. Type ***Lipitor*** in Search.
24. Click **Search**.
25. Select **Atorvastatin**.
26. Type ***1 tab qd #90*** in the SIG: field.
27. Click **Save to Queue**.
28. Type ***Lisinopril*** and add all three doses.
29. Type ***Pravacol***.
30. Select **Pravastatin** and add.
31. Click **Save to Queue**.
32. Click the **Order Set** tab.
33. Click **Save as Order Set**.
34. Save in **Personal**.
35. Type ***ORD—Hyperlipidemia-XX*** in the template name field.
36. Click **Save**.
37. Click **Close** on the Action Bar.
38. Click **Yes** on A/P Warning Screen.
39. Click **Close**.

Scenario 3

The user would like to remove one order from the order set and then merge the hyperlipidemia order set with the hyperlipidemia encounter template.

1. Click **+** next to Tools in the Folder List.
2. Click **Template Management** icon under Tools.
3. Click **Search** on the Action Bar.
4. Search for **XX**.
5. Press **CRTL** and select the **ORD** and **ENC** template.
6. Click **Merge** on the Action Bar.
7. Remove **Pravastatin** from the Order Sets window.
8. Click **Save As** on the Action Bar.
9. Change the template name to **Comp—Enc—Hyperlipidemia—XX**.
10. Select **Family Medicine** as Specialty.
11. Click **Save**.

Scenario 4

The user would now like to delete an order template.

1. Click **Search** on the Action Bar.
2. Search for **ORD—Hyperlipidemia--XX**.
3. Highlight the template.
4. Click the **Delete** icon on the Action Bar.
5. Click **Yes** on the confirmation window.

Scenario 5

The user is PCSing to another MTF and would like to take his templates to the new site. The user will need to export the encounter templates. You remind the user to use the Search/Browse tab in Template Management unless it is an S/O template. If you are exporting an S/O template, you must be in the S/O template management function within the S/O module.

1. Click **Search** icon on the Action Bar.
2. Type ***Enc—Hyperlipidemia—XX***.
3. Click **Search**.
4. Highlight **Enc—Hyperlipidemia—XX**.
5. Click the **Export** icon on the Action Bar.
6. Click on the **Desktop** icon.
7. Click **Save**.

Scenario 6

The user is PCSing here from another MTF and would like to import his templates. You remind him to import encounter templates he needs to use the Search/Browse tab of Template Management and for S/O templates he needs to be in the S/O Module.

1. Click **Import** icon on the Action Bar.
2. Expand the **C:** drive.
3. Open Documents and Settings.
4. Open your folder.
5. Click **Desktop**.
6. Select **Enc—Hyperlipidemia—XX**.
7. Click the **>** button.
8. Deselect **Shared.**
9. Select **Add to Favorites**.
10. Click **Import**.
11. Click **Close** on the Action Bar

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises.

Scenario 1

You would like to build an encounter template for your conjunctivitis patients. You would like the diagnoses of conjunctivitis, chronic conjunctivitis, allergic conjunctivitis, scleitis, episcleritis, gonococcal conjunctivitis and visit for bacterial conjunctivitis. You would like to include the S/O template you just created along with the following procedures: slit lamp examination, left and right eye irrigation, and patient instructions: warm and cold compresses and personal hygiene hand washing.

Scenario 2

You would like to edit the breast mass encounter template found in the system. You would like to add the Visit--Breast mass S/O template and Breast Cancer and Breast Neoplasm Malignant to the diagnoses list. You would like to add breast biopsy [Percutaneous needle core, open and rotating biopsy device] as procedures and watch for signs of infection under Other Therapies.

Scenario 3

You documented LCDR Suarez's S/O in the last lesson and now would like to document the A/P and at the same time build a Diabetes Order Set and save the encounter as a template. You would like to document the following:

DX	Diabetes Mellitus Type II (problems list)
Procedure	Glucose Fingerstick
Order Lab (Save to Queue)	Glucose, CBC w/Auto Diff, Hemoglobin A1c, Urinalysis, Lipid Panel
Order Meds (Save to Queue)	Glucophage
SIG	T1 TAB BID #60 RF11
Order Set	Save as ORDERS—Diabetes—Order Set—XX. Select and modify the

	Glucose, CBC and Lipid Panel to processing status of STAT and order these lab tests and the medication only.
Other Therapies	Diabetes Blood Glucose Monitor home

Now you would like to save this encounter as a template (Remember to save the S/O template) and add the following information to the template:

