



CHCS II Nurse Lesson Plan



December 2004
Rev 1.2

PLEASE DO NOT REMOVE FROM CLASSROOM

Change History

Date	Name	Change Description	Source:
10-25-2004	Kathleen Chapman	Created	Consolidation of Services materials
11-5-2004	Kathleen Chapman	Updated	CITPO comments
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Preparation for Delivery

This lesson plan is designed to teach Nurses at each MTF.

Materials Needed

- CHCS II Sign-In Roster. (Electronically or Paper Form)
- CHCS II Nurse Course Lesson Plan
- CHCS II Nurse Presentation
- CHCS II Training Templates
- CHCS II QRC (one per student)
- CHCS II Nurse Training Student Guide (one per seat)
- CHCS II User Manual (one per classroom)
- Addendum to the Release Notes (one per instructor; supplied by MTF)
- CHCS II Training Course Evaluation Form (one per student)

Note: Students can keep the QRC; other training items are to be left in the classroom. The Student Evaluation Forms are to be completed by each student and left with instructor upon completion of class.

Tasks to be Completed Prior to Class

- Set up classroom with one workstation per student and one for the instructor, each workstation loaded with the following:
 - CHCS II Training System (CTS)
 - Training Templates
 - CHCS II Nurse Course PowerPoint Presentation (instructor workstation only) updated with instructor name and current date.
- Reset data (**Encounter Data** button) for each CTS prior to starting class daily. **Note:** The entire database should be refreshed weekly after the last Nurse's class to ensure that CHCS II does not generate messages saying that templates created during class already exist because students created them in a previous class.
- Import training templates.
 - TRAINING—ECP—PREGNANCY TEST—VISIT
 - TRAINING—TRIAGE—COLD&COUGH—ENC
 - TRAINING—ECP—UTI—ENC
 - TRAINING—TRIAGE—DIARRHEA—ENC
 - TRAINING—TRIAGE—FEVER—ENC

- Become aware of local policies and variations with respect to such things as template naming conventions, pharmacy locations and other similar factors relevant to training. The site coordinator and the MTF's CHCS II training team are resources for this type of information.
- From the lead instructor, find out how students can obtain copies of the CHCS II User Manual at each site.
- Review the release notes addendum (a.k.a. Disclaimer List).

Tasks to be Completed at the End of Class

- Distribute the Training Course Evaluation forms and collect them from the students before they leave the classroom.
- Explain to the class how assistance will be provided the first time they attempt to use their account in the live system.

Duration	Training Activities	Instructor Notes
Introduction		
	<p data-bbox="296 253 1562 298">Welcome/Logistics</p> <div data-bbox="842 370 1018 431" style="text-align: center; border: 1px dashed gray; padding: 5px;"><i>Next Slide</i></div> <p data-bbox="296 570 1507 634">Logistics. Room location in building, fire escape routes, restrooms, kitchen facilities, smoking area</p> <p data-bbox="296 659 485 688">Workstations</p> <p data-bbox="296 712 600 742">Instructional material</p> <p data-bbox="296 766 919 795">Pagers and cell phones. Off or on vibrate mode</p> <p data-bbox="296 820 401 849">Breaks</p> <p data-bbox="296 873 1493 938">Resources. Indicate how to obtain additional information regarding additional support on the system.</p> <p data-bbox="296 963 470 992">Parking Lot</p> <p data-bbox="296 1016 520 1045">Introductions</p> <p data-bbox="296 1076 1419 1141">Instructor and students exchange personal introductions, providing relevant background information.</p> <div data-bbox="842 1166 1018 1227" style="text-align: center; border: 1px dashed gray; padding: 5px;"><i>Next Slide</i></div>	<p data-bbox="1583 285 1961 358"><input type="checkbox"/> Slide 1: Nurse Training Course</p> <p data-bbox="1583 431 1929 505"><input type="checkbox"/> Slide 2: Logistics and Introductions</p>
CHCS II Overview		
	<p data-bbox="296 1325 590 1354">What is CHCS II?</p> <p data-bbox="296 1385 1535 1450">CHCS II is a computer-based patient record (CPR) system selected by Department of Defense to meet the requirements of the Military Health System.</p>	<p data-bbox="1583 1352 1955 1425"><input type="checkbox"/> Slide 3: What is CHCS II?</p>

Duration	Training Activities	Instructor Notes
	<p>CHCS II provides:</p> <ul style="list-style-type: none"> • A Graphical user interface that networks with existing systems • Efficient means of creating, managing and retrieving of medical records • Anytime, anywhere delivery of patient records to the point of care • Future access military records for health studies worldwide <p>Add this brief comment as transition to next slide:</p> <p>One of the greatest benefits of CHCS II is that it is an electronic patient record. Not only does this help to meet the presidential directive for a “comprehensive, life-long medical record,” but it also eliminates some of the risks and inefficiencies of paper based medical records.</p> <p style="text-align: center;"><i>Next Slide</i></p>	
	<p>Limitations of Paper Based Medical Records</p> <ul style="list-style-type: none"> • Paper charts are lost • No automatic drug interaction alerts • Penmanship counts • Only one person can access a record at a time <p style="text-align: center;"><i>Next Slide</i></p>	<p><input type="checkbox"/> Slide 4: Limitations of Paper Based Medical Records</p>
	<p>CHCS II Benefits</p> <ul style="list-style-type: none"> • Interfaces with MHS Standard systems, e.g. CHCS I & ADM • Uses a standard, structured language, which is Medcin, which has the ICD-9 and CPT codes tied to those structured terms. • Facilitates compliance through electronic capture of elements required for: <ul style="list-style-type: none"> • JCAHO (Joint Commission on Accreditation of Healthcare Organizations) • Evaluation & Management (E&M) coding 	<p><input type="checkbox"/> Slide 5: CHCS II Benefits</p> <p>Elaborate on each benefit.</p>

Duration	Training Activities	Instructor Notes
	<p data-bbox="298 181 594 220">CHCS II Training</p> <p data-bbox="298 240 1472 279">Classroom training is accomplished using Clinical Scenarios appropriate to each user's role.</p> <p data-bbox="298 347 1524 490">Clerk and Support receive four hours of Instructor-Led Training and four hours of On the Job Training. Providers have eight hours of Instructor-Led Training, while Nurses have six hours of Instructor-Led Training. Providers and Nurses have sixteen hours of On the Job Training. Records Reviewer receives 2 hours of ILT/OJT.</p> <p data-bbox="848 516 1016 555" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1587 211 1871 282"><input type="checkbox"/> Slide 8: Training Schedule</p> <p data-bbox="1587 389 1948 493">This slide should be used as a brief transition to the next slide.</p>
	<p data-bbox="298 649 1083 688">Key Information Technology Training Resources</p> <ul data-bbox="348 721 831 1052" style="list-style-type: none"> • MTF CHCS II Team <ul style="list-style-type: none"> • MTF Project Officer • Facility Training Coordinator • Clinical Champion/SuperUser • Unisys On-Site Team <ul style="list-style-type: none"> • Site Training coordinator • ILT Lead • OJT Lead • Trainers <p data-bbox="298 1068 1558 1140">Note: Provide the names of those filling these roles locally and an indication of how they might be contacted.</p> <p data-bbox="848 1166 1016 1205" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1587 678 1808 750"><input type="checkbox"/> Slide 9: Key Information</p> <p data-bbox="1587 776 1965 880">These resources are available during the training implementation.</p>

- The role assigned to you in the live CHCS II system may not allow you to perform all tasks covered in training – duties of staff vary from clinic to clinic.

Next Slide

Training MTF Business Rules

- Slide 13: Training and MTF Business Rules**

Next Slide

Session One Course Agenda

- Slide14: Session One Course Agenda**

Next Slide



Lesson 1: Navigation

Lesson Goal

The goal of this lesson is to enable the user to access and navigate within the CHCS II application.

Learning Objectives

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

- Log in to the CHCS II application
- Access modules quickly using Folder List
- Open and close an application module
- Exit the CHCS II application
- Lock CHCS II session

Slide 15: Navigation Learning Objectives

Basic Navigation

Explain: General layout of the screen (similar to Outlook)

- Title Bar
- Main menu
- Action Bar

Demonstrate:

Log on to the system, view the current list of appointments and open and close modules

1. Double-click the CHCS II Training System icon on the computer desktop. Press the escape key (Esc) on your keyboard twice to progress through the informational messages.
2. Verify the Appointments module is open.
3. The list of current appointments will display.
4. Review the icons in the Action Bar for Appointments. Icons in the Action Bar are relevant to the module that is open. Icons that are used in one module might not be used in another, so what appears in the Action Bar changes.

The Action Bar icons change according to the active module, providing quick access functionality for the module.

	<p>5. Click the Co-signs folder in the Folders List to open the Co-signs module. The Co-signs module will display.</p> <p>6. Click the Close icon on the Action Bar to close the Co-signs module.</p> <p>7. Click the Close X button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display.</p> <p>8. Click Yes to confirm the exit</p> <p>Key Points: Module access</p> <ul style="list-style-type: none"> • For navigating, the Folder List and Action Bar are the most efficient method. <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p style="text-align: center;"><i>Next Slide</i></p>	<p>Note: Emphasize how the desktop can be customized.</p>
	<p>Security and Session Management</p> <p>Explain:</p> <ul style="list-style-type: none"> • Passwords expire every 85 days – user is prompted at 80 days to change. • Password can be changed prior to expiration. • CHCS II password and CHCS verify codes are synchronized. • Two or more users can have their own session open on a single workstation. <p>Changing passwords: This cannot be demonstrated on the CHCS II Training System; you will be shown how to change your password in your OJT session.</p> <p>Demonstrate:</p> <ul style="list-style-type: none"> • User has the option to lock the session to avoid system time-out. <ul style="list-style-type: none"> • Press Ctrl-Z. (Can also select the Lock command in the Tools menu.) • To unlock the session, maximize the application and click the OK button. (In the live system, you will be asked for your password.) 	<p>Note: Emphasize that passwords must be changed in CHCS II.</p>

SUMMARY

- Navigation
- Security

Next Slide

Lesson 2: Patient Search and Appointments

Lesson Goals

The goal of this lesson is to enable the user to locate a patient record and use the appointment functions in CHCS II.

