CHCS II Provider Lesson Plan

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Rev 2.0

Change History

Date	Name	Change Description	Source:
10-25-2004	Kathleen Chapman	Created	Consolidation of Services materials
11-5-2004	Kathleen Chapman	Updated	CITPO comments
12-01-2004	Linda Armstead	Revised	Services Comments
12-16-2004	Linda Armstead	Build Enhancement	Build 837.2 Release

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Preparation for Delivery

This lesson plan is designed to teach the Providers at each MTF.

Materials Needed

- CHCS II Sign-In Roster may be electronic or paper based.
- CHCS II Provider Course Lesson Plan.
- CHCS II Provider Presentation.
- CHCS II Training Templates.
- CHCS II Provider Training Student Guide (one per seat).
- CHCS II QRC (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: Student can all items except the evaluation form, which is to be completed by each student and left with instructor.

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 Provider Training Course presentation (instructor workstation only) completed with current date and location
- Reset data (**Encounter Data** button) for each CTS prior to starting class daily. **Note**: The entire database should be refreshed weekly after the last Provider 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 the following training templates to all training systems:
  - TRAINING--VISIT--URI MEDCIN
  - TRAINING--VISIT--RASH MEDCIN
  - TRAINING--URI ENCOUNTER
  - ENC—ASTHMA—TRAINING
  - AIM—FORMS--Ankle Pain
- 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 for the 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 providers before they leave the classroom.

- Explain to the class how assistance will be provided the first time they attempt to log on to system.

Duration	Training Activities	Instructor Notes
Introduction		
	Welcome/Logistics	❑ **Slide 1: Provider 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***	
CHCS II Overview		
	What is CHCS II?	❑ **Slide 3: What is CHCS II?**
	CHCS II is a computer-based patient record (CPR) system selected by the Department of Defense to meet the requirements of the Military Health System.	

Duration	Training Activities	Instructor Notes
	CHCS II provides: ❑ A graphical user interface that networks with existing systems ❑ Efficient means of creating, managing and retrieving medical records ❑ Anytime, anywhere delivery of patient records to the point of care ❑ Future access to 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***	
	Limitations of Paper Based Medical Records • Paper charts get 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** Speak to slide, adding this brief comment.

	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
		❑ **Slide 5: CHCS II Benefits**
		Elaborate on each benefit.

Duration	Training Activities	Instructor Notes
	• 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***	
	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**
	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 attend training, as scheduled. Providers should be available to receive On-the-Job Training (OJT, one-on-one-training), as scheduled.	**Slide 7: Expectations**

Duration	Training Activities	Instructor Notes
	CHCS II Training Role-based training is built into training delivery. Clerk and Support receive four hours of Instructor-Led Training and four hours of On the Job Training; Nurses and Providers receive sixteen hours of OJT. Providers receive eight hours of ILT while Nurses receive six hours of ILT. Records Reviewer receive two hours of ILT and Two hours of OJT. ***Next Slide***	❑ **Slide 8: Training Schedule** This slide should be used as a brief transition to the next slide.
	On the Job Training (OJT) This time has been set aside to provide one-on-one support with an instructor in your clinical workspace. It is to your benefit that you be available and on time at your scheduled times. ***Next Slide***	

	Key Information and Technology Training Resources
	
	• MTF CHCS II Team
	  • Clinical Champion
	  • MTF Project Officer
	  • Facility Training Coordinator
	• Unisys On-Site Team
	  • Site coordinator
	  • Classroom Lead
	  • Lead OJT Trainer
	  • 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.

Duration	Training Activities	Instructor Notes
	System Demo	❑ **Slide 10: System Demonstration**
	Go to Appendix B: ***Next Slide***	**Found in Appendix B but needs to be added here.**
	Course Goal The goal of this course is to enable Providers to access, navigate, and use the CHCS II application to document patient encounters in the clinic. ***Next Slide***	❑ **Slide 11: Course Goal**
	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. **Explain:** • Click the caduceus icon on the desktop to start • Stand-alone practice version of CHCS II • Simulates functionality • Patient data is fictitious • Limited choices for labs, rads, and meds • Some variations from live CHCS II system	❑ **Slide 12: CHCS II Training System**

Duration	Training Activities	Instructor Notes
	• Modules covered vary by assigned role • System logs you on as a Provider; remember that available icons, buttons, fields may be different when you log on in the live CHCS II system • 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***	
	MTF Business Rules	❑ **Slide 13: Training and MTF Business Rules**
	Next Slide	
	Course Agenda	❑ **Slide 14: Session One Agenda**
	Next Slide	

Duration	Training Activities	Instructor Notes
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 provider will be able to: • Log in to the CHCS II application • Use the primary method of navigation • Customize the desktop • Lock a CHCS II session • Open and close an application module • Exit the CHCS II application	❑ **Slide 15: Navigation Learning Objectives**
	Training Environment – CHCS II Training System (CTS) ## Demonstrate: Open the application. **Explain:** • Standalone version of CHCS II • Used for training only • Simulates CHCS II functionality • Very limited choices for labs, rads and meds • Fictitious patient data • Slight variations from the CTS and the application in the field • Automatic log on of user as a Provider	

Duration	Training Activities	Instructor Notes
	Basic Navigation	
	Explain: General layout of the screen (similar to Outlook) • Title Bar • Main menu • Action Bar	Action Bar changes according to the module, providing quick access to navigation and functionality for the module.
	Demonstrate: ▪ Log on to the system, view the current list of appointments and open and close modules 1. Open the CHCS II Application. 2. Click the **Appointments** folder in the Folders List (if the Appointment module is not already selected). 3. The list of current appointments will display. 4. Click the **Co-signs** folder in the Folders List to open the Co-signs module. The Co-signs module will display. 5. Click the **Close** icon on the Action Bar to close the Co-signs module. 6. Click the Close **X** button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display. 7. Click **Yes** to confirm the exit	For navigating, the *Folder List* and Action Bar are the most efficient methods—fewest clicks.
	Key Points: Module access • Summarize the various methods of accessing modules: Menu, *Folder List*, Action Bar. • Customizing the desktop. • *Folder List* and Action Bar are the most efficient.	**Note:** Emphasize how the desktop can be customized by preference.

Duration	Training Activities	Instructor Notes
	Exercises • Complete the exercises. • Check for understanding and answer participant questions.	

	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.
	
	Changing passwords: This cannot be demonstrated on the CHCS II Training System; use the slide to explain.
	
	• Two or more users can have their own session open on a single workstation.
	
	Example: Provider and Nurse can both have an instance of CHCS II open on the same PC.
	
	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.
	
	SUMMARY
	
	• Navigation
	• Customizing the desktop
	• Security
	
	Next Slide
		Note: Emphasize that passwords **must** be changed in CHCS II.

Duration	Training Activities	Instructor Notes
Lesson 2: Patient Search and Appointments		
	Lesson Goals The goal of this lesson is to enable the student to search for, open and close a patient record in CHCS II. **Learning Objectives** Upon completion of this lesson, the provider will be able to: • Locate the patient record • Set the display for appointments by adjusting the appointment display properties using clinic, provider, date, and status • Use three methods for changing the appointment display • Change and save the column order • Create a walk-in appointment • Check in a patient • Check out a patient • Transfer an appointment to another provider • Add a provider to an appointment	❑ **Slide 16: Patient Search & Appointments Learning Objectives**
	Patient Search Module Pulling a Patient Record features: ▪ Different search methods available ▪ Patient must have a record in CHCS ▪ "Search CHCS" is an option	

Duration	Training Activities	Instructor Notes

	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 the appointment creation process.
		
		Explain that 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 Violet's record, set the appointment filters and create a new appointment. 1. Open the CHCS II Application 2. Click the **Search** module in the Folders List to search for a patient. The Patient Search window will display 3. Type ***ALEXANDER*** in the Last Name: field and click **Find** for a list of names.Click on ***ALEXANDER, VIOLET W*** in the list of names and click **OK**. Violet Alexander's information will appear on the Patient ID line and the Appointments List will display. 5. To set the appointment filters, click the button in the Appointment list Workspace. The Appointment Search Selections window will display. 6. Click the following radio buttons for the associated Field: 7. When the information has been completed, click the button to change the default settings. The Appointment List will re-display. 8. Click on the Action Bar to create a new appointment for Violet Alexander. A New Appointment	Explain differences between methods for accessing properties set-up options. Explain the five setup options: 1. Column order 2. Clinic (Clinic assignments are in CHCS) 1. Provider 2. Date 3. Status Explain appointment types and statuses. Do not need to show all steps in Transfer and Add Provider—but, do point out these functions.

