CHCS II Nurse Lesson Plan

COMPOSITE HEALTH CARE SYSTEM II

December 2004
Rev 2

Change History

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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		
	Welcome/Logistics	❑ **Slide 1: Nurse Training Course**
	Next Slide **Logistics**. Room location in building, fire escape routes, restrooms, kitchen facilities, smoking area **Workstations** **Instructional material** **Pagers and cell phones.** Off or on vibrate mode **Breaks** **Resources.** Indicate how to obtain additional information regarding additional support on the system. **Parking Lot**	
	Introductions	❑ **Slide 2: Logistics and Introductions**
	Instructor and students exchange personal introductions, providing relevant background information. ***Next Slide***	

Duration	Training Activities	Instructor Notes
CHCS II Overview		
	What is CHCS II? CHCS II is a computer-based patient record (CPR) system selected by Department of Defense to meet the requirements of the Military Health System. CHCS II provides: • 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 **Add this brief comment as transition to next slide:** 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. ***Next Slide***	❑ **Slide 3: What is CHCS II?**
	Limitations of Paper Based Medical Records • Paper charts are lost • No automatic drug interaction alerts • Penmanship counts • Only one person can access a record at a time ***Next Slide***	❑ **Slide 4: Limitations of Paper Based Medical Records**

Duration	Training Activities	Instructor Notes

	CHCS II Benefits
	• 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:
	  • JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
	  • Evaluation & Management (E&M) coding
	• Supports team-based health care and clinic workflow, providing appropriate access for each team member and simultaneous multi-user access
	• Supports problem-oriented health care
	• Accumulates data for reports and studies, such as clinical and population health
	• When fully implemented world-wide, will provide access to patient records anywhere, anytime
	• Maintains security
	Next Slide
		❑ **Slide 5: CHCS II Benefits**
		Elaborate on each benefit.

	Security Security is a crucial requirement of patient medical records. CHCS II security is multi-leveled and conforms with HIPAA/MHS Security standards. User access to patient information within the application is based on user role. • The system administrator assigns passwords that can be changed later by the user. • Users must have a CHCS account prior to registering for a CHCS II account. • The CHCS II password replaces CHCS verify code. • Roles and privileges are tied to unique user name and password. ***Next Slide***	❑ **Slide 6: Security**

Duration	Training Activities	Instructor Notes
	Expectations Upon completion of training, it is expected that service-directed expectations will be used as guidelines for each site as they ramp up to 100% productivity in CHCS II. To accomplish this, it is expected that: • 100% of CHCS II users shall attend scheduled classroom training • Nurses shall be available to receive On the Job Training (OJT • 100% of patient encounters shall be documented in CHCS II	❑ **Slide 7: Expectations**
	CHCS II Training Classroom training is accomplished using Clinical Scenarios appropriate to each user's role. 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. ***Next Slide***	❑ **Slide 8: Training Schedule**

Duration	Training Activities	Instructor Notes

	Key Information Technology Training Resources
	
	• MTF CHCS II Team
	  • MTF Project Officer
	  • Facility Training Coordinator
	  • Clinical Champion/SuperUser
	• Unisys On-Site Team
	  • Site Training coordinator
	  • ILT Lead
	  • OJT Lead
	  • Trainers
	
	Note: Provide the names of those filling these roles locally and an indication of how they might be contacted.
	
	Next Slide
		❑ **Slide 9: Key Information**
		
		These resources are available during the training implementation.

System Demo

Go to Appendix B

Next Slide

❑ **Slide 10: Systems Demonstration**

Note: Invite class participation to assist with roles in demonstration.

Course Goal

❑ **Slide 11: Course Goal**

The goal of this course is to enable Nurses to access, navigate, and use the CHCS II application to document patient encounters in the clinic.

Next Slide

CHCS II Training System

❑ **Slide 12: CHCS II Training System**

Instruct students to log into the CHCS II Training System. Explain that you will demonstrate each lesson and they should watch you, and then they will practice by performing the exercises in the Student Guide.

- Click the caduceus icon on the desktop to start

Explain:

- Stand-alone practice version of CHCS II
- Used for training only
- Simulates CHCS II functionality
- Very limited choices for labs, rads and meds
- Patient data is fictitious
- Slight variations between the CTS and the application in the field
- Users are automatically logged on as a Provider
- Live system access may vary depending on roles

	• 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** ***Next Slide*** **Session One Course Agenda** ***Next Slide***	❑ **Slide 13: Training and MTF Business Rules** ❑ **Slide14: Session One Course Agenda** ❑

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**

Note: At a CHCS II workstation equipped with a CAC reader, users will have the option of using their personal CAC to log into CHCS II.

Basic Navigation

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

- Title Bar
- Main menu
- Action Bar

Explain: You will demonstrate each lesson first and after each lesson demonstration the class will practice these lessons by performing the exercises in the Student Guide.

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. A Role identification screen will appear, the medical radial button is selected by default.
2. Click **OK**.
3. Press the escape key (Esc) on your keyboard twice to progress through the informational messages.
4. Verify the Appointments module is open.

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

	5. The list of current appointments will display. 6. 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. 7. Click the **Co-signs** folder in the Folders List to open the Co-signs module. The Co-signs module will display. 8. Click the **Close** icon on the Action Bar to close the Co-signs module. 9. Click the Close **X** button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display. 10. Click **Yes** to confirm the exit **Key Points:** Module access • For navigating, the Folder List and Action Bar are the most efficient method. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. ***Next Slide***	**Note:** Emphasize how the desktop can be customized.
	Security and Session Management **Explain:** • 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. **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.	**Note**: Emphasize that passwords **must** be changed in CHCS II.

Demonstrate:

- User has the option to lock the session to avoid system time-out.
  - 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.)

