CHCS II SUPPORT STAFF/CLERK
Advanced Skills Student Guide

PLEASE DO NOT REMOVE FROM CLASSROOM

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Rev 1.0

CHANGE HISTORY			
Date	**Name**	**Change Description**	**Source**
5/12/2005	Elizabeth Burrows	New Release	837.4 Release
5/18/2005	Pamela Mankoff	Formatting and Revising	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, 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
Do you have any problems or trouble with the following:	Multi Select	Vision Hearing Walking Eating Preparing meals Cleaning yourself	Add
Do you feel sad or depressed much of the time?	Yes/No	Yes No	Add
Are you experiencing emotional, physical or sexual abuse?	Yes/No	Yes No	Add
Do you have a problem with alcohol or drug use?	Multiple Choice	Yes No Not sure (Do not hit enter)	Add
Have you lost or gained more than 10 lbs without any reason in the past 6 months?	Yes/No	Yes No	Add
Do you have pain that affects your daily activities?	Yes/No	Yes No	Add
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
Is it hard to understand instructions from your doctor or nurse?	Yes/No	Yes No	Add
Do you have any social, religious, cultural or ethnic concerns that may affect the medical treatment we give you?	Yes/No	Yes No	Add
Do you have a living will or advance medical directive?	Yes/No	Yes No	Add
What is the date on your living will or advance medical directive? (Do not click Add)	Date	Date	Do not click Add

9. Click the **Save** icon on the Action Bar.
10. Highlight the Questionnaire just saved and click the **Mark Ready** icon.
11. 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 associated 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 the **Patient Questionnaires** icon.
10. Click the **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 Williams 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.*

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10. Click **Close**.
11. Click **Open Appt** on the Action Bar.
12. Click **Options** on the Action Bar.
13. Click the 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	Date	

a headache?		
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	Yes/No	

family been diagnosed with Depression?		
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: Vital Signs Entry

The **Search** module enables you to locate and select a patient chart for use in CHCS II. After you open a patient chart, you have access to the range of patient-specific modules and functions.

The **Appointments** module is used to view, manage, and open patient appointments. This module displays appointments created in both CHCS and CHCS II. Scheduled appointments, including same-day scheduled appointments, are still created in CHCS. CHCS II pulls scheduled appointments from CHCS on a nightly basis.

Lesson Goal

The goal of this lesson is to enable the user to set their default properties in the Vital Signs Entry module in CHCS II.

Learning Objectives

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

- ✓ Set Default Properties.
- ✓ Change Default Properties for a single patient.

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: You are assisting a user for the first time in documenting Vital Signs. The user would like see the last 15 sets of vital signs. They also document the height of patients in feet and inches and the weight in pounds. Assist the user in setting these defaults.

***Note**: You have to close the Vital Signs Entry module to get CHCS II to accept the default settings just selected.*

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1. Open Mr. Clayton Williams' eSF600.
2. Click the **Vitals** button on the eSF600.
3. Click **Options** on the Patient ID line.
4. Click **Default Time**.
5. Select the **Last 'N'** radial button.
6. Click **OK**.
7. Click the **Height** drop-down list and select ft./in.
8. Click **OK**.
9. Click **Close** on the Action Bar.
10. Click the **Vitals** button on eSF600.
11. Document a Ht of **68 inches**.
12. Select **in.** from the Ht. drop-down list
13. Type ***68*** in the Ht window.

Exercises – CHCS II Training System

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

Scenario 1

Indira Chang and her mother have just arrived for her 6 mo Well Baby Check. After looking you notice Mom has the wrong date and her appointment is really for next week, but the provider has an opening right now. You will need to make a wellness walk in appointment for her. You will then document her vitals. Make sure you change the filter.

Vitals	
HR:	115 bpm
RR:	28 / min
Ht:	23 in
Wt:	10lbs 4 oz
Head Circumference:	44 cm

Lesson 3: 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.*

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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 **Rapid Pediatric Immunization**.
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 4: Documenting the S/O

Lesson Goal

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

Learning Objectives

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

- ✓ Load an S/O template.
- ✓ Document S/O note using an S/O 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

Since Col. Alexander has come in today complaining of a cough, we will document Col. Alexander's visit using a standard URI template. We need to document the following:

1. Click the **S/O** button on the electronic version of the SF600 to open the S/O module. The S/O screen will display.
2. Click the **Template Mgmt** icon on the Action Bar.
3. In the Name Contains field, enter **URI**.
4. Click **Find Now**.
5. Select the **VISIT—URI—MEDCIN** template. You can review the template in the Template Preview pane.
6. Click **Load** on the Action Bar. Once the template is loaded, the S/O module starts with the **HPI** tab selected.