Duration	Training Activities	Instructor Notes
	confirmation window will display. 9. Click so you can complete the New Appointment information for Violet 10. Click on ***ACUTE APPT (ACUT$ 30)*** to select the acute appointment type. You will now be able to select the Reason for Appointment. 11. Type ***cough*** in the Reason for Appointment field and click to complete the new appointment process for Violet. 12. Violet Alexander 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) **Exercises** • Complete the exercises. • Check for understanding and answer participant questions.	**Note:** You might want to type in the whole last name, rather then the first four letters of the last name since there will be a longer list on the "Live" side and this suggestion might give users the wrong impression. It is better to use the patient's Rank and last name then the first name, we are training military personnel and this is more respectful when training).
	SUMMARY • Explained patient search module • Explained appointment list properties • Explained how to make appointment display selections • Created a new appointment • Pointed out function for transferring appointments to other Providers • Pointed out function for adding a Provider to an appointment	

Duration	Training Activities	Instructor Notes
	Next Slide	
Lesson 3: List Management		

	Lesson Goal:
	The goal of this lesson is to enable the provider to create and manage Favorites Lists of diagnoses and procedures for streamlining selection in the Screening, Problems and A/P modules.
	
	Learning Objectives:
	Upon completion of this lesson, the provider will be able to:
	• Create lists of favorites for use in the application:
	  • Diagnoses
	  • Procedures
	  • Clinic Favorites
	• Delete items from lists.
		❑ **Slide 17: List Management Learning Objectives**

	List Management	
	Demonstrate: After talking to the provider, it is decided they do not want Upper Respiratory Infection on their favorites list. They would like to add flu shot to their procedures list and have electrocardiogram as the last procedure on the list. 1. To begin, click the **List Management** module in the Folder List The List Management screen will display. 2. To Delete Upper Respiratory Infection from the Diagnosis favorites list, click ⊞ to expand ***My***	

Duration	Training Activities	Instructor Notes
	Favorites (if not already expanded) and click ⊞ to expand ***My Diagnosis*** (if not already expanded). A list of favorite diagnoses will be displayed. 3. Click on ***UPPER RESPIRATORY INFECTION*** to select it and click the **Delete** icon on the Action Bar. Upper Respiratory Infection will be deleted from the Favorite List. 4. To add a flu shot to the procedures favorites list, click to highlight ***My Procedures*** and click the **Add** icon on the Action Bar. The Select Procedure window will display. 5. Type ***flu shot*** in the Search field and click **Search**. Terms related to flu shot will be displayed. 6. Click ⊞ to expand ***Vaccines Viral Influenza*** 7. Click ⊞ to expand ***Split Virus*** 8. Click ⊞ to expand 3 years of age and above 9. Click ***For Intramuscular Use 90658*** to select it and click **OK**. The For Intramuscular Use procedure will be added to the Procedure Favorite List. 10. To move the electrocardiogram procedure to the bottom of the Procedures favorites list, click ***Electrocardiogram*** in the Procedures favorites list. 11. Click the **Move Down** icon on the Action Bar. Electrocardiogram will be moved to the bottom of the list. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. **Summary** • Delete items from lists. • Create lists of favorites for use in the application Next Slide	

Duration	Training Activities	Instructor Notes
Lesson 4: Patient Encounter		
	Lesson Goals The goal of this lesson is to document the patient encounter in CHCS II and create electronic record. **Learning Objectives** Upon completion of this lesson, the provider will be able to: • Open the encounter • Document S/O using MEDCIN • Document A/P • Complete Disposition and verify E&M code • Sign Encounter	❑ **Slide 18: Patient Encounter Learning Objectives**
	Introduction to MEDCIN	
	MEDCIN **MEDCIN** ▪ Medical terminology relating to the encounter ▪ Over 250,000 terms with 5.5 million semantic links ▪ Linked to ICD-9 and CPT codes in A/P ▪ Narrative engine used in S/O, A/P, Disposition, Template Management, Screening and Problems modules	**Explain:** Review screen layout.

Duration	Training Activities	Instructor Notes
	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 (–). **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. 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.	It is up to the Instructor to give this information.

Duration	Training Activities	Instructor Notes
	MEDCIN: Advanced Search Options **Explain:** • Dx (Diagnosis) Prompt generates a list of findings based on a diagnosis. This is helpful in selecting terms for a template built around a diagnosis. • List Size - There are three levels that create a broader list of findings. • Find Term • Browse From Here **Subjective/Objective Module** ## Subjective/Objective ▪ Subjective - what the patient told the provider ▪ Objective - what the provider 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 provider. The Objective portion of the note includes the Physical Examination (PE) and is what the provider observes. **Key Points:** • Visit templates are clinical note using MEDCIN terms • E&M coding is done quickly and accurately using structured terminology.	

Duration	Training Activities	Instructor Notes
	Subjective/Objective	
	Demonstrate: ▪ Since Col. Alexander has come in today complaining of a cough, we will document Col. Alexander's visit using a standard URI template. We need to document the following: **HPI** ▪ Chief Complaint of URI symptoms ▪ Cough that has been occurring for 2 days, mainly at night ▪ Indicate that Col. Alexander went to the Urgent Care Clinic. ▪ Patient denies all other symptoms **PMH** ▪ Col. Alexander smokes cigarettes and has been smoking 2 packs a day for 6 years (12 pack years) ▪ No history of Acute Bronchitis ▪ No history of Asthma ▪ Maternal History of Diabetes Mellitus Type II **ROS** ▪ Col. Alexander denies all of the symptoms **PE** ▪ Vital Signs (Reviewed) ▪ Nasal discharge ▪ Auscultation wheezing ▪ All other items are normal	Don't forget we are training Military and not civilians. Please use the rank of the patient instead of the first name. Discuss use of Favorites List

Duration	Training Activities	Instructor Notes
	Documenting the note: 1. Click the **S/O** button on the electronic SF600 to open the S/O module. The S/O screen will display (the parts of the screen have been annotated for easy reference). 2. Click the Template Menu List drop down. The list of available templates will display. 3. Scroll down to locate and click VISIT--URI. The VISIT-- URI template will display in the MEDCIN Tree pane. 4. Once the template is loaded, the S/O module starts with the **HPI** tab selected 5. Click + to select The Chief Complaint is: URI symptoms 6. Click + to select a cough 7. Click on the Duration grid icon on the dashboard 8. Click on **2** and then click on **Days** 9. Type **MAINLY AT NIGHT** in the Free Text area of the dashboard and press the [Enter] key 10. Click on the free text Note Pad icon in the S/O MEDCIN pane. The Preliminary Background HPI window for entering free text will display. 11. Type **PT SAW MD AT UCC** in the Preliminary Background HPI area and click **Save and Close** to save the information. 12. Patient denies everything else so click the **AutoNeg** on the S/O dashboard. 13. Once the HPI is complete, click the **PMH** tab in the S/O window to document the Past Medical History. 14. Click + to expand Smoking 15. Click + to expand Cigarettes 16. Click **Plus Sign** to select for ___ pack-years 17. Type 12 in the Value Field on the dashboard and press [Enter} to record the information in the narrative pane. 18. Click **Minus Sign** to select no history of ACUTE BRONCHITIS	when searching for and loading templates. Explain/Show: • select/deselect • expand/collapse • emitting Explain that documenting by exception is the common practice and crucial to the use and purpose of AutoNeg. Explain use of AutoNeg further. Reinforce to Providers the criteria between HPI and ROS. This is typically not familiar to some Providers. **Be sure to explain the parent-child relationship and that a parent term need not be selected if a child term is selected; for**