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.

❑ **Slide 16: Patient Search & Appointments Learning Objectives**

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

	Patient Search Module
	
	Pulling a Patient Record features:
	▪ Different search methods available
	▪ Patient must have a record in CHCS
	▪ "Search CHCS" is an option
	
	Appointment Module
	
	Module specific screen features:
	• Module title bar
	• Appointment list
	• Columns
	• Access to properties setup options:
	  • Drop-down box
	  • Options
	  • Change selections
		Explain specific *Appointment* screen features.
		
		Explain: Scheduled (future) appointments are still made in CHCS and come over to CHCS II nightly and every 15 minutes throughout the day.

	Patient Search and Appointments ## Demonstrate: 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. 1. Open the CHCS II Application. **NOTE:** By default the Appointment module displays 2. Click **Search** in the Folders List to search for a patient. The Patient Search window will display 3. Click in the Last Name field and type ***ALEXANDER***, then click **Find** for a list of names. 4. 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. Click the **Change Selections…** button in the top left corner of the **Appointments** module.	**Explain:** Appointment display options: • Column order • Clinic (Clinic assignments are in CHCS) • Provider • Date • Status Selection **Explain:** Appointment types and statuses. Do not need to show all steps in Transfer and Add Provider—but, do point out these functions.

	a. In the *Clinic* section, click the radio button for **This Clinic** b. In the *Provider* section, select the radio button **Me**. c. In the *Dates* section, select the correct radio button to show **Today's Only** appointments. d. Click the **Set Selections as Default** button to save your changes. 6. To move a column: e. Scroll to the right just until the **Type** column is visible. f. Click the **Type** column heading and hold down the left mouse button. g. Drag the **Type** column horizontally right (or left). Release the left mouse button when the **Type** column is between the **Patient** and **Status** columns. Practice moving columns until the *Appointments* screen is most useful for you. If you wish to save the new column arrangement, click the **Change Selections** button. Then click the **Set Column Order as Defaults**. You need to Create a New Unscheduled Appointment for **Col. Alexander (a5743)**. 7. Click **New Appt**. on the Action Bar. A New Appointment confirmation window will display. 8. Click **Yes** to complete the New Appointment information for Col. Alexander. 9. Click on ***ACUTE APPT (ACUT$) 30*** to select the acute appointment type. 10. Type ***cough*** in the Reason for Appointment field and click **OK** to complete the new appointment process for Col. Alexander. (The Allergy synchronization simulation from CHCS will begin.) 11. Col. Alexander's appointment will now appear at the bottom of the Appointment list with a status of **CheckedIn**. **Key Points:** • 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)	**Explain:** Live system, *Today plus Incomplete* pulls in old appointments from CHCS. Suggest using *Today Only* to view current day's appointments **Explain:** The Related to Injury/Accident checkbox, a HIPAA 837 compliant feature.

	Exercises • 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 Providers • Pointed out function for adding a Nurse to an appointment ***Next Slide***	

Lesson 3: Telephone Consults

Lesson Goals

The goal of this lesson is to enable the user to use the Telcon function in CHCS II.

Learning Objectives

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

- 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

❑ **Slide 17: Telephone Consults Learning Objectives**

Telephone Consults Module

Demonstrate:

To set Telcon display properties:

1. Click **Telephone Consults** from the Folder List. The Telephone Consults module opens.
2. Click the **Urgency** column and drag it to the left of the Status column.
3. Click **Change Selections**. The Telephone Consults Search Selections window opens.
4. In the Clinics area, select **This Clinic**.
5. In Provider area, select **Me**.
6. In Dates area, select the **All Outstanding** checkbox.
7. Click **Set Selections as Default**.

Telcons created in CHCS must be completed in CHCS.

In order to access and complete a Telcon in CHCS II the Telcon must be created in CHCS II.

	Anna Wunderlich (w8118) phones the clinic to report that she has lost her Zyrtec allergy medication. You review the appointment note and return her call. You speak to her, but need to phone her back after consulting the Provider. She indicates that she is leaving her office and wants her call returned at a different number: 555-9999. You confer with the Provider and complete the Telcon according to the Provider's instructions. 1. Select **Anna Wunderlich's** Telcon appointment. 2. Click **Notes** on the Action bar. The Appointment Comment (Read Only) window opens. 3. Click **Cancel**. 4. Click **Edit Phone #** on the Action bar. 5. Change the Callback Phone Number to (123) 555-9999. 6. Click OK. Notice that the Callback phone number has changed in the type column. 7. Double-click Anna Wunderlich's Telcon. (The Allergy synchronization simulation from CHCS will begin.) 8. The Telcon Quick Entry window displays. 9. In the Provider Note field, enter **NURSE'S NOTE**: *Physician consulted reference PT losing medication. PT requests refill, Zyrtec refill entered per physicians order*. 10. Select the **Problem List (Chronic)** radio button. 11. Select *ALLERGIC RHINITIS* and click **Add**. 12. Accept the default E&M value of 99371 Lvl I, Simple/Brief. 13. Select the **Save and Open A/P** radio button. 14. Click OK. The A/P module opens. 15. Click the **Order Med** tab. 16. In the **New Med Order** field, enter Zyrtec and click **Search**. 17. Select CETIRIZINE (ZYRTEC)--PO 10MG TAB. 18. In the SIG field, enter 1 PO QD PRN #30 RF0 and press Enter on your keyboard. 19. A Drug Warning message appears: *One Drug Order warning returned*. To override the warning.	**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.

