COMPOSITE HEALTH CARE SYSTEM II

Super User Training

CHCS II Lesson Plan

December 2004
Rev 2.0

Updated CHCS II Course Curriculum – Super User Guide

Change History			
Date	**Name**	**Change Description**	**Source:**
10-5-2004	E. Chesnut	Created	

Table of Contents

DAY ONE ... 3
Introduction ... 3
Lesson 1: Navigation Skills ... 10
Lesson 2: Patient Search and Appointments ... 12
Lesson 3: Telephone Consults (Telcons) ... 15
Lesson 4: Demographics ... 17
Lesson 5: Patient List ... 20
Lesson 6: Patient Encounter ... 22
Lesson 7: S/O Template Management ... 36
DAY TWO ... 42
Lesson 8: Encounter Templates and Order Sets ... 42
Lesson 9: Health History Module ... 47
Lesson 10: Problems Module ... 48
Lesson 11: Meds Module ... 50
Lesson 12: Allergy Module ... 52
Lesson 13: Wellness Module ... 54
Lesson 14: PKC Couplers ... 58
Lesson 15: Vitals Sign Review Module ... 59
DAY THREE ... 62
Lesson 16: Readiness Module ... 62
Lesson 17: Laboratory Results Module ... 63
Lesson 18: Radiology Results Module ... 65
Lesson 19: Clinical Notes Module ... 66
Lesson 20: Previous Encounters Module ... 68
Lesson 21: Alerts Review Module ... 71
DAY FOUR ... 74
Lesson 22: New Results Module ... 74
Lesson 23: Co-Signs Module ... 76
Lesson 24: Sign Orders ... 78
Lesson 25: List Management ... 80
Lesson 26: Questionnaire Setup/Questionnaire ... 81
Lesson 27: Screening Notification ... 85
Lesson 28: Reports ... 87
Lesson 29: Immunizations ... 88
Course Summary ... 92
Appendix A: Immunizations ... 93

Preparation for Delivery

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

Materials Needed

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

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

Tasks to be Completed Prior to Class

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

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

Tasks to be Completed at the End of Class

- Distribute the Training Course Evaluation forms and collect them from the students before they leave the classroom.

- Explain to the class how assistance will be provided the first time they attempt to use their account in the live system.

Duration	Training Activities	Instructor Notes
DAY ONE		
Introduction		
	Welcome/Logistics ***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**	**Slide 1: Super User Training Course** **Slide 2: Logistics and Introductions**
	Introductions Instructor and End-users exchange personal introductions, providing relevant background information. ***Next Slide***	

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td colspan="3">CHCS II Overview</td></tr>
<tr><td></td><td>What is CHCS II?

CHCS II is a computer-based patient record (CPR) system selected by Department of Defense to meet the requirements of the Military Health System.

CHCS II provides:
A Graphical user interface that networks with existing systems
Efficient means of creating, managing and retrieving of medical records
Anytime, anywhere delivery of patient records to the point of care
Future access military records for health studies worldwide
Add this brief comment as transition to next slide:

One of the greatest benefits of CHCS II is that it is an electronic patient record. Not only does this help to meet the presidential directive for a “comprehensive, life-long medical record,” but it also eliminates some of the risks and inefficiencies of paper based medical records.

Next Slide</td><td>Slide 3: What is CHCS II?</td></tr>
<tr><td></td><td>Limitations of Paper Based Medical Records
Paper charts are lost
No automatic drug interaction alerts
Penmanship counts
Only one person can access a record at a time
Next Slide</td><td>Slide 4: Limitations of Paper Based Medical Records

Speak to slide, adding this brief comment.</td></tr>
</table>

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>CHCS II Benefits
Interfaces with existing systems
Uses a standard, structured, and coded language for note writing--Medcin®
Facilitates compliance through electronic capture of elements required for:
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
Evaluation & Management (E&M) coding
Supports team-based health care and clinic workflow, providing appropriate access for each team member and simultaneous multi-user access
Supports problem-oriented health care
Accumulates data for reports and studies, such as clinical and population health
When fully implemented world-wide, will provide access to patient records anywhere, anytime
Maintains security
Next Slide</td><td>Slide 5: CHCS II Benefits
Elaborate on each benefit.</td></tr>
<tr><td></td><td>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</td><td>Slide 6: Security</td></tr>
</table>

Duration	Training Activities	Instructor Notes
	Expectations Upon completion of training, it is expected that service-directed expectations will be used as guidelines for each site as they ramp up to 100% productivity in CHCS II. To accomplish this, it is expected that: • 100% of CHCS II users shall attend scheduled classroom training • SuperUsers shall be available to receive On the Job Training (OJT • 100% of patient encounters shall be documented in CHCS II	**Slide 8: Expectations**
	CHCS II Training Classroom training is accomplished using Clinical Scenarios appropriate to each user's role. Clerk and Support receive four hours of Instructor-Led Training and four hours of On the Job Training. Providers have eight hours of Instructor-Led Training, while Nurses have six hours of Instructor-Led Training. Providers and Nurses have sixteen hours of On the Job Training. Records Reviewer receives 2 hours of ILT/OJT. ***Next Slide***	**Slide 9: Training Schedule**

	Key Information and Technology Training Resources
	
	• MTF CHCS II Team
	  • MTF Project Officer
	  • Facility Training Coordinator
	  • Clinical Champion/SuperUser
	• Unisys On-Site Team
	  • Site Training coordinator
		Slide 10: Key Information and Technology Training Resources
		
		These resources are available during the training implementation.

Duration	Training Activities	Instructor Notes
	• ILT Lead • OJT Lead • Trainers **Note**: Provide the names of those filling these roles locally and an indication of how they might be contacted. ***Next Slide***	

Duration	Training Activities	Instructor Notes
	Systems Demo Go To Appendix B ***Next Slide***	**Slide 10: Systems Demonstration** **Note:** Invite class participation to assist with roles in demonstration.
	Course Goal The goal of this course is to enable Nurses to access, navigate, and use the CHCS II application to document patient encounters in the clinic. ***Next Slide*** **CHCS II Training System** Instruct students to log into the CHCS II Training System. Explain that you will demonstrate each lesson and they should watch you, and then they will practice by performing the exercises in the Student Guide. • Click the caduceus icon on the desktop to start **Explain:** • Stand-alone practice version of CHCS II • Used for training only • Simulates CHCS II functionality • Very limited choices for labs, rads and meds • Patient data is fictitious • Slight variations between the CTS and the application in the field • Users are automatically logged on as a Provider • Live system access may vary depending on roles	**Slide 13: Course Goal**

Duration	Training Activities	Instructor Notes
	• The role assigned to you in the live CHCS II system may not allow you to perform all tasks covered in training – duties of staff vary from clinic to clinic. ***Next Slide*** **Training MTF Business Rules** ***Next Slide*** **Day One Agenda** ***Next Slide***	

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td colspan="3">Lesson 1: Navigation Skills</td></tr>
<tr><td></td><td><h3>Lesson Goal</h3>
The goal of this lesson is to enable the user to access and navigate within the CHCS II application.
<h3>Learning Objectives</h3>
Upon completion of this lesson, the end-user will be able to:

Log in to the CHCS II application
Access modules quickly using Folder List
Open and close an application module
Exit the CHCS II application
Lock CHCS II session
</td><td>Slide 18: Learning Objectives

Note: At a CHCS II workstation equipped with a CAC reader, users will have the option of using their personal CAC to log into CHCS II.</td></tr>
<tr><td></td><td>Basic Navigation

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

Title Bar
Main menu
Action Bar

<h3>Demonstration</h3>

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

Open the CHCS II Application.
Click the Appointments folder in the Folders List (if the Appointment module is not
</td><td>Action Bar changes according to the module, providing quick access to high use navigation and functionality for the module.</td></tr>
</table>

Duration	Training Activities	Instructor Notes
	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 **Key Points:** Module access • *Folder List* and Action Bar are the most efficient.	For navigating, the *Folder List* and Action Bar are the most efficient methods—fewest clicks. **Note:** Emphasize how the desktop can be adjusted by preference.
	Exercises • Complete the exercises. • Check for understanding and answer participant questions. ***Next Slide***	
	Security and Session Management **Explain:** Passwords expire every 85 days – user is prompted at 80 days to change. Password can be changed prior to expiration. CHCS II password and CHCS verify codes are synchronized. Two or more users can have their own session open on a single workstation. **Changing passwords:** This cannot be demonstrated on the CHCS II Training System; you will be shown how to change your password in your OJT session.	**Note**: Emphasize that passwords **must** be changed in CHCS II.

Duration	Training Activities	Instructor Notes
	Demonstrate: • User has the option to lock the session to avoid system time-out. Press **Ctrl-Z**. (Can also select the **Lock** command in the **Tools** menu.) To unlock the session, maximize the application and click the **OK** button. (In the live system, you will be asked for your password.) **SUMMARY** • Navigation • Security ***Next Slide***	
Lesson 2: Patient Search and Appointments		
	Lesson Goals The goal of this lesson is to enable the user to locate a patient record and use the appointment functions in CHCS II. **Learning Objectives** Upon completion of this lesson, the user will be able to: • Search for a patient • Set the display for appointments • Change and save the column order • Create a walk-in appointment • Transfer an appointment • Add a nurse to an appointment	**Slide 19: Learning Objectives**

Duration	Training Activities	Instructor Notes

	Patient Search Module
	Pulling a Patient Record features:
	▪ Different search methods available
	▪ Patient must have a record in CHCS
	▪ "Search CHCS" is an option
	Appointment Module
	Module specific screen features:
	• Module title bar
	• Appointment list
	• Columns
	• Access to properties setup options:
	  • Drop-down box
	  • Options
	  • Change selections
		Explain specific *Appointment* screen features.
		