Duration	Training Activities	Instructor Notes
	19. Click **Minus Sign** to select no history of ASTHMA 20. Click + to expand History of DIABETES MELLITUS 21. Click **Plus Sign** to select TYPE II 22. Click the FamHist drop down button on the dashboard and select Maternal History 23. Once the PMH is complete, click the **ROS** tab in the S/O window to document the Review of Systems portion of the encounter note. 24. The provider asks all the ROS questions and the patient denies all the symptoms so click **AutoNeg**. 25. The provider is now ready to perform the physical examination, so click the **PE** tab. 26. Click the Plus Sign to select Vital Signs (Reviewed) 27. Click **Plus Sign** to select Nasal Discharge 28. Click **Plus Sign** to select Auscultation Wheezing 29. Everything else in the physical examination is normal, so click **AutoNeg**. 30. Review the information in the narrative pane to ensure that everything is correct 31. Click on the **Close** icon on the Action Bar so we can review the information on the SF600.	**example, if the term cigarettes is chosen, no need to select smoking.** Explain AutoNeg—when to use and when not to use. Explain "flipping" and the use of **ROS/HPI** button. Emphasize that use of structured documentation results in a more accurate code.
	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 text from ROS to HPI	

Duration	Training Activities	Instructor Notes
	• Explained AutoNeg • Explained reverse sensing terms	
	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 diagnosis. • Order Entry selections are similar to the ones in CHCS. • Same drug-drug, drug-allergy, and duplicate order warnings as in CHCS.
	Assessment/Plan	
	Demonstrate: As a result of the physical examination, the provider has determined the patient has both an Upper Respiratory Infection as well as Acute Bronchitis. The primary diagnosis being the Acute Bronchitis. The provider also noticed with the Acute Bronchitis, the patient has bronchospasms, but is not in distress. The provider wants to order:	

Duration	Training Activities	Instructor Notes
	▪ A peak flow procedure associated with the Acute Bronchitis ▪ A CBC W/Auto diff associated with the Acute Bronchitis ▪ A chest x-ray with (PA) and lateral views. We want to rule out pneumonia and associate the chest x-ray with the Acute Bronchitis ▪ Order Amoxicillin to treat the Acute Bronchitis ▪ Have the patient take frequent oral fluids for the Acute Bronchitis and the Upper Respiratory Infection **Documenting the note:** 1. To document these items, click **A/P** on the electronic SF600 to open the A/P module. The A/P screen will display with the Diagnosis tab selected: 2. Type ACUTE BRONCH (short for Acute Bronchitis) in the Search field and click **Find Now**. Diagnosis terms containing 'acute bronch' will display in the Diagnosis List 3. Click on ACUTE BRONCHITIS 466.0 in the list and click **Add to Encounter** to add the diagnosis to the Diagnosis List. 4. A comment to the Acute Bronchitis diagnosis needs to be added. To do this, click on the comment line associated with Acute Bronchitis in the Diagnosis List. The Extended Comments window will display: 5. Type **PT HAS BRONCHOSPASMS BUT IS NOT IN DISTRESS** in the Comments area and click **OK**. The comment will be added to the Acute Bronchitis diagnosis. 6. Type ***UPPER RESP*** (short for Upper Respiratory) in the Search field and click **Find Now**. Diagnosis terms containing 'upper resp' will display in the Diagnosis List in the bottom half of the screen. 7. Click on **UPPER RESPIRATORY INFECTION 465.9** in the list and click **Add to Encounter** to add the diagnosis to the Diagnosis List. 8. Click on the **Procedure** tab. The Procedure List area will display in the bottom area of the window. 9. Type **PEAK FLOW** in the Search field and click **Find Now**. Procedure terms containing 'peak flow' will display in the Procedure List. 10. Click on the **ACUTE BRONCHITIS 466.0** diagnosis in the Diagnosis List to ensure the peak	**Order sets currently in CHCS must be recreated for use in CHCS II.** 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 Codes • Partial Words Explain that the user can delete a diagnosis, procedure or order that was documented in error. If an order has been sent the

Duration	Training Activities	Instructor Notes
	flow procedure will be associated with acute bronchitis (this step is not necessary if acute bronchitis is already selected). 11. Click on Pulmonary Function Tests Peak Flow 94150 in the Procedure List and click **Add to Encounter** to add the procedure to the Acute Bronchitis diagnosis. 12. Click on the **Order Lab**. The Order Lab area will display in the bottom area of the window: 13. Type **CBC** in the search field and click. Order Lab terms containing 'CBC' will be listed. 14. Click on **CBC W/Auto Diff** to select it 15. Click the **Submit** button. The CBC will be associated with the Acute Bronchitis diagnosis 16. Click on the **Order Rad** tab to be able to order the chest x-ray. The Order Rad area will display in the bottom area of the window. 17. Type **CHEST** in the search field and click **Search**. Order Rad terms containing 'chest' will be listed. 18. Click on **CHEST, PA AND LATERAL** to select it and type **R/O PNEUMONIA** in the Clinical Impression area 19. Click on the **ACUTE BRONCHITIS 466.0** diagnosis in the Diagnosis List to ensure the chest x-ray will be associated with the Acute Bronchitis diagnosis (this step is not necessary if Acute Bronchitis is already selected). 20. Click the **Submit** button for the chest x-ray. The chest x-ray will be associated with the Acute Bronchitis diagnosis. 21. Click on **Order Med**. The Order Med area will display in the bottom area of the window. 22. Type **AMOXICILLIN** in the search field and click **Order Med,** terms containing 'Amoxicillin,' will display. 23. Click on **AMOXICILLIN--PO 500MG CAP** to select it. 24. In the SIG field, type **T 1 CAP PO QID X7 #28 RF0** and press [Enter] to ensure the SIG information entered matches SIG requirements. 25. Click on the **ACUTE BRONCHITIS 466.0** diagnosis in the Diagnosis List to ensure Amoxicillin will be associated with the Acute Bronchitis diagnosis (this step is not necessary if Acute Bronchitis is already selected).	Provider still needs to notify the receiving location because if the delete the order it is still at the other end. If orders were submitted they would be listed under the show orders area. **Explain**: Civilian **(Non-MTF)** consults continue to be completed in CHCS rather than in CHCS II.

Duration	Training Activities	Instructor Notes
	26. Click the **Submit** button for Amoxicillin. Amoxicillin will be associated with the Acute Bronchitis diagnosis. 27. Click on the **Other Therapies** tab to include other instructions given to a patient. The Other Therapies List area will display in the bottom area of the window. 28. Type **FREQUENT ORAL FLUIDS** in the search field and click **Find Now**. Other Therapy terms containing 'frequent oral fluids', will display in the Other Therapies List. 29. Click on the **ACUTE BRONCHITIS 466.0** diagnosis in the Diagnosis List to ensure that Frequent Oral Fluids will be associated with the Acute Bronchitis diagnosis (this step is not necessary if Acute Bronchitis is already selected). 30. Click on Oral Fluids Frequent in the Other Therapies List and click **Add** to add it to the Acute Bronchitis diagnosis. 31. As indicated in the scenario, we also want to associate Frequent Oral Fluids with the Upper Respiratory Infection diagnosis. 32. Click on **UPPER RESPIRATORY INFECTION 465.9** in the Diagnosis List. 33. Click on Oral Fluids Frequent in the Orders and Procedure List and click the < > (Associates/UnAssociates Orders & Procedures) button. Oral Fluids Frequent will now be associated with the Upper Respiratory Infection diagnosis. 34. Click the **Close** icon on the Action Bar so we can review the information on the SF600.	
	Exercises • Complete the exercises. • Check for understanding and answer participant questions.	
	Summary • Document A/P • Explained how codes are captured with diagnoses and procedures • Procedures, orders and other therapies must be associated to a logical diagnosis	

Duration	Training Activities	Instructor Notes
	• Consults, labs, rads and meds can be submitted or saved 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 who indicated an understanding of the items discussed. We want to see the effect of filters on the E&M code before signing the encounter. 1. Click **Disposition** button on the electronic SF600 to open the Disposition module. The Disposition screen will display: 2. Enter the following data:	**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 more free text then MEDCIN terminology. **Emphasize selection of Preventative Med types, when appropriate. Most often missed; results in inappropriate coding.** **NOTE:** 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. They can be documented using the correct Procedure code.