Learning Objectives

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

- Search for a patient
- Set the display for appointments
- Change and save the column order
- Create a walk-in appointment
- Transfer an appointment
- Add a nurse to an appointment

Slide 16: Patient Search & Appointments
Learning Objectives

	<p>Patient Search Module</p> <p>Pulling a Patient Record features:</p> <ul style="list-style-type: none"> ▪ Different search methods available ▪ Patient must have a record in CHCS ▪ “Search CHCS” is an option <p>Appointment Module</p> <p>Module specific screen features:</p> <ul style="list-style-type: none"> • Module title bar • Appointment list • Columns • Access to properties setup options: <ul style="list-style-type: none"> • Drop-down box • Options • Change selections 	<p>Explain specific <i>Appointment</i> screen features.</p> <p>Explain: Scheduled (future) appointments are still made in CHCS and come over to CHCS II nightly and every 15 minutes throughout the day.</p>
	<p>Patient Search and Appointments</p> <p>Demonstrate:</p> <p>Col. Violet Alexander has come in today complaining of a cough. We need to search for Col. Alexander’s record, set the appointment filters and create a new appointment.</p> <ol style="list-style-type: none"> 1. Open the CHCS II Application 2. Click the Search in the Folders List to search for a patient. The Patient Search window will display 3. Type ALEXANDER in the Last Name: field and click Find for a list of names. Click on ALEXANDER, VIOLET W in the list of names and click OK. Col. Alexander’s information will appear on the Patient ID line and the Appointments List will display. 5. To set the appointment filters, click Change Selections the button in the Appointment list Workspace. The Appointment Search Selections window will display. 6. Click the following radio buttons for the associated Field: 	<p>Explain: Appointment display options:</p> <ul style="list-style-type: none"> • Column order • Clinic <p>(Clinic assignments are in CHCS)</p> <ul style="list-style-type: none"> • Provider • Date • Status Selection <p>Explain: Appointment types and statuses.</p> <p>Do not need to show all steps in Transfer and Add Provider—but, do point out these functions.</p>

	<p>Clinics: This Clinic Providers: Me Dates: Today Only Status Selection: Any Status</p> <ol style="list-style-type: none"> 7. When the information has been completed, click the Change Selections button to change the default settings. The Appointment List will re-display. 8. Click on the Action Bar to create a new appointment for Col. Alexander. A New Appointment confirmation window will display. 9. Click so you can complete the New Appointment information for Col. Alexander. 10. Click on ACUTE APPT (ACUT\$) 30 to select the acute appointment type. You will now be able to select the Reason for Appointment. 11. Type cough in the Reason for Appointment field and click to complete the new appointment process for Col. Alexander. <ul style="list-style-type: none"> • Point out how a clerk can add comments to an appointment, as well as how to view and edit those comments. 12. Col. Alexander will now appear at the bottom of the Appointment list with a status of CheckedIn. <p>Key Points:</p> <ul style="list-style-type: none"> • Point out the Transfer icon. • Point out the Add Providers icon. (Can add a Provider only to patient encounter with status of CheckedIn, Waiting, or In Progress) 	<p>Explain: Live system, <i>Today plus Incomplete</i> pulls in old appointments from CHCS.</p> <p>Suggest using <i>Today Only</i> to view current day's appointments</p>
	Exercises	
	<ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	

SUMMARY

- Explained patient search module
- Explained appointment list properties
- Explained how to make appointment display selections
- Created a new appointment
- Pointed out function for transferring appointments to other Providers
- Pointed out function for adding a Provider to an appointment

Next Slide

Lesson 3: Telephone Consults		
	<p>Lesson Goals</p> <p>The goal of this lesson is to enable the user to use the Telcon function in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the user will be able to:</p> <ul style="list-style-type: none"> • Set default search and display options for the telephone consults appointment list • Create a Telephone Consult appointment • View clerk notes for an appointment from the Appointment screen • Select and open a Telephone Consult appointment • Transfer a telephone consult to a different Provider • Edit a call back phone number 	<p><input type="checkbox"/> Slide 17: Telephone Consults Learning Objectives</p>
	Telephone Consults Module	
	<p>Demonstrate:</p> <p>You receive a call from Ret. CAPT Clayton Williams (w8867). He states that he needs a refill for his Hypertension medication, Lisinopril. You create a level one telephone consult for a Med refill. You ask CAPT Williams if the phone number listed in the callback field is correct. He indicates that he has moved and provides a new number: (123) 223-4444. You consult with the provider after reviewing his meds history and complete the Telcon.</p> <ol style="list-style-type: none"> 1. Click the Telephone Consults folder in the Folder List. The Telephone Consult window will display: 2. Click the New Telcon icon on the Action Bar. The Patient Search window will display: 3. Type (w8867) in the Quick Search Field and click the Find button. The Patient Search window will re-display. Highlight CAPT. Clayton Williams' name in the Patient Name area. 4. Click on CAPT Williams name and click OK. The New Telcon window will display. 	<p>Telcons created in CHCS must be completed in CHCS.</p> <p>In order to access and complete a Telcon in CHCS II the Telcon must be created in CHCS II.</p>

5. Change the Callback Phone Number to (123) 223-4444.
 6. Type *Med refill* in the Reason for Telephone Consult field, type *PT request refill, Lisinopril PO 20mg T* in the Notes area and click on the **OK** button. The Telcon Quick Entry screen will display.
- NOTE:** If the user has the provider role assigned to their log on, they will receive the Quick Entry Screen after clicking OK. Any other user will be taken back to the Telephone Consults module
7. In the Provider Note area type **Nurse's Note:** *Lisinopril PO 20mg Tabs refill entered per physicians's order type v68.1* in the Search field and click **Find Now**.
 8. Click on *reason for visit: issue repeat prescription for medication V68.1* to select it and click **ADD** '*reason for visit: issue repeat prescription for medication V68.1*', will display in the Selected Diagnosis field.
 9. Accept the default E&M value of 99371 Lvl I, Simple/Brief.
 10. Select the **Save and Open A/P** radio button.
 11. Click **OK**. The A/P module opens.
 12. Click the **Order Med** tab.
 13. In the **New Med Order** field, enter *Lisinopril* and click **Search**.
 14. Select LISINOPRIL (PRINIVIL/ZESTRIL)--PO 20MG TAB.
 15. In the SIG field, enter 1 PO QD #30 RF5 and press Enter on your keyboard.
 16. Click **Submit**.
 17. Click **Sign** on the Action bar.
 18. Select the **Cosigner Required** checkbox.
 19. Click **Sign**. The encounter closes and the Telcon appears on the Telephone Consults Appointments list with a status of NeedsCoSignature.
 20. Click **Close** on the Action bar.

Explain: Reason for Telcon field and Note field. Both must be completed.

Lower case terms in diagnosis list are symptoms.

Review quick entry screen.

Explain: Rather than signing the note and designating a Physician as the cosigner, an end user could transfer the Telcon to the Physician for their signature using the Action Bar icon.

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

SUMMARY

- Explained default search and display telephone consults appointment list options
- Created a telephone consult appointment
- Explained how to transfer a telephone consult to a different Provider
- Edited a call back phone number

Next Slide

Lesson 4: Demographics

Lesson Goals

The goal of this lesson is to enable the user to verify demographic information in CHCS II.

Learning Objectives

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

- Verify patient demographic information

Slide 18: Demographics Learning Objectives

Demographics

	<p>Demonstrate:</p> <p>CAPT. Clayton Williams informs you that he has moved since his last visit, and you want to verify that you have his latest demographic information. Using his open encounter,</p> <ol style="list-style-type: none"> 1. Click on the Demographics folder in the Folder List. The Demographics module will display. 2. Verify his home address as 877 Main Street. 3. Click the CLOSE icon on the Action Bar to close the module. <p>Key Points</p> <ul style="list-style-type: none"> • Demographic and third party insurance information may currently be viewed in CHCS II, but any required changes should be done in the respective legacy systems. Follow your MTF business rules. <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	<ul style="list-style-type: none"> • Use the Demographic module to verify patient demographic information. • Address and phone number information should not be updated in CHCS II. Changes in CHCS II do not write back to CHCS. • To update this information, continue to follow current MTF policies. • Insurance information does not write back from CHCS II to CHCS. Continue to follow your MTF policy for collecting third party insurance information.
	<p style="text-align: center;">SUMMARY</p> <ul style="list-style-type: none"> • Verified patient demographic information <p style="text-align: center;">Next Slide</p>	

Lesson 5: Patient Encounter		
	<p>Lesson Goals</p> <p>The goal of this lesson is to document the patient encounter in CHCS II and create electronic record.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the user will be able to:</p> <ul style="list-style-type: none"> • Open the encounter • Document “reason for visit” • Verify patient’s allergies • Document patient’s vital signs • Document S/O using MEDCIN • Document A/P • Disposition and Sign Encounter 	<p><input type="checkbox"/> Slide 19: Patient Encounter Learning Objectives</p>
	Screening and Vitals Modules	
	<p>Screening and Vitals</p> <ul style="list-style-type: none"> ▪ Screening ▪ Vital signs <p>Once the patient has been checked in, it is now time to open an encounter document for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening. The appointment, or encounter for the patient can be opened.</p>	<p>Review screen layout: SF600 features</p>

Screening and Vitals

Demonstrate:

Wilma Wunderlich's mother brings her to the clinic. She states that Wilma Wunderlich has a cough, sore throat, and runny nose. Based on your assessment, you suggested she have a throat culture done, and be seen by a Provider. Create a new appointment for Wilma Wunderlich (w8118)

During this portion of the encounter, you will set the AutoCite properties, screen the patient including entry of the reason for visit and verifying allergies, enter the vital signs and review the results in the electronic SF600. To get started:

Field	Data
Patient Search	
Quick Search	w8118
New Unscheduled Appointment/Telcon Visit	
Appointment Type	Acute Appt (Acute) 30
Reason for Appointment	Cough, runny nose
Encounter Summary Properties	
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family	[Select]
Active Dispensed Medications	[Select]
Screening	
In the Search field	[Enter] a cough and click Find Now . Select a cough and click Add . [Enter] nasal discharge and click Find Now select nasal discharge and click Add
Verified This Encounter	[Select to verify allergies]
Vitals	
BP	110/70
Rt arm	[Select]
Pediatric cuff	[Select]
HR	95
Radial	[Select]

Explain: Use of the Screening module to document:

- Appointment reason for visit (including comments)
- Verification of allergies (only opportunity in the application)
- Special Work Status
- Use of allergy icons in the patient ID line for quick assessment of the status of the patient's allergies
- Screen layouts for Screening and Allergy modules
- Problem lists and search

Explain: Either select the **Verified This Encounter** check box and add an allergy, or select the **No Known Allergies** check box.

Regular	[Select]
RR	13
Temperature F	100 F
Oral	[Select]
Ht	[Enter] 52 in
Wt	70 lbs
Habits	
Tobacco	[Select] No
Alcohol	[Select] No
Pain Severity	
	[Select] 1 Hurts a little bit
Where is pain located?	Throat
	NOTE: Add comments when pain scale is selected (other than "0 pain free").
Save Vitals	
	[Select] Save Vitals (Action Bar Icon)
	[Select] Close (Action Bar Icon)

In review, ask students in which module allergies are verified: *Screening, not Allergy.*

Key Points:

- Reason for Visit is a structured term and may be more accurate than Reason for Appointment
- Screening during the patient encounter is the only area where a patient's allergies can be verified
- Allergy information, however, can be added without an open encounter

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Open the encounter
- Setup AutoCite properties
- Document “reason for visit”
- Verify patient’s allergies
- Document patient’s vital signs

Next Slide

Introduction to MEDCIN

MEDCIN

- Medical terminology narrative engine used in S/O, A/P, Disposition, Template Management, Screening and Problems modules
- Relates to the encounter
- Over 250,000 terms with 5.5 million semantic links
- Linked to ICD-9 and CPT codes in A/P

Explain: MEDCIN

- Structure: Tree, hierarchy, parent-child relationships; navigational nodes, gender-specific aspects.
Expand **head-related symptoms**, then **headache** for this.
- Tabs: Move through and open and show terms.
- Organization: Head to toe.
- Location in application: Stored in and used in both S/O and A/P (diagnosis and treatment terms).
- PMH hidden nodes: Diagnosis and therapy.
- Use of terms: Demonstrate add/remove a term; change from plus (+) to minus (-).

Emphasize that use of structured documentation results in a more accurate code.

Be sure to explain the parent-child relationship and that a parent term need not be selected if a child term is selected; for example, if the term cigarettes is chosen, no need to select smoking.

Explain: AutoNeg—when to use and when not to use.

Explain: “flipping” and the use of **ROS/HPI** button.