20. Click in the **Specify a reason for this override** field. Enter: *Pt lost medication.*

21. Click the **Accept override** button to submit the order. You are returned to the A/P module.

22. Click **Close** on the Action Bar.

23. You return to the encounter screen.

24. Click **Close** on the Action bar.

25. In the Appointments module click the **Transfer** icon on the Action Bar. To transfer this appointment to DOCTOR, DAVID.

26. The Transfer window appears, click **OK**.

Notice that DOCTOR, DAVID appears in the Provider column for this appt.

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: Patient Encounter

Lesson Goals

The goal of this lesson is to document the patient encounter in CHCS II and create electronic record.

❑ **Slide 18: Patient Encounter Learning Objectives**

Learning Objectives

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

- 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

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 SF600 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.

Briefly discuss. You will update autocite preferences in the next scenario.

	AutoCite modules include: a. Problems module b. Lab module c. Radiology module d. Medications module e. Allergies module f. 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 SF600. 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 SF600. The AutoCite button on the SF600 refreshes all information selected for AutoCite display regardless of where it appears.	
	Screening and Vitals Modules ## Screening and Vitals ▪ Screening ▪ Vital signs 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.	**Review screen layout:** **SF600 features**

Screening and Vitals

Demonstrate:

Anna Wunderlich (w8118) has come in for a pregnancy test, you create a new appointment. You begin screening along with verifying her allergy information and documenting her vitals.

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:

Clinical data:

Field	Data
New Unscheduled Appointment/Telcon Visit	
Appointment Type	Acute Appt (Acut$) 30
Reason for Appointment	Pregnancy Test
	Click OK
To open appt.	Double-click the appointment
Encounter Summary Properties	
	Click the Options button (on the Patient ID line.)
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family	[Select]
Active Dispensed Medications	[Select]
	Click OK
Screening	
In the Search field	[Enter] Pregnancy Test and click Find Now. Scroll down the list to select: *Pregnancy Test* Click Add.
For Females Only	
[Birth Control] G P	[Select] None 4 4

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.

		A LC Last menstrual period	0 4 [Two months Prior]	**In review, ask students in which module allergies are verified: *Screening, not Allergy.***
		Pain Severity		
			[Select] 0 Pain Free	
		Where is pain located?	Note: Add comments when pain scale is selected (other than “0 pain free”)	
		Verified This Encounter	[Select to verify allergies]	
			Click Close (Action Bar Icon)	
		Vitals		
		Habits		
		Tobacco	[Select] No	
		Alcohol	[Select] No	
		BP Rt arm Adult cuff	130/70 [Select] [Select]	
		HR Radial Regular	80 [Select] [Select]	
		RR	16	
		Temperature F Oral	96.7 F [Select]	
		Ht	[Click] the drop-down list next to Ht [Select] ft/in. [Enter] 5 ft 5 in	
		Wt	132	
		Save Vitals		
			[Select] Save Vitals (Action Bar Icon)	
			[Select] Close (Action Bar Icon)	

	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	Emphasize that use of structured documentation results in a more accurate code.
	Exercises • Complete the exercises. • Check for understanding and answer participant questions.	**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.**
	Summary • Open the encounter • Setup AutoCite properties • Document "reason for visit" • Verify patient's allergies • Document patient's vital signs ***Next Slide***	**Explain:** AutoNeg—when to use and when not to use.
	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:** "flipping" and the use of **ROS/HPI** button.
	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 (–).

Subjective/Objective Module

Subjective/Objective

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:

- Subjective - what the patient told the end user
- Objective - what the end user observed during physical exam

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.

The Objective portion of the note includes the Physical Examination (PE) and is what the end user observes.

Key Points:

- Standard visit templates are clinical notewriters using MEDCIN terms
- E&M coding is done quickly and accurately using structured terminology.

Reinforce to Users the criteria between HPI and ROS. This is typically not familiar to some Users.

Review screen layout

	Subjective/Objective	
	Demonstrate: Anna Wunderlich's results were positive with a home pregnancy test, and she is now ready to be seen. **To load and unload an S/O template to document an encounter:** 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--ECP--PREGNANCY TEST--VISIT template. You can review the template in the Template Preview pane. 5. Click **Load** on the Action bar. 6. Add The reason for visit is: Pregnancy Test as a positive finding. 7. Click the **Notepad** icon, enter *HOME TEST RESULTS POSITIVE.* and Click **OK**. 8. Add *nausea* as a positive finding. 9. Click **Find Term** on the Action bar. 10. In the search field, enter *Fatigue* and click **OK**. 11. Add *feeling tired (fatigue)* as a positive finding. 12. Click the **<< Go Back** button to return to the template. 13. Click **AutoNeg**. 14. Click the **PMH** tab. 15. Add reported home pregnancy test as a positive finding. 16. Add *taking vitamin supplements* as a positive finding. 17. In the Free Text field, enter *CALCIUM 500mg DAILY* and press Enter on your keyboard.	**Show how to:** • select/deselect • expand/collapse **Explain:** Documenting by exception is the common practice and crucial to the use and purpose of AutoNeg

	18. Expand *pregnancy history*. 19. Add age at first pregnancy years old as a positive finding. 20. In the **Value** field, enter 20 and press Enter on your keyboard. 21. Add *planning to become pregnant* as a negative finding. 22. Click **Find Term** on the Action bar. 23. In the **Search** field, enter DOWN SYNDROME and click **OK**. 24. Expand History of Diagnoses, Syndromes And Conditions. 25. Add history of *DOWN'S SYNDROME (TRISOMY-21 MONGOLISM)* as a positive finding. 26. Click the **FamHist** button on the Dashboard. 27. Click the **<< Go Back** button to return to the template. 28. Click the **PE** tab. 29. Add Pain Level (0-10) as a positive finding. 30. In the **Value** field, enter 0 and press Enter on your keyboard. 31. Click the **Notepad** icon. 32. In the note field, enter **EDUCATION**: *Pt instructed to make OB appt. Pick-up prenatal vitamins from pharmacy. Pt instructed not to drink alcohol or take other medications* and click **OK**. 33. Click **Close** on the Action bar. **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

Assessment/Plan Module

Assessment/Plan

- Assessment – knowledge gained from the S/O determines diagnosis
- Plan – what needs to be accomplished to treat the patient

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.