Duration	Training Activities	Instructor Notes

Field	Data or [Description of Data]
Disposition	Click ***Released w/o Limitations*** from the pull down list
Follow Up	Click the  checkbox
Discussed	Click the  checkbox

To see the effect of filters on the E&M code:

a. Change the Service Type drop down to ***Prev Eval/Mgt*** and observe the E&M code. Change the Service type back to ***Outpatient Visit*** to reset the code.

b. Click on the >50% time spent counseling or coordinating care and indicate > 50 minutes spent in total face to face floor time in minutes. Observe the new E&M code. Click to reset the >50% time spent counseling or coordinating care.

c. Change the Patient Status drop down to New Patient and observe the E&M code. Change the Patient status back to Existing Patient to reset the code.

3. Click the **Sign** icon on the Action Bar to initiate the signing process. The Sign Encounter window will display.

4. Review the note to ensure that everything is complete and accurate. Enter your password in the field provided and click **Sign** to complete the patient encounter process.

Exercises

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

Summary

Complete Disposition and verify E&M code
Sign Encounter

Duration	Training Activities	Instructor Notes
	Next Slide	

Duration	Training Activities	Instructor Notes
Lesson 5: Previous Encounters		
	Lesson Goal The goal of this lesson is to enable the provider to use the Previous Encounters module in CHCS II. **Learning Objectives** Upon completion of these modules, the provider will be able to: • Amend a completed encounter • Append a narrative to a completed encounter • Copy Forward a previous patient encounter	❑ **Slide 19: Previous Encounters Learning Objectives** The *Change History* section of the Encounter Note shows the original S/O note. This is the electronic equivalent of lining out the information in the paper medical record.
	Previous Encounters **Demonstrate:** The user would like to add the results of the Lipid Panel tests to LCDR Eduardo Suarez' completed encounter. **Amend a completed encounter:** Highlight the *Screening exam Lipoid Disorders* note and click **Amend Encounter** on the Action bar. The SF600 opens. 1. Click **Lab** on the Folder List. 2. Click **Time**. The Time Search window opens. 3. Select the **All Time Periods** radio button. 4. Click **OK**. 5. Select the *Lipid Panel Complete* report. The report details populate below.	New findings can also be documented for the current encounter. **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.

Duration	Training Activities	Instructor Notes
	6. Highlight the report by left-clicking and dragging over the text with your mouse. 7. Perform a right-click and select **Copy to Note**. 8. Click **Close** on the Action bar. 9. Click **Close** on the Action bar to return to the Previous Encounters module. **Appending a Narrative** The provider needs to annotate Eduardo Suarez's diabetes is now controlled by adding a note to his Diabetes Mellitus Type II – Uncontrolled encounter 1. From the list of appointments, click on any of Eduardo Suarez's appointments to pull his record. 2. Click the **Previous Encounters** module in the Folder List. The Previous Encounters window will display. 3. Highlight the Diabetes Mellitus Type II – Uncontrolled Encounter. 4. Click the **Append Narrative** icon on the Action Bar. The Encounter Note window will display. 5. Type ***DIABETES*** in the Note Category field. 6. Type ***DIABETES CONTROLLED*** in the Note Title field. 7. Type **BASED ON THE PT A1C, HIS DIABETES SEEMS UNDER CONTROL. PT WILL CONTINUE TO MONITOR HIS GLUCOSE LEVEL.** in the text area. 8. Click the **Save and Sign** button. The Sign Appended Note window will display. 9. Click the **Sign** button to sign the encounter. The Previous Encounters window will re-display. 10. Notice status has changed from completed to updated. 11. Click the **Close** icon on the Action Bar to close the module.	**NOTE:** Previous Encounters will only list/show encounters completed in CHCS II.

Duration	Training Activities	Instructor Notes
	Copy Forward a Previous Encounter The provider is seeing Eduardo Suarez for his follow-up appointment. You would like to use the information from his previous encounter to document his follow-up appointment. 1. Select the ***diabetes follow-up*** appointment for Eduardo Suarez. 2. Click the **Open Appt** icon on the Action Bar. Eduardo Suarez's SF600 will open. 3. Click the **Previous Encounter** icon in the Folder List. The Previous Encounters window will display. 4. Highlight Mr. Suarez's ***Diabetes Mellitus Type II*** encounter. 5. Right click on the highlighted appointment. 6. Click the **Copy Forward** button. The Previous Encounters window will close. 7. Click the SO button on the SF600. The copy forward template will display. 8. Since none of Mr. Suarez's symptoms or findings has changed we can quickly document the abnormal and normal findings in all tabs by clicking the **AutoEnter** button. 9. Click the **Close** icon on the Action Bar to close the SF600. **Key Points:** • Access to past encounters is available at any workstation that has CHSC II access. • Only the signer or cosigner of a particular note can amend that note. • Anyone with signing privileges can append a note.	
	Exercises • Complete the exercises. • Check for understanding and answer participant questions.	

Duration	Training Activities	Instructor Notes
	Summary ▪ Amend a completed encounter ▪ Append a narrative to a completed encounter ▪ Copy Forward a previous patient encounter ***Next Slide***	
Lesson 6: 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 provider will be able to: • Search for Visit Template • Use Template Edit Mode • Use FindTerm • Use Browse from Here • Save the Template as "VISIT--[name]--[your initials]" • Search for Forms • Documenting Note with Forms	❑ **Slide 20: S/O Template Management Learning Objectives** **Explain**: • Templates have pre-positioned terms • Benefits of using templates: streamline documentation • Folder location of templates in CTS versus the live system
	S/O Template Management **Demonstrate:** You have determined your patient Olaf Berg, who has come in with reason for visit as Cold and Flu, actually has allergic rhinitis. You would like to edit then use the Allergic Rhinitis Template.	Templates specific to the site imported to the CTS appear under the Favorites and Personal Templates; however, in the live system, for those in Family Practice or Primary Care these

Duration	Training Activities	Instructor Notes
	Edit a Visit template 1. Highlight and open the appointment for Olaf Berg, **(b8943).** 2. Click the **S/O** button on the SF600. The MEDCIN window will display. 3. Click the **Template Mgt** icon on the Action Bar. The S/O Template Management screen will display. 4. In the Name Contains field type **VISIT**. 5. Click the **Find Now** button, this will return a list of templates containing VISIT. 6. Scroll until you find the **VISIT--Allergic Rhinitis** template. Click on it to select it. The terms for the template will display in the MEDCIN Tree Pane. 7. Click the **Edit** icon on the Action Bar. You will be placed in Template Edit mode (refer to top of Narrative Pane). 8. We would like to remove the following terms from the template: a. cardiovascular symptoms (ROS) b. gastrointestinal symptoms (ROS) c. endocrine symptoms (ROS) d. External Auditory Meatus (PE) 9. We would like to add the following terms a. swollen eyelids (HPI) b. hoarseness (HPI) c. reported a family history of allergies (PMH) d. sinus pain (ROS) e. Constantly Wiping Nose (PE) 10. To remove the ROS term highlight cardiovascular symptoms in the right pane. 11. Click **Plus Sign** to deselect cardiovascular symptoms in the left pane. 12. To remove the ROS term highlight gastrointestinal symptoms in the right pane.	templates are found in the Clinic Templates folder; and, for those in other areas, use the search feature to locate them. • 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 Where: TYPE = Encounter (ENC), Visit, Education (EDU), Procedure (PROC), Consent, PE, and so on, SUBJECT = Allergy, URI, Asthma Followup, and so on, LDR = Personal initials (3) of the template owner