	<p>Subjective/Objective Module</p> <p>Subjective/Objective</p> <p>Most Nurses are familiar with the SOAP format that is used in paper charting. MEDCIN is organized into a SOAP format as well. To review:</p> <ul style="list-style-type: none"> ▪ Subjective - what the patient told the end user ▪ Objective - what the end user observed during physical exam <p>The Subjective portion of the note includes the History of Present Illness (HPI), Past Medical History (PMH) and Review of Systems (ROS). This information comes from the patient and is organized by the end user.</p> <p>The Objective portion of the note includes the Physical Examination (PE) and is what the end user observes.</p> <p>Key Points:</p> <ul style="list-style-type: none"> • Standard visit templates are clinical notewriters using MEDCIN terms • E&M coding is done quickly and accurately using structured terminology. 	<p>Reinforce to End-users the criteria between HPI and ROS. This is typically not familiar to some End-users.</p>
	<p>Subjective/Objective</p> <p>Demonstrate:</p> <p>Since Wilma Wunderlich has come in today with a cough and runny nose, we will document her visit using a standard Cold & Cough template. We need to document the following:</p> <ol style="list-style-type: none"> 1. Click S/O on the SF600. The S/O module opens. 2. Click Template Mgt on the Action bar. 3. In the Name Contains field, enter TRAINING and click Find Now. 4. Select the TRAINING—TRIAGE--COLD & COUGH--VISIT template. You can review the template in the Template Preview pane. 5. Click Load on the Action bar. 	<p>Review screen layout</p>

	<p>HPI</p> <ul style="list-style-type: none"> ▪ Chief Complaint of URI symptoms ▪ Nasal discharge which is watery ▪ A cough, duration 2 Days ▪ Sore throat ▪ Patient denies all other symptoms <p>PMH</p> <ul style="list-style-type: none"> ▪ History of Acute Bronchitis, in the Free Text field, enter <i>2000</i> and press Enter on your keyboard. ▪ No history of Asthma ▪ Education and Counseling per approved protocol. ▪ Patient Goals per approved protocols. <p>PE</p> <ul style="list-style-type: none"> ▪ Pain Level ___(0-10) 3. ▪ All other items are normal <p>Documenting the note:</p> <ol style="list-style-type: none"> 1. Once the template is loaded, the S/O module starts with the HPI tab selected 2. Click + to select The Chief Complaint is: URI symptoms 3. Click + to select nasal discharge which is watery 4. Click + to select a cough 5. Click on the Duration (numeric) icon on the dashboard 6. Click on 2 and then click on Days 7. Click + to select sore throat 8. Patient denies everything else so click the AutoNeg on the S/O dashboard. 9. Once the HPI is complete, click the PMH tab in the S/O window to document the Past Medical History. 	<p>Show how to:</p> <ul style="list-style-type: none"> • select/deselect • expand/collapse <p>Explain: Documenting by exception is the common practice and crucial to the use and purpose of AutoNeg</p>
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10. Click + to select history of ACUTE BRONCHITIS
11. In the **Free Text** field, enter *2000* and press Enter on your keyboard.
12. Click - to select history of ASTHMA
13. Click + to select Education and Counseling per approved protocol.
14. Click + to select Patient Goals per approved protocols.
15. Next, click the **PE** tab.
16. Click + to select Pain Level ___(0-10).
17. In the Value field, enter **3**.
18. Review the information in the narrative pane to ensure that everything is correct
19. Click on the **Close** icon on the Action Bar so we can review the information on the SF600.

Explain: Reverse sensing terms

The patient does not appear well nourished.

After reviewing your S/O note, You noticed this statement and realized you failed to select the minus sign to document this as an abnormal finding, so AutoNeg emitted a normal term, if a reverse sensing term is not specifically noted as a (-). You must now open the S/O (*PE*) tab to correct this term in the note.

Explain:

This is a *reverse sensing* term. Abnormal conditions for these terms are documented by *explicitly* selecting the minus, rather than the plus.

There are around 300 reverse sensing terms; they usually describe a normal condition, like *well nourished* or *does not appear stressed*; rather than an abnormal one, like *headache* or *nasal congestion*.

For these terms, when a plus is selected, the condition is described as normal, and when no plus is selected, AutoNeg assumes a normal condition.

So, to document an abnormal condition, the minus must be explicitly selected.

In summary: When using AutoNeg, for reverse sensing terms, select nothing unless the condition described is a problem; then, explicitly select the minus rather than plus. When

not using AutoNeg, select the plus when the condition is checked and found to be normal.

MEDCIN: Advanced Search Options

Explain:

- Dx Prompt creates a list of findings based on a diagnosis. This is helpful in selecting terms for a template built around a diagnosis.
- List Size creates a broader or narrower list of findings. There are three levels.
- Find Term
- Browse From Here

Next Slide

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Explained MEDCIN
 - Dashboard
 - MEDCIN Tree
 - Narrative Pane
- Searched, loaded and used a template
- Explained moving narrative from ROS to HPI
- Explained AutoNeg
- Explained reverse sensing terms

Next Slide

	<p>Assessment/Plan Module</p> <p>Assessment/Plan</p> <ul style="list-style-type: none"> ▪ Assessment – knowledge gained from the S/O determines diagnosis ▪ Plan – what needs to be accomplished to treat the patient <p>The Assessment and Plan module allows you to document your assessment of a patient’s condition and the plan for treatment by entering diagnoses, procedures, patient instructions and order consults, laboratory and radiology procedures and medications.</p> <p>A/P Processes</p> <ul style="list-style-type: none"> ▪ Codes are captured with diagnoses and procedures ▪ Procedures, orders and other therapies must be associated to a logical diagnosis ▪ Consults, labs, rads and meds can be submitted or saved to queue <p>ICD-9 and CPT codes are automatically included with the appropriate terms in MEDCIN. When a diagnosis is added to the encounter the associated ICD-9 code is also added. When a procedure is added, the associated CPT code is included.</p> <p>Assessment/Plan</p> <p>Demonstrate:</p> <p>As a result of the physical examination, the user has observed that Wilma Wunderlich has a cough.</p> <p>The user wants to order a Lab:</p> <ul style="list-style-type: none"> ▪ THROAT CULTURE <p>Documenting the note:</p> <ol style="list-style-type: none"> 1. To document these items, click A/P on the electronic SF600 to open the A/P module. The A/P screen will display with the Diagnosis tab selected: 2. Type <i>a cough</i> in the Search field and click Find Now. Diagnosis terms containing ‘<i>a cough</i>’ 	<p>Explain:</p> <ul style="list-style-type: none"> ● CHCS II supports creating a problem-oriented medical record. ● Procedures and orders must be associated with a diagnosis. ● Association of orders and procedures supports problem-oriented healthcare. ● Procedures and orders can be associated and disassociated with one or more diagnosis. ● Order Entry selections are similar to the ones in CHCS. ● Same drug-to-drug, drug and allergy, and duplicate order warnings as in CHCS. <p>When adding diagnosis and procedures, point out ICD and CPT Codes.</p> <p>Add diagnoses to the working diagnosis list.</p>
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will display in the Diagnosis List

3. Click on *a cough* 786.2 in the list and click **Add to Encounter** to add the diagnosis to the Diagnosis List.
4. Click **Order Lab** tab
5. In the New Lab Order field, enter *Throat Culture* and click **Search**.
6. Select THROAT CULTURE.
7. Click **Submit**.
8. Click on the **Other Therapies** tab to include other instructions given to a patient. The Other Therapies List area will display in the bottom area of the window.
9. Type **Gargle saltwater** in the search field and click **Find Now**.
10. '*Gargle saltwater*' will display in the Description of patient instruction window. Select *Gargle saltwater* and click **Add**.
11. Click the **Close** icon on the Action Bar so we can review the information on the SF600.

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Document A/P
- Explained how codes are captured with diagnoses and procedures
- Procedures, orders and other therapies must be associated to a logical diagnosis
- Consults, labs, rads and meds can be submitted or saved to queue

Next Slide

Explain Searches can be performed using:

- WHO language
- ICD 9 Codes
- Partial Words

Explain: User can delete a diagnosis, procedure or order that was documented in error.

If orders were submitted they would be listed under the show orders area.

Discuss pros and cons of saving to queue.

- Point out you might lose orders if the system should fail; but you can delete from queued orders.
- Show how to delete before submitting queued.
- Recommend submit over save to queue.

Explain: Civilian (**Non-MTF**) consults continue to be completed in CHCS rather than in CHCS II.

Disposition and Sign Module

Disposition and Signing

- Release of the patient
- Follow-up information
- Items discussed
- E&M code
- Review the note
- Assign a co-signer if required

Disposition and Sign

Demonstrate:

We are now ready to discharge the patient. In this case we want to release the patient without limitations and have them follow up as needed. All items were discussed with the patient mother who indicated an understanding of the items discussed. We want to see the effect of filters on the E&M code before signing the encounter.

1. Click **Disposition** button on the electronic SF600 to open the Disposition module. The Disposition screen will display:
2. Enter the following data:

Field	Data or [Description of Data]
Disposition	Click Released w/o Limitations from the pull down list
Follow Up	Click the <input type="checkbox"/> PRN checkbox
Comments	<i>Will call if throat culture positive</i>
Discussed	<i>Select the Diagnosis and Medication(s)/ Treatment(s) checkboxes. Notice that the indicated understanding drop-down list defaults to Parent.</i>

Important Notes:

Emphasize that verification of the E&M code is essential and that it can be changed, if necessary, based on documentation. This is especially important when using free text.

Emphasize selection of Preventative Med types, when appropriate. Most often missed; results in inappropriate coding.

3. Click the **Selection** tab.
4. In the E&M Codes area, select 99211 OFFICE/OUTPATIENT VISIT, EST.
5. Click the **Sign** icon on the Action Bar to initiate the signing process. The Sign Encounter window will display.
6. Select the Cosigner Required checkbox.
7. Review the note to ensure that everything is complete and accurate. Enter your password in the field provided and click **Sign** to complete the patient encounter process.

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Complete Disposition
- Sign Encounter

Next Slide

Remind Users of Mental Health Clinics, they won't use the >50% time spent counseling box but will use the appropriate Procedure code because these sessions are designed as counseling sessions with this already factored in.

Lesson 6: Previous Encounters

Lesson Goal

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

Learning Objectives

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

- Display a previous patient encounter
- Append a narrative to a completed encounter
- Amend a completed encounter

Previous Encounters

Demonstrate:

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

Appending a Narrative

1. From the list of appointments, click on any of Lcdr Eduardo Suarez's appointments to pull his record.
2. Click the **Previous Encounters** icon in the Folder List. The Previous Encounters window will display.
3. Click the **Append Narrative** icon on the Action Bar. The Encounter Note window will display.
4. Type **DIABETES** in the Note Category field.
5. Type **DIABETES CONTROLLED** in the Note Title field.
6. Type **BASED ON THE PT A1C, HIS DIABETES SEEMS UNDER CONTROL. PT WILL CONTINUE TO MONITOR HIS GLUCOSE LEVEL.** in the text area.
7. Click the **Save and Sign** button. The Sign Appended Note window will display.

Slide 20: Previous Encounters Learning Objectives

The *Change History* section of the Encounter Note shows the original S/O note. This is the electronic equivalent of lining out the information in the paper medical record.

New findings can also be documented for the current encounter.

8. Click the **Sign** button to sign the encounter. The Previous Encounters window will re-display.
9. Click the **Close** icon on the Action Bar to close the module.

The user needs to add the lab results of the Lipid Panel Complete report to another completed encounter for LCDR Suarez's.