7. Select **Chief Complaint is: URI symptoms** as a positive finding.
8. Select **cough** as a positive finding.
9. Click on the **Duration** grid icon on the Dashboard.
10. Select **2** and **Days**.
11. Type ***MAINLY AT NIGHT*** in the Free Text area of the dashboard.
12. Press the **Enter** key.
13. Select **sore throat** as a negative finding.
14. Click on the free text **Note Pad** icon in the S/O MEDCIN pane. The Preliminary Background HPI window for entering free text will display.
15. Type ***PT SAW DR AT UCC*** in the Preliminary Background HPI area.
16. Click **Save and Close** to save the information.
17. Click the **PMH** tab.
18. Click **+** to expand Smoking.
19. Click **+** to expand Cigarettes.
20. Click the **Plus Sign** to select for ____ pack-years.
21. Type ***12*** in the Value Field on the Dashboard and press **Enter**.
22. Select **history of ACUTE BRONCHITIS** as a negative finding.
23. Select **history of ASTHMA** as a negative finding.
24. Click **+** to expand history of DIABETES MELLITUS.
25. Click the **Plus Sign** to select **TYPE II**.
26. Click the **FamHist** drop-down button on the Dashboard to select **Maternal History**.
27. Click the **ROS** tab.
28. Select **sinus pain** as a positive finding.
29. Select **headache** as a positive finding.
30. Select **chest pain** as a negative finding.
31. Click the **PE** tab.
32. Select **vital signs (Reviewed)** as a positive finding.
33. Select **nasal discharge** as a positive finding.
34. Select **auscultation wheezing** as a positive finding.
35. Click **AutoNeg**.

36. Review the information in the narrative pane to ensure that everything is correct.
37. Click the **Close** icon on the Action Bar.

Exercises – CHCS II Training System

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

Scenario 1

The provider has asked you to document the history of present illness and medical history of Indira. You need to load the female 6 month well baby exam template. Document the following:

Chief complaint is 6 month well baby exam female. Source of information was the mother and she has had no illness since her last visit. She is bottle fed and drinks approximately 30 oz, she is cared for at home and her vaccinations are up to date. Her mom also states she thinks Indira is wheezing.

Scenario 2

You are now ready to document the first portion of Marie Alexander's encounter. You need to load the Visit--Ankle Sprain Rt template. Document the following:

Chief complaint is possible ankle sprain right. She has localized soft tissue swelling of the right ankle but no joint stiffness. There has never been any trauma to the ankle before this incident and she is in good physical condition. She is limping and the pain is worse with weight. You would also like to document in the HPI "SHE TURNED HER ANKLE WHILE PLAYING SOCCER LAST NIGHT."

Lesson 5: S/O Template Management

Lesson Goal

The goal of this lesson is to enable the user to manage their S/O templates.

Learning Objectives

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

- ✓ Create a Procedure template.
- ✓ Modify a Procedure template.
- ✓ Add a template to Favorites.
- ✓ Remove template from Favorites.
- ✓ Delete an S/O 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 frequently performs dressing changes and would like an S/O note template to document them.

1. Open an appointment.
2. Click **S/O**.
3. Click the **PE** tab.
4. Select the **notepad icon** in the upper right corner of the MEDCIN window.

5. Type ***PROC-DRESSING CHANGE:~*** and press **CTRL+ENTER**.
6. Type ***WOUND DESCRIPTION:~*** and press **CTRL+ENTER**.
7. Type ***CLEANSING AGENT:~*** and press **CTRL+ENTER**.
8. TYPE ***DRESSING APPLIED:~*** and press **CTRL+ENTER**.
9. Press **Enter**.
10. Click **OK**.

Scenario 2

The user reviewed the S/O template and would like to add a list of cleansing agents to the Cleansing Agent section.