A/P Processes

- 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

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.

Explain:

- 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

Assessment/Plan

Demonstrate:

1. Click **A/P** on the SF600. The A/P module opens.
2. In the **Search** field, enter *Pregnancy Test* and click **Find Now**.
3. Select **Pregnancy Test V72.9** and click **Add to Encounter.**
4. Click the **Order Lab** tab.
5. In the **New Lab Order** field, enter *HCG* and click **Search**.
6. Select *HCG QL*.
7. Click **Submit**.

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

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.

When adding diagnosis and procedures, point out ICD and CPT Codes.

Add diagnoses to the working diagnosis list.

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.

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** on the Action bar.
2. Accept the default Disposition, **Released w/o Limitations**.
3. In the Follow Up area, select the **With PCM** checkbox.
4. In the Comments field, enter *Call tomorrow for pregnancy test results.*
5. In the **Meets Output Visit Criteria (Workload)?,** select **Yes** (Default).
6. Accept the default E&M value, 99211 - Established Outpatient Minimal Service.
7. Click **Sign** on the Action bar.

- 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.

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.

	8. Select the **Cosigner Required** checkbox. 9. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID. 10. Select DOCTOR, DAVID 11. Click **Sign**.	**Emphasize selection of Preventative Med types, when appropriate. Most often missed; results in inappropriate coding.**
	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 5: 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

❑ **Slide 19: Previous Encounters Learning Objectives**

Previous Encounters

Demonstrate:

You need to write a note explaining that during this encounter, the patient was educated on a low cholesterol diet.

To view a previous encounters:

1. Perform a search for **LCDR Eduardo Suarez (s3217)**.
2. Click **Previous Encounters** on the Folder List.
3. Select the *HYPERLIPIDEMIA* previous encounter. The encounter note populates below.

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.

To append a previous encounter:

4. Highlight the *HYPERLIPIDEMIA* note and click **Append Narrative** on the Action bar. The Encounter Note window opens.
5. In the **Note Category** field, enter *Nursing Note*.
6. In the **Note Title** field, enter *Patient Education.*

New findings can also be documented for the current encounter.

	7. In the note area, enter *Patient was educated on low cholesterol diet*. 8. Click **Save** and **Sign**. 9. Click **Sign**. **To amend a previous encounter:** 1. Highlight the DIABETES MELLITUS TYPE II - UNCONTROLLED 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 *Hemoglobin A1c* 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. 11. Clear Patient form the Patient ID line. **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,

Exercises

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

Summary

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

Next Slide

Lesson 6: Medicomp Forms Tool

Medicomp Form Tools is an alternative mode of documentation during an encounter. The Medicomp Form Tool also provides enterprise management capability for forms that emulates Template Management functionality within the S/O portion of the encounter.

❑ **Slide 20: Medicomp Forms Tool Learning Objectives**

Lesson Goal:

The goal of this lesson is to locate and use available Medicomp Forms in CHCS II.

Learning Objectives:

Upon completion of this lesson, you will be able to:

- Search for a Form
- Load Form
- Document the S/O using a Form

Marie Alexander has come in with ankle pain. You wish to document the S/O portion of the note using Forms.

1. In the list of appointments in the appointment module, highlight and open the encounter for Marie Alexander.
2. Click the **S/O** tab.
3. Click the **Template Mgmt** tab on the Action Bar.

	4. In the Name Contains field enter **Ankle pain**. 5. The Name Search should provide one AIM Form for Ankle pain. 6. Highlight the form and click **Load** on the Action Bar. 7. The AIM Form will load 8. Verify the right ankle History Tab is selected before documenting the Note. 9. Click the **Y** under the Chief Complaint section to indicate right ankle pain. 10. Select the **T** to indicate Local Tissue Swelling Right Ankle. 11. Click in the square beside the term you just selected. This will open up a dialog box to add free text or insert text to the note. *12.* Type in the following: *Patient states she was playing tennis when she twisted her ankle and feels it is sprained.* **Note:** You will notice and arrow with a question mark beside it. When you right mouse click on it the child terms under Local Tissue Swelling Right Ankle will appear. 13. Select the child terms – **Medial right ankle soft tissue swelling**, and Right ankle soft tissue swelling with black and blue discoloration, to be more specific with your documentation. 14. Next go to **PMH.** 15. Select **T** to indicate previous Ankle Fracture under the Previous Diagnosis section. 16. Once you complete documentation of the patient's HPI, PMH and ROS, click on the **Right Ankle** Physical Exam Tab 17. Document the Vital Signs reviewed 18. Select **F** in the In No Acute Distress box**.** 19. Click the **Note** box to the right of the statement. *20.* A free text box will appear. In this box type in: *Pt. States ankle very painful to walk on.* 21. In the Examination of the Right Lower Leg section click **T** for each item in this section. 22. In the Appearance of the Right Ankle section select **F** for the first four entries. Leave the others blank. 23. In the Tenderness of the Right Ankle section check **F** Medial Palpation without Tenderness	

24. In the Motion of the Right Ankle section check **F** Right Ankle without Abnormal Motion.
25. In the Pain of the Right Ankle section check **F** No Pain Elicited by Motion.
26. In the Examination of the Right Foot section check **F** Right Foot Not Swollen and **F** Right Foot Not Tender to Palpation.
27. In the Test Results section, under the Results of Right Ankle X-Ray, free text *Fractured right ankle*.
28. Select **AutoNeg** from the Dashboard to indicate a "normal" result for the rest of the history.
29. Click **Close** to save and close the S/O Forms note.