Amend a completed encounter:

1. Highlight the *Screening exam Lipoid Disorders* note and click **Amend Encounter** on the Action bar. The SF600 opens.
2. Click **Lab** on the Folder List.
3. Click **Time**. The Time Search window opens.
4. Select the **All Time Periods** radio button.
5. Click **OK**.
6. Select the *Lipid Panel Complete* report. The report details populate below.
7. Highlight the report by left-clicking and dragging over the text with your mouse.
8. Perform a right-click and select **Copy to Note**.
9. Click **Close** on the Action bar.
10. Click **Close** on the Action bar to return to the Previous Encounters module.

Key Points:

- Access to past encounters is available at any workstation that has CHSC II access.
- Anyone with signing privileges can append a note.
- Only the signer or cosigner of a particular note can amend that note.

Explain: Amending an encounter allows information in the original note to be changed by the original Provider, co-signing Provider, or the original Provider's supervisor. If they are the originator of the note,

	<p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> ▪ Display a previous patient encounter ▪ Append a narrative to a completed encounter ▪ Amend a completed encounter <p style="text-align: center;"><i>Next Slide</i></p>	
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Lesson 7: S/O Template Management

	<p>Lesson Goals</p> <p>The goal of this lesson is to locate available S/O templates in CHCS II and edit templates using MEDCIN.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the user will be able to:</p> <ul style="list-style-type: none"> • Search for Visit Template • Use Template Edit Mode • Use FindTerm • Use Browse from Here • Rename and Save the Template 	<p><input type="checkbox"/> Slide 21: S/O Template Management Learning Objectives</p> <p>Explain: use of Favorites List when searching for and loading templates.</p> <p>Explain:</p> <ul style="list-style-type: none"> • Templates have pre-positioned terms • Benefits of using templates: streamline documentation • Folder location of templates in CTS versus the live system
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S/O Template Management	Training system templates
<p>Demonstrate:</p> <p>The Nurse states “I like the Visit—Fever template in the list of available templates. Is there anyway I can edit this template to reflect the notes I write?”</p> <p>Edit a Visit template</p> <ol style="list-style-type: none"> 1. Create an appointment for LT Jon Chang (c9231). <ul style="list-style-type: none"> — Appointment Type: ACUTE APPT (ACUT\$) 30 — Reason for Appointment: Test Patient 2. Open the encounter. 3. Click S/O on the SF600. 4. Click Template Mgt on the Action bar. 5. In the Name Contains field, enter <i>Fever</i> and click FindNow. 6. Highlight TRAINING--TRIAGE--FEVER--VISIT. 7. Click Edit on the Action bar. 8. In the right pane, under Review of Systems, highlight <i>difficulty breathing (dyspnea)</i>. 9. Click ROS/HPI on the dashboard. The term is flipped into the HPI. 10. In the right pane, under History of Present Illness, highlight <i>nipple discharge yellow-clear, watery (serous)</i>. 11. Click – to remove <i>nipple discharge yellow-clear, watery (serous)</i>. 12. Click Find Term on the Action bar. 13. In the search field, enter <i>nasal discharge which is watery</i> and click OK. 	<p>The naming convention for templates used in the training system begins with TRAINING rather than BRANCH; and there are other training system templates you will use that do not follow either of these conventions.</p> <ul style="list-style-type: none"> • How to search for the template <p>Explain: Template preview screen (point out)</p> <ul style="list-style-type: none"> • Load the template. (Action Bar icon or double-click) <p>Explain: Template availability within S/O using drop-down</p> <ul style="list-style-type: none"> • Explain: Service specific naming convention <p>Templates for all branches are stored together in the live system. Each service uses a different naming convention to organize templates for browsing. For example:</p> <p style="text-align: center;">BRANCH--ENC--URI--LDR</p>

14. Click + to add *nasal discharge which is watery* to the template.
15. Click **Browse From Here** on the Action bar.
16. Click + to add *nasal discharge from both nostrils*.
17. Click **Save As** on the Action bar.
18. In the Template Name field, enter **VISIT--FEVER--[YOUR INITIALS]** and click **Save**.
19. Click **Close** on the Action bar. To return to the S/O Template Management module.
20. Click **No** on the warning window.
21. Click **Close** on the Action bar to return to the S/O module.
22. Click **Close** on the Action bar to return to the SF600.

Next Slide

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Explained S/O Template Management features
- Search for Visit Template
- Use Template Edit Mode
- Use FindTerm
- Use Browse from Here
- Save the Template as “VISIT--[name]--[your initials]”

Key:

BRANCH=
 TYPE = Encounter
 (ENC), Visit, Education
 (EDU), Procedure
 (PROC), Consent, PE,
 and so on,
 SUBJECT = Allergy,
 URI, Asthma Followup,
 and so on,
 LDR = Personal initials
 (3) of the template
 owner

Next Slide

END OF SESSION ONE

Note: Remember to reset the database for the day and import the training templates

Next Slide

Slide 22: Session Two Course Agenda

NOTE: This is a flexible agenda. Topics/Time to be determined per site

Lesson 8: Encounter Templates and Order Sets

Lesson Goal

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

Learning Objectives

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

- Use an Encounter template
- Customize an Encounter template
- Create an Order Set in A/P
- Merge an Encounter template with an Order Set

Slide 23: Encounter Templates and Order Sets Learning Objectives

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

Encounter Templates

Demonstrate:

LT Jon Chang (c9231) is calling the clinic. He indicates he has a Fever. The Nurse taking the call needs to document the findings and assessment.

1. Click **Telephone Consults** on the Folder List.
2. Create a **New Telcon** appointment for **LT Jon Chang (c9231)**.
 - Appointment Type: **TELEPHONE CONSULTS (TCON) 10**.
 - Reason for Telephone Consult: **Fever**.
3. Click **OK**. The Telcon Quick Entry window opens.
4. On the Telcon Quick Entry window, click **Cancel**. The SF600 opens.
5. Click **Templates** on the Action bar.
6. Expand the My Favorites folder.
7. Select the **TRAINING--TRIAGE--FEVER--ENC** template and click **Add**.
8. Click **OK**.
9. Click **S/O** on the SF600.
10. Add The **Chief Complaint** is: *FEVER* as a positive finding.
11. Expand *Fever*.
12. Add *Temperature taken at home* as a positive finding.
13. In the Value field Enter *101*. Click **Enter** on your keyboard.

Explain:

- Purpose of the encounter template.
- The use of the Template Management module to create an original encounter template
- Mention that 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. (OJT).

14. Click the **Duration grid** and then click **2** and **Days**.
15. Add *nasal discharge* as a positive finding.
16. Add *cough* as a positive finding.
17. Click **AutoNeg**.
18. Click the **PE** tab.
19. Add *Pain Level (0-10)* as a positive finding.
20. In the **Value** field, enter **2** and press **Enter** on your keyboard.
21. In the **Free Text** field, enter *As reported by patient* and press **Enter** on your keyboard.
22. Click the **PMH** tab.
23. Add *taking over-the-counter medication* as a positive finding.
24. Click the **Notepad** icon.
25. In the Note field, enter *Pt. reports he has been taken Tylenol to reduce fever* and
26. Click **OK**.
27. Click **A/P** on the Action bar.
28. Select *a fever (as a symptom)* and click **Add to Encounter**.
29. Click the **Order Lab** tab.
30. In the **New Lab Order** field, enter *urinalysis* and click Search.
31. Select *URINALYSIS*.

32. Select the **ASAP** radio button.
33. In the **New Lab Order** field, enter *THROAT CULTURE* and click **Search**.
34. Select *THROAT CULTURE*.
35. Select the **ASAP** radio button
36. Click **Submit**.
37. Click **Disposition** on the Action bar.
38. In the **Follow Up** area, click the **In Clinic** drop-down list and select *CHCS II Test Clinic*.
39. In the **Comments** field, enter *Walk in for Fever*.
40. In the E&M Codes area, select 99371 PHYSICIAN PHONE CONSULTATION.
41. Click **Sign** on the Action bar.
42. Select the **Cosigner Required** checkbox.
43. Click **Sign**.
44. Close the all open modules and return to the Appointments module.

To personalize an encounter template:

1. Expand Tools on the Folder List and select **Template Management**.
2. The **Search/Browse** tab will display.
3. Click **Search** on the Action bar.
4. In Template Name type FEVER and click **Search**.

Explain:

- Point out the five main components of the encounter template: diagnoses, notes templates (visit, S/O), other therapies, procedures and order sets.
- Mention that the top four

<ol style="list-style-type: none"> 5. Highlight the TRAINING-- TRIAGE--FEVER--ENC template. 6. Click View/Edit on the Action bar. The Template Details tab opens. 7. In the Diagnoses area, select BACKACHE 724.5 8. Click Remove. 9. In the Other Therapies area, click Add. 10. In the Search Term field, enter <i>frequent oral fluids</i> and click Search. 11. Select <i>Oral Fluids Frequent</i> and click Add Items. 12. Click Done. 13. Click Save As on the Action bar. 14. In the Template Name field, enter TRIAGE--FEVER--ENC--TEST and click Save. 15. Click Close on the Action bar. <p>To create an order set:</p> <ol style="list-style-type: none"> 1. In the Appointments module. Double-click Lt. Jon Chang's Test Patient Appointment. 2. Click A/P on the SF600. 3. Click the Order Lab tab. 4. In the New Lab Order field, enter <i>Urinalysis</i> and click Search. 5. Select <i>URINALYSIS</i>. 6. Select the ASAP radio button. 7. Click Save to Queue. 	<p>sections (Associated Reasons for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Notes) are not used.</p> <ul style="list-style-type: none"> ● Discussion of order sets will follow the building of the parts of the template mentioned above. <p>When adding diagnosis, show how to do multiple searches and select results before clicking the Done button.</p> <p>When adding therapies, show double-clicking to add, rather than using the Add Items button.</p> <p>When adding procedures, show entry of multiple selections pressing Ctrl key</p>
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8. In the **New Lab Order** field, enter *HCG QL* and click **Search**.
 9. Select *HCG QL*.
 10. Click **Save to Queue**.
 11. In the **New Lab Order** field, enter *CBC W/AUTO DIFF* and click **Search**.
 12. Select *CBC W/AUTO DIFF*.
 13. Click **Save to Queue**.
 14. In the **New Lab Order** field, enter *THROAT CULTURE* and click **Search**.
 15. Select *THROAT CULTURE*.
 16. Click **Save to Queue**.
 17. Click the **Order Sets** tab.
 18. Click **Save As Order Set**. The Save Encounter Template window opens.
 19. In the **Template Name** field, enter **FEVER--Orders--Test** and click **Save**.
 20. Close the A/P module.
 21. Click **Yes** on the A/P Warning window. You are returned to the SF600.
- To merge an order set with an Encounter template:**
1. Expand Tools on the *Folder List* and select **Template Management**.
 2. Click **Search** on the Action bar.
 3. In the Template Name field, enter FEVER.
 4. Click **Search**.

5. Press and hold Ctrl on your keyboard and select **FEVER--Orders-- Test** and **TRIAGE--FEVER--ENC--TEST**.
6. Click **Merge** on the Action bar.
7. Click **Save As** on the Action bar.
8. In the Template Name field, enter **ENC--FEVER with Orders** and click **Save**.
9. Click **Cancel** on the Action bar to go back to the Search/Display window.
10. Click **Search** on the Action bar.
11. In the Template Name field, enter **ENC--FEVER with Orders** and click **Search**.
12. Highlight **ENC--FEVER with Orders** Template.
13. Click **View/Edit** on the Action bar to verify both templates merged.
14. Click **Close** on the Action bar.