Duration	Training Activities	Instructor Notes
	13. Click **Plus Sign** to deselect gastrointestinal symptoms in the left pane. 14. To remove the ROS term highlight endocrine symptoms in the right pane. 15. Click **Plus Sign** to deselect endocrine symptoms in the left pane. 16. To remove the PE term highlight External Auditory Meatus in the right pane. 17. Click **Plus Sign** to deselect External Auditory Meatus in the left pane. 18. To add the additional terms: Click the **DX Prompt** icon on the Action Bar 19. Enter ALLERGIC RHINITIS in the search window and click **OK**. Terms related to Allergic Rhinitis will display. 20. Click **ALLERGIC RHINITS** to select it and click **OK**. Terms related to Allergic Rhinitis will display in the MEDCIN Tree pane. 21. Click the **HPI** tab to make sure you are adding terms to the HPI part of the template. 22. Click **Plus Sign** to select swollen eyelids. 23. Click **Plus Sign** to select hoarseness 24. Click the **PMH** tab to make sure you are adding terms to the PMH part of the template. 25. Click **Plus Sign** to select reported family history of allergies. 26. Click the **ROS** tab to make sure you are adding terms to the ROS part of the template. 27. Click **Plus Sign** to select sinus pain. 28. Click the **PE** tab to make sure you are adding terms to the PE part of the template. 29. Click the **Plus Sign** to select Constantly Wiping Nose. 30. When the template is correct, click the **Save As** icon on the Action Bar. The Save List Note Template window will display. 31. Type **VISIT--ALLERGIC RHINITIS--Your Initials** in the Template Name field leaving the Add to Favorites and Shared check boxes checked and click **SAVE**. The template will be saved with the name specified. 32. To terminate the template building process, click the **Cancel** icon on the Action Bar. The Template Management window will re-display.	**Examples**: BRANCH--ENC--URI--LDR • 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 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

Duration	Training Activities	Instructor Notes
	33. Since you also want to save the List Note, click **Yes** to close the module. 34. Click **Close** on the Action Bar. This takes you back to the S/O documentation window. 35. Click **Close** on the Action Bar to take you back to the SF600. **Search for and use the Ankle Pain Form** Your patient Marie Alexander has come in with ankle pain. You wish to document the S/O portion of the note using Forms. 1. Open the encounter for Marie Alexander. 2. Click the S/O tab. 3. Click the Template Management tab on the Action Bar. 4. In the Name Contains field enter the text Ankle pain. 5. The Name Search should provide one AIM Form for Ankle pain. 6. Highlight the name and click the Load tab from 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.**	

Duration	Training Activities	Instructor Notes
	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 in 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.	

Duration	Training Activities	Instructor Notes
	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]” • Explain Forms • Explain documenting using forms Next Slide	

Lesson 7: Encounter Templates and Order Sets

Lesson Goal

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

Learning Objectives

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

- Edit an encounter template
- Create an Order Set in A/P
- Merge an encounter template with an order set
- Use an encounter template

❑ **Slide 21: Session Two Agenda**

❑ **Slide 22: Encounter Templates and Order Sets Learning Objectives**

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

Encounter Templates

Demonstrate:

You have an Asthma Encounter Template from another provider you wish to edit this template to contain the information you will use with your patients. You would also like to merge this template with the order set you just created.

The provider wants to verify the following are included in the template, if not, add them for easy selection

Diagnosis

- Asthma
- Chronic Asthmatic Bronchitis
- Chronic Obstructive Asthma

Procedures

When adding diagnosis, show how to do multiple 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.

	▪ Pulse Oximetry ▪ Arterial Puncture ▪ Pulmonary Functions Tests ▪ Pulmonary Functions Tests Peak FLow **Notes Template** ▪ Visit-Asthma **Other Therapies** ▪ Patient Education Asthma Exposure to Triggers ▪ Patient Education Asthma Metered Dose Inhaler ▪ Patient Education Asthma Peak Flow Monitor **Editing a Template** 1. Click the **Template Mgt**. module in the Folder List. The Template Management window will display. 2. Click the **Search** icon on the Action Bar to look for the ENC-ASTHMA--TRAINING Encounter Template. The Template Management, Template Details window will display. 3. Click on the word **ESOPHAGEAL REFLUX** to select. Click the remove button to remove this term from your encounter. 4. Click the **Add** button in the Procedures window. A Procedure Search window will display. 5. Click **Done**. The Template Management window will be re-displayed with the information added. 6. Click the **Add** button in the Other Therapies window. An Other Therapies Search window will display. 7. Type ***TRIGGERS*** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 8. Click on **PATIENT EDUCATION ASTHMA EXPOSURE TO TRIGGERS** to select. Click **Add Items**. 9. Type **INHALER** in the Search Term Field, and click the **Search** button. Terms related to the search term will display.	**Explain**: • Purpose of the encounter template. • The use of the Template Management module to create an original encounter template Mention that encounter templates can also be created from existing encounters and from previous encounters. Both require editing because actual patient encounters are tailored to the specific circumstances; so, they need to be generalized to be used as templates. (OJT).

	10. Click on **PATIENT EDUCATION ASTHMA METERED DOSE INHALER** to select. Click **Add Items**. 11. Type **PEAK FLOW** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 12. Click on **PATIENT EDUCATION ASTHMA PEAK FLOW MONITOR** to select. Click **Add Items**. 13. Verify the top four boxes *Associated Reason for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Note* are empty, since they are generally not used. 14. Click **Done**. The Template Management window will be re-displayed with the information added.. 15. Click the **Save As** icon on the Action Bar to save the Template. The Save Encounter Template window will display: 16. Type ENC**--ASTHMA--Your Initials** in the Template Name field. Since we want to add the template to our Favorites list, and share the template we will leave these boxes checked. Click to save the template. The Template Management, Template Details window will re-display. 17. Click the **Close** icon on the Action Bar to close the module. **Merging two templates** 1. Click the **Template Mgt** icon in the Folder List. The Template Management window will display 2. Click the **Search** icon on the Action Bar to search for the Asthma Order Set and encounter template you just created. 3. Type **URI** in the search field. 4. Highlight **ENC--ASTHMA**--your initials and while holding down the [Ctrl] key select **URI--ORDERS**. 5. Click **Merge** icon the Action Bar to bring both templates to the **Template Details** tab. 6. Review the template. 7. Click the **Save As** icon on the Action Bar to save the Template. The Save Encounter Template	**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 and if populated, they should be removed. • Discussion of order sets will follow the building of the parts of the template mentioned above.

	window will display. 8. Type **ENC--ASTHMA--COMPLETE**--your initials in the Template Name field. Since we want to add the template to our Favorites list, and share the template we will leave these boxes checked. Click **Save** to save the template. The Template Management, Template Details window will re-display. 9. Click the **Close** icon on the Action Bar to close the module. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. **Summary** • Edit an encounter template • Create an Order Set in A/P • Merge an encounter template with an order set Next Slide	**Explain**: • Created separately because of local variations. Order sets cannot be imported from other bases because of differences in Lab/Rad/Med availability. • Created in A/P using a test patient and test clinic. • Merged with appropriate encounter template. • Can be loaded and used independently.

Lesson 8: Health History Folder

Lesson Goal

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

Learning Objective

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

- Setup Health History patient data modules
- View Demographic information
- 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
  - Set and review the properties for the Vital Signs module
  - Select appropriate screen options for the category of patient
  - Enter vital signs and related information
  - Graph vital signs

❑ **Slide 23: Health History Folder Learning Objectives**

Explain:

- Use this module to set up a display of selected patient health history information for quick review.
- There is no default setup. The first time you access the module; you need to setup the display.
- Setup can be done from either the Tools menu or the **Options** button.
- Once set up, the same setup applies to all patient records.

Health History

Students should follow along.

Students Follow along:

The provider would like to change the Health History modules to display only Problems, Allergies, and Lab. To select this module you will need to pull Eduardo Suarez's record.

1. Click the **Health History** folder in the Folders List. If this is the first time you have selected the icon, a warning message may appear.
   Click the **OK** button to remove the message.
2. If you clicked the **OK** button on the warning message (or did not receive the warning message), click the **Options** button on the Patient ID line. The Health History Design Summary screen will display.
3. Notice the default settings are: Problems, Labs, Rads, Meds, Allergies, and Demographics.
4. We do not want Demographics as part of our default. To delete this simply unclick the box next to Demographics.
5. Click Align to re-align the screen.
6. Click the **OK** button to view the results.
7. Click the **Close** icon on the Action Bar to close the module.

Demographics

Eduardo Suarez informs you that he has moved since his last visit and you want to verify his demographic information.