		Explain how the appointments process is handled in the application. 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 Managing Appointments **Demonstrate:** Col. Violet Alexander has come in today complaining of a cough. We need to search for Col. Alexander's record, set the appointment filters and create a new appointment. 1. Open the CHCS II Application. **NOTE:** By default the Appointment module displays 2. Click **Search** in the Folders List to search for a patient. The Patient Search window will display	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)

Duration	Training Activities	Instructor Notes
	3. Click in the Last Name field and type ***ALEXANDER***, then click **Find** for a list of names. 4. Click on ***ALEXANDER, VIOLET W*** in the list of names and click **OK**. Col. Alexander's information will appear on the Patient ID line and the Appointments List will display. 5. Click the **Change Selections…** button in the top left corner of the **Appointments** module. a. In the *Clinic* section, click the radio button for **This Clinic** b. In the *Provider* section, select the radio button **Me**. c. In the *Dates* section, select the correct radio button to show **Today's Only** appointments. d. Click the **Set Selections as Default** button to save your changes. 6. To move a column: e. Scroll to the right just until the **Type** column is visible. f. Click the **Type** column heading and hold down the left mouse button. g. Drag the **Type** column horizontally right (or left). Release the left mouse button when the **Type** column is between the **Patient** and **Status** columns. Practice moving columns until the *Appointments* screen is most useful for you. If you wish to save the new column arrangement, click the **Change Selections** button. Then click the **Set Column Order as Defaults**. You need to Create a New Unscheduled Appointment for **Col. Alexander (a5743)**. 7. Click **New Appt**. on the Action Bar. A New Appointment confirmation window will display. 8. Click **Yes** to complete the New Appointment information for Col. Alexander. 9. Click on ***ACUTE APPT (ACUT$) 30*** to select the acute appointment type. 10. Type ***cough*** in the Reason for Appointment field and click **OK** to complete the new appointment process for Col. Alexander. (The Allergy synchronization simulation from CHCS will begin.) 11. Col. Alexander's appointment will now appear at the bottom of the Appointment list with a status of **CheckedIn**.	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
	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.	
	SUMMARY • Explained patient search module • Explained appointment list properties • Explained how to make appointment display selections • Created a new appointment • Pointed out function for transferring appointments to other Providers • Pointed out function for adding a Provider to an appointment ***Next Slide***	
Lesson 3: Telephone Consults (Telcons)		
	Lesson Goals The goal of this lesson is to enable the user to use the Telcon function in CHCS II. **Learning Objectives** Upon completion of this lesson, the user will be able to: • Set default search and display options for the telephone consults appointment list	**Slide 20 Learning Objectives**

Duration	Training Activities	Instructor Notes
	• Create a Telephone Consult appointment • View clerk notes for an appointment from the Appointment screen • Select and open a Telephone Consult appointment • Transfer a telephone consult to a different Provider • Edit a call back phone number	
	Telephone Consults Module **Demonstration** **Scenario** An end user just received a telephone call from Ester Chang's mother, stating that Ester has a fever of 100.2º 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 end user diagnosed a low-grade fever (a level one telephone consult). The end user told the mother to give the child a dose of 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 end user in documenting this telephone call. 1. Click the **Telephone Consults** folder in the Folder List. The Telephone Consult window will display: 2. Click the **New Telcon** icon on the Action Bar. The Patient Search window will display: 3. Type CHANG in the Last Name Field and ESTER in the First Name field and click the **Find** 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 DEGREES 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 end user has the provider role assigned to their log on, they will receive the Quick Entry Screen after clicking OK. Any other end user will be taken back to the Telephone Consults	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. 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

Duration	Training Activities	Instructor Notes
	module 6. In the Provider Note area type **GIVE PT A DOSE OF 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. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. **SUMMARY** • Explained default search and display telephone consults appointment list options • Created a telephone consult appointment • Explained how to transfer a telephone consult to a different Provider • Edited a call back phone number Next Slide	note and designating a Physician as the cosigner, an end user could transfer the Telcon to the Physician for their signature. • Transfer the Telcon using the Action Bar icon.
Lesson 4: Demographics		

Duration	Training Activities	Instructor Notes
	Lesson Goals The goal of this lesson is to enable the end-user to verify third-party insurance and demographic information in CHCS II. **Learning Objectives** Upon completion of this lesson, the end-user will be able to: • Verify third party insurance information • Verify patient demographic information • Modify patient demographic information	**Slide 21: Learning Objectives**
	Demographics **Demonstration** Eduardo Suarez informs you that he has moved since his last visit and you must edit his demographic information. He has also acquired additional health insurance for his family and this information also needs to be added. 1. Using the open encounter for Eduardo Suarez, click on the **Demographics** folder in the Folder List. The Demographics module will display: 2. Click **EDIT** on the Action Bar to be able to edit the demographic information and complete the following information:	**Explain:** • Use the Demographic module to verify patient demographic information. • Address and phone number information should not be updated in CHCS II. Changes in CHCS II do not write back to CHCS. • To update this information, continue

Module or Field	Data or [Description of Data]

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>
<table>
<tr><td>Home Address</td><td>1234 My Street</td></tr>
<tr><td>City</td><td>Chantilly</td></tr>
<tr><td>State/Country</td><td>VA</td></tr>
<tr><td>Zip</td><td>20151</td></tr>
<tr><td>Home Phone</td><td>703-444-4848</td></tr>
<tr><td>Religion</td><td>Jewish</td></tr>
</table>
3. To enter the Third-Party Insurance information, click the Enter Changes to Patient Insurance Information button on the bottom of the window. The Patient Insurance Information window will display

Enter the following information:

4. Click the Yes radio button for ‘Does Patient have health insurance other than Medicare or Champus?’
5. Click the Yes radio button for ‘Has any health insurance information been changed since last visit?’
6. Insurance Company Name: Blue Cross Blue Shield
7. Insurance Company Telephone: 703-444-4848
8. Insurance Company Address: 1234 My Street Chantilly, VA 20151
9. Insurance ID Number: 1311-2323-111
10. Group Name: CHCS II
11. Group Number: ABC 123
12. Subscriber’s Name: Eduardo Suarez
13. Patient’s Relationship to Subscriber: Self
14. Effective Date: (Enter one month ago today)
15. Expiration Date: (Enter one year from Effective Date)
16. Person Capturing Information: (Enter your name)
17. Information Source: Patient
18. Click the SAVE on the bottom of the window to save the information. The insurance
</td><td>to follow current MTF policies.

• Insurance information does not write back from CHCS II to CHCS. Continue to follow your MTF policy for collecting third party insurance information.</td></tr>
</table>

Duration	Training Activities	Instructor Notes
	information will display as follows: 19. Click **SAVE** on the Action Bar to save the updates 20. Click the **CLOSE** icon on the Action Bar to close the module. **Key Points** • Demographic and third party insurance information may currently be viewed in CHCS II, but any required changes should be done in the respective legacy (former) systems. Follow your MTF business rules. **Exercises** • Complete the exercises. • Check for understanding and answer participant questions.	
	SUMMARY • Explained how to verify third party insurance information • Verify patient demographic information • Modify patient demographic information Next Slide	
Lesson 5: Patient List		
	Lesson Goals The goal of this lesson is to enable the end-user to create a patient list in CHCS II. **Learning Objectives** Upon completion of this lesson, the end-user will be able to	**Slide 22: Learning Objectives**

Duration	Training Activities	Instructor Notes
	• Add patients to a patient list • Delete a patient from a patient list • Delete the patient list	
	Patient List **Demonstration** The end user would like to create a list of their frequently seen patients. **Creating a patient list** 1. Click either the **Patient List** folder in the Folder List to open the Patient List. The Patient List window will display: 2. Click the **Add** icon on the Action Bar to open the Patient Search window. 3. Type ***WUND*** in the Last Name field and click the **Find** button. 4. Highlight WUNDERLICH, ANNA W and click **OK**. 5. Repeat steps 2-4 to add the whole Wunderlich family to the patient list. **Deleting a patient from the list** 1. With the Patient List module open, highlight WUNDERLICH, HERMAN. 2. Click the DELETE icon on the Action Bar. A Delete patient from list window will appear. 3. Click OK. The Patient List module will redisplay with Herman Wunderlich’s name removed. **Deleting the entire patient list** 1. With the Patient List module open, click the **Delete List** icon on the Action Bar. 2. A **Delete All Patients** window will appear asking if you want to delete all patients from the current list.	

Duration	Training Activities	Instructor Notes
	3. Click **OK**. The Patient List module will redisplay with all the names removed. 4. Click **Close** on the Action Bar to close the Patient List module. **Exercises** • There are no exercises for this lesson. • Check for understanding and answer participant questions.	
	SUMMARY • Add patients to a patient list • Delete a patient from a patient list • Delete the patient list Next Slide	
Lesson 6: 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 end-user will be able to: • Open the encounter • Document “reason for visit” • Verify patient’s allergies • Document patient’s vital signs • Document S/O using MEDCIN • Document A/P	**Slide 23: Learning Objectives**

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>Complete Disposition and verify E&M code
Sign Encounter</td><td></td></tr>
<tr><td></td><td>Screening and Vitals Modules
<h2>Screening and Vitals</h2>
Screening
Vital signs
Once the patient has been checked in, it is now time to open an encounter document for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening. The appointment, or encounter for the patient can be opened. The initial open encounter document (SF600) for Col Violet Alexander will look like this:</td><td>Slide 24: Learning Objectives

Slide 25: Learning Objectives</td></tr>
<tr><td></td><td>Screening and Vitals
<h2>Demonstration</h2>During this portion of the encounter, you will set the AutoCite properties, screen the patient including entry of the reason for visit and verifying allergies, enter the vital signs and review the results in the electronic SF600. To get started:
Click ALEXANDER, VIOLET W (the appointment you just created) in the Appointment list and click the Open Appt icon on the Action Bar, to open the electronic SF600
Click Options on the right side of the Patient ID line to open the Encounter Summary Properties window
Click to select the following check boxes:
Active Problems
Allergies
Active Dispensed Medications</td><td>Explain:
Use of the Screening module to document:
Appointment reason for visit (including comments)
Verification of allergies (only opportunity in the application)
Special Work Status
Use of allergy icons in the patient ID line for quick assessment of the status of the patient’s allergies</td></tr>
</table>