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Used an Encounter template
- Customized an Encounter template
- Customized an Order Set in A/P
- Merged an Encounter template with an Order Set

Next Slide

Lesson 9: Health History Folder

Lesson Goal

The goal of this lesson is to setup and customize the Health History module and enable the user to access and modify selected patient information accumulated from earlier encounters and outside the current encounter..

Learning Objective

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

- Setup Health History patient data modules
- View and modify problem information
- View and copy lab results into an encounter
- View and copy radiology results into an encounter
- View and modify medication information
- View and modify allergy information
- Setup and review the properties for Vitals Signs Review

Health History

Demonstrate:

The user would like to set up the Health History folders to display only Problems, Allergies, and Lab. To select this module you will need to pull LCDR Eduardo Suarez's record.

1. Click the **Health History** folder in the Folders List. A warning message may appear. Click the **OK** button to remove the message.
2. Click the **Options** button on the Patient ID line. The Health History Design Summary screen will display.
3. Click the check box next to the Problems, Allergy and Lab. The Design Summary window will look like this (the Module Options are "stacked" on top of each other).

Slide 24: Health History Learning Objectives

Explain:

- Use this module to set up a display of selected patient health history information for quick review.
- The first time you access the module, you will be prompted by Warning message prior to setup.
- Setup can be done from the **Options** button.
- the same setup applies to all patient records.

4. Click in the center of the Lab box in the Design Summary window and drag it to the upper left of the design area.
5. Click and drag the Allergy box to the center left of the design area.
6. Click and drag the Problems box to the lower left of design area.
7. Click the **Align** button to view the format
8. Click the **OK** button to view the results
9. Click the **Close** icon on the Action Bar to close the module.

Key Points:

- Can be changed to fit the current requirements

AutoCite Information

Explain: As encounters are completed for a patient, information from them is accessible through several modules from the Folders List. Information from some of these modules can be selected for display in the electronic SF 600 of a new encounter that is opened for the patient. These modules are referred to as AutoCite modules. You make selections for display of information from these modules in the *Encounter Summary Properties* window when you set up your system for personal use. Information in some of these modules can also be edited and modified by additions and deletions that are appropriate outside of encounters.

AutoCite modules include:

- Problems module
- Lab module
- Radiology module
- Medications module
- Allergies module
- Vital Signs module

Problems, Allergies, Medications, and Vital Signs are considered Health History modules and are located in the Health History Folder for the patient in the Folder List. AutoCite information for these modules appears in the AutoCite section of the SF 600.

The Lab module and the Radiology module are directly accessible in the patient's folder. Information from these modules, when selected for AutoCite display, appears in the S/O section of the SF 600.

The AutoCite button on the SF 600 refreshes all information selected for AutoCite display regardless of where it appears.

Problems Module

Explain: Information from completed encounters is available in the Problems module. In this module, information from all previous encounters is accumulated and organized according to the problems that have been identified in encounters. Not only can you view this information, you can also add or delete problems, as appropriate.

Set the scene: CAPT Clayton Williams (w8867) has previously been diagnosed with cancer of the gallbladder. This needs to be added to his Problems List in the Problems module under Health History.

Students follow along:

1. Select (highlight) CAPT Williams' name in the list of appointments. The patient's name must show in the ID line.
2. In the Folder List, click the **Problems** module located under Health History.
3. Complete the Following:

Field	Data
Problem	Gallbladder Neoplasm Malignant
Onset Date	06 Dec 2000
Chronicity	Chronic
Status	Active
Source	Patient

Review Screen layout

Lab Module	
<p>Set the Scene: Provider Test User is out of the office till this afternoon. He tells you he has just talked to patient LCDR Suarez and wants to see him to discuss his previous Lab and Rad results. Dr. User asks you to add the results to the patient encounter he wants you to create.</p> <p>Students follow along:</p> <ol style="list-style-type: none"> 1. Create a new appointment for LCDR Suarez. Note: Loading the patient name to the patient ID line is sufficient for viewing lab results. An appointment is created in this exercise to illustrate additional features of CHCS II. 2. Open the encounter. 3. Click Lab in the Folder List. <i>Review what appears based upon the default settings.</i> 4. Provider User is specifically interested in the results of a urinalysis test. Change the properties and the filter to locate this test. (Hint: Change Time to All time periods) 5. Highlight the urinalysis lab result. The result details display in the lower section of the screen. Use the Display Criteria check boxes and radio buttons to select the optimal view of the test results. 6. Highlight the result details and right-click. Note the two options: Copy: puts the results onto the clipboard and they can be pasted into another document Copy to Note: enters the results onto the patient encounter in the S/O portion 7. Select Copy to Note. 8. Close the Lab module and the highlighted urinalysis results appear in the S/O portion of the encounter note. <p>Do not close SF 600.</p> <p>Caution: Nothing seems to happen when clicking Copy to Note; however, results are copied. Selecting Copy to Note again results in multiple copies that cannot be deleted.</p> <ul style="list-style-type: none"> • Close Lab Module and show lab results in the encounter note. 	<p>Explain: Review screen layout and quickly review other options.</p> <ul style="list-style-type: none"> • Click the Options button to set the Lab Results Properties.). • Select the <i>Filter</i> tab radio button: <i>All labs</i>. In the Preferences tab. • Time Options section, select Default Time: <i>All Time Periods</i>. • Click the OK button. • Click the OK button to display the list of labs. <p>Explain: The difference between Copy and Copy to Note.</p>

	<p>Radiology Module</p>	<p>Review the screen layout.</p>
<p>Set the Scene: Add the following Radiology results to LCDR Suarez’s Encounter note.</p> <p>Students follow along:</p> <ol style="list-style-type: none"> 1. In the Folder List, click the Radiology icon. The results of three tests appear. 2. Click each test in turn; note that the Result Code appears in red when the results are not normal, but the color change is not visible when that report is selected. 3. In the Display Criteria section, select the Select All Results check box. 4. Scroll through the results that appear in the lower section of the window. 5. Clear the Select All Results check box. Press and hold the Ctrl key (on your keyboard) and select both the Sinus Series Report and the Chest PA and Lateral Series Report. 6. Review what appears in the lower section. (Scroll down to view the results of both of the selected tests.) 7. Use your mouse to highlight all, or a portion of, the test results and right-click. This allows you to copy to an open encounter note, or copy to the clipboard and paste in another document. 8. Copy the note. 9. Close the Radiology module <p>Close the encounter.</p>		
	<p>Meds Module</p>	<p>Review the screen layout.</p>
<p>Explain:</p> <ul style="list-style-type: none"> • The Medications module lists the patient’s past and present medications. • It includes all over-the-counter (OTC), outside, and CHCS II-ordered medications. • Ordered meds appear once the prescription is filled at the pharmacy. <p>Set the Scene: Col Violet Alexander (a5743) seems to have caught the cough that many of the clinic’s patients are exhibiting. She tells you that she has added taking one enteric-coated aspirin each day to her daily routine as suggested by earlier by Dr. David Doctor. Check her medication health history and update it with the new medication.</p> <p>Students follow along:</p>		

	<ol style="list-style-type: none"> 1. Make a new appointment for Col Violet Alexander (a5743). Use Appointment Type, ACUTE APPT (ACUT\$) 30. 2. Open the encounter and complete the screening. 3. In the <i>Folder List</i> under Health History, click the Meds icon. In the Meds module, the Search Filter field default is Outpatient Current. 4. Review the functions available using the Action Bar icons: Add, Details, Discontinue, Modify and Renew. 5. Click the drop-down arrow for the Search Filter field and review the options. Change the selection to All. 6. Select an existing medication and, on the Action Bar, click the Details icon. 7. Click Discontinue; click Refresh. <p>How can you view the discontinued medication? (Select All Discontinued in the Search Filter field.) Note that the Status column entry is now (Out) Discontinued.</p> <ol style="list-style-type: none"> 8. Change the Search Filter selection back to Outpatient Current. 9. Click the Add icon to record the addition of the aspirin. 10. Click the Record OTC/Outside Medication button. 11. Click the Medications button to begin searching for Ecotrin in the <i>Healthcare Data Dictionary Search</i> window. 12. Select ECOTRIN, 325 MG, CAPSULE EC, 105 ea. BOTTLE, SMITHK and click the OK button. 13. Complete all required fields (including the Sig: 1 tab QD) and add a comment that it was a suggestion by her doctor for secondary prevention for heart disease. 14. Click the OK button. Note the O in the OTC column to indicate this is an over-the-counter medication. 15. Close the Meds module. 16. Close the encounter. <p>Return to encounter; refresh AutoCite to show medication in encounter</p>	<p>Explain: Point out that the order, renew and modify buttons are accessible from the Meds module, but do not attempt to use them. This functionality does not work in the CHCS II Training System. Providers will find it easier to order prescription medications through A/P, but, in the live system, medication can be ordered, renewed and modified from the Meds module. To do this, an encounter must be open.</p>
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Allergy Module

Explain:

- Keeps track of a patient's reactions to specific allergens
- Allergy icons: NKA, nose, and nose with question mark
- Allergy synchronization occurs when the appointment is created and when the Allergy module opened
- A common list of allergens can also be specified to make entering data more convenient

Set the Scene: MG Ramona Marcos (m9876) is on the telephone requesting that her CHCS II allergies record be updated. She was stung by a wasp last month and had a reaction to the sting.

Students Follow along:

1. Search for MG Marcos' patient record and load her name to the patient ID line.
2. Open the **Allergy** module from the Folder List.
3. Click the **Add** button to display the *New Allergy* section.
4. Click the **Allergen** button and search for **wasp venom** in the *Health Care Dictionary Search for Allergens* window.
5. Double-click **WASP VENOM (WASP VENOM)** to add it as an allergen.
6. Click the **Reaction** button and search for **BRONCHOCONSTRICTION** as a reaction.
7. Highlight **BRONCHOCONSTRICTION** in the left column of the *Health Data Dictionary Search for Reactions* window and click the **Add>>** button to move it to the right column.
8. Click the **OK** button to close the window.
9. Enter the following information:

Review the screen layout.

Field	Data
Info Source	Patient
Onset	[four weeks ago]
Entered by	[accept default]

10. Click the **Save** button.

The clinic has had several patients recently report an allergic reaction to wasp venom, so it needs to be added to the drop-down list of common allergens.

11. Click **Options** to open the *Properties* window.

12. Click **Add** to open the *Add Common List Items* window. Search for and select to highlight **wasp venom** and click the **Add to Common List** button.

13. Click **Close**.

14. Click **Save** and **Close** the *Properties* window.

15. Click the **Add** button in the Action Bar, and review the **Allergen** drop-down list. Notice that **WASP VENOM (WASP VENOM)** has been added.

Note: In the live CHCS II system, allergens can also be deleted using **Options**.

Close the **Allergy** module and return to the **Appointments** module.

Vitals Sign Review

Demonstrate:

Set the Scene: LCDR Suarez' (s3217) comes in for his diabetes follow-up exam. Review and graph his past vitals.

Students follow along:

16. Open the **Appointment** module.

17. Click once to highlight LCDR Suarez Diabetes follow-up visit in the appointment list to pull

Review the screen layout

his patient record.

18. Verify that LCDR Suarez is now listed in the Patient ID line.
 19. Open the **Vitals Sign Review** module from the Folder List.
 20. Click the **Search Type** button to open the *Time Search* screen.
 21. Select the **Sliding Time Range** radio button and select **2 months** as the time range.
 22. Click **OK**.
 23. Click the **Refresh** button to the right of the time period display. (This may not work correctly in the CHCS II Training System.)
 24. Highlight a single line and click the **Graph Vitals** icon on the Action Bar to open the *Graph Vitals* window.
 25. Select each of the **Graph Options**, **Chart Types**, and **Vitals Keys** in turn to review their functions.
- Note:** The graphs can be printed from the live CHCS II system.
26. Click **OK** to exit and return to the Review role with LCDR Suarez' vitals.
 27. Press the **Shift** key on your keyboard and select the entries in the **BP** and **HR** columns. Click the **Graph Vitals** button.
- Review the display options available.
28. Return to the *Vital Signs Entry* screen.
 29. Click the **Close** button.
 30. Click **Close** to close the encounter.