Exercises

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

Summary

- Searched for a Form
- Loaded Form
- Documented the S/O using a Form

Next Slide

Lesson 7: S/O Template Management

Lesson Goals

The goal of this lesson is to locate available S/O templates in CHCS II and edit templates using MEDCIN.

Learning Objectives

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

- Search for Visit Template
- Use Template Edit Mode
- Use FindTerm
- Use Browse from Here
- Rename and Save the Template

S/O Template Management

Demonstrate:

UTI encounters are among your most frequent clinic visit types. You decide to customize a UTI S/O template for your clinic.

1. Create an appointment for **CPT Heather Cloud (c0058)**.

    — Appointment Type: **ACUTE APPT (ACUT$) 30**
    — Reason for Appointment: **Test Patient**

❑ **Slide 21: S/O Template Management Learning Objectives**

Explain: use of Favorites List when searching for and loading templates.

Explain:

- Templates have pre-positioned terms
- Benefits of using templates: streamline documentation
- Folder location of templates in CTS versus the live system

Training system templates

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.

- How to search for the

	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 *UTI* and click **FindNow**. 6. Highlight **VISIT--UTI**. 7. Click **Edit** on the Action bar. 8. In the right pane, under Review of Systems, highlight a *vaginal discharge*. 9. Click **ROS/HPI** on the dashboard. The term is flipped into the **HPI**. 10. Click **Find Term** on the Action bar. 11. In the search field, enter *incomplete emptying of bladder* and click **OK**. 12. Click **+** to add *incomplete emptying of bladder* to the template. 13. Click **Browse From Here** on the Action bar. 14. Click **+** to add *a vaginal discharge of urine.* 15. Click **Save As** on the Action bar. 16. In the Template Name field, enter **VISIT--UTI FEMALE--[Your Initials]** and click **Save**. 17. Click **Close** on the Action bar. To return to the S/O Template Management module. 18. Click **No** on the warning window. 19. Click **Close** on the Action bar to return to the S/O module. 20. Click **Close** on the Action bar to return to the SF600.	template **Explain:** Template preview screen (point out) • Load the template. (Action Bar icon or double-click) **Explain:** Template availability within S/O using drop-down • **Explain:** Service specific naming convention 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: BRANCH--ENC--URI--LDR **Key:** BRANCH= TYPE = Encounter (ENC), Visit, Education (EDU), Procedure (PROC), Consent, PE, and so on, SUBJECT = Allergy, URI, Asthma Followup, and so on,

	Next Slide	LDR = Personal initials (3) of the template owner
	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]"	
	Next Slide	
	END OF SESSION ONE	
	Note: Remember to reset the database for the day and import the training templates	❑ **Slide 22: Session Two Course Agenda**
	Next Slide	**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:

CPT Heather Cloud (c0058) is calling the clinic because she is experiencing UTI symptoms. 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 **CPT Cloud (c0058)**.
   - — Appointment Type: **TELEPHONE CONSULTS (TCON) 10**.
   - — Reason for Telephone Consult: **UTI symptoms**.

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

	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--ECP--UTI--ENC** template and click Add. 8. Click **OK**. 9. Click **S/O** on the SF600. 10. Add The Chief Complaint is: *UTI symptoms* as a positive finding. 11. Add *pain during urination (dysuria)* as a positive finding. 12. Click the **Duration grid** and then click **2** and **Days**. 13. Add feelings of *urinary urgency* as a positive finding. 14. Add *diarrhea* as a positive finding. 15. Click the **Duration grid** and then click **1** and **Days**. 16. Click **AutoNeg**. 17. Click the **PE** tab. 18. Add *Pain Level (0-10)* as a positive finding. 19. In the Value field, enter **4** and press Enter on your keyboard. 20. In the Free Text field, enter *As reported by patient* and press Enter on your keyboard. 21. Click the **PMH** tab.	require editing because actual patient encounters are tailored to the specific circumstances; so, they need to be generalized to be used as templates. (OJT).

	22. Expand *sexually active*. 23. Add *trying to become pregnant* as a positive finding. 24. Click the **Notepad** icon. 25. In the Note field, enter *Pt. reports she has been previously diagnosed with a UTI* and click **OK**. 26. Add *Disposition of Patient* as a positive finding. 27. In the Free Text field, enter an **X** next to *WITHIN 24 HOURS.* 28. Click **A/P** on the Action bar. 29. Select urinary symptoms and click **Add to Encounter**. 30. Click the **Order Lab tab**. 31. In the New Lab Order field, enter *urinalysis* and click **Search**. 32. Select **URINALYSIS**. 33. Select the **ASAP** radio button. 34. Click **Submit**. 35. Click **Disposition** on the Action bar. 36. In the Follow Up area, click the **In Clinic** drop-down list and select **CHCS II Test Clinic**. 37. In the Comments field, enter *Walk in for UTI.* 38. In the E&M Codes area, select **99371 PHYSICIAN PHONE CONSULTATION**. 39. Click **Sign** on the Action bar.	