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>

- Active Family

4. Click **OK** to update the AutoCite properties. The SF600 will re-display with the updated AutoCite information.
5. Click **Screening** on the electronic SF600 to open the Screening module.
6. Type **COUGH** in the Search field and click **Find Now** to locate cough symptoms and diagnoses in MEDCIN. Terms containing ‘cough’ will be displayed.
7. Click on a cough in the results field and click **ADD** to add a cough as the Selected Reason for Visit. The Screening module window will re-display.
8. Click the **Verify Allergy** icon on the Action Bar. The Allergy module will display the following screen.
9. Click the **Verified This Encounter** check box and click **Close** on the Action Bar to indicate that allergies have been verified during this encounter. You will be returned to the Screening module.
10. Click **OK** to return to the electronic SF600.
11. Click **Vitals** on the electronic SF600 to open the Vital Signs Entry module. The Vital Signs Entry module window will display:
12. Enter the following information in the field indicated:

<table>
<tr><th>Field</th><th>Data [Description]</th></tr>
<tr><td>Standard Vital Signs</td><td></td></tr>
<tr><td>BP</td><td>120/70</td></tr>
<tr><td>HR</td><td>55</td></tr>
<tr><td>RR</td><td>23</td></tr>
<tr><td>Temperature F</td><td>99.6</td></tr>
<tr><td>Height & Weight</td><td></td></tr>
<tr><td>Ht</td><td>5’9”</td></tr>
<tr><td>Wt</td><td>157 lbs</td></tr>
</table>

</td><td>

- Screen layouts for Screening and Allergy modules
- Problem lists and search

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

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

</td></tr>
</table>

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>13. In the “For Females Only” section, enter the following:
Click the Natural Family Planning Method check box.
Click No for the Pregnant? radio button.
Select the Last Menstrual Period radio button and type the first of the present month for the date. The example shows 10/1/2003.

14. Click OK to save the current information and close the window. The SF600 will re-display.

15. Review the SF600 to confirm the information has been collected properly.

Key Points:
Reason for Visit is a structured term and may be more accurate than Reason for Appointment
Screening during the patient encounter is the only area where a patient’s allergies can be verified
Allergy information, however, can be added without an open encounter</td><td></td></tr>
<tr><td></td><td>Exercises</td><td></td></tr>
<tr><td></td><td>Complete the exercises.
Check for understanding and answer participant questions.
Section Summary
Open the encounter
Setup AutoCite properties
Document “reason for visit”
Verify patient’s allergies
Document patient’s vital signs
Next Slide</td><td>Slide 26: Learning Objectives

Review screen layout.</td></tr>
<tr><td></td><td>MEDCIN</td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table>

Duration	Training Activities	Instructor Notes
	MEDCIN ▪ Medical terminology whose subject is 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:** 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. You failed to select the plus to document this as an abnormal finding, so AutoNeg emitted a normal note. You must now open the S/O *PE* tab to correct 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*.	

Duration	Training Activities	Instructor Notes
	For these terms, when a plus is selected, the condition is described as normal, and when no plus is selected, AutoNeg assumes a normal condition. So, to document an abnormal condition, the minus must be explicitly selected. In summary: When using AutoNeg, for reverse sensing terms, select nothing unless the condition described is a problem; then, explicitly select the minus rather than plus. When not using AutoNeg, select the plus when the condition is checked and found to be normal.	
	MEDCIN: Advanced Search Options	
	Explain: • Dx Prompt creates a list of findings based on a diagnosis. This is helpful in selecting terms for a template built around a diagnosis. • List Size creates a broader or narrower list of findings. There are three levels. • Dx Prompt • List Size • Find Term • Browse From Here ***Next Slide***	
	Subjective/Objective Module	
	Subjective/Objective ▪ Subjective - what the patient told the end user ▪ Objective - what the end user observed during physical exam The Subjective portion of the note includes the History of Present Illness (HPI), Past Medical History (PMH) and Review of Systems (ROS). This information comes from the patient and is organized by the end user. The Objective portion of the note includes the Physical Examination (PE) and is what the end user observes.	

Duration	Training Activities	Instructor Notes
	Key Points: • Standard visit templates are clinical notewriters using MEDCIN terms • E&M coding is done quickly and accurately using structured terminology.	
	Subjective/Objective	
	Demonstration ▪ 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 and was given Keflex ▪ 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** ▪ Nasal discharge ▪ Auscultation wheezing ▪ All other items are normal	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 (numeric) 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 AND GIVEN KEFLEX** 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 19. Click **Minus Sign** to select no history of ASTHMA	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 End-users the criteria between HPI and ROS. This is typically not familiar to some End-users. **Be sure to explain the parent-child relationship**

Duration	Training Activities	Instructor Notes
	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 end user asks all the ROS questions and the patient denies all the symptoms so click **AutoNeg**. 25. The end user is now ready to perform the physical examination, so click the **PE** tab. 26. Click **Plus Sign** to select Nasal Discharge 27. Click **Plus Sign** to select Auscultation Wheezing 28. Everything else in the physical examination is normal, so click **AutoNeg**. 29. Review the information in the narrative pane to ensure that everything is correct 30. Click on the **Close** icon on the Action Bar so we can review the information on the SF600.	**and that a parent term need not be selected if a child term is selected; for example, if the term cigarettes is chosen, no need to select smoking.** Explain AutoNeg—when to use and when not to use.
	Exercises • Complete the exercises. • Check for understanding and answer participant questions. **Section Summary** • Explained MEDCIN • Dashboard • MEDCIN Tree • Narrative Pane • Searched, loaded and used a template • Explained moving narrative from ROS to HPI • Explained AutoNeg • Explained reverse sensing terms Next Slide	Explain "flipping" and the use of **ROS/HPI** button. Emphasize that use of structured documentation results in a more accurate code. **Slide 27: Learning Objectives**

Duration	Training Activities	Instructor Notes
	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.	
	Assessment/Plan	**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
	Demonstration As a result of the physical examination, the end user has determined the patient has both an Upper Respiratory Infection as well as Acute Bronchitis. The primary diagnosis being the Acute Bronchitis. The end user also noticed with the Acute Bronchitis, the patient has bronchospasms, but is not in distress. The end user wants to order: ▪ A peak flow procedure associated with the Acute Bronchitis ▪ A CBC W/Auto diff associated with the Acute Bronchitis ▪ A chest x-ray with posterior/anterior (PA) and lateral views. We want to rule out pneumonia and associate the chest x-ray with the Acute Bronchitis	

Duration	Training Activities	Instructor Notes
	▪ 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 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.	associated and disassociated with one or more diagnosis. ● Order Entry selections are identical to the ones in CHCS. ● Same drug-drug, drug-allergy, and duplicate order warnings as in CHCS. **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:

Duration	Training Activities	Instructor Notes
	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). 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.	• WHO language • ICD Codes • Partial Words Explain that the user can delete a diagnosis, procedure or order that was documented in error. If orders were submitted they would be listed under the show orders area. Discuss pros and cons of saving to queue. • Point out you might lose orders if the system should fail; but you can delete from queued orders. • Show how to delete before submitting queued.

Duration	Training Activities	Instructor Notes
	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.	• Recommend submit over save to queue. **Explain**: Civilian consults continue to be completed in CHCS rather than in CHCS II.
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions. **Section Summary** • Document A/P • Explained how codes are captured with diagnoses and procedures • Procedures, orders and other therapies must be associated to a logical diagnosis • Consults, labs, rads and meds can be submitted or saved to queue Next Slide	**Slide 28: Learning Objectives**
	Disposition and Sign Module	

Duration	Training Activities	Instructor Notes

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

Demonstration

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:

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

Important Notes:

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

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

<table>
<tr><th>Duration</th><th>Training Activities</th><th>Instructor Notes</th></tr>
<tr><td></td><td>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.
Section Summary
• Complete Disposition and verify E&M code
• Sign Encounter
Next Slide</td><td></td></tr>
<tr><td colspan="3">Lesson 7: S/O Template Management</td></tr>
<tr><td></td><td>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 end-user will be able to:
• Search for Visit Template
• Use Template Edit Mode</td><td>Slide 29: Learning Objectives
Explain:
• Templates have pre-positioned terms
• Benefits of using templates: streamline documentation</td></tr>
</table>

Duration	Training Activities	Instructor Notes
	• Use FindTerm • Use Browse from Here • Save the Template as "VISIT--[name]--[your initials]" **S/O Template Management** **Demonstration** I like the Visit—Allergic Rhinitis template in the list of available templates. Is there anyway I can edit this template to reflect my allergic rhinitis notes I write? **Edit a Visit template** 1. Click the **S/O** button on the SF600. The MEDCIN window will display. 2. Click the **New Note** button in the Encounter S/O Notes window. 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. eyes itch (HPI) b. nasal discharge which is watery (HPI) c. cardiovascular symptoms (ROS) d. gastrointestinal symptoms (ROS) e. endocrine symptoms (ROS)	• Folder location of templates in CTS versus the live system 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 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: Where: TYPE = Encounter,

Duration	Training Activities	Instructor Notes
	f. External Auditory Meatus (PE) g. Tympanic Membrane Erythematous (PE) h. Middle Ear Fluid (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 HPI term highlight eyes itch in the right pane. 11. Click **Plus Sign** to deselect eyes itch in the left pane. 12. To remove the HPI term highlight nasal discharge which is watery in the right pane. 13. Click **Plus Sign** to deselect nasal discharge, which is water in the left pane. 14. To remove the ROS term highlight cardiovascular symptoms in the right pane. 15. Click **Plus Sign** to deselect cardiovascular symptoms in the left pane. 16. To remove the ROS term highlight gastrointestinal symptoms in the right pane. 17. Click **Plus Sign** to deselect gastrointestinal symptoms in the left pane. 18. To remove the ROS term highlight endocrine symptoms in the right pane. 19. Click **Plus Sign** to deselect endocrine symptoms in the left pane. 20. To remove the PE term highlight External Auditory Meatus in the right pane. 21. Click **Plus Sign** to deselect External Auditory Meatus in the left pane. 22. To remove the PE term highlight Tympanic Membrane Erythematous in the right pane. 23. Click **Plus Sign** to deselect Tympanic Membrane Erythematous in the left pane. 24. To remove the PE term highlight Middle Ear Fluid in the right pane.	Visit, Education, Procedure, Consent, PE, and so on SUBJECT = Allergy, Initial Visit, Asthma Followup, and so on AAA = Personal initials (3) of the template owner **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