Exercises

- No Exercises (Students completed follow alongs with the Instructor)
- Check for understanding and answer participant questions

Summary

- Explained Health History folder
- Setup Health History patient data modules

- | | | |
|--|--|--|
| | <ul style="list-style-type: none">▪ Viewed and modified problem information▪ Viewed and copied lab results▪ Viewed and copied radiology results▪ Viewed and modified medications▪ Viewed and modified allergy information▪ Set and review the properties for the Vital Signs module | |
|--|--|--|

Next Slide

Lesson 10: Readiness

Lesson Goal

The goal of this lesson is to learn how to work within the Readiness module in CHCS II.

Learning Objectives

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

- View the readiness module
- Edit the readiness information

Readiness

Demonstrate:

An end user's appointments for this afternoon are all yearly physicals. The end user would like to see the readiness of his patients prior to their appointments. He notes his patient had a recent HIV test and sickle cell drawn. He would like to update Mr. Suarez's Readiness module.

1. Pull Eduardo Suarez's record.
2. Click the **Readiness** folder in the Folders List. The Readiness window will display:
3. Click on the **Edit** icon on the Action Bar to activate the window.
4. Click the *HIV Done* drop-down, and select **25 November 2003** from the associated Date drop-down fields.
5. Click the *Sickle Cell* drop-down, and select **25 November 2003** from the associated Date drop-down fields.
6. Click the *Sickle Cell Result* drop-down, and select **Positive** from the drop-down.
7. Click **Save** on the Action Bar to save the information entered.
8. Click **Close** on the Action Bar to close the module.

Slide 25: Readiness Learning Objectives

	<p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> ▪ View the readiness module ▪ Edit the readiness information <p style="text-align: center;"><i>Next Slide</i></p>	
Lesson 11: Questionnaire Setup & Patient Questionnaire		
	<p>Questionnaire Setup/Questionnaire</p> <p>Lesson Goal: The goal of this lesson is to enable the end-user to set up patient questionnaires in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the end-user will be able to:</p> <ul style="list-style-type: none"> • Create and release a questionnaire • Edit an existing questionnaire • Change the status of a questionnaire <p>Explain:</p> <ul style="list-style-type: none"> • Allow 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. <p>With this module, you can format your answers as multi-select (patient can select more than one of the provided answers), free-text, yes or no, number, and single-select (patient can only select one of the provided answers.)</p>	<p><input type="checkbox"/> Slide 26: Questionnaires Learning Objectives</p>

Learning Objectives:

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

- Enter questions for your questionnaire.
- Enter appropriate answers in a range of different answer formats.
- Mark the questionnaire as ready for use.
- Save a questionnaire.

Creating a New Questionnaire

Students follow along.

- Expand **Tools**, and select **Questionnaire Set Up**.
- Click the **New** icon on the Action Bar.
- In Name, enter **Asthma**.
- Click the **Add** button. You can now create questions for your questionnaire.
- In the **Question** text field, enter: **How would you rate your asthma compared to your last visit?**
- From the **Answer Type** drop-down list, select **Multiple Choice**.
- Next to **Choice 1**, enter **Better** and press **Enter**.
- Next to **Choice 2**, enter **Worse** and press **Enter**.
- Next to **Choice 3**, enter **Same**. DO NOT press **Enter** this time.
- Click the **Add** button.
- Question #2: **Do you have an asthma action plan?**
- From the **Answer Type** drop-down list, select **Yes/No**.
- Click the **Add** button.
- Question #3: **How many times a week do you have a worsening of your asthma requiring use of your inhaler?**
- From the **Answer Type** drop-down list, select **Number**.
 - Min value: **0**
 - Max value: **100**
- Click the **Add** button.
- Question #4: **What seems to trigger a worsening of your asthma?**

- From the **Answer Type** drop-down list, select **Multi-select**.
- Next to **Choice 1**, enter **Exercise** and press **Enter**.
- Next to **Choice 2**, enter **Common cold** and press **Enter**.
- Next to **Choice 3**, enter **Dust** and press **Enter**.
- Next to **Choice 4**, enter **Animal fur** and press **Enter**.
- Next to **Choice 5**, enter **Unknown**. DO NOT press **Enter** this time.
- Click the **Add** button.
- Question #5: **What date was your last asthma attack?**
- From the **Answer Type** drop-down list, select **Date**. DO NOT press **Enter**.
- Click the **Save** icon on the Action Bar.
- Click the **Mark Ready** icon on Action Bar.
- Close the Questionnaire Setup module

Using a Questionnaire for your Patient

- There are two options for how you use it to collect patient information.
- Patient interview: you enter the questionnaires from the patient's response.
- The patient takes the questionnaire at a kiosk in the clinic: enables the patient to manually enter the answers from a workstation setup in your clinic.
- In this section, manually enter answers in the asthma questionnaire.

Complete a Questionnaire via Interview

Explain:

- Use the interview when talking with the patient.
- Answers are entered directly into the application.

Explain while students follow along:

- Create a new appointment for **Edward Alexander (a5743)**, reason for appointment **Asthma follow up**. Open the encounter
- Expand the **Health History** folder, and select **Patient Questionnaires**.
- Expand **Questionnaires**.
- Select the **Asthma** questionnaire.

- Click the **Interview** icon on the Action Bar.
- Click the **Options** button and show **Properties**. In the **Questions** drop down box, select **Single Question View**.
- Click **OK**.
- Select the appropriate answer for each question and follow the hyperlink **Next Question** to navigate through the questions.
- Proceed to answer questions:
 - Answer #1: **Better**
 - Answer #2: **Yes**
 - Answer #3: **2**
 - Answer #4: **Animal fur**.
 - Click the **Add Comment** hyperlink to add the following comment: **Patient wheezes after being around cats**. Click **OK**.
 - Answer #5: **1st of month** using format dd mmm yyyy)
- Click the **Done** icon on the Action Bar.
- Click the **Encounter** button in the Action bar
 - Show how to link Questionnaires to a specific Encounter
- Close the Patient Questionnaires module
- In the open Encounter, click the **Options** button
- In *Encounter Summary Properties* select the **Questionnaires** checkbox. Close Encounter Summary Properties.
- Review the S/O note with the Questionnaire results.
- Close the Encounter

Exercises

- Complete the exercises.
- Check for understanding and answer participant questions.

Summary

- Create and release a questionnaire
- Edit an existing questionnaire
- Change the status of a questionnaire

Course Summary

Briefly summarize the course and open to questions and answers.

Overview of the system, the training, the expectations
Basic skills: navigating through documenting
MEDCIN and templates
Ancillary modules
Alerts
Previous Encounters

Slide 27: Course Summary

Summarize course based on modules taught

What Do I Do If I Encounter a Problem While Working with CHCS II?

- Write down any error message received.
- Remember what action was taken before the error message was received.
- Take screen shots
- Report the problem to your local Help Desk.

Capturing Screens

To capture screens:

1. On the workstation keyboard, press **PrtScrn**.
2. Open PowerPoint.
3. To paste the screen capture into PowerPoint, on the workstation keyboard, right mouse click and select **Paste**.
4. Save the screen capture to the appropriate folder on the workstation. In many clinics, there is a specific folder on a shared network drive for storing these files.

Slide 28: What Do I Do If I Encounter a Problem While Working with CHCS II?

Ensuring Patient Data is concealed in the Screen Capture

1. In PowerPoint, use the drawing tools to conceal any patient-specific information on the screen.
2. From the View menu, select Slide Show.
3. On the workstation keyboard, press PrtScrn.
4. Exit the slide show to return to the normal view by pressing Esc on the workstation keyboard.
5. On the PowerPoint toolbar, click the new presentation icon (i.e., the blank piece of paper).
6. To paste the screen capture into the new presentation, on the workstation keyboard, right mouse click and select Paste.
7. Save the screen capture (in the new presentation) to the appropriate folder location on the workstation.
8. Close the original screen capture without saving the document.

Next Slide

Other Help Resources

- QRC's.
- CHCS II User Manual. Should be available in each clinic.
- Application Help menu.
 - Detailed information on use of modules
 - Step-by-step procedures

Explain: Both are readily available within the application help files. Help is structured like other Windows application help files.

Next Slide

Questions and Answers

Slide 29: Other Help Resources

Remind the class that the student guide is not to be removed from the classroom, and inform them about the process for obtaining their own copies at the site.

Emphasize the use of Help in the application.

Appendix A: Immunizations Admin & Patient Immunizations

Overview of Immunizations Admin

The Immunization Admin module is used to administer and manage vaccines, providers, reports, user groups, and refrigeration temperature logs. Also used to document multiple vaccine entries for selected patients.

The Immunizations Admin module can be accessed without having a patient's record open.

Action Bar Icons

Refresh Refreshes updated information documented in the Immunizations Administration and Management areas.

Close Closes the Immunization admin module. Immunizations Admin

Vaccination Management

To add vaccines in stock for clinic:

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

Selecting a Default Vaccination Clinic

To select a default vaccination clinic:

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

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

33. Select the clinic from the list.

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

34. Click **Set Default**. You are returned to the Vaccine Management area.

35. Do one of the following:

- If you want to associate stocked vaccines to the default clinic:
 1. Select a vaccine from the list of available vaccines.

Slide 31:
**Immunizations Admin
& Patient
Immunization Learning
Objectives**

2. Click the **Right Arrow** button. The vaccine is moved to the Vaccines in Stock list.

- If you want to set the default typhoid product, select the typhoid product from the drop-down list.
- If you want to set the default body area where the vaccine is given, select the site from the drop-down list.
- If you want to view manufacturer and lot number information for the vaccines in stock:

1. Click **Mfg/Lot Nbr** to open the Vaccines in Stock Information Window

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

6. On Admin tab select a Vaccine from Available Vaccines.

7. Add the following Vaccines by selecting and clicking on Right arrow:

DTP
DTP-hib
Hep A
Hep B
Hib-HbOC
Influenza
IPPD
IPV
Measles
Meningococcal
MMR
Pneumococcal Conjugate
TD
Tetanus
Typhoid
Varicella
Smallpox
Yellow Fever

Viewing the Vaccine Lot Number List

To view the Vaccine Lot Number List:

1. Click **Reports** on the Admin tab.

The Reports area displays.

2. Click **Lot Numbers**.
The Vaccine Lot Number List window opens.
3. Select a vaccine from the drop-down list.
Manufacturer information displays for each manufacturer associated with the selected vaccine.

36. Select a manufacturer.

37. Click Details.

All patients associated with the vaccine distributed by the selected manufacturer display.

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

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

To add vaccines Mfg/Lot Nbr:

2. Click Mfg/Lot Nbr button to add vaccine information.
3. Use drop-down list to add Mfg name, Lot numbers, dosage and route.