1. Open an appointment.
2. Click **S/O**.
3. Click **Template Management** icon on the Action Bar.
4. Type ***DRESSING***.
5. Click **Find Now**.
6. Highlight **PROC—DRESSING CHANGE—XX**.
7. Click **Edit** icon on the Action Bar.
8. In the documentation window, confirm **Template edit mode** is displayed.
9. Highlight the text in the documentation window.
10. In the Entry details for current selection window, add each of the following, pressing **CTRL+ ENTER** after you enter each:
    - Alcohol:~
    - Hydrogen Peroxide:~
    - Normal Saline:~
11. Click **Enter**.
12. Click **Save** icon on the Action Bar.
13. Click **Save** on the Save List Note Template window.
14. Click **Replace** on This Template Name already exists window.
15. Click **Close**.

Scenario 3

The user would like to add the SUPPORT–Chest Pain template to their favorites folder.

1. Open an appointment.
2. Click **S/O**.
3. Click **Template Management** icon on the Action Bar.
4. Type ***SUPPORT*** in the Name Contains: field.
5. Click **Find Now**.
6. Highlight **SUPPORT—Chest Pain**.
7. Click **Save As** icon on the Action Bar.
8. Click **Save** in drop-down box and select **Personal**.
9. Change Template Name to **SUPPORT—Chest Pain—XX**.
10. Click **Add to Favorites**.
11. Click **Save**.

Scenario 4

The user would like to remove the SUPPORT –Back Pain template from their favorites folder.

1. Open an appointment.
2. Click **S/O**.
3. Click **Template Management** icon on the Action Bar.
4. Type ***SUPPORT*** in the Name Contains: field.
5. Click **Find Now**.
6. Highlight **SUPPORT—Back Pain**.
7. Click **Delete** icon on the Action Bar.
8. Click **Yes** on the List Tool Templates window.
9. Click **Close** on the Action Bar.
10. Clear **Patient**.

Exercises – CHCS II Training System

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

Scenario 1

You see a lot of patients who are on Concerta for ADHD. You would like to create an education template to include in the patient's chart whenever this medication is prescribed. You would like the template to read as follows:

EDUCATION: PATIENT AND PARENT EDUCATED ON ATTENTION DEFICIT HYPERACTIVITY DISORDER. GIVEN INFORMATION ON THE MEDICATION CONCERTA EXPLAINING IT HAS FEW SIDE EFFECTS AND WORKS WELL ON CONTROLLING BEHAVIOR. DISCUSSED THE USE AND SIDE EFFECTS OF THE MEDICATION AND THE PATIENT/PARENT INDICATED AN UNDERSTANDING.

Scenario 2

You work in a podiatry clinic and have been asked by the providers to document the toenail culture removal procedure in patient's eSF600. You would like to create the standard text into a procedure template attaching the text to a structured term. You would like to use the term Toenail Culture and add the following free text:

ANESTHESIA WITH 5 CC 1% LIDOCAINE PLAIN AS A RING BLOCK WAS USED. TOE WAS PREPPED WITH BETADINE AND DRAPED. THE LATERAL THIRD OF THE NAIL IS ELEVATED AND EXCISED TO THE NAIL BED. THE NAIL IS SENT TO MICROBIOLOGY FOR FUNGAL CULTURE. HEMOSTASIS BY PRESSURE, AREA IS CLEANED AND DRESSED. USUAL WOUND CARE AND INFECTION WARNINGS GIVEN AS A HANDOUT. PATIENT INDICATED AN UNDERSTANDING OF INSTRUCTION.

Lesson 6: Template Management

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.

The five main components of the encounter template are diagnoses, notes templates (visit, S/O), other therapies, procedures and order sets.

The top four sections (Associated Reasons for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Notes) are not used.

Lesson Goal

The goal of this lesson is to enable the user to view and manage encounter templates.

Learning Objectives

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

- ✓ Search for template.
- ✓ View details.
- ✓ Add template to Favorites.
- ✓ Remove a template from Favorites.
- ✓ Load 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 would like to search for an encounter template, view the details before adding the template to their favorites. The user decides to remove a template from their favorites while on the screen. After removing the template, they will load the Asthma _starter kit template to the patient's current encounter.

1. Open an appointment.
2. Click **+** to expand Tools.
3. Click the **Template Management** icon in the Folder List.
4. Click the **Search** icon on the Action Bar.
5. Click the **Search** button on the Encounter Template Search window.
6. Click **OK** on the Military Clinical Desktop window.
7. Highlight **Asthma_starter** kit.
8. Click the **View/Edit** icon on the Action Bar.
9. Review the details of the encounter template.
10. Click the **Search/Browse** tab.
11. Click the **Add Favorite** icon on the Action Bar.
12. If you get an error message, click **OK**.
13. Click the **Template Selection** tab.
14. Click **+** to expand My Favorites.