1. Using the open encounter for Eduardo Suarez, click on the **Demographics** module in the Folder List. The Demographics module will display:
2. Verify the home address as: 233 Main Street.
3. Click the **CLOSE** icon on the Action Bar to close the module.

AutoCite Information

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

AutoCite modules include:

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

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

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

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

Problems Module

Explain: Information from the encounter for COL. Violet Alexander that you just completed documenting is now 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: You want to review **COL Violet Alexander's (a5743)** problem list now that you have completed this new encounter. You want to add to her Problem List that she mentioned had childhood asthma; you would also make this problem *Inactive* since this is a past problem. To indicate this is a past problem.

Demonstrate:

With **COL Alexander's (a5743)** name highlighted on the Appointments list, select the **Problems** module from the *Folder List*.

Explain:

- Review the screen layout.
- Expand a problem (use **Acute Bronchitis**) to show encounter information beneath.

Add a problem:

- Click the **Add** icon on the Action Bar.
- Select for the Problem: **asthma** (using *Search* tab).
- Select **Asthma 493.90**.
- Enter comments: **History of childhood asthma.**
- Save.

Modify the status of a problem:

- Highlight **Asthma**.
- Select Status: **Inactive**.
- Enter comment: **Improved**.
- Save.
- Close module and return to the appointments screen.

Lab Module

Set the scene: LCDR Eduardo Suarez (s3217) is in for a follow-up appointment. While reviewing his Labs, you notice his elevated HGB A1C. You would like to include this information in the encounter note.

Students follow along.

- Create a new unscheduled walk-in appointment for a follow-up physical exam for **LCDR Eduardo Suarez** (**s3217**).
- Open the encounter.
- Open the Lab module from the Folder List.

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.
- From the Labs list, click to select: **Hemoglobin A1C**.
- Copy results to note.

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

Caution: Nothing seems to happen when clicking **Copy to Note**; however, results are copied. Selecting **Copy to Note** again results in multiple copies that cannot be deleted.

- Close Lab Module and show lab results in the encounter note.

Explain how to use **Copy to Note.**

Radiology Module

Set the scene: While reviewing **LCDR Suarez's (s3217)** radiology results, you noted his abnormal Sinus Series. You would like to include this information in the encounter note.

Demonstrate:

- Select the Radiology module from the Folder List.

Explain: Review the screen layout.

- Set the properties (**Options** button).
  - Filter Name: **All Types**
  - *Preferences* tab, Time Options
    - Default Time: All time periods

Explain: Review the screen layout

- Click the **OK** button.

Explain: Point out temporary change options

- **Select: Sinus Series Report**.
- Highlight the impression portion of the report.
- Copy the results to the note.

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: While being seen, **LCDR Suarez (s3217)** says he is taking Tums for his heartburn. You want to document this in his medications.

Demonstrate:

- Open Meds module

Explain: Review the screen layout.

- Show Meds module properties.
  - Select **Options**.
  - Show Default Filter: **Outpatient Current**.
  - Show Default Encounter View Filter: **Current**.
- Add a New Medication.
  - Click the **Record OTC/Outside Medication** button in the *Select Type of New Medication* window.
  - Search for and add: Calcium Carbonate (TUMS) – PO 500mg tab
  - Sig: **Taking one table daily**
  - Ordering Provider: **Patient**
  - Order Start Date: **[2 weeks ago]**
- Click **OK**
- Review the Medications window.
- Notice the check mark in the OTC section, indicating an over-the-counter medication

Explain: Point out that the buttons order, renew and modify are also accessible from the Meds module. This functionality does not work in the CHCS II Training System. Providers will find it easier to order prescription medications through A/P, in the live system, but medication can be ordered, renewed and modified from the Meds module. An encounter must be open to do this.

Return to encounter; refresh AutoCite to show medication in encounter.

Note: Make sure the Active medication tab is selected in the AutoCite module.

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: LCDR Suarez (s3217) also indicated he is allergic to aspirin. You need to document this.

Demonstrate:

- From the Folder List, select the **Allergy** module.
- Add the Allergen: **Aspirin** (from the common list.)
- Add the Reaction: **Rash** (from drop-down list.)
- Onset date: **[2 years ago]**.
- Save.
- Close module and refresh AutoCite.

Vitals Sign Review

Demonstrate:

After talking to Eduardo Suarez, you would like to view his past blood pressure and heart rate values. You need to graph them to get a better feel for the results.

Reviewing Vital Signs

To review Eduardo Suarez's past vital signs:

1. Click either **Vital Signs Review** the folder in the Folder List. The Vital Signs Review window

will display.

2. Highlight all of his past blood pressure ***BP*** and heart rate ***HR*** values (click in the upper left ***BP*** cell and drag the mouse to the lower right ***HR*** cell).
3. Click the **Graph Vitals** icon on the Action Bar. The Graph Vitals window will display a 2-D chart.
4. Click the ***3-D Bar*** radio button to display the results as a 3-D Bar Chart and click **OK** to close the graph window.
5. Click the **Close** icon on the Action Bar to complete the process

Exercises

- Complete the exercises.
- 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
- Graph vital signs

Next Slide

Lesson Goals

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

Learning Objectives

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

- Set default search and display options for the telephone consults list
- Use a method for changing the temporary search and display options for the telephone consult list
- Create a Telephone Consult
- View clerk notes for a Telcon from the Telephone Consults screen
- Select and open a Telephone Consult
- Transfer a telephone consult to a different Provider
- Edit a call back phone number

❑ **Slide 24:Telephone Consults Learning Objectives**

Telephone Consults Module

Demonstrate:

A provider just received a telephone call from Ester Chang's mother, stating that Ester has a fever of 100.2 F°. Ester's mother wants to know what to do. During the call, the mother indicated there were no other symptoms. Based on this information, the provider diagnosed a low-grade fever (a level one telephone consult). The provider told the mother to give the child Children's Tylenol and a cool bath. If the patient's temperature has not gone down by morning, the mother should make an appointment for Ester. Assist the provider in documenting this telephone call.

1. Click the **Telephone Consults** module in the Folder List. The Telephone Consult window will display:
2. Click the **New Telcon** icon on the Action Bar. The Patient Search window will display:
3. Type CHANG in the Last Name Field and ESTER in the First Name field and click the **Find**

Point out that the *Status Selection* section is the only difference from *Appointment Search Selections* screen.

Telcons created in CHCS must be completed in CHCS. Telcons must be created in CHCS II in order to be completed in CHCS II.

	button. The Patient Search window will re-display with Ester Chang's name in the Patient Name area. 4. Click on Ester's name and click **OK**. The New Telcon window will display for Ester. 5. Type FEVER in the Reason for Telephone Consult field, type PT HAS A FEVER OF 100.2 F°. WITH NO OTHER SYMPTOMS in the Notes area and click on the **OK** button. The Telcon Quick Entry screen will display. **NOTE:** If the user has the provider role assigned to their log on, they will receive the Quick Entry Screen after clicking OK. Any other user will be taken back to the Telephone Consults module 6. In the Provider Note area type **GIVE PT CHILDREN'S TYLENOL AND A COOL BATH. IF TEMPERATURE HAS NOT GONE DOWN BY MORNING, MAKE AN APPOINTMENT FOR PT.,** type **FEVER** in the Search field and click **Find Now**. A list of terms containing or related to fever will display. 7. Click on a fever (as a symptom) 780.6 to select it and click **ADD** "a fever (as a symptom)", will display in the Selected Diagnosis field. 8. Click the **drop-down arrow** on the right of the E&M field to get a list of possible E&M codes for the Telephone Consult. 9. Click to select 99371 Telcon: Lvl I, Simple/Brief, click the Save and Sign radio button (if not already selected) and click **OK**. The Sign Encounter window will display. 10. Click **SIGN** to sign the order and complete the process and return to the Telephone Consults window. The Telephone Consult for Ester Chang will indicate it is Complete. 11. Click the **CLOSE** icon on the Action Bar to close the module.	Indicate that the Provider sees the Notes not the Reason for the appointment. Lower case terms in diagnosis list are symptoms. Point out that all elements of a telephone consult are covered in the quick entry screen. **Explain:** Rather than signing the note and designating a Physician as the cosigner, a user could transfer the Telcon to the Physician for their signature. • Transfer the Telcon using the Action Bar icon. Indicate difference between symptom and diagnosis (symptoms are in lower case, diagnoses are in upper case.
	Exercises • Complete the exercises. • Check for understanding and answer participant questions.	