DTP	Smith Kline	022	.5 ml	IM
DTP-hib	Smith Kline	022A2	.5 ml	IM
Hep A	Smith Kline	11032L	.1 ml	IM
Hep B	Smith Kline	11032H	.1 ml	IM
Hib-HbOC	Merck	0528R	.5 ml	IM
Influenza	Unkn	005339	.5 ml	IM
IPPD	Aventis	C1601NA	.5 ml	IM
IPV	Avivon	12BH6578	.5 ml	IM
Measles	Unkn	123456	.5 ml	SC
Meningococcal	Wyeth	496590	.5 ml	IM
MMR	Merck	1082M	.5 ml	SC
Pneumococcal Conjug	Aventis	492540	.5 ml	IM
TD	Aventis	22AHA	.1 ml	ID
Tetanus	Unkn		.5 ml	IM
Typhoid	Unkn		.5 ml	Oral
Varicella	Unkn		.5 ml	
Smallpox				
Yellow Fever				

4. Select Close when completed.

To record a patient vaccines previously given:

1. Click **Rapid Data Entry** tab on Vaccine Management window.
2. Select vaccine by clicking on Add button.
3. Enter Immunization Date
4. Enter Immunization Providers
5. Click on **Rapid Data Entry** Button
6. Either read patient's ID bar code or enter required data.
7. Select OK
8. Select Close

Adding User Defined Groups

To add user defined groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays
2. Click **Add**. The Add User Defined Group window opens
3. Enter the name of the user group (have input from class)
4. Click **OK**.

Adding/Modifying a Refrigerator

To add/modify a refrigerator:

1. Click **Temperature Log** on the Admin tab.
The Refrigerator Temperature Log area displays.
2. Select the clinic for which you are adding/modifying the refrigerator.
3. Click **Add/Mod**.
The Add/Modify a Refrigerator window opens.

If you are modifying a refrigerator, double-click the refrigerator you want to modify.

1. Complete the following fields:
 - Alias Name
 - Serial Number

- Low Temperature
 - High Temperature
2. Click **A/M**.

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

To add a vaccine for multiple entry:

1. Click **Add** on the Multiple Entry tab.
The Vaccines in Stock window opens.
2. Select a vaccine from the list of available vaccines.
3. Click **OK**.
The vaccine is added to the list of vaccines on the Multiple Entry tab.

To delete a vaccine from the multiple entry list, select the vaccine and click Delete.

To edit vaccine information from the multiple entry list, click the field you want to edit. Click the down arrow to open the applicable window and modify the information.

Assigning Vaccines to User Defined Groups

To assign vaccines to User Defined Groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays
2. Select a User Defined Group.
3. Select a vaccine from the Available vaccine list. (Have input from class).
4. Click the **Right Arrow** button to move the vaccine to the Assigned Vaccines list.

Deleting Providers from Administering Immunizations

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

To delete a provider from administering immunizations:

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

	<p>displays (see Figure 12-9: Immunizations Admin—Provider Management).</p> <ol style="list-style-type: none"> 2. Select a provider from the list in the <i>Provider Management</i> area. 3. Click Delete. 	
	<p>Entering Multiple Vaccines for a Patient</p>	
	<p>To enter multiple vaccines for a patient:</p> <ol style="list-style-type: none"> 1. Select an Immunization Provider from the drop-down list on the Multiple Entry tab. <i>The Immunization Date field defaults to the current date. Type the applicable date in the field if the current date is not the correct date.</i> 2. Select the Unit in which the patient is located from the drop-down list. <i>A list of patients assigned to the unit displays.</i> 3. Select the patient for which you want to enter multiple vaccines. Click the Select field for the associated patient and click the down arrow to select the patient. <i>Click Select All if you want to enter the same multiple vaccines for every patient in the list.</i> 4. Click Log Selected. 	
	<p>Printing Immunization Reports</p>	
	<p>To print immunization reports:</p> <ol style="list-style-type: none"> 1. Click Reports on the Admin tab. The Reports area displays. 2. Select a report from the drop-down list. <p>Note: Information for the selected report displays in the Report area. The information displayed depends on what report you select.</p> <ol style="list-style-type: none"> 3. Click Print. 4. Select a print range on the Print window. 5. Click OK. 	
	<p>Logging Refrigerator Temperatures</p>	
	<p>To log refrigerator temperatures:</p> <ol style="list-style-type: none"> 1. Click Temperature Log on the Admin tab. 	

	<p><i>The Refrigerator Temperature Log area displays.</i></p> <ol style="list-style-type: none"> 2. Select a clinic from the drop-down list. 3. Select a refrigerator from the drop-down list. 4. Complete the following fields: <ul style="list-style-type: none"> • Temperature • Date • Time 5. Click Add. <p><i>To view all logged refrigerator temperatures for the selected clinic, click the All Refrigerators radio button and click Show All Entries.</i></p>	
	<p>Modifying Refrigerator Temperature Logs</p> <p>To modify refrigerator temperature logs:</p> <ol style="list-style-type: none"> 1. Click Temperature Log on the Admin tab. <p><i>The Refrigerator Temperature Log area displays.</i></p> <ol style="list-style-type: none"> 2. Select a clinic from the drop-down list. 3. Select a refrigerator from the drop-down list. 4. Click the Selected Only radio button. <p><i>To view all logged refrigerator temperatures for the selected clinic, click the All Refrigerators radio button and click Show All Entries.</i></p> <ol style="list-style-type: none"> 5. Click Show All Entries. 6. Update the following fields, as necessary: <ul style="list-style-type: none"> • Temperature • Date • Time 7. Click Modify. 	
	<p>Patient Immunizations Module</p>	
	<p>Overview of Patient Immunizations</p> <p>The Immunizations Module 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.</p>	

Documenting a Vaccination Visit

- Select New Appt on the Action bar
- Search for Violet Alexander
- Select the Appt Type (Wellness\$)
- Select the Provider/Nurse authorized to sign SF 600
- Reason for Appt: **Patient requires vaccination s for** MMR, HEP A, Influenza, Small Pox
- Select OK

Editing Vaccination Groups

All vaccination groups established for service type or occupational status are listed in the *Vaccination Groups* field.

The patient receives vaccinations assigned to the selected group(s).

To edit the Vaccination Groups:

1. Click **Edit Groups** in the Individual Immunization tab. The Immunization Groups window opens

Note: All vaccination groups established for service type or occupation status are listed in the Immunization Groups list. The vaccination groups assigned to the unit to which this patient belongs are shown in the *Groups From Unit* field. These groups are assigned in the Unit window, and cannot be edited. Groups defined by the support staff are listed in the User-Defined Groups field.

2. Select a group name from the *Immunization Group* or *User-Defined Group* list.
3. Click the right arrow to move the selected group to the *Groups Selected* list.

Note: Multiple groups can be selected to appear in the Vaccination Groups list.

4. Click **Close**. The selected groups appear on the Individual Immunization tab in the Vaccination Groups list.

Entering Historical Pediatric Vaccines

The Transcribed window allows you to transcribe a pediatric patient's paper shot record into the database. It also enables you to document various missing pieces of vaccine information such as:

- Manufacturer

- Lot Number
- Provider.

For example, if you were recording a vaccine and there was no lot number, you can document the entry "Transcribed" in the applicable Lot Number field. This signifies that the information was not available when the it was recorded from the paper shot record.

To enter historical immunizations for pediatric patients 18 years of age or younger:

1. Click **Rapid Pediatrics Entry** on the Vaccine History tab.
The Transcribed window opens.
The Rapid Pediatrics Entry button is only visible for pediatric patients that are 18 years of age or younger.
2. Select the tab for which you want to enter vaccine information.
3. Enter the vaccine in the Vaccine field.
Double-click the vaccine field to open the Vaccines window to display a list of pediatric patient vaccines.
4. If you want to enter a vaccination date:
 1. Double-click the vaccine date. The Date Builder window opens.
 2. Select the date from the calendar.
 3. Click **OK**.
5. If you want to enter the vaccine's manufacturer:
 - Double-click the manufacturer. The Manufacturer List window opens.
 - Select the manufacturer you want to use.
 - Click **Select**.
6. If you want to enter the provider administering the vaccine:
 - Double-click the provider. The Provider List window opens.
 - Select the provider you want to use.
 - Click **Select**.

Enter the word "Transcribed" in any field to signify that the information was not available when it was recorded from the patient shot record.
7. Click **Save and Close**.
 - There is an option to print the worksheet and the DD Form 2766C from the Individual Immunization window. The report is sent to your printer.
 - Print DD 2766C: Use this function to print a Vaccine Administration Record.
 - Print Worksheet: Use this function to print required immunizations for the selected patient.

	<p>Selecting the Immunization Exempt Type</p> <p>To select the immunization exempt type:</p> <ul style="list-style-type: none"> • Global: If a patient has never been given any of the immunizations that are listed in the vaccination record section, they can be exempted using this function from the Individual Immunization tab. • Focused: If an exemption has been given for that immunization, the exempt function must be performed from the Vaccine History tab. <p>To make a global exemption for all immunizations in the Individual Immunizations tab:</p> <ol style="list-style-type: none"> 1. Select an Exempt Type from the drop-down list. <p>Note: If you select Medical (Temp), Admin (PCS), or Admin (Temp) as an <i>Exemption Type</i>, an exempt date is required. The system formats that date.</p> <ol style="list-style-type: none"> 2. Click, Click to Save Exemption. <p>To make a focused exemption for a specific vaccination in the Vaccine History tab</p> <ol style="list-style-type: none"> 1. Select the vaccination to be exempted. 2. Click Edit. The Immunization History Edit window opens 3. Select the exempt type from the <i>Exempt</i> drop-down list. <p>Note: Depending on the reason, an exempt date may be required. The system formats the date.</p> <ol style="list-style-type: none"> 4. Click Update. The Exempt Reason appears on the Vaccine History tab. 	
	<p>Giving a Vaccine</p> <p>To select an immunization:</p> <ol style="list-style-type: none"> 1. Click Give Vacc on the Individual Immunizations tab. The Select Immunization window opens 2. Select an Immunization. <p>Note: The <i>Immunizations Recommended</i> list is based on the vaccination groups to which the patient is assigned. The Other Immunizations list is a list of all vaccines.</p> <ol style="list-style-type: none"> 3. Click the right arrow to move the items from the <i>Immunizations Recommended</i> list or 	

Other Immunizations list to the *Immunizations Selected* list.

Note: Click the double arrow to move the entire group of *Immunizations Recommended* to the *Immunizations Selected* list.

4. Click the left arrow to remove the selected immunization from the *Immunizations Selected* list back to the *Immunizations Recommended* or *Other Immunizations* list.
5. Click **OK**. The Vaccine Select window opens displaying the selected vaccines
6. Select the vaccine(s).
7. Click **OK**.

Adding a Vaccination

Vaccinations can be added to a patient's record.

To add a vaccination:

1. Click the Vaccine History tab on the Immunizations window. The Vaccine History tab
2. Click **Add**. The Vaccines window
3. Select the vaccine you want to add.
4. **Note:** To view a list of all vaccines in stock, click the List All Immunizations checkbox. All vaccines in stock appear on the list. To edit the list of favorite vaccines, click **Edit List**. On the Edit Favorite Vaccine List window, select a vaccine from the *All Vaccines* list and click the right arrow to move the vaccine to the *Selected Vaccines* list. Click **Close**.
5. Click **Select**. The Add Vaccine window opens
6. Complete the following fields
 - **Vacc Date:** Enter a date, or click the **ellipsis** button and select a date from the calendar, to assign a vaccination date.
 - **Series Number:** Enter the series number of the vaccine, if necessary.
 - **Manufacturer:** Select a manufacturer from the drop-down list, if necessary.
 - **Lot Number:** Enter the lot number of the vaccine, if necessary.
 - **Dosage:** Select a dosage for the vaccine from the drop-down list, if necessary.
 - **Site:** Select an area of the body where the vaccine is given from the dropdown list, if necessary.
 - **Route:** Select the vaccine route from the drop-down list, if necessary.
 - **Next Vaccination Due:** Click **Recalc** to automatically calculate the next vaccination due date. The date is automatically entered.
 - **Exempt:** Select an exemption from the drop-down list, if necessary.