	40. Select the **Cosigner Required** checkbox. 41. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID. 42. Select DOCTOR, DAVID 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** displays by default. 3. Click **Search** on the Action bar. 4. In Template Name type UTI and click **Search.** 5. Highlight the **TRAINING-- ECP--UTI--ENC** template. 6. Click **View/Edit** on the Action bar. The Template Details tab opens. 7. In the **Diagnose**s area, click **Add**. 8. In the Search Term field, enter *pain during urination* and click **Search**. 9. Select *pain during urination (dysuria) 788.1* and click **Add Items**. 10. Click **Done**. 11. In the **Other Therapies** area, click **Add**. 12. In the Search Term field, enter *frequent oral fluids* 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 sections (Associated Reasons for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Notes) are not used. • Discussion of order sets will follow the building of the parts of the template mentioned above. When adding diagnosis, show how to do multiple

	13. Select *Oral Fluids Frequent* and click **Add Items**. 14. Click **Done**. 15. In the Notes Template area, highlight [List] **TRAINING--ECP-- UTI--VISIT** and click **Remove**. 16. Click **Add**. 17. Click **Search** on the Notes Template Lookup. 18. In the Template Name field, enter **VISIT--UTI FEMALE--TEST**. 19. Click **Search** on the Medcin Template Search. 20. Select **VISIT--UTI FEMALE--TEST** and click **Add Items**. 21. Click **Done**. 22. Click **Save As** on the Action bar. 23. In the Template Name field, enter **ECP--UTI--ENC--TEST** and click **Save**. 24. Click **Close** on the Action bar.	searches and select results before clicking the **Done** button. When adding therapies, show double-clicking to add, rather than using the **Add Items** button. When adding procedures, show entry of multiple selections pressing **Ctrl** key

	To create an order set: You have just personalized a UTI encounter template and you want to complete it by adding a UTI Order Set. 1. Click **A/P** on the SF600. 2. Click the **Order Lab** tab. 3. In the **New Lab Order** field, enter *Urinalysis* and click **Search**. 4. Select *URINALYSIS*. 5. Select the **ASAP** radio button. 6. Click **Save to Queue**. 7. In the **New Lab Order** field, enter *HCG QL* and click **Search**. 8. Select **HCG QL**. 9. Click **Save to Queue**. 10. In the **New Lab Order** field, enter *urine culture* and click **Search**. 11. Select *URINE CULTURE*. 12. Click **Save to Queue**. 13. Click the **Order Sets** tab. 14. Click **Save As Order Set**. The Save Encounter Template window opens. 15. In the **Template Name** field, enter **UTI--Orders--Test** and click **Save**. 16. Close the A/P module.	

17. 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 UTI.
4. Click Search.
5. Press and hold Ctrl on your keyboard and select UTI--Orders-- Test and ECP—UTI 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--UTI 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--UTI with Orders** and click **Search**.
12. Highlight **ENC--UTI with Orders** Template.
13. Click **View/Edit** on the Action bar to verify both templates merged.
14. Click **Close** on the Action bar to close SF600.

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 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	❑ **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.

Health History

Demonstrate:

You would like to set-up the Health History modules to display only Problems, Allergies, and Lab. You will need to pull LCDR Eduardo Suarez's record.

1. Click the **Health History** folder in the Folders List.
2. The Health History module displays with default modules selected.

To customize the Health History folder:

1. Click the **Options** button on the Patient ID line. The Health History Design Summary screen will display.
2. Uncheck the box next to **Demographics**.
3. Click the **Align** button to view the format.
4. Click the **OK** button to view the results.
5. Click the **Close** icon on the Action Bar to close the module.

Key Points:

- Can be changed to fit the current requirements

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 **Problems** located under Health History.
3. Problem List is highlighted by default. Click the **Add** button on the Action bar to add *Gallbladder Neoplasm Malignant* to his list of problems.
4. The Select **Diagnosis** window appears and defaults to the clinic list role.
5. Click the **Search** tab and enter *gallbladder neoplasm malignant* in the MEDCIN Search field.
6. Click the **Search** button.
7. Highlight *Gallbladder Neoplasm Malignant* and click **OK**.
8. Complete the remaining fields in the New Problem section with the following information:

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

Hint: Click the year on the calendar to quickly select the year.

9. Click **Save**.

Close the **Problems** module.

Review Screen layout

Lab Module

Set the Scene: Provider Test User has to atend a meeting this morning. He tells you he has just talked to patient LCDR Suarez and wants to see him today 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.

Students follow along:

1. Create a new appointment for **LCDR Suarez (s3217)**.

   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.

   Review what appears based upon the default settings.
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.
9. Do not close SF 600.

Explain: Review screen layout and quickly review other options.

- Click the **Options** button to set the Lab Results Properties.).
- Select the *Filter* tab radio button: *All labs*.

In the Preferences tab.

- Time Options section, select Default Time*: All Time Periods.*
- Click the **OK** button.
- Click the **OK** button to display the list of labs.

Radiology Module

Set the Scene: Add the following Radiology results to LCDR Suarez's Encounter note.

Explain: The difference between **Copy** and **Copy to**

	Students follow along: 1. In the Folder List, click **Radiology**. 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 . 10. Close the encounter.	**Note**. **Review the screen layout.**
	Meds Module **Explain:** • 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. **Set the Scene: Col Violet Alexander (a5743)** tells you that she has added taking Motrin each day to her daily routine as suggested earlier by Dr. David Doctor. Check her medication health history and update it with the new medication. **Students follow along:** 1. Search for **Col Violet Alexander (a5743)** to open her patient record. 2. In the *Folder List* under Health History, click **Meds**. In the Meds module, the **Search Filter**	

	field default is **Outpatient Current**. 3. Review the functions available using the Action Bar icons: **Add**, **Details**, **Discontinue**, **Modify** and **Renew**. 4. Click the drop-down arrow for the **Search Filter** field and review the options. Change the selection to **All**. 5. Select an existing medication and, on the Action Bar, click the **Details** icon. 6. Click **Discontinue** on the Action Bar. 7. A Medication box appears confirming the medication was successfully discontinued. 8. The **Search Filter** selection changes back to **Outpatient Current**. 9. Click the **Add** icon to record Motrin. 10. Click the Record OTC/Outside Medication button. 11. Click the **Medications** button to begin searching for **Motrin** in the *Healthcare Data Dictionary Search* window. 12. Select *IBUPROFEN (MOTRN) 800 MG, (U/D)--PO, 800 MG* 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 muscle aches. 14. Click the **OK** button. Note the checkmark in the **OTC** column indicates this is an over-the-counter medication. 15. Close the Meds module. 16. Close the encounter.	**Review the screen layout.** **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.
	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 **Allergy** 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:

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.