	SUMMARY	
	• Explained default search and display telephone consults list options • Created a telephone consult • Explained how to transfer a telephone consult to a different Provider • Edited a call back phone number **Next Slide**	
Lesson 10: Clinical Notes		
	## Lesson Goal The goal of this lesson is to enable the provider to view and edit clinical notes in CHCS II. ## Learning Objectives Upon completion of this lesson, the provider will be able to: • View a clinical note • Add a clinical note • Edit a clinical note • Save a clinical note	❑ **Slide 25: Clinical Notes Learning Objectives**

Clinical Notes

Clinical Notes are notes that are entered on the patient but are not attached to the SF600.

Demonstrate:

A provider specializing in Ear Nose and Throat (ENT) performed minor surgery yesterday on Klaus Wunderlich, who had an object lodged in his ear. The provider saw the patient in the hall today and examined his ear. He now wants to add the following note with graphic to the patient's record. Search for Klaus Wunderlich to "pull" his chart.

The provider would also like to insert a graphic of the ear. Assist the provider in performing these tasks. The graphic of the ear is located on your CD of materials.

Creating a Clinical Note

1. Click on the **Clinical Notes** folder in the Folder List. The Clinical Notes module will display:
2. Click the **New** icon on the Action Bar to create the new note. The New Clinical Note window will display.
3. Select ***Physician Progress Notes:*** from the Note Types drop-down list.
4. Select ***CHCS II ITT*** from the POC: drop-down list.
5. Type **2-YEAR-OLD MALE WITH PENCIL ERASER LODGED IN AUDITORY CANAL. REMOVED OBJECT YESTERDAY. SAW PATIENT TODAY. EAR HEALING WELL. WILL CONTINUE WITH FOLLOW-UP PLAN**. in the documentation area. Press [Enter].
6. Click the **Insert Image** button on the bottom of the window. Locate and load the ear image into the Clinical Note.
7. Click either **Save** the icon on the Action Bar or the **Save** button to save the information. The Clinical Note Window will re-display with the updated information.

Add Note: Are notes that are attached to the patient's SF600

Copying a Clinical Note

1. Klaus Wunderlich has come in for his appointment and the provider would like to add the Clinical Note to his encounter
2. You need to create an appointment for Klaus Wunderlich (for this example).

	3. Highlight and opened the appointment 4. Go to Clinical Notes from his Health History Folder. 5. Highlight the Clinical Note you just created. 6. Select **Edit** to open the note. 7. Highlight the contents of the note, including the image. 8. Perform the copy process by using [Ctrl] C. 9. Click the **Close** icon on the Action Bar to close the module. 10. Click the **Add Note** icon on the Action Bar. 11. Select **New Note** on the Select Note field. 12. With cursor in the documentation area, right click and select paste. 13. Click **Note Complete** button. 14. Review the SF600. 15. Click the **Close** icon on the Action Bar to close the SF600. **Key Points:** • Graphical images can be inserted into clinical notes. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. **Summary** ▪ View a clinical note ▪ Add a clinical note ▪ Edit a clinical note ▪ Save a clinical note	**Explain**: You can also use [Ctrl] V to paste to the note.

	Next Slide	

Lesson 11: Alerts, New Results, Co-Signs, Sign Orders

	Lesson Goal
	The goal of this lesson is to enable the provider to review and respond to notifications of diagnostic results and to orders and encounters requiring the provider's signature.
	
	Learning Objectives
	Upon completion of this lesson, the provider will be able to:
	▪ Access alerts:
	Folder List
	Alerts icon
	▪ Address an alert from the Alert Review module
	▪ Delete alerts that have been resolved
	• Access the labs or rads modules from the New Results module to view new results
	• Discard a lab or rad result
	• Toss a new lab or rad result
	• Save a new lab or rad result
	• Move a new result into saved results
	• Forwarding new results to another provider
	• Review encounters needing co-signatures
	• Co-sign an encounter completed by another Provider
	• Append a narrative to an encounter prior to co-signing
	• Display details of non-Provider orders needing signing:
	  • One at a time
	  • All at once
	• Sign non-Provider orders:
		❑ **Slide 26: Alerts, New Results, Co-Signs, Sign Orders Learning Objectives**

- One at a time
- Several selected orders at one time
- All at one time

Alerts Review

Demonstrate:

A provider needs to address the alert for a new result that has been posted. Review the result and delete the alert.

1. Click either the **Alert Review** folder in the Folder List or the ! icon on the Action Bar. The Alert Review window will display.
2. Click to select the ***New Result*** alert and click the **Address Alert** icon on the Action Bar. The New Result window will open.
3. Click to select ***Olaf Berg's Chem 7*** result and click the **View Result** icon on the Action Bar. The Lab module will display.
4. View the result and click the **Close** icon on the Action Bar. The New Results window will re-display.
5. Click the **Toss** icon on the Action Bar. A confirmation message will be displayed.
6. Click **Yes** to confirm the Toss. The New Results window will be re-displayed less the New Result just tossed.
7. Click the **Close** icon on the Action Bar to close the New Results window. The Alert Review window will re-display indicating the New Results alert has been resolved.
8. Click on the New Result line to select it and click the **Delete** icon on the Action Bar. The Alert Review window will re-display with the New Result alert deleted.
9. Click the **Close** icon on the Action Bar to close the module.

New Results

Demonstrate:

To view results:

1. Click the **New Results** folder in the Folder List. The New Results window will display.
2. Click to select the ***New Results*** tab if not already selected.

3. Click the ***Lipid Panel Complete*** lab test result for Eduardo Suarez. The line will be highlighted.
4. Click the **View Result** icon on the Action Bar to view the result. The Lab module will display the result.
5. When you are finished viewing the detailed result information in the Lab module, click the **Close** icon on the Action Bar. The New Results module window will re-display.

To discard results:

1. Click to select the ***New Results*** tab if not already selected.
2. Click the ***Urinalysis*** lab test result for Eduardo Suarez. The line will be highlighted.
3. Click the **Discard** icon on the Action Bar. A Discard confirmation window will display.
4. Click **Yes** to discard the Urinalysis lab test. The New Results window will re-display.

To save results

8. Click the ***Lipid Panel Complete*** lab test result for Eduardo Suarez. The line will be highlighted.
9. Click the **Save** icon on the Action Bar. A CHCS II Results window will display, asking if you want to move this result(s) to your saved result list?
10. Click **Yes** to save the Lipid Panel Complete lab test. The New Results window will re-display and the Lipid Panel Complete result will disappear.

To forward a new result to a provider:

1. Click on the **Provider Search** button. The Clinician Search window will display.
2. Type ***DOCTOR*** in the Last Name field and click the **Find** button at the bottom of the window. Clinicians matching the search criteria will display.
3. Click to select ***DOCTOR, DAVID*** in the results area and click the **Select** button at the bottom of the window. The New Results window will be re-displayed.
4. Click to select the ***CBC W/o Diff*** lab test for Violet Alexander and click the **Forward** icon to forward the lab test result. A confirmation message will display.
5. Click **Yes** to forward the result. The New Results window will re-display.

6. Click the **Close** icon to terminate the process.

Note: The system creates a signature to confirm that a provider has viewed the new result information.

Co-Signs

Demonstrate:

The provider notices three encounters requiring their co-signature. The Allergic Rhinitis encounter needs a co-signature. The encounter for Eduardo Suarez's Hyperlipidemia visit is missing the lab result within the encounter. Assist the provider in amending this encounter to include this report. The provider is then ready to sign the encounter.