Duration	Training Activities	Instructor Notes
	25. Click to **Plus Sign** deselect Middle Ear Fluid in the left pane. 26. To add the additional terms: Click the **DX Prompt** icon on the Action Bar 27. Enter ALLERGIC RHINITIS in the search window and click **OK**. Terms related to Allergic Rhinitis will display. 28. Click **ALLERGIC RHINITS** to select it and click **OK**. Terms related to Allergic Rhinitis will display in the MEDCIN Tree pane. 29. Click the **HPI** tab to make sure you are adding terms to the HPI part of the template. 30. Click **Plus Sign** to select swollen eyelids. 31. Click **Plus Sign** to select hoarseness 32. Click the **PMH** tab to make sure you are adding terms to the PMH part of the template. 33. Click **Plus Sign** to select reported family history of allergies. 34. Click the **ROS** tab to make sure you are adding terms to the ROS part of the template. 35. Click **Plus Sign** to select sinus pain. 36. Click the **PE** tab to make sure you are adding terms to the PE part of the template. 37. Click the **Plus Sign** to select Constantly Wiping Nose. 38. When the template is correct, click the **Save As** icon on the Action Bar. The Save List Note Template window will display. 39. 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. 40. To terminate the template building process, click the **Cancel** icon on the Action Bar. The Template Management window will re-display. 41. Since you do not want to save the List Note (you are creating a template), click **No** to close the module. 42. Click **Close** on the Action Bar. This takes you back to the S/O documentation window. 43. Click **Close** on the Action Bar to take you back to the SF600.	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
	Next Slide **Exercises** • Complete the exercises. • Check for understanding and answer participant questions. **Summary** • Explained S/O Template Management features • Search for Visit Template • Use Template Edit Mode • Use FindTerm • Use Browse from Here • Save the Template as "VISIT--[name]--[your initials]" Next Slide **Day One Summary** • Navigation • Patient Search and Appointments • Telephone Consults • Demographics • Patient List • Patient Encounter • S/O Template Management ***Next Slide***	**Slide 30: Day One Summary**
	Exercises • Refer participants to the CHCS II Exercises for Super Users in the back of the manual.	

Duration	Training Activities	Instructor Notes
	Question and Answer and Summary **End of Day One**	

Duration	Training Activities	Instructor Notes
DAY TWO		
	Next Slide Review Day One. ***Next Slide*** Introduce Day Two lessons. Stress using structured text from a standardized medical language (MEDCIN). Documentation is facilitated by the creation and use of templates with appropriate terms for more common encounters. ***Next Slide***	**Slide 31: Day Two Agenda**
Lesson 8: Encounter Templates and Order Sets		
	Lesson Goal The goal of this lesson is to enable the end user to create encounter templates and commonly used Order Sets. **Learning Objectives** Upon completion of this lesson, the end-user will be able to • Create an encounter template	**Slide 32: Learning Objectives** **Note**: Remember to reset the database for the day and import the training templates.

Duration	Training Activities	Instructor Notes
	• Create an Order Set in A/P • Merge an encounter template with an order set • Use an encounter template	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.
	Encounter Templates	
	Demonstration An end user wants to build an Asthma Encounter Template. The template will contain diagnoses, note template, procedures and other therapies. They would also like to merge this template with the order set they just created. The end user wants to include the following for easy selection in the following areas of the template: **Diagnosis** ▪ Asthma ▪ Chronic Asthmatic Bronchitis ▪ Chronic Obstructive Asthma **Procedures** ▪ Pulse Oximetry ▪ ABG Panel **Notes Template** ▪ Visit-Asthma **Other Therapies** ▪ Patient Education Asthma Exposure to Triggers ▪ Patient Education Asthma Metered Dose Inhaler ▪ Patient Education Asthma Peak Flow Monitor **Creating a Template** 1. Click the **Template Mgt**. icon in the Folder List. The Template Management window will	

Duration	Training Activities	Instructor Notes
	display. 2. Click the **New** icon on the Action Bar to create a new Encounter Template. The Template Management, Template Details window will display. 3. Click the **Add** button in the Diagnoses window. A Diagnosis Search window will display. 4. Type **ASTHMA** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 5. Click on **ASTHMA** to select. Click ⊞ to expand ASTHMA. Holding down the [Ctrl] key select CHRONIC OBSTRUCTIVE BRONCHITIS and scroll down and select CHRONIC ASTH***MATIC BRONCHITIS.*** Release the [Ctrl] key and click **Add Items**. 6. Click **Done**. The Template Management window will be re-displayed with the information added. 7. Click the **Add** button in the Procedures window. A Procedure Search window will display. 8. Type ***PULSE OX*** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 9. Click on ***PULSE OXIMETRY 94760*** to select. Click **Add Items**. 10. Type ***ABG PANEL*** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 11. Click on ***ABG PANEL 82803*** to select. Click **Add Items**. 12. Click **Done**. The Template Management window will be re-displayed with the information added. 13. Click the **Add** button in the Notes Template window. A Notes Template Lookup window will display. 14. Click **Search**. 15. Type ***ASTHMA*** in the Template Name field, and click the **Search** button. Terms related to the search term will display. 16. Click on ***VISIT--Asthma*** to select. Click **Add Items**. 17. Click **Done**. The Template Management window will be re-displayed with the information added.	**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).

Duration	Training Activities	Instructor Notes
	18. Click the **Add** button in the Other Therapies window. An Other Therapies Search window will display. 19. Type ***TRIGGERS*** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 20. Click on **PATIENT EDUCATION ASTHMA EXPOSURE TO TRIGGERS** to select. Click **Add Items**. 21. Type **INHALER** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 22. Click on **PATIENT EDUCATION ASTHMA METERED DOSE INHALER** to select. Click **Add Items**. 23. Type **PEAK FLOW** in the Search Term Field, and click the **Search** button. Terms related to the search term will display. 24. Click on **PATIENT EDUCATION ASTHMA PEAK FLOW MONITOR** to select. Click **Add Items**. 25. Click **Done**. The Template Management window will be re-displayed with the information added. 26. The completed Template Management window will be as follows 27. Click the **Save As** icon on the Action Bar to save the Template. The Save Encounter Template window will display: 28. 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. 29. 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.	**Explain**: • Point out the five main components of the encounter template: diagnoses, notes templates (visit, S/O), other therapies, procedures and order sets. Mention that the top four sections (*Associated Reasons for Visit*, *Associated Appointment Types*, *Associated Problems*, and *Items to Autocite into Notes*) are not used. • Discussion of order sets will follow the building of the parts of the template mentioned above.

Duration	Training Activities	Instructor Notes
	3. Type **ASTHMA** in the search field. 4. Highlight **ENC--ASTHMA**--your initials and while holding down the [Ctrl] key select **ORDERS--ASTHMA**--your initials. 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 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** • Create an encounter template • Create an Order Set in A/P • Merge an encounter template with an order set • Use an encounter template 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 9: Health History Module

Lesson Goal

The goal of this lesson is to allow the end user to setup and customize the Health History module.

Learning Objective

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

- Setup Health History patient data modules

Slide 33: Learning Objectives

Health History

Demonstration

The end user 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. Click the check box next to the Problems, Allergy and Lab. The Design Summary window will look like this (the Module Options are "stacked" on top of each other).
4. Click in the center of the Lab box in the Design Summary window and drag it to the upper left of the design area.
5. Click and drag the Allergy box to the center left of the design area.
6. Click and drag the Problems box to the lower left of design area.
7. Click the **Align** button to view the format

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 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.

	8. Click the **OK** button to view the results 9. Click the **Close** icon on the Action Bar to close the module. **Key Points:** • Can be changed to fit the current requirements	
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions. **Summary** ▪ Explained Health History folder ▪ Setup Health History patient data modules Next Slide	
Lesson 10: Problems Module		
	Lesson Goal The goal of this lesson is to enable the end-user to add and update patient problems in CHCS II. **Learning Objectives** Upon completion of this module, the end-user will be able to: • Add a problem, family history, or historical procedure • Update a problem, family history, or historical procedure • Set and reset the viewing options • Display all information in all categories at once	**Slide 34: Learning Objectives** Default tab for adding items in problem list is *Clinic List*; select the *Search* tab for doing the search.
	Problems	

Demonstration

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

Add a Historical Procedure

1. Highlight Eduardo Suarez's name.
2. Click on the **Problems** folder in the Folder List. The Problems window will display:
3. Click on the Historical Procedures header and click the **Add** icon on the Action Bar. The Select Procedure window will display.
4. Click the **Search** tab and type **TONSILLECTOMY** in the MEDCIN Search field and click the **Search** button. Tonsillectomy terms will populate the search results area.
5. Click on **TONSILLECTOMY 42825** and click the **OK** button. The New Procedure area of the Procedures window will display.
6. Click the **Procedure Date drop-down**, and click on December and select June.
7. Then select 06/29/2003.
8. Click the **Save** button and tonsillectomy will be added to the historical procedures list.

Inactivate a Problem

1. Select the Diabetes Mellitus Type ii – Uncontrolled problem from Mr. Suarez's Problem list.

2. Click the status drop-down and select **Inactivate**.

Point out fields that are unchanged.

Problems designated **Acute/Active** are automatically changed to **Acute/Inactive** when listed for over 180 days based on last date modified, or creation date if never modified.

Exercises

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

Summary

- Added a historical procedure.
- Updated a problem.

<table>
<tr><td></td><td>

- Set and reset the viewing options
- Display all information in all categories at once

Next Slide

</td><td></td></tr>
<tr><td colspan="3">Lesson 11: Meds Module</td></tr>
<tr><td></td><td>

Lesson Goal

The goal of this lesson is to enable the end user to view patient meds and discontinue or add OTC and prescription medications.