Note: *The Asthma_starter kit has been added.*

---

15. Highlight **URI Encounter**.
16. Click the **Remove Favorite** icon on the Action Bar.
17. Click **Yes** to warning message.

Note: *The URI Encounter template has been removed.*

18. Highlight **Asthma_starter kit**.
19. Click **Add**.
20. Click **OK** and encounter template loads.
21. Click **Close** on the Action Bar.
22. Clear **Patient**.

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 7: A/P Order Entry

The **Order Entry** module enables entry of new outpatient medication, laboratory, and radiology orders and modification of previously processed orders of all three types. The orders are validated based on pre-defined knowledge, duplicate orders, patient allergies, and drug interactions that are stored in CHCS. In the case of invalid orders, CHCS generates warning and error messages.

Lesson Goal

The goal of this lesson is to enable the user to view and manage encounter templates.

Learning Objectives

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

- ✓ Set Processing priority.
- ✓ View active orders.
- ✓ Discontinue submitted orders.
- ✓ Modify an order.
- ✓ Renew an active order.
- ✓ Associate an order to a diagnosis.

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

1. Open LCDR Eduardo's appointment.
2. Click **A/P**.
3. Click the **Order Lab** tab.
4. Type ***CBC*** in New Lab Order window.
5. Click **Search**.
6. Highlight **CBC W/O diff**.
7. Click **ASAP** in Processing Priority window.
8. Click **More Detail**.
9. Change Collection Priority to **ASAP**.
10. Change Collection Method to **Ward or Clinic to Collect**.
11. Click **Submit**.
12. Click **Show Orders**.
13. View **Active Lab** orders in Laboratory Orders window.
14. Highlight **LIPID PROFILE**.
15. Click **Discontinue**.
16. Click **Yes** in the Confirm Discontinue Order window.
17. Type ***PROVIDER REQUEST***.
18. Click **OK**.
19. Highlight **HEMOGLOBIN A1C**.
20. Click **Modify**.
21. Type ***PROVIDER REQUEST***.
22. Click **OK**.
23. Click **More Detail**.
24. Change the **Start Date** to today.
25. Click **Submit**.

26. Highlight **OCC Liver**.
27. Click **Renew + Modify**.
28. Type ***PROVIDER REQUEST***.
29. Click **More Detail**.
30. Change the **Start Date** to today.
31. Click **Submit**.
32. Type ***PROVIDER REQUEST***.
33. Click **OK**.
34. Type ***PROVIDER REQUEST*** on the duplicate order screen.
35. Click the **Diagnosis** tab.
36. Highlight **DIABETES MELLITUS**.
37. Click **Add to Encounter**.
38. Highlight **HEMOGLOBIN A1C** in Orders & Procedures window.
39. Click the **< >** button to associate with highlighted diagnosis.
40. Click **Close** icon on the Action Bar.

Exercises – CHCS II Training System

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

Scenario 1

You need to order a laboratory test and a chest x-ray on Indira Chang. The provider would like these ordered STAT. Order the following:

- CBC w/Auto Diff
- Chest X-Ray
- Clinical Impression: R/O pneumonia

Scenario 2

You need to order two laboratory tests and an ankle series x-ray on Marie Alexander. The provider would like these ordered STAT. Order the following:

- CBC w/o Diff
- Chem 17
- Ankle Trauma Rt
- Clinical Impression: R/O ankle fracture

Lesson 8: 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.

Lesson Goal

The goal of this lesson is to enable the user to manipulate the Procedure tab of A/P module.

Learning Objectives

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

- ✓ Add procedure to favorites list.
- ✓ Associate procedure with diagnosis.

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

While in the clinic, a Fingerstick cholesterol was performed on LCDR Suarez. You need to document the cholesterol procedure.

1. Reopen **LCDR Suarez's** encounter.
2. Click the **Procedure** tab.
3. Type ***CHOLESTEROL*** in the Search field.
4. Expand Serum Lipoproteins and select **Total Cholesterol**.
5. Click **Add to Favorites List**.

6. Click **Add to Encounter**.
7. Click the **< >** button to associated with the highlighted diagnosis.
8. Click **Close** on the Action Bar.