Diagnosis	Diabetes Mellitus Type I, Diabetes Mellitus Poorly Controlled, Diabetic Foot Ulcer, and Visit for screening exam diabetes mellitus. Move Diabetes Mellitus Type I to the second diagnosis.
Procedure	Glucose Fingerstick
Other Therapies	Diabetes Blood Glucose Monitor home, Patient Education – Diabetes Dietary Counseling, Diabetic Foot Care
Orders	Merge Diabetes Order Set

Scenario 4

You would like to save COL Violet Alexander's previous encounter for Essential Hypertension as a template. You would like to add the Visit--HTN follow up S/O template instead of what is currently documented in the S/O. (Cancel Save List Note Template window.) After saving the template you would like to add additional terms to the diagnoses, and other therapies boxes prior to saving the template.

Diagnoses: Essential Hypertension, Secondary Hypertension, Hypertensive Intracerebral Hemorrhage, Heart Disease, Atherosclerosis, and Stroke Syndrome.

Other Therapies: Regular Exercise, Smoking Cessation Self Help, Seminar on Smoking Cessation, Stress Management Therapy, Low Sodium Diet and Patient Monitoring of Blood Pressure

Lesson 5: List Management

Lesson Goal

The goal of this lesson is to enable the end-user to create and manage Favorites Lists of diagnoses and procedures for streamlining selection in the Screening, Problems and A/P modules.

Learning Objectives

Upon completion of this lesson, the end-user will be able to:

- ✓ Create lists of favorite Diagnoses and Procedures.
- ✓ Create a Clinic Favorites List.
- ✓ Delete items from lists.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

After talking to the user, it is decided they do not want Upper Respiratory Infection on their favorites list. They would like to add flu shot to their procedures list and have electrocardiogram as the last procedure on the list.

1. To begin, click the **List Management** folder in the Folder List.
2. To Delete Upper Respiratory Infection from the Diagnosis favorites list, click ⊞ to expand ***My Favorites*** (if the folder is not already expanded).
3. Click ⊞ to expand ***My Diagnosis*** (if the folder is not already expanded). A list of favorite diagnoses displays.

4. Click on **UPPER RESPIRATORY INFECTION** to select it.
5. Click the **Delete** icon on the Action Bar. Upper Respiratory Infection will be deleted from the Favorite List.
6. To add flu shot to the procedures favorites list, highlight **My Procedures.**
7. Click the **Add** icon on the Action Bar. The Select Procedure window displays.
8. Type ***flu shot*** in the search field.
9. Click **Search**. Terms related to flu shot display.
10. Click ⊞ to expand Vaccines Viral Influenza.
11. Select **For Live, Intranasal Use 90660**.
12. Click **OK**. The **For Intranasal Use** procedure is added to the Procedure Favorite List.
13. To move the electrocardiogram procedure to the bottom of the Procedures favorites list, click **Electrocardiogram** in the Procedures favorites list.
14. Click the **Move Down** icon on the Action Bar. Electrocardiogram is moved to the bottom of the list.

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises.

Scenario 1

You are a provider working in an OB Clinic and would like to build a Clinic Favorites List of Diagnoses and Procedures. You would like to add the following Diagnoses: Diabetes Mellitus Gestational, Pregnancy, Pregnancy Toxemia, Eclampsia, Preeclampsia, visit for prenatal exam first pregnancy, first trimester, high-risk pregnancy, initial, second trimester, and third trimester.

You would like to add the following Procedures: Obstetric Ultrasound, placement of external Fetal Monitor and Multiple Gestation Ultrasound.

You would like visit for prenatal exam initial as your first diagnoses, visit for prenatal exam first trimester, second trimester and third trimester as the next three diagnoses.

Scenario 2

You would like to set up a personal list of frequently used diagnoses for easy access. You would also like to have a list of frequently used diagnoses for the clinic providers.

Your list of common diagnoses:

- Backache
- Lumbago (Low Back Pain)
- Upper Back Pain

Clinic's list of common diagnoses:

- Cervical Spondylosis
- Lumbrosacral Spondylosis
- Neuralgia
- Headache
- Middle Back Pain
- Lumbago

Scenario 3

You would like to set up a personal list of frequently used procedures for easy access. You would also like to have a list of frequently used procedures for the clinic providers.