Learning Objectives

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

- Add over-the-counter medications
- Change the temporary display filter
- Discontinue a medication
- Review the details of a selected medication

</td><td>Slide 35: Learning Objectives</td></tr>
<tr><td></td><td>Meds</td><td></td></tr>
<tr><td></td><td>

Demonstration

During Eduardo Suarez’s examination, it was determined he has been taking an adult low dose aspirin everyday for the past year. He usually buys them in a 250-tablet bottle. We need to record this information in Mr. Suarez’s record:

</td><td>Options are used to set the Medications Module properties. The purpose is to show the user how to set the properties. Outpatient Current is the default.</td></tr>
</table>

	1. Click the **Add** icon on the Action Bar to display the Select Type of New Medication window 2. Click on the **Record OTC/Outside Medication** button to display the New OTC Outside Medication window. 3. Click on the **Medications** button so you can search the Health Data Dictionary for the low dose aspirin. The Healthcare Data Dictionary Search window will display: 4. Type **ADULT LOW DOSE** in the search field and click **Search.** Words containing 'adult low dose' will be displayed. 5. Click on ***ADULT LOW DOSE ASPIRIN, 81MG, TABLET EC, 250 ea B*** to select it and click **OK**. The New OTC Outside Medication window will re-display with the Adult Low Dose Aspirin included. 6. Complete the following fields as shown: **Field** — **Data or [Description of Data]** SIG — ***Take one tablet daily*** Ordering End user — ***Self*** Order Start Date — ***One year ago*** 7. Click **OK** to add the OTC medication to the Eduardo's record. The adult low dose aspirin will display. 8. Click the **Close** icon on the Action Bar to close the Meds module and return to the SF600. 9. Click the **AutoCite** button to refresh the AutoCite properties (the Refresh icon on the Action Bar will not refresh the AutoCite properties). The multivitamin will be shown in the Active Dispensed Medications area. **Key Points:** • Accuracy is very important.	**Explain:** • The list includes all over-the-counter, outside, and CHCS II-ordered medications. • Current medications can be viewed, re-ordered, or modified and new medications can be added and ordered. • Active medications appear in bold text. • Inactive medications appear in regular text. • Medications are listed based on the search filter you selected.
	Exercises	

	Complete the exercises. Check for understanding and answer participant questions **SUMMARY** ▪ Add over-the-counter medications ▪ Change the temporary display filter ▪ Discontinue a medication ▪ Review the details of a selected medication ***Next Slide***	
Lesson 12: Allergy Module		
	Lesson Goal The goal of this lesson is to enable the end-user to update patient allergy information in CHCS II. **Learning Objectives** Upon completion of these modules, you will be able to: ▪ Review and verify allergy information ▪ Add, edit, or delete patient allergy information ▪ Search for and select common allergens to add to the allergen drop-down list ▪ Delete allergens from the drop-down list	**Slide 36: Learning Objectives** **Note**: If participants closed the *Folder List* for the previous lesson and it is still closed, direct them to open it (From the View menu, select **Folders**). Point out the **Allergy** icon in the patient ID line.
	Allergy **Demonstration** After talking to Eduardo Suarez, you discover he is allergic to peanuts, but this is not annotated in his medical record. He also states the last time he came into contact with iodine he had a reaction of hives (urticaria) instead of a rash. He is also allergic to Sulfa drugs. Add the allergy of peanuts and sulfa drugs to his allergen list and change the reaction with the iodine.	Allergy information is searched from within the Healthcare Data Dictionary

	Using the open encounter for Eduardo Suarez: 1. Click on the **Allergy** folder in the Folder List. The New Allergy window will display: 2. To add a new allergen, click the **Add** icon on the Action Bar. The New Allergy window will display. 3. To search for a new allergen, click the **Allergen** button. The Healthcare Data Dictionary window will display. 4. Type ***PEANUT*** in the search field and click the button. Health Care Dictionary words containing peanut will be displayed 5. Click on ***PEANUT OIL (PEANUT OIL)*** to select it and click the **OK** button. The Allergy window will re-display with the Peanut Oil allergy noted. 6. Click the **Reaction drop-down** to get a list of common reactions: 7. Click on *Rash* to select it. The New Allergy window will re-display with the Rash noted. 8. Click the **Onset** button and select a date of one month ago. The new date will be displayed. 9. Click the **Save** button to save the information. The Allergy list will be re-displayed with the new allergen. 10. Add an Allergy with multiple reactions. 11. Click the **Add** icon on the Action Bar. The New Allergy window will display. 12. Click the *Allergen* drop-down to get a list of common allergies. 13. Click ***Sulfa-Drugs*** to select it. The New Allergy window will re-display with Sulfa-Drugs noted. 14. To annotate multiple reactions, click the **Reaction** button. The Healthcare Data Dictionary window will display. 15. Type ***NAUSEA*** in the search field and click the **Search** button. Health Care Dictionary words containing nausea will be displayed. 16. Type ***VOMITING*** in the search field and click the **Search** button. Health Care Dictionary words containing vomiting will be displayed. 17. Click on ***NAUSEA*** to select it and while holding down the control key click on ***VOMITING*** to select it. Click the **Add >>** button to move the terms to the right pane. 18. Click the **OK** button. The Allergy window will re-display with the nausea and vomiting reactions noted. 19. Click the **Onset** button and select a date of one week ago. The new date will be displayed. 20. Click the **Save** button to save the information. The Allergy list will be re-displayed with the new allergen.	(HDD). **Explain** • By pressing the **Shift** or **Ctrl** key, multiple allergens from a single search can be selected before clicking the **Add to Common List** button. • Multiple searches can be done in succession to select allergens for the common list prior to clicking the **OK** button to close the *Properties* window. • Display the **Allergen** drop-down list with the addition. (May need to click the **Add** icon.) • To delete the **Iodine Containing Agents** allergy. • Click the **Cancel** button. • Highlight the **Iodine Containing Agents** allergy. • Click the **Delete** icon on the Action Bar. **Explain:** Explain the edit capability. • Close the Allergy

	Editing an Allergy To edit the Iodine Containing Agents reaction: 1. From the Allergen list, click ***Iodine Containing Agents*** to select it and click the icon on the Action Bar. **Note:** the Allergen field is not editable. 2. Click the **Reaction drop-down** to get a list of common reactions. 3. Click **Urticaria** to select. The New Allergy window will re-display with Urticaria noted. 4. Click the **Save** button to save the information. The Allergy list will be re-displayed with the new reaction noted. **Key Points:** • *Reason for Visit* is a structured term and may be more accurate than *Reason for Appointment.* • Screening during the patient encounter is the only area where a patient's allergies can be verified. • Allergy information, however, can be added without an open encounter. **Exercises** Complete the exercises. Check for understanding and answer participant questions **Summary** ▪ Review and verify allergy information ▪ Add, edit, or delete patient allergy information ▪ Search for and select common allergens to add to the allergen drop-down list ▪ Delete allergens from the drop-down list ***Next Slide***	module. • Refresh the AutoCite display. **Explain:** Comments also write back to the SF600.
Lesson 13: Wellness Module		
	Lesson Goal	

The goal of this lesson is to enable the end-user to work within the Wellness module in CHCS II.

Learning Objectives

Slide 37: Learning Objectives

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

- Use due reminders
- Use documentation histories
- Use reminder histories
- Use wellness schedules
- Set the default time periods for display due reminders, reminder history and documentation history
- Create a status display filter

Wellness

Demonstration

After talking to Eduardo Suarez, he informs you he attended an Anti-Tobacco class a month ago and that he is refusing to complete his Blood Pressure screen because he does not have time to come into the clinic. Due to his diagnosis of Hyperlipidemia, we need to add a Total Cholesterol Screen to his wellness schedule and the Rh Screen can be inactivated.

Documenting a Due Reminder in the Due Reminders Tab

1. To start the Wellness module, click the **Wellness** folder in the Folder List. The Wellness window will display.
2. Click the ***Due Reminders*** tab to select it. The Due Reminders window will display.
3. Scroll to the bottom of the list and click + to expand ***Counseling*** and click on ***Anti-Tobacco Counseling*** to select it.
4. Click **Document** on the Action Bar. The Document Anti-Tobacco Counseling window will display.
5. Select the ***Completed*** radio button for the Status (if not already selected).
6. Click the Coded: drop-down in the Comments area and click ***Patient states Preventive Service Complete*** to select it.

7. Click the **Date** button and enter a date of one month ago.
8. Click the Information Source drop-down and click ***Patient*** (may have to scroll down) to select and click **Save**. The Wellness window will re-display.
9. Click the ***Documentation History*** tab to see the completed Anti-Tobacco Counseling.

Adding a Reminder History in the Documentation History Tab

To add a reminder history in the Documentation History tab:

1. Click the ***Documentation History*** tab to select it. The Documentation History window will display.
2. Click **Add History** on the Action Bar. The Select History Type window opens.
3. Click Blood Pressure Screen to select it and click OK. The Blood Pressure Screen History Window will display.
4. **Note: The *Date*, *Information Source* and *Status* are required fields**.
    a. Complete the following fields.
    b. Status: Click the ***Refused*** radio button to select it
    c. Date: enter today's date
    d. Information Source: Click ***Patient*** from the drop-down list
    e. Freetext Comments: Type - Patient states blood pressure is under control and he does not have time to come into the clinic for the next 5 days
5. Click **Save** to add this reminder history information to the documentation history list.
6. Click **OK** to accept Eduardo's refusal. The Blood Pressure screen will display in the Documentation History window.

Adding a Wellness Schedule Reminder in the Wellness Schedule Tab

To add a wellness schedule reminder in the Wellness Schedule tab:

1. Click the ***Wellness Schedule*** tab. The Wellness Schedule Window will display.
2. Click the **Add** icon on the Action Bar. The Add Wellness Schedule window will display.

3. Click ***Total Cholesterol Screen*** to select it from the **Select A Wellness Item** drop-down list.
4. Click ***2*** and click ***years*** using the *Specify A Patient Specific Schedule* drop-down lists and click **Save**.
5. The Total Cholesterol Screen will be added to Eduardo's Wellness Schedule.

Activating/Inactivating a Wellness Reminder in the Wellness Schedule Tab

The Activate/Inactivate button toggles between activate and inactivate depending on the state of the selected reminder. If the reminder is already active, the **Inactivate** button is seen. If the reminder is inactive, the **Activate** button is seen.

