CHCS II Support Lesson Plan

COMPOSITE HEALTH CARE SYSTEM II

December 2004
Rev 1.2

Change History

Date	Name	Change Description	Source:
10/20/04	Kathleen Chapman	New Course created from consolidation of service materials	[Authorizor communication]
11/5/04	Erin Chesnut	Updated	CITPO comments
12/6/04	Melissa Bickham	Revised	Service comments

Table of Contents

Preparation for Delivery

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

Materials Needed

- CHCS II Sign-In Roster. (Electronically or Paper Form)
- CHCS II Support Course Lesson Plan
- CHCS II Support Presentation
- CHCS II Training Templates
- CHCS II QRC (one per student)
- CHCS II Support 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 Training Course 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 Support Course Presentation (instructor workstation only) completed with current date and location
- Reset data (**Encounter Data** button) for each CTS prior to starting class daily.

   Note: The entire database should be refreshed weekly after the last Support'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 template.
- TRAINING—
- 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. Ensure users has included a comment for any line item rated "3" or lower.

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

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

Duration	Training Activities	Instructor Notes
	CHCS II Overview	

What is CHCS II?

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

CHCS II provides:

- A Graphical user interface that networks with existing systems

- Efficient means of creating, managing and retrieving medical records

- Anytime, anywhere delivery of patient records to the point of care

- Future access to military records