Your most frequently used procedures:

- Patch Testing
- Multi-Allergen Screen
- Respiratory equip IPPB related equip nebulizer

Clinic's most frequently used procedures:

- Dr. Supervised Infusion – Initial Hour
- Dr. Supervised Infusion – Additional Hour
- Dr. Supervised Injection Intravenous

Scenario 4

You are assigned to assist a technician today. She would like to build a favorites list of patient complaints. Can you assist the user in developing a list of the following complaints?

- Cough
- Wheezing
- Abdominal Pain
- Nausea
- Vomiting
- Earache

Lesson 6: Telephone Consults

Lesson Goal

The goal of this lesson is to enable the user to use some advanced features in the Telephone Consults module in CHCS II.

Learning Objectives

Upon completion of this lesson, the user will be able to:

- ✓ Edit a call back phone number.
- ✓ Explain how to transfer a telephone consult to a different Provider.
- ✓ Cancel a Telcon.
- ✓ Add a cosigner to a telephone consult.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

Anna Wunderlich (w8118) phones the clinic to report that she has lost her Zyrtec allergy medication. You review the appointment note and return her call. You speak to her, but need to transfer the TelCon to Dr. Doctor. She indicates she is leaving her office and wants her call returned at a different number: (703) 555-9999. You also need to cancel LCDR Eduardo Suarez's telcon as he has just reported to the emergency room. You will document Evelyn Alexander's Telcon but would like Dr Doctor to review it and co-sign it.

To transfer a Telcon:

1. Select **Anna Wunderlich's** Telcon appointment.
2. Click **Edit Phone #** on the Action bar.

3. Change the Callback Phone Number to **(703) 555-9999**.
4. Click **OK**.

Note: *Notice the callback phone number has changed in the type column.*

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5. With Ms. Wunderlich's Telcon highlighted, select **Transfer** icon on the Action Bar.
6. Select **Doctor, David** from the *New Provider* drop-down list.
7. Click **OK**.

To cancel a Telcon:

1. Select **Suarez, Eduardo A.**'s Telcon from the Telcon list.
2. Select **Cancel** icon on the Action Bar.
3. Select **Facility Cancelled** from the *Reason for Cancellation* drop-down list.
4. Click **OK.**

To complete a Telcon and add a co-signer:

1. Select **Alexander, Evelyn L.**'s Telcon from the Telcon list.
2. Click **Open** icon on the Action Bar.
3. Type the following in Provider Note box:

   CALLED MOM AND INFORMED HER TO ALTERNATE GIVING CHILDREN'S TYLENOL AND CHILDREN'S MOTRIN EVERY 4 HOURS. IF NOT BETTER IN THE AM, BRING EVELYN INTO THE CLINIC TOMORROW.
4. Select **Otitis Media Acute Serous** from the patient Problem List (Acute).
5. Click **Add**.
6. Accept the default of **Save and Sign** and click **OK.**
7. Select the **Cosigner Required** check box.
8. Click **Search**.
9. Type ***DOCTOR*** in the Name field.

10. Highlight **Doctor, David**.
11. Click **Select**.
12. Click **Sign.**

Exercises – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and complete the exercises.

Scenario 1

You want to make sure the options for the Telephone Consult Module are set the way you want them. You want to see all of the telephone consults for today for yourself in this clinic. You would like to set these selections as default.

Scenario 2

You are unable to complete Evelyn Alexander's Telcon. You have asked Dr. David Doctor if he can do it for you and he has agreed. Please transfer the Telcon to him.

Scenario 3

Sonya Jackson just called you saying she is real anxious and would like to know what she can do to calm down. You would like to document that you told her to take a warm bath and if this did not help, make a same day appointment for tomorrow and you will evaluate her. You have diagnosed her with Anxiety and signed the Telcon.

Lesson 7: Flowsheets

Lesson Goal

The goal of this lesson is to enable the user to view and print Flowsheets.

Learning Objectives

Upon completion of this lesson, the student will be able to:

- ✓ View a Flowsheet.
- ✓ Print Flowsheets.

Demonstration – CHCS II Training System

DIRECTIONS: Open the CHCS II Training System and follow along with the instructor as you walk through the following demonstration material.

Scenario 1

You need to view and print a copy of Eduardo Suarez's vital signs. There is no current encounter so you would like to use the Flowsheets module.

1. Click the **Flowsheets** folder in the Folder List.

Note: *The Flowsheets window displays.*

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2. Select **Vital Signs** in the drop-down filter window.
3. Highlight the **BP, HR,** and **RR** portion of the Vital Signs.
4. Click **Print Flowsheet Portion**.
5. Click the **Close** icon on the Action Bar to close the module.