To inactivate a reminder in the Wellness Schedule tab:

1. Click the ***Wellness Schedule*** tab (if not already selected). The Wellness Schedule window will display.
2. Click the **Rh Type Screen** reminder to select it and click **Inactivate** on the Action Bar. The Confirm Inactivation window will display.
3. Click **Yes** on the Confirm Inactivation window. The Inactivate Rh Type Screen will display.
4. Click ***Clinician does not agree with the Reminder*** from the Coded: drop-down and click **OK**. The Wellness Schedule information will be updated.
5. Click the **Close** icon on the Action Bar to close the module.

Exercises

Complete the exercises.

Check for understanding and answer participant questions

Summary

- Review and verify allergy information
- Add, edit, or delete patient allergy information
- Search for and select common allergens to add to the allergen drop-down list
- Delete allergens from the drop-down list

Next Slide

Lesson 14: PKC Couplers

Slide 38: Learning Objectives

Lesson Goal

The goal of this lesson is to enable the end-user to acquire basic skills in using the Couplers modules.

Learning Objectives

Upon completion of this lesson, the end-user will understand how the Couplers module is used to:

- View a coupler
- Run a coupler
- Run a finding summary report
- Resolving a finding error summary report note.

Next Slide

PKC Couplers

Demonstration

An end user would like to administer the HEAR Questionnaire for Eduardo Suarez. Once Eduardo has completed the HEAR Questionnaire, the end user would like to review it.

1. Click the **Couplers** folder in the Folder List. The **PKC Couplers** window will display with the Military tab selected.
2. In the Run New Coupler section, click on the HEAR questionnaire to select it (if not already selected) and click **Run Coupler**. The Coupler session will display.
3. Press the [Enter] key or click in the space provided at the bottom of the window to begin. The HEAR Overview window will display.
4. Click the **CLICK HERE** area to begin the questionnaire. The HEAR Welcome window will display.
5. You can continue to the next page of the questionnaire by doing one of the following: Clicking on the ‘continue’ bar
    a. Pressing the [F10] key

b. Clicking the **Next** icon on PKC Couplers Military Action Bar.

6. Answer approximately 10 of the questions (the HEAR questionnaire is rather lengthy) and then click on the **Save** icon on the PKC Couplers Action Bar. The Coupler will be saved (the Coupler Save icon will become dim).
7. Click the **File/Couplers** button on the Coupler Menu bar. The File/Couplers drop-down will display.
8. Click **Exit and Return to CHCS II**. A save confirmation message will display:
9. Click **Yes** and the PKC Couplers module will re-display, with information about the HEAR Coupler just administered.
10. Click on the HEAR coupler just administered, and click **View**. The completed questionnaire is available for review.
11. Once the review is complete, click the **File/Couplers** button on the Coupler Menu bar. The File/Couplers drop-down will display.
12. Click the **Exit & Return to CHCS II** button on the drop-down. The PKC Couplers module will re-display.
13. Click the **Close** icon on the Action Bar to close the module.

Exercises

Complete the exercises.

Check for understanding and answer participant questions

Summary

- View a coupler
- Run a coupler
- Run a finding summary report
- Resolving a finding error summary report note.

Next Slide

Lesson 15: Vitals Sign Review Module

	Lesson Goal The goal of this lesson is to enable the end-user to record and graph vital sign information in CHCS II. **Learning Objectives** Upon completion of this module, the end-user will be able to: ▪ 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 39: Learning Objectives**
	Vitals Sign Review	
	Demonstration 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** ▪ 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 ***Next Slide***	
	Day Two Summary Encounter Templates and Order Sets Health History Problems Meds Allergies Wellness PKC Couplers Vital Signs Review ***Next Slide***	**Slide 40: Day Two Summary**
	Exercises Direct participants to the CHCS II Exercises for the Super User un the back of the manual. **Questions and Answers and Summary** **End of Day Two**	

DAY THREE

	Next Slide	**Slide 41: Day Three Agenda**

Lesson 16: Readiness Module

Lesson Goal

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

Learning Objectives

Slide 42: Learning Objectives

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

- View the readiness module
- Edit the readiness information

Readiness

Demonstration

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

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

	Exercises Complete the exercises. Check for understanding and answer participant questions. **Summary** ▪ View the readiness module ▪ Edit the readiness information ***Next Slide***	
Lesson 17: Laboratory Results Module		
	## Lesson Goal The goal of this lesson is to enable the end-user to set Lab module properties and copy lab results in CHCS II. ## Learning Objectives Upon completion of this module, the end-user will be able to: ▪ Select lab results search criteria ▪ Select a default time period for searching ▪ Select preferences for display of abnormal results ▪ Select lab results display criteria ▪ Select various display criteria and preferences ▪ View laboratory test results ▪ Copy lab results into a patient encounter **Laboratory**	**Slide 43: Learning Objectives** Comment about “break glass” permissions; for example, user can’t view HIV lab results without “break glass” permissions. **Note:** You must open an encounter to use the **Copy to Note** function. The result is pasted directly into the patient encounter. If you (accidentally) copied more than once, it will show up in your note more than once. The Lab module is designed

	## Demonstration We want to view Eduardo Suarez's Lipid Panel Complete lab results and copy the result to his encounter. 1. To start the Lab module, click the **Lab** folder in the Folder List. The Lab module window will display. 2. Click on ***Lipid Panel Complete***. The Lab result will display in the Display Criteria section of the window. 3. Click the ***Ref Range/Units*** check box to display the reference ranges for the test. 4. 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). 5. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note. 6. Since we want to copy these lab results to the note, click the **Copy to Note** button. **7.** The lab result will re-display, with the lab result no longer highlighted (the result has been copied to the note). 8. Click the **Close** icon on the Action Bar **Key Points:** • Results can be copied to the clipboard for insertion into, for example, an MS Word document.	to display the results of laboratory tests. Results are viewed, not ordered, from this module. Lab results are pulled from CHCS. An alert is triggered when new results are received.
	Exercises	
	Complete the exercises. Check for understanding and answer participant questions. **Summary** ▪ Select lab results search criteria ▪ Select a default time period for searching ▪ Select preferences for display of abnormal results	

- Select lab results display criteria
- Select various display criteria and preferences
- View laboratory test results
- Copy lab results into a patient encounter

Next Slide

Lesson 18: Radiology Results Module

Lesson Goal

The goal of this lesson is to enable the end-user to set Radiology module properties and to copy Radiology results into the encounter in CHCS II.

Slide 44: Learning Objectives

Learning Objectives

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

- View radiology test results
- Set the search criteria for the radiology results
- Set the display criteria for the radiology results
- Set the default time period for searching results
- Copy radiology results into an encounter

Results are viewed, not ordered, from this module. Radiology results are pulled from CHCS. An alert is triggered when new results are received.

Radiology

Demonstration

We want to view Eduardo Suarez's Chest PA And Lateral Series Report result and copy the result to his encounter

1. To start the Radiology module, click the **Radiology** folder in the Folder List. The Radiology module window will display.
2. To view the ***Chest PA And Lateral Series Report***, click to select it. The result will display in the results section of the window.
3. Place the cursor in front of the word Report and drag the mouse to highlight the Report Text

and Impression of the result.

4. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note.
5. Since we want to copy this radiology result to the note, click the Copy to Note button.
6. Click the **Close** icon on the Action Bar.
7. View the rad result in S/O section of the SF600, under the S/O note.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- View radiology test results
- Set the search criteria for the radiology results
- Set the display criteria for the radiology results
- Set the default time period for searching results
- Copy radiology results into an encounter

Next Slide

Lesson 19: Clinical Notes Module

Lesson Goal

The goal of this lesson is to enable the end-user to view and edit clinical notes in CHCS II.

Learning Objectives

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

- View a clinical note
- Add a clinical note
- Edit a clinical note
- Save a clinical note

Slide 45: Learning Objectives

Clinical Notes

Demonstration

An end user specializing in Ear Nose and Throat (ENT) performed minor surgery yesterday on Klaus Wunderlich, who had an object lodged in his ear. The end user 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. Open Klaus Wunderlich's appointment for earache.

The end user would also like to insert a graphic of the ear. Assist the end user 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 **3-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.

Copying a Clinical Note

1. With Klaus Wunderlich's encounter opened, highlight the Clinical Note you just created.
2. Perform the copy process by using [Ctrl] C.
3. Click the **Close** icon on the Action Bar to close the module.
4. Click the **Add Note** icon on the Action Bar.
5. Select **New Note** on the Select Note field.
6. With cursor in the documentation area, right click and select paste.
7. Click **Note Complete** button.
8. Review the SF600.
9. 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

Next Slide

Lesson 20: Previous Encounters Module

	## Lesson Goal The goal of this lesson is to enable the end-user to use the Previous Encounters module in CHCS II. ## Learning Objectives Upon completion of these modules, the end-user will be able to: ▪ Display a previous patient encounter ▪ Amend a completed encounter ▪ Append a narrative to a completed encounter	**Slide 46: Learning Objectives**
	Previous Encounters	
	## Demonstration The end user needs to annotate Eduardo Suarez's diabetes is now controlled by adding a note to his Diabetes Mellitus Type II – Uncontrolled encounter ### Appending a Narrative 1. From the list of appointments, click on any of Eduardo Suarez's appointments to pull his record. 2. Click the **Previous Encounters** icon in the Folder List. The Previous Encounters window will display. 3. Click the **Append Narrative** icon on the Action Bar. The Encounter Note window will display. 4. Type ***DIABETES*** in the Note Category field. 5. Type ***DIABETES CONTROLLED*** in the Note Title field. 6. Type **PATIENT HAS HIS DIABETES MELLITUS TYPE II UNDER CONTROL**. in the text area. 7. Click the **Save and Sign** button. The Sign Appended Note window will display.	The *Change History* section of the Encounter Note shows the original S/O note. This is the electronic equivalent of lining out the information in the paper medical record. New findings can also be documented for the current encounter. **Explain:** Amending an encounter allows information in the original note to be

	8. Click the **Sign** button to sign the encounter. The Previous Encounters window will re-display. 9. Click the **Close** icon on the Action Bar to close the module. **Copy Forward a Previous Encounter** 1. Select the ***diabetes/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.	changed by the original Provider, co-signing Provider, or the original Provider's supervisor.
	Exercises	
	Complete the exercises. Check for understanding and answer participant questions. **Summary** ▪ Display a previous patient encounter ▪ Amend a completed encounter	

	▪ Append a narrative to a completed encounter ***Next Slide***	

Lesson 21: Alerts Review Module

	Lesson Goal The goal of this lesson is to enable the end user to review and respond to notifications of diagnostic results and to orders and encounters requiring the end user's signature. **Learning Objectives** Upon completion of this lesson, the end-user will be able to: ▪ Access alerts: *Folder List* **Alerts** icon ▪ Address an alert from the Alert Review module ▪ Delete alerts that have been resolved	**Slide 47: Learning Objectives**
	Alerts Review	
	Demonstration An end user 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.	
	Exercises	

	Complete the exercises.
	