Review the screen layout.

13. Click **Close**.
14. Click **Save**, then **OK** to **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**.

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

Vitals Sign Review

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

Students follow along:

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

1. Open the **Appointment** module.
2. Click once to highlight LCDR Suarez Diabetes follow-up visit in the appointment list to pull his patient record.
3. Verify that LCDR Suarez is now listed on the Patient ID line.
4. Open **Vitals Sign Review** in the Folder List.
5. Click the **Search Type** button to open the *Time Search* screen.
6. Select the **Sliding Time Range** radio button and select **2 months** as the time range.
7. Click **OK**.
8. Click the **Refresh** button to the right of the time period display. (This may not work correctly in the CHCS II Training System.)
9. Highlight a single line and click the **Graph Vitals** icon on the Action Bar to open the *Graph Vitals* window.
10. 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. 11. Click **OK** to exit and return to the Review role with LCDR Suarez' vitals. 12. Click and hold to select the entries in the **BP** and **HR** columns. 13. Click the **Graph Vitals** button on the Action Bar. Review the display options available. 14. Return to the *Vital Signs Entry* screen. 15. Click the **Close** button. 16. Click **Close** to close the encounter.	**Review the screen layout**

Exercises

- Students follow along with the Instructor
- Check for understanding and answer participant questions

Summary

- Explained Health History folder
- Setup Health History patient data modules
- 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 user will be able to:

- View the readiness module
- Edit the readiness information

Readiness

Demonstrate:

Your task is to update the **Readiness** module for LCDR Eduardo Suarez (S3217). After a record review, you discover the patient had a G6PD done 18 SEP 03 with a normal result.

1. Verify LCDR Suarez's name appears in the patient ID line.
2. Click the **Readiness** module in the Folders List.
3. Click the **Edit** icon on the Action Bar.
4. Update the G6PD information in the *Lab Tests* section by clicking the dropdown in the **Date** field and selecting the appropriate date.
5. Select **Normal** in the **Result** field.
6. Click **Save** on the Action Bar.
7. Close the **Readiness** module.

Note: Readiness data can be entered in CHCS II, but also must be entered in PIMR.

❑ **Slide 25: Readiness Learning Objectives**

	Exercises • Complete the exercises. • Check for understanding and answer participant questions. **Summary** ▪ View the readiness module ▪ Edit the readiness information ***Next Slide***	
Lesson 11: Questionnaire Setup & Patient Questionnaire		
	Questionnaire Setup/Questionnaire **Lesson Goal:** The goal of this lesson is to enable the user to set up patient questionnaires in CHCS II. **Learning Objectives** Upon completion of this lesson, the user will be able to: • Create and release a questionnaire • Edit an existing questionnaire • Change the status of a questionnaire **Explain:** • 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. 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.)	❑ **Slide 26: Questionnaires Learning Objectives**

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.

The Headache Clinic has just been brought up on CHCS II. When screening patients for the first time, the clinic has a form for patients to complete prior to seeing a Provider. You have been asked to add this form as a questionnaire in CHCS II.

1. Clear any patient data from your screen. (Follow the menu path ***Go > Patient > Clear Patient***.)
2. In the *Folder List* under the Tools folder, click the **Questionnaire Setup** icon.
3. On the Action Bar, click the **New** icon to create a new questionnaire.
4. In the Name field, enter: Headache – Initial Visit.
5. In the Instructions to Display field, enter these instructions: Please complete all questions.
6. Click the **Add** button.
7. In the **Question Text** field, add each question below, click the **Answer Type** field drop-down arrow to select the answer type, and enter each possible answer in the space provided.

Question	Answer Type	Possible Answers
Do you have a headache right now?	Yes/No	Yes No
When was the last time you had a headache?	Multiple Choice	Less than 1 month 1-6 months 7-12 months Greater than 1 year
Have the headaches gotten worse or better?	Multiple Choice	Worse Better
Are you taking any medication for the headaches?	Yes/No	Yes No
Does the medication help the headaches?	Yes/No	Yes No
Have you seen a medical provider regarding these headaches within the last year?	Yes/No	Yes No
Does anyone else in your family suffer from headaches?	Yes/No	Yes No
If so, who suffers from headaches?	Multi Select	Mother Father Sibling Grandparent No One
Is there a lot of stress in your normal day?	Yes/No	Yes No

8. Click **Save** on the Action Bar.
9. Enter Owner information:
10. Level: Select *Clinic*
11. Owner: Select *CHCS II Test Clinic*
12. Select the second to last question and change the possible answer **Sibling** to **Male Sibling**.
13. Highlight the last question and click the **Delete** button. Click **Yes**
14. On the Action Bar, click the **Save** icon to save the questionnaire.
15. Highlight the questionnaire just saved and click the **Mark Ready** icon.
16. Refresh the screen and locate the **Headache** questionnaire under **Questionnaires** in the side bar panel (expand the **Questionnaires and Tests** hierarchy).
17. Close the Questionnaires 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.