Exercises – CHCS II Training System

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

Scenario 1

The provider has asked you to give Indira a nebulizer treatment. You gave her the treatment and now need to document the procedure. You first need to add yourself (Nurse, Karen) as an additional provider (nurse or paraprofessional) and then document the nebulizer treatment. (Respiratory Equip IPPB Related Nebulizer w/Compress) giving yourself credit.

The provider has just checked Indira and has asked you to give her another treatment. You need to change the nebulizer treatment to 2 units of service. To do this you must delete the initial nebulizer treatment and then document the treatment indicating the two treatments.

Scenario 2

The provider has asked you to wrap Marie Alexander's ankle and issue her a pair of crutches. You need to add yourself as an additional provider and then document the orthopedic wrapping and the issue of wooden crutches. (Crutches are a HCPCS code.)

Lesson 9: Order Consults

The **Order Consults** tab allows you to enter a consult request for a specific encounter.

Lesson Goal

The goal of this lesson is to enable the user to order consults within the A/P module.

Learning Objectives

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

- ✓ Submit an order 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

1. Open CAPT Clayton Williams' appointment.
2. Click **A/P**.
3. Click the **Order Consults** tab.
4. Confirm **Military/Tricare (SF 513)** is selected in Consulting Network.
5. Click the **Refer To:** drop-down box.
6. Select **CONSULT (SCHEDULED)**.
7. Click the **Specialty:** drop-down box.
8. Select **NUTRITION**.
9. Click the **Clinic:** drop-down box.

10. Select **Family Practice Clinic**.
11. Click in the **Reason for Request** window or click on the down arrow.
12. Type ***INSTRUCT IN 1800 CALORIE DIET***.
13. Click in the **Provisional Diagnosis** window.
14. Type ***WEIGHT REDUCTION***.

Exercises – CHCS II Training System

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

Scenario 1

The provider would like to send Indira to the Internal medicine clinic to be evaluated for her wheezing. He would like to indicate that "BILATERAL WHEEZING WAS HEARD AND WOULD LIKE INDIRA TO BE EVALUATED FOR POSSIBLE ASTHMA. CHEST X-RAY WAS NORMAL." Provisional diagnosis is Asthma. He is authorizing 2 visits and wants to send the consult electronically. He has asked you to complete the consult and submit it.

Lesson 10: Previous Encounters

The **Previous Encounters** module displays a list of a patient's completed CHCS II encounters. Select a previous encounter to view the signed electronic SF600 in the bottom of the workspace. You must select a patient record to view previous encounters. You can append a narrative, amend an encounter, create a new Encounter Template from a completed encounter and "copy forward" the details of a previous encounter to the current encounter, easing effort and saving time in documenting follow-up visits.

Lesson Goal

The goal of this lesson is to enable the end-user to use the Previous Encounters module in CHCS II.

Learning Objectives

Upon completion of these modules, the end-user will be able to:

- ✓ Display a previous patient encounter.
- ✓ Append a narrative to a completed encounter.
- ✓ Amend a completed encounter.
- ✓ Copy Forward a previous encounter.

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 provider needs to annotate LCDR Eduardo Suarez's diabetes is now controlled by adding a note to his Diabetes Mellitus Type II – Uncontrolled encounter.

1. From the list of appointments, click on any of LCDR Suarez's appointments to pull his record.
2. Click the **Previous Encounters** module in the Folder List.
3. Highlight the **Diabetes Mellitus Type II – Uncontrolled** encounter.
4. Click the **Append Narrative** icon on the Action Bar.

Note: *The Encounter Note window displays.*

---

5. Type ***DIABETES*** in the Note Category field.
6. Type ***DIABETES CONTROLLED*** in the Note Title field.
7. Type ***BASED ON THE PT A1C, HIS DIABETES SEEMS UNDER CONTROL. PT WILL CONTINUE TO MONITOR HIS GLUCOSE LEVEL***. in the text area.
8. Click **Save and Sign**.

Note: *The Sign Appended Note window displays.*

---

9. Click **Sign** to sign the encounter.

Note: *Notice the status has changed from completed to updated.*

---

10. Click the **Close** icon on the Action Bar to close the module.

Scenario 2

Amend a completed encounter: The user would like to add the results of the Lipid Panel tests to LCDR Eduardo Suarez' completed encounter.