	Check for understanding and answer participant questions.
	
	Summary
	
	• Access alerts:
	    o *Folder List*
	    o **Alerts** icon
	• Address an alert from the Alert Review module
	• Delete alerts that have been resolved
	
	Next Slide	

	Day Three Summary Readiness Laboratory Radiology Clinical Notes Previous Encounter Alert Review	**Slide 48: Day Three Summary**

	Exercises Direct particiapants to the CHCS II Exercises for the Super User in the back of the manual.	
	Questions and Answers and Summary ***Next Slide*** **End of Day Three**	

DAY FOUR

Lesson 22: New Results Module

Lesson Goal

The goal of this lesson is to enable the end user to review and process new lab and radiology results.

Slide 49: Day Four Agenda

Learning Objectives

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

- 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

Note: This is for instructor information and to use in the previous description of Day Four activities as time permits.

Slide 50: Learning Objectives

New Results

Demonstration

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 comfirmation 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 an end user:** 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 an end user has viewed the new result information.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- 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

Lesson 23: Co-Signs Module

Lesson Goal

The goal of this lesson is to enable the end user to review and refine encounters requiring the Provider's signature.

Learning Objectives

Slide 51: Learning Objectives

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

- Review encounters needing co-signatures
- Co-sign an encounter completed by another Provider
- Append a narrative to an encounter prior to co-signing

Co-Signs

Demonstration

The end user 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 end user in amending this encounter to include this report. The end user 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.
15.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Review encounters needing co-signatures
- Co-sign an encounter completed by another Provider
- Append a narrative to an encounter prior to co-signing

Lesson 24: Sign Orders

Lesson Goal

The goal of this lesson is to enable the end user to access, review and sign orders created by non-providers.

Learning Objectives

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

Slide 52: Learning Objectives

- Display details of non-Provider orders needing signing:
- One at a time
- All at once
- Sign non-Provider orders:

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

Sign Orders

Demonstration

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

Signing non-end user orders

1. Click either the icon in the Patient ID line, or the Sign Orders 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.
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.

Canceling a Non-End user Order

1. Click the check box to the left of Clayton William's name.
2. 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.
3. Click **Close** on the Action Bar to close the Sign Orders module.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Cancel non-Provider orders
- Sign non-Provider orders:

	• Display details of non-Provider orders needing signing:	

Lesson 25: List Management

Lesson Goal:

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

Learning Objectives:

Slide 53: Learning Objectives

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

- Create lists of favorites for use in the application:
- Diagnoses
- Procedures
- Clinic Favorites
- Delete items from lists.

List Management

Demonstration

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

1. To begin, click the **List Management** folder in the Folder List The List Management screen will display.
2. To Delete Upper Respiratory Infection from the Diagnosis favorites list, click ⊞ to expand ***My 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 ***Whole Virus***
8. Click ***For Intramuscular Use 90659*** to select it and click **OK**. The For Intramuscular Use procedure will be added to the Procedure Favorite List.
9. To move the electrocardiogram procedure to the bottom of the Procedures favorites list, click ***Electrocardiogram*** in the Procedures favorites list.
10. 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

Lesson 26: Questionnaire Setup/Questionnaire

Questionnaire Setup/Questionnaire

Lesson Goal:

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

Learning Objectives

Slide 54: Learning Objectives

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

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

Questionnaires

Demonstration

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

Building the Questionnaire

1. Click **Questionnaire Setup** in the Folder List (you may have to expand the Tools folder). The Questionnaire Setup window will display.
2. Click the **New** icon on the Action Bar to create a new questionnaire. The Questionnaire Setup window will re-display with the [New] in the Name: field and in the large, center window.
3. Overtype [New] in the Name field with ***HEADACHE INITIAL VISIT*** in the Name: field. The name will appear in the large, center window.
4. Click the **Add** button on the right side of the window. The input area for question one will display.
5. In the Question Text area, overtype [New Question] with ***DO YOU HAVE A HEADACHE RIGHT NOW?***, click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display.
6. In the Question Text area, overtype [New Question] with ***WHEN WAS THE LAST TIME YOU HAD A HEADACHE?***, click ***Date*** in the Answer Type drop-down and click **Add** to add

	a new question. The Questionnaire input area will re-display. 7. In the Question Text area, overtype [New Question] with ***HOW LONG HAVE YOU BEEN HAVING HEADACHES?***, click ***Multiple-Choice*** in the Answer Type drop-down. In the Multiple-Choice area type: ***LESS THAN 1 MONTH*** and press the [Enter] key ***1-6 MONTHS*** and press the [Enter] key ***7-12 MONTHS*** and press the [Enter] key ***GREATER THAN 1 YEAR*** and click **Add** to add a new question. The Questionnaire input area will re-display. 8. In the Question Text area, overtype [New Question] with ***HAVE THE HEADACHES GOTTEN WORSE OR BETTER?***, click ***Multiple-Choice*** in the Answer Type drop-down. In the Multiple Choice area type: ***WORSE*** and press the [Enter] key ***BETTER*** and click **Add** to add a new question. The Questionnaire input area will re-display. 9. In the Question Text area, overtype [New Question] with ***ARE YOU TAKING ANY MEDICATION FOR THE HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down, type ***7*** in the Skip To field associated with No, and click **Add** to add a new question. The Questionnaire input area will re-display. 10. In the Question Text area, overtype [New Question] with ***DOES THE MEDICATION HELP THE HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display. 11. In the Question Text area, overtype [New Question] with ***HAVE YOU SEEN A MEDICAL END USER REGARDING THESE HEADACHES IN THE LAST YEAR?***, click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display. 12. In the Question Text area, overtype [New Question] with ***DOES ANYONE ELSE IN YOUR FAMILY SUFFER FROM HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down, type ***10*** in the Skip To field associated with no, and click **Add** to add a new question. The Questionnaire input area will re-display. 13. In the Question Text area, overtype [New Question] with ***IF SO, WHO SUFFERS FROM HEADACHES?*** click ***Multi-Select*** in the Answer Type drop-down and type the following in the Multi-Select area: ***MOTHER*** and press the [Enter] key	

	FATHER and press the [Enter] key ***SIBLINGS*** and press the [Enter] key ***GRANDPARENTS*** and press the [Enter] key click **Add** to add a new question. The Questionnaire input area will re-display. 14. In the Question Text area, overtype [New Question] with ***IS THERE A LOT OF STRESS IN YOUR NORMAL DAY?*** click ***Yes/No*** in the Answer Type drop-down. Click the **Save** on the Action Bar (do not click the **Add** button to add another question) to save the questionnaire. 15. The questionnaire will appear in the list of questionnaires with a status of In Development. 16. Click the ***Headache Initial Visit*** questionnaire to select it and click the **Mark Ready** icon on the Action Bar. The questionnaire status will change from In development to Ready for Use. 17. Click **Close** on the Action Bar to complete the questionnaire setup process. We will now complete the Headache Initial Visit questionnaire with Eduardo Suarez. Answer each question as if you were completing the questionnaire for Mr. Suarez: 1. Click the Patient Questionnaires folder in the Folder List. The Patient Questionnaires window will display. 2. To locate the questionnaire: a. Click ⊞ to expand Questionnaires b. Click ***Headache Initial Visit*** to select it. The questionnaire will be displayed: 3. Click the Options button on the Patient ID line to select the Properties for administering the Patient Questionnaire. The Patient Questionnaire Properties window will display. 4. Click on ***Single Question View*** from the drop-down to select it and click **OK**. The questionnaire will re-display. 5. Click the **Interview** icon on the Action Bar to begin the questionnaire. The questionnaire will display. 6. Answer each question and click ***<u>Next Question</u>*** 7. When the last question is displayed answer the question and click ***Mark Questionnaire As Done***.	

8. The Patient Questionnaire window will be re-displayed showing the questionnaire that has just been completed.
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

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

Lesson 27: Screening Notification

Screening Notification

Lesson Goal

The goal of this lesson is to enable the end-user to perform screening services in CHCS II.

Learning Objectives

Slide 55: Learning Objectives

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

- Select properties for the screening notification module
- Set screening search properties for a specific notification
- Select or deselect search results

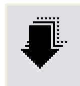
Screening Notification

Demonstration

You have been instructed to mail a notification to all patients requiring the Anti-Tobacco

Counseling.

To select Screening Notifications reminder search options:

1. Click the **Screening Notification** folder in the Folder List (you may have to expand the Tools folder). The Screening Notifications window will display
2. Click **Change Selections** at the top of the window. The Screening Notifications Reminder Search Options screen will display.
3. In the Available Reminder(s) list, click the ***Anti-Tobacco Counseling*** reminder to select it and click the  icon. Anti-Tobacco Counseling will display in the Selected Reminder(s) list.