Co-Sign an encounter

1. Click the **Co-signs** icon in the Folder List. The Co-Sign window will display.
2. Click to select the Allergic Rhinitis encounter or Anna Wunderlich. The encounter information will display in the encounter window.
3. Review the encounter.
4. Click **Sign Encounter** icon on the Action Bar.
5. Review the note again and click the **Sign** button to sign the encounter. The Co-Signs window will re-display

Amend an encounter

1. Click the **Co-signs** icon in the Folder List. The Co-Sign window will display.
2. Click to select the ***HYPERLIPIDEMIA*** encounter of Eduardo Suarez. The encounter information will display in the encounter window.
3. Click the **Amend Encounter** icon on the Action Bar. The SF600 will display.
4. Click the **Lab** folder in the Folder List. The Lab module window will display.
5. Click on ***Lipid Panel Complete***. The Lab result will display in the Display Criteria section of the

window.

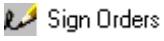
6. Click the ***Ref Range/Units*** check box to display the reference ranges for the test.
7. Drag the mouse from Lipid Panel Complete in the upper left of the lab result area to the lower right of the area (this selects the entire lab result).
8. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note.
9. Since we want to copy these lab results to the note, click the **Copy to Note** button.
10. The lab result will re-display, with the lab result no longer highlighted (the result has been copied to the note).
11. Click the **Close** icon on the Action Bar.
12. View the lab result in S/O section of the SF600, under the S/O note.
13. Click the **Sign** icon on the Action Bar. The Co-Sign Encounter window will display.
14. Review the note again and click the **Sign** button to sign the encounter. The Appointments window will re-display.

Sign Orders

Demonstrate:

The provider notices the  icon in the Patient ID line. Assist the provider in signing the orders for Eduardo Suarez. The provider would also like to cancel the Chem 7 Panel ordered for Clayton Williams.

Signing non-provider orders

1. Click either the  icon in the Patient ID line, or the  folder in the Folder List to open the Sign Orders process. The Sign Orders window will display
2. Click the check boxes to the left of Eduardo Suarez's name for the Liver Panel test.
3. Click either the **Sign Selected Orders** icon on the Action Bar or **Sign Selected Orders** button. The window will re-display with the sign orders removed.

4. Click **Close** on the Action Bar to close the module.

Note: These orders are from 2002.

Canceling a Non-Provider Order

11. Click the check box to the left of Clayton William's name.
12. Click either the **Cancel Selected Orders** icon on the Action Bar or **Cancel Selected Orders** button. The window will re-display with the canceled order removed.

Summary

- Access alerts:
  - *Folder List*
  - **Alerts** icon
- Address an alert from the Alert Review module
- Delete alerts that have been resolved
  - Cancel non-Provider orders
  - Sign non-Provider orders:
  - Display details of non-Provider orders needing signing:
  - Access the labs or rads modules from the New Results module to view new results
  - Discard a lab or rad result
  - Toss a new lab or rad result
  - Save a new lab or rad result
  - Move a new result into saved results
  - Forwarding new results to another provider
  - Review encounters needing co-signatures
  - Co-sign an encounter completed by another Provider
  - Append a narrative to an encounter prior to co-signing

Note: Mention Discard and Toss

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

Next Slide

❑ **Slide 27: Course Summary**

❑ **Slide 28: Course Summary, Cont**

Summarize the course and show the video that re-emphasizes how the workflow is supported by the application.

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.
- Report the problem.
- Post training, report the problem to your local Help Desk.

❑ **Slide 29: What Do I Do If I Encounter a Problem While Working with CHCS II?**

Note: **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 and click. You can also perform a right mouse click and select **Paste** or from the Edit menu, 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

❑ **Slide 30: 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

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, press **right mouse and click**. You can also perform a right mouse click and select Paste or from the Edit menu, 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.

Other Help Resources

- Quick Reference Guide. A quick reference for frequent tasks.
- Quick Start Cards.
- CHCS II User Manual. Should be available in each clinic.
- Student Guide. Can be used during class and also can be accessed online after class.
- 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

their own copies at the site.

Emphasize the use of Help in the application.

❑ **Slide 30: Blank Slide, this indicates the end of the lesson unless Immunizations is being taught at this site.**

Add the Immunizations slide only if this will be taught for your class per site information.

Questions and Answers

Next Slide

Appendix A: Immunizations

Next Slide

- ❑ **Slide 32: Immunizations Learning Objectives**

Overview of Immunizations Admin

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

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

Action Bar Icons

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

Close Closes the Immunization admin module. Immunizations Admin

Vaccination Management

To add vaccines in stock for clinic:

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

Selecting a Default Vaccination Clinic

To select a default vaccination clinic:

13. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays
14. Click the **Ellipsis** button next to the *Default Clinic* field. The Clinic List Edit window opens
15. 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.

16. Click **Set Default**. You are returned to the Vaccine Management area.
17. 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.
18. Select a manufacturer.
19. Click Details.
    All patients associated with the vaccine distributed by the selected manufacturer display.
20. 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:

1. Click Mfg/Lot Nbr button to add vaccine information.
2. 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	
Variccella	Unkn		.5 ml		
Smallpox					
Yellow Fever					

3. 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

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:

5. 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.

6. 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 Encephalitis. Use 90636 fro Hep A and B together

6. Document Disposition/E&M Code of 99211
7. Have Provider/Nurse sign encounter

❑ **Slide 33: Course Summary**

Course Summary

Last Slide

Appendix B

System Demo

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

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

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

Role/Function	**Field**	**Data**
CLERK: Creates an Acute $30 walk-in appointment for Col. Violet Alexander (A4211). Reason for appointment – Shortness of Breath.	Patient Search	
	Quick Search	w8118
	New Unscheduled Appointment/Telcon Visit	
	Appointment Type	Acute Appt (Acut$) 30
	Reason for Appointment	Shortness of Breath
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. Double-click appt. to open SF 600
	Screening	

	In the Search field	[Enter] Shortness of breath and click **Find Now**. Select difficulty breathing (dyspnea) 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	35 99 F [Select]
	Ht	[Enter] 5 ft 6 in
	Wt	140 lbs
	Habits	
	Tobacco	[Select] No
	Alcohol	[Select] No
	Pain Severity	
		[Select] 1 Hurts a little bit
	Where is pain located?	Chest NOTE: Add comments when pain scale is selected (other than "0 pain free").
	Save Vitals	

		[Click] Save Vitals (Action Bar Icon) [Select] Close (Action Bar Icon) to return to SF600
	A/P	
	Go to procedures tab	(Enter) Peak Flow in the Search box – Click Find Now (Add) Peak Flow, repeat for Oxygen saturation [Select] Close
	SF600	[Click] Close to return to Appts. Module. Return to the SF600. [Click] Close again and return to the appointments screen.

PROVIDER: Sees the patient. Reviews what has been documented so far and loads the URI template. After documenting he uses Auto Neg – where appropriate.	Appointments	
		[Select] Col Alexander's walk-in appt. Double-click 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 appearance 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. Double-click appt. to open SF600
	A/P	
	Order Lab Tab Routine	[Select] [Type] CBC w/o Diff in New Lab Order field. [Click] Search [Select] CBC w/o Diff in lab field. [Select] [Click] Submit

	Order Rad Tab Clinical Impression Routine More Details	[Select] Chest [Type] Chest in the new Rad 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 encounter.	Appointments	
		[Select] Col Alexander's walk-in appt. Double-click appt. to open SF600

	A/P	
	Diagnosis	[Select] Asthma (to associate orders w/diagnosis)
	Order Meds Sig	[Type] Albuterol in new Med order field [Click] Search [Select] Albuterol [Enter] [Click] Submit
	Other Therapies	[Type] Asthma [Select] Patient Education – Asthma [Click] Add to Encounter
	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
CLERK:	Appointments	

Clerk Checks out the patient and prints the instructions and SF600 to give to the patient.		[Select] Col Alexander's walk-in appt. [Select] Check out on Action Bar Print patient a copy of SF600

You as 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.

You as Support/Tech:

The support/tech calls Col. Violet Alexander into the screening room. Open the SF600 and go to the Screening tab. In the Search box enter difficulty breathing and press Find Now. Highlight the words and Add difficulty breathing (dyspnea) 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	95
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. enters 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. Now enter oxygen saturation in the Search box and push Find Now. Select the term Pulse Oximetry. 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.

You as Provider:

The Provider now can open 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.

You as Nurse:

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).

You as Provider:

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.

You as clerk:

Check out the patient; print her instructions and SF600.