	<ul style="list-style-type: none"> • Provider: Select a provider from the drop-down list, if necessary. <p>7. Click Update to save the data and return to the Vaccine History tab.</p> <p>Deleting Immunization History</p> <p>To delete an immunization History:</p> <ol style="list-style-type: none"> 1. Select the immunization you want to delete. 2. Click Delete. <p>Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.</p> <p>Editing Immunization History</p> <p>To edit an immunization history:</p> <ol style="list-style-type: none"> 1. Select the immunization you want to edit. 2. Click Edit. The Immunization History Edit window opens 3. Complete the following fields: <ul style="list-style-type: none"> • Series • Manufacturer • Lot Number • Dosage • Site • Route • Next Vacc Due • Exempt • Provider 4. Click Update to save the data and return to the Vaccine History tab. 	
	<p>Printing Immunization Records</p> <p>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.</p> <p>To print immunization records:</p> <ol style="list-style-type: none"> 11. Print Worksheet: Use this function to print required immunizations for the selected patient. 12. Print DD 2766C: Use this function to print a Vaccine Administration Record. <p>Reviewing Immunization Records</p> <p>This area of the Individual Immunization tab displays all immunizations the patient is required to</p>	

have based on the vaccination groups to which the patient is assigned.

When immunizations are due, but have not been given, the column under Next Due displays in red. Once the required immunizations have been given through the Give VAX function, the column changes to green.

Immunization
Series
Date
Next Due
Vaccination Groups

Finishing the Documentation for Vaccination Visit:

1. Double click on Violet Alexander
2. Select A/P module
3. Document Diagnosis
 - i. MMR – V06.4
 - ii. HEP A – V05.3
 - iii. Influenza – V04.8
 - iv. Small Pox – V04.7
4. Document Procedures:
 - v. MMR – 9707
 - vi. HEP A – 90632
 - vii. Influenza – 90659
 - viii. Small Pox – 90749
5. Select each Procedure code (as necessary) to add the modifier for **Units of Service**
Note: Use ICD-9 code V06.8 for other combinations of shots. Use V05.8 for other specific disease and Japanese Ecephalitis. Use 90636 fro Hep A and B together
6. Document Disposition/E&M Code of 99211

Appendix B: System Demonstration

System Demo

Note: You may choose to invite your co-instructor or a class member to assist you in the role-play demo.

Set the scene for the class, you will demonstrate the flow of the clinic for a ‘walk-in’ patient. You will play each role, the clerk who will check in the patient, the Tech who will triage the patient, the Provider who will exam and disposition the patient and the nurse who will provide patient education and submit the orders for the provider:

A patient comes in needing to be seen by the provider. The clerk creates a walk-in appointment. The tech will perform the screening and vitals. The provider examines the patient. He hands the orders to the nurse who will submit them and send the patient to Lab and Radiology clinics. When the patient returns the provider reviews the results and determines a diagnosis. He gives the patient a prescription and instructs the nurse to provide patient education. The provider completes disposition and signs the encounter. The patient is checked out.

Role/Function	Field	Data
CLERK: Creates an Acute \$30 walk-in appointment for Col. Violet Alexander (A4211). Reason for appointment – Shortness of Breath.	Patient Search	
	Quick Search	w8118
	New Unscheduled Appointment/Telcon Visit	
	Appointment Type	Acute Appt (Acut\$) 30
	Reason for Appointment	Cough, runny nose
SUPPORT: Performs screening, document female only data, verify allergies. Record vitals, document performing a Peak Flow under the AP portion of the SF600.	Appointments	
		[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF 600
	Screening	
	In the Search field	[Enter] a cough and click Find Now . Select a cough and click Add . [Enter] nasal discharge and click Find Now select nasal discharge and click Add
	Verified This Encounter	[Select to verify allergies]
		[Click] Close (Action Bar Icon)
	Vitals	
	BP Rt arm Pediatric cuff	110/70 [Select] [Select]
	HR Radial Regular	95 [Select] [Select]

	RR Temperature F Oral	13 99 F [Select]
	Ht	[Enter] 52 in
	Wt	70 lbs
Habits		
	Tobacco	[Select] No
	Alcohol	[Select] No
Pain Severity		
		[Select] 1 Hurts a little bit
	Where is pain located?	Throat NOTE: Add comments when pain scale is selected (other than "0 pain free").
Save Vitals		
		[Click] Save Vitals (Action Bar Icon) [Select] Close (Action Bar Icon) to return to SF600
	SF600	[Click] Close and return to Appts. module
Appointments		

<p>PROVIDER: Sees the patient. Reviews what has been documented so far and loads the URI template. After documenting he uses Auto Neg – where appropriate.</p>		<p>[Select] Col Alexander’s walk-in appt.</p> <p>Doubleclick appt. to open SF600</p>
	S/O	
		[Select] S/O Button on SF600
	Favorites List	[Select] Visit--URI From the favorites drop-down window.
	HPI <i>Find Term</i>	[Select] + CC: URI Symptoms a cough coughing up sputum shortness of breath [Select] << Go Back button to return to URI Template.
	PMH	[Select]+ History of Asthma
	ROS	[Select] + nausea [Select] — vomiting
	PE	[Select] +

		<p>Vital signs reviewed All general appearance terms Auscultation Wheezing AutoNeg</p> <p>[Click] Close (Action Bar Icon) to return to SF600</p>
	SF600	<p>[Click] Close (Action Bar Icon) to return to Appts. Module</p>
<p>NURSE: Enters the AP section and orders the Lab and Rad tests.</p>	Appointments	
		<p>[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF600</p>
	A/P	
	Order Lab Tab	<p>[Select] [Type] CBC w/auto Diff in New Order field. [Click] Search [Select] CBC w/auto Diff in lab field.</p>
	Routine	<p>[Select] [Click] Submit</p>

	Order Rad Tab	[Select]Chest [Type] Chest in the new order field. [Click] Search [Select] Chest in the new order field. [Enter] r/o pneumonia [Select] [Select] Ordering Provider
	Clinical Impression Routine More Details	[Click] Submit [Click] Close (Action Bar Icon)
	SF600	[Click] Close (Action Bar Icon) to return to Appts. module
NURSE: Reviews Results and copies results to encounter	RESULTS ARE READY!!!	
	Lab	
		Open module Highlight Result Copy to Note
	Rad	
		Open module Highlight Result Copy to Note
PROVIDER: Returns to patient to discussed results and give a Diagnosis. He then completes the Disposition and Signs	Apointments	
		[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF600

encounter.	A/P	
	Diagnosis	[Select] Asthma (to associate orders w/diagnosis)
	Order Meds Sig	[Type] Albuterol in new order field [Click] Search [Select] Albuterol [Enter] [Click] Submit
	Other Therapies	[Type] Patient Education [Select] Patient Education Patient Education
	Disposition and Sign	
	Release w/out limitations	[Select]
	Follow-up	[Select] with PCM [Enter] 2 and weeks
	Discussed Items	[Select] Discussed all items
	E & M Code	Verify coding
	Sign	[Select] Sign (Action Bar Icon) Close SF600
	Appointments	

<p>CLERK:</p> <p>Clerk Checks out the patient and provides patient with a copy of the signed encounter.</p>		<p>[Select] Col Alexander's walk-in appt.</p> <p>[Select] Check out on Action Bar</p> <p>Print patient a copy of SF600</p>
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As the **CLERK:** Col. Violet Alexander walks into your clinic complaining of shortness of breath, she does not have an appointment but needs to see her PCM – Dr. Test User. You create an (Acute \$) 30 walk-in appointment for the patient and enter the reason for appointment as shortness of breath.

SUPPORT/TECH calls Col. Violet Alexander into the screening room. Open the SF600 and go to the Screening tab. In the Search box enter Upper Respir and press Find Now. Highlight the words and Add Upper Respiratory Infection to the Selected Reason for Visit. Complete the lower half of the screen – Female Only Data. You also need to verify the allergies for the patient. Next you will enter the patient vital signs.

BP	110/70
HR	75
RR	35
°F	99
Ht	5' 6"
Wt	140

Enter Peak Flow of 92, and Oxygen Sat. 92%, Note: you will get a low warning for the Oxygen Sat., enter yes. Notice the Oxygen Sat. will be bolded to indicate an abnormal result.

Close. Go to the A/P tab and enter the Peak Flow under the Procedure Tab. Enter Peak Flow in the Search box and push Find Now. Select the term. Note the term will go to the right side of the screen under orders and procedures. When you close this you will get a warning. Enter Yes. When you see the SF600 it will show the procedure as unassociated.

Close the encounter and select the refresh button. Notice the appointment status is now Waiting or In Progress.

The **PROVIDER** opens this encounter. He/she reviews the vitals and goes to the SO. He/she loads the URI template from the drop-down window. The Provider enters the + for chief complaint (URI symptoms).

Also select cough and coughing up sputum and search using Find Term – shortness of breath, select the << to go back to the URI template. Now click on the PMH tab.

Select + for History of Asthma

Click on the ROS tab select + for nausea and – for vomiting

Click on the PE tab select + for Vital signs reviewed, and all of the general appearance terms and well as Auscultation Wheezing, AutoNeg all of the other terms because you have performed these checks and found them to be normal.

You close the SF600. You tell the patient you want them to go to Lab to have a CBC and Radiology to have a chest X-Ray, when they have been performed to come back to you. You (the provider) give the nurse the orders to enter into the system and see the next patient.

The **NURSE** now opens the SF600 and goes to the A/P section. She enters the CBC w/o diff under Lab and the Chest X-Ray under radiology. When the rad is entered the nurse needs to put in the clinical impression. The note the provider has entered is rule out pneumonia. She/he verifies the ordering Provider by clicking the more details tab. She/he then submits the test. The nurse then closes the module once again getting the warning she/he clicks yes then closes the encounter.

When the patient returns the provider sees her. She/he opens the encounter and goes to her Lab. The lab work is in, the provider wants to add this to the encounter. Highlight the CBC and the results will show under the results portion of the module. Left click and drag the mouse to the end the results. Press the right mouse and two entries will appear click the copy to note. Close the module, view the SF600 and notice the results are under the SO portion of the note. (Note: there is no chest x-ray result in the system for this patient).

The **PROVIDER** then goes to the A/P and enters the diagnosis of asthma then associates the orders and procedures to the diagnosis. The provider places the order for albuterol under the Rx module. The provider also enters the patient education under the other therapies tab. The provider enters: Patient Education Asthma Exposure to Triggers, Patient Education Asthma Metered Dose inhaler, Patient Education Peak Flow Monitor.

The **PROVIDER** now selects disposition and enters in the follow-up section: with PCM in 2 weeks, in the comments section enter – sooner, if needed. Check the discussed all box in the discussed section. Verify the E & M code and sign the encounter.

The **NURSE** then returns the signed encounter and double clicks it. This will take you to the previous encounter. The nurse highlights the encounter and selects the Append Narrative on the action bar. This will open the encounter note. The nurse will import the nebulizer treatment word document. The nurse will also indicate the second peak flow result after the treatment on the note. She/he saved the note and goes to sign the

encounter. The nurse will add the provider as the co-signer of the note. The encounter will have the status of updating until the provider enters the countersignature. The status will change to updated.

NOTE: Make sure the Nebulizer treatment note is added to the word documents before the demonstration.