   Note: To select multiple reminders, select the reminders while pressing the [Ctrl] key on your keyboard and click the associated icon or individually select.
4. You can click to select the ***PCM*** radio button (if not already selected) and search for the end user.
   Note: Performing a search for patients associated with an MTF may take an extended period of time.
5. Click ***Letter*** as the Method of notification from the drop-down list.
6. Click **OK**. The Screening Notifications window will re-display. Patients listed in the Screening Notifications window have a date in the corresponding wellness reminder column that determines when they need to be notified, either by e-mail, letter or both. To notify patients about future Screening Notifications.
7. Click **Select All** on the Action Bar to select all the patients. The check box associated with each patient, will be selected.
8. Click **Notify** on the Action Bar to notify the selected patients of the wellness reminder. A Notification Options window will display.
9. Click the ***Print letter now*** radio button to indicate use of a pre-printed letter. The Screening Notifications window will re-display.

   Note: A Print Preview window opens when printing, displaying the letter for the patient(s) being notified.

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

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Select properties for the screening notification module
- Set screening search properties for a specific notification
- Select or deselect search results

Lesson 28: Reports

Reports

Lesson Goal

The goal of this lesson is to understand how to run and print reports.

Learning Objectives

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

- Run a report
- View a Report

Slide 56: Learning Objectives

Reports

Demonstration

An end user wants to run a customized Appointments report for the clinic/lab for the last year. The report should be run in a separate window and should be grouped by end user.

- Click the **Reports** folder in the Folder List. The Reports window will display.
- Click the ***Report on***: drop-down to get a list of report types.
- Click on ***Appointments*** to select it. The Reports window will re-display.
- Complete the following fields:

- With Scope of: - ***Clinic/Lab***
- From: field - One year prior to the To: field
- Click to select the ☐ Display in separate window check box
- Click to select the ☐ Provider check box

- Click the **Run Report** button. The report will be run and the result displayed in a separate window.
- Click the **Close** icon in the upper right of the screen to close the Print Preview window. The Reports window will re-display.
- Click the **Close** icon on the Action Bar to close the module.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Run a report
- View a Report

Lesson 29: Immunizations

Lesson Goal

The goal of this lesson is to introduce the student to Immunizations Administration.

Learning Objectives

Upon completion of these modules the student will be able to:

- Define vaccine groups
- Track vaccines in stock
- Add details to in-stock vaccines
- Maintain groups

Slide 57: Learning Objectives

- Document multiple patient vaccines
- Manage providers
- Produce reports
-

Immunizations

Immunizations

- Two separate modules

  Immunization Admin

  Immunizations

- Allows the documentation of immunizations for a patient.

CHCS II Immunization consists of two modules:

- The Immunization Admin module is used to administer and manage vaccines, end users, reports, end user groups, and refrigeration temperature logs. The module is also used to document multiple vaccine entries for selected patients. The Immunizations Admin module can be accessed without having a patient's record open.
- The Patient Immunizations Module is used to manage and track patient immunization records and vaccine history. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

Immunizations

Demonstration

Create a group of immunizations for a battalion that is being deployed.

Add the following list of immunizations to your group. Define the group with your full name.

- Hep A – Hep B
- Influenza
- MMR
- Anthrax

Ensure the following vaccines are in stock and contain the following information:

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Anthrax	Ortho Diagnostic	OD13579	0.25 ml	IM
Hep A – Hep B	Abbott	4444444	0.1 ml	IM
Influenza	Baxter	BA 12345	0.1 ml	IM
MMR	Merck	ME67890	0.5 ml	IM

1. Click the folder in the in the Folder List. The Immunization Admin screen will display with the tab selected:
2. Click on ***User Defined Groups*** in the 'Please select the area you wish to Administer' area. The User Defined Groups window will display:
3. Click the button to add a new group. The Add User Defined Groups window will display:
4. Type your first and last name in the entry area and click. The User Defined Groups window will re-display showing the newly defined group:
5. Click to select the name of your end user group in the User Defined Groups window and select the following from the Generic Vaccine Names list:
    a. Click on ***Anthrax*** and click
    b. Click on ***Hep A - Hep B*** and click
    c. Click on ***Influenza*** and click
    d. Click on ***MMR*** and click

You have now successfully added the list of immunizations to your group.

6. To ensure these medications are in stock, click ***Vaccine Management*** in the 'Please select the area you wish to administer' section if not already selected. In the Available Vaccines area, do the following:
    a. Click on ***Anthrax*** and click
    b. Click on ***Hep A - Hep B*** and click

c. Click on ***Influenza*** and click

d. Click on ***MMR*** and click

The screen will appear

7. Click on the button. The Vaccinations In Stock Information screen will display.
8. Complete the Vaccines In Stock Information with the following data (click in the table cell to get a drop-down for data entry):

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Anthrax	Ortho Diagnostic	OD13579	0.25 ml	IM
Hep A – Hep B	Abbott	4444444	0.1 ml	IM
Influenza	Baxter	BA 12345	0.1 ml	IM
MMR	Merck	ME67890	0.5 ml	IM

9. Click the button to complete the Vaccines In Stock Information and close the window.
10. Click the icon on the Action Bar to close the module.

Exercises

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

Summary

- Define vaccine groups
- Track vaccines in stock
- Add details to in-stock vaccines
- Maintain groups
- Document multiple patient vaccines
- Manage providers
- Produce reports

Next Slide

	Day Four Summary • Results • Co-Signs • Sign Orders • List Management • Questionnaire Set-Up • Screening Notification • Reports • Immunizations Administration**Exercises** • Refer participants to the CHCS II Exercises for Super Users in the back of the manual. **Question and Answer and Summary** **End of Day Four**	**Slide 58: Day Four Summary**

Course Summary

	Briefly summarize the course and open to questions and answers.
	Day One
	    Overview of the system, the training, the expectations
	    Basic skills: navigating through documenting
	Day Two
	    MEDCIN and templates
	    Ancillary modules
	Day Three
	    Alerts
	    Previous Encounters
	Workflow Tips Video
	Introduce and show the Training Tools video, Workflow Tips.
	Questions and Answers
		Summarize the course and show the video that re-emphasizes how the workflow is supported by the application.
		
		Slide 59 Review
		
		Slide 60 Review (cont.)

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:

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

14. Click **Set Default**. You are returned to the Vaccine Management area.
15. 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 manufcutrer 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.

16. Select a manufacturer.

17. Click Details.

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

18. 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 Module

Overview of Patient Immunizations

The Immunizations Module to manage and track patient immunization records and vaccine history. The Immunizations module contains two tabs: Individual Immunizations and Vaccine History. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

Documenting a Vaccination Visit

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

Editing Vaccination Groups

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

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

To edit the Vaccination Groups:

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

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

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

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

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

Entering Historical Pediatric Vaccines

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

- Manufacturer
- Lot Number
- Provider.

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

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

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

- Click **Select.**

Enter the word "Transcribed" in any field to signify that the information was not available when it was recorded from the patient shot record.

7. Click **Save and Close.**
   - There is an option to print the worksheet and the DD Form 2766C from the Individual Immunization window. The report is sent to your printer.
   - Print DD 2766C: Use this function to print a Vaccine Administration Record.
   - Print Worksheet: Use this function to print required immunizations for the selected patient.

Selecting the Immunization Exempt Type

To select the immunization exempt type:

- **Global:** If a patient has never been given any of the immunizations that are listed in the vaccination record section, they can be exempted using this function from the Individual Immunization tab.
- **Focused:** If an exemption has been given for that immunization, the exempt function must be performed from the Vaccine History tab.

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

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

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

2. Click, Click to Save Exemption.

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

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

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

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

Giving a Vaccine

To select an immunization:

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

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

3. Click the right arrow to move the items from the *Immunizations Recommended l*ist or Other Immunizations list to the *Immunizations Selected* list.

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

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

Adding a Vaccination

Vaccinations can be added to a patient's record.

To add a vaccination:

1. Click the Vaccine History tab on the Immunizations window. The Vaccine History tab
2. Click **Add**. The Vaccines window
3. Select the vaccine you want to add.
4. **Note:** To view a list of all vaccines in stock, click the List All Immunizations checkbox. All vaccines in stock appear on the list. To edit the list of favorite vaccines, click **Edit List**. On the Edit Favorite Vaccine List window, select a vaccine from the *All Vaccines* list and click the right arrow to move the vaccine to the *Selected Vaccines* list. Click **Close**.
5. Click **Select**. The Add Vaccine window opens
6. Complete the following fields
    - **Vacc Date:** Enter a date, or click the **ellipsis** button and select a date from the calendar, to assign a vaccination date.

- **Series Number:** Enter the series number of the vaccine, if necessary.
- **Manufacturer:** Select a manufacturer from the drop-down list, if necessary.
- **Lot Number:** Enter the lot number of the vaccine, if necessary.
- **Dosage:** Select a dosage for the vaccine from the drop-down list, if necessary.
- **Site:** Select an area of the body where the vaccine is given from the dropdown list, if necessary.
- **Route:** Select the vaccine route from the drop-down list, if necessary.
- **Next Vaccination Due:** Click **Recalc** to automatically calculate the next vaccination due date. The date is automatically entered.
- **Exempt:** Select an exemption from the drop-down list, if necessary.
- **Provider:** Select a provider from the drop-down list, if necessary.

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

Deleting Immunization History

To delete an immunization History:

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

Editing Immunization History

To edit an immunization history:

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

Printing Immunization Records

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

To print immunization records:

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

Reviewing Immunization Records

This area of the Individual Immunization tab displays all immunizations the patient is required to have based on the vaccination groups to which the patient is assigned.

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

Immunization
Series
Date
Next Due
Vaccination Groups

Finishing the Documentation for Vaccination Visit:

1. Double click on Violet Alexander
2. Select A/P module
3. Document Diagnosis
   i. MMR – V06.4
   ii. HEP A – V05.3
   iii. Influenza – V04.8
   iv. Small Pox – V04.7
4. Document Procedures:
   v. MMR – 9707
   vi. HEP A – 90632
   vii. Influenza – 90659

	viii. Small Pox – 90749 5. Select each Procedure code (as necessary) to add the modifier for **Units of Service** **Note**: Use ICD-9 code V06.8 for other combinations of shots. Use V05.8 for other specific disease and Japanese Ecephalitis. Use 90636 fro Hep A and B together 6. Document Disposition/E&M Code of 99211 7. Have Provider/Nurse sign encounter	
	Review	