Students follow along:

We will now complete the Headache Initial Visit questionnaire with LCDR Eduardo Suarez. Answer each question as if you were completing the questionnaire for LCDR Suarez:

1. Click **Patient Questionnaires** in the Folder List. The Patient Questionnaires window will display.

2. Click the **Interview** icon on the Action Bar to begin the questionnaire. The questionnaire window will display.
3. To locate the questionnaire:
   a. Click ⊞ to expand Clinic
   b. Click ⊞ to expand Questionnaires
   c. Click ***Headache Initial Visit*** to select it. The questionnaire will be displayed:
4. Click Select to start the questionnaire.
5. Click the **Options** button on the Patient ID line to select the Properties for administering the Patient Questionnaire. The Patient Questionnaire Properties window will display.
6. Click on ***Single Question View*** from the drop-down to select it and click **OK**. The questionnaire will re-display.
7. Answer each question and click ***Next Question***
8. When the last question is displayed, answer the question.
9. The Patient Questionnaire window will be re-displayed showing the questionnaire that has just been completed.
10. Click the **Close** icon on the Action Bar to close the module.

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.

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

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.

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.

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.

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

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:

17. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays
18. Click the **Ellipsis** button next to the *Default Clinic* field. The Clinic List Edit window opens
19. 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.
20. Click **Set Default**. You are returned to the Vaccine Management area.
21. 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.

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
Pneumoccoccal Conjugate
TD
Tetanus
Typhoid
Variccella
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.

22. Select a manufacturer.

23. Click Details.

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

24. 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
Pneumoccoccal 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

displays (see Figure 12-9: Immunizations Admin—Provider Management).

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

Entering Multiple Vaccines for a Patient

To enter multiple vaccines for a patient:

1. Select an Immunization Provider from the drop-down list on the Multiple Entry tab. ***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***.
2. Select the Unit in which the patient is located from the drop-down list.

   A list of patients assigned to the unit displays.
3. Select the patient for which you want to enter multiple vaccines.lick the Select field for the associated patient and click the down arrow to select the patient.

   Click Select All if you want to enter the same multiple vaccines for every patient in the list.
4. Click **Log Selected.**

Printing Immunization Reports

To print immunization reports:

1. Click Reports on the Admin tab. The Reports area displays.
2. Select a report from the drop-down list.

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

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

Logging Refrigerator Temperatures

To log refrigerator temperatures:

1. Click **Temperature Log** on the Admin tab.

The Refrigerator Temperature Log area displays.

2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.
4. Complete the following fields:
   - Temperature
   - Date
   - Time
5. Click **Add**.

To view all logged refrigerator temperatures for the selected clinic, click the All Refrigerators radio button and click Show All Entries.

Modifying Refrigerator Temperature Logs

To modify refrigerator temperature logs:

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

   To view all logged refrigerator temperatures for the selected clinic, click the All Refrigerators radio button and click Show All Entries.

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

Patient Immunizations Module

Overview of Patient Immunizations

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.

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.

Selecting the Immunization Exempt Type

To select the immunization exempt type:

- **Global:** If a patient has never been given any of the immunizations that are listed in the vaccination record section, 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.

To make a global exemption for all immunizations in the Individual Immunizations tab:

1. Select an **Exempt Type** from the drop-down list.

   Note: If you select Medical (Temp), Admin (PCS), or Admin (Temp) as an *Exemption Type*, an exempt date is required. The system formats that date.

2. Click, Click to Save Exemption.

To make a focused exemption for a specific vaccination in the Vaccine History tab

1. Select the vaccination to be exempted.
2. Click **Edit**. The Immunization History Edit window opens
3. Select the exempt type from the *Exempt* drop-down list.

   Note: Depending on the reason, an exempt date may be required. The system formats the date.

4. Click **Update**. The Exempt Reason appears on the Vaccine History tab.

Giving a Vaccine

To select an immunization:

1. Click **Give Vacc** on the Individual Immunizations tab. The Select Immunization window opens
2. Select an Immunization.

   Note: The *Immunizations Recommended* list is based on the vaccination groups to which the patient is assigned. The Other Immunizations list is a list of all vaccines.

3. Click the right arrow to move the items from the *Immunizations Recommended l*ist 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.

- **Provider:** Select a provider from the drop-down list, if necessary.

7. Click **Update** to save the data and return to the Vaccine History tab.

Deleting Immunization History

To delete an immunization History:

1. Select the immunization you want to delete.
2. Click **Delete**.
   Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.

Editing Immunization History

To edit an immunization history:

1. Select the immunization you want to edit.
2. Click **Edit**. The Immunization History Edit window opens
3. Complete the following fields:
   - Series
   - Manufacturer
   - Lot Number
   - Dosage
   - Site
   - Route
   - Next Vacc Due
   - Exempt
   - Provider
4. Click **Update** to save the data and return to the Vaccine History tab.

Printing Immunization Records

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.

To print immunization records:

1. **Print Worksheet:** Use this function to print required immunizations for the selected patient.
2. **Print DD 2766C:** Use this function to print a Vaccine Administration Record.

Reviewing Immunization Records

This area of the Individual Immunization tab displays all immunizations the patient is required to

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

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

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 Demonstration Scenario

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 retur to SF600
	SF600	[Click] Close and return to Appts. module
	Appointments	

PROVIDER: Sees the patient. Reviews what has been documented so far and loads the URI template. After documenting he uses Auto Neg – where appropriate.		[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF600
	S/O	
		[Select] S/O Button on SF600
	Favorites List	[Select] Visit--URI From the favorites drop-down window.
	HPI *Find Term*	[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] +

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

	Order Rad Tab Clinical Impression Routine More Details	 [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 [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	

CLERK: Clerk Checks out the patient and provides patient with a copy of the signed encounter.		[Select] Col Alexander's walk-in appt. [Select] Check out on Action Bar Print patient a copy of SF600

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.