1. In the appointment list select LCDR Eduardo Suarez's Diabetes follow-up appointment to pull his patient record.
2. Click **Previous Encounters** in the Folder List.
3. Highlight the **Screening Exam Lipoid Disorders** note.
4. Click **Amend Encounter** on the Action Bar.

Note: *The SF 600 displays.*

---

5. Open the **S/O** section.
6. Click **Edit Note**.
7. Click on the **Test** tab.
8. Click the **Find Term** icon on the Action Bar.
9. In the Search String field, type ***cholesterol***.
10. Expand **Serum Lipoproteins**.
11. Select **Total Cholesterol** as a negative finding.
12. Enter **171** in the Value field on the Dashboard.
13. Click **Sign** on the Action Bar.
14. Review **Change History**.
15. Click the **Sign** button on Sign encounter window.

Note: *The encounter status has changed.*

Scenario 3

Copy Forward a Previous Encounter

The provider is seeing Eduardo Suarez for his follow-up appointment. You would like to use the information from his previous encounter to document his follow-up appointment.

1. Select the **diabetes follow-up** appointment for LCDR Suarez.
2. Click the **Open Appt** icon on the Action Bar.

Note: *LCDR Suarez's ELECTRONIC MEDICAL RECORD opens.*

---

3. Click the **Previous Encounter** icon in the Folder List.

Note: *The Previous Encounters window displays.*

---

4. Highlight LCDR Suarez's Diabetes Mellitus Type II encounter.
5. Right-click on the highlighted appointment.
6. Click **Copy Forward**.

Note: *The Previous Encounters window closes.*

---

7. Click the **S/O** button on the ENCOUNTER WINDOW.

Note: *The copy forward template displays.*

---

8. Since none of LCDR Suarez's symptoms or findings has changed we can quickly document the abnormal and normal findings in all tabs by clicking the **AutoEnter** button.
9. Click the **Close** icon on the Action Bar to close the Encounter window.

Exercises – CHCS II Training System

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

Scenario 1

A user realizes during a return visit for Clayton Williams that the initial encounter for *difficulty breathing*, documents that a Chem 7 was performed, this is incorrect; the note should read that a CBC w/Auto was performed. The user would like to correct this documentation error. Assist the user in making this change.

Scenario 2

The user needs to make an annotation to the *Normal Exam* encounter for Clayton Williams. The note should read, "Patient was instructed to reduce strenuous exercise activity". Can you assist the user in making this change?

Lesson 11: Problems

Lesson Goal

The goal of this lesson is to enable the end-user to add and update patient problems in CHCS II.

Learning Objectives

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

- ✓ View a patient's Problem list and associated encounters.
- ✓ Add a family history to a Problem list.
- ✓ Update a problem, family history, or historical procedure.

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

Retired VADM Olaf Berg (b8943) father has Essential Hypertension. This needs to be added to his Problems List in the Problems module under Health History.

1. Search for **Ret. VADM Olaf Berg** in the Search module to pull his patient record.
2. In the Folder List, click the **Problems** module located under Health History.
3. Expand the Problem list to view VADM Berg's Acute/Chronic problems.
4. Highlight **Family History**.
5. Click **Add** on the Action Bar.

6. The Select Diagnosis window appears with Clinic List selected by default.
7. Select the **Search** tab.
8. Type ***Hypertension*** in the Find field.
9. Select **Essential Hypertension**.
10. Click **OK**.
11. Click the down arrow next to the **Onset Date** to display the date calendar.
12. Enter the Onset Date: **06 Dec 2000**.
13. Use the **< >** to select the December.
14. Click on **the year** to display up/down arrows.
15. Select the year **2000**.
16. Click on **day 6**.
17. Select **Father** from the drop-down Relationship list.
18. In the Status field accept default: **Active**.
19. In the Chronicity field accept default: **Chronic**.
20. In the Source field accept default: **Patient**.

Exercises – CHCS II Training System

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

Scenario 1

CAPT Clayton Williams (W8867) has previously been diagnosed with cancer of the gallbladder. He was diagnosed on Dec 6, 2000. He also had coronary bypass surgery 6 months ago. These both need to be added to his Problems List.

Scenario 2

After seeing Eduardo Suarez for his chest pain, we documented he had a tonsillectomy in June of 2003. This information is not currently in the patient's record and needs to be added to the patient's Historical Procedure list. His diabetes is now under control so we need to inactivate this problem.

Lesson 12: 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.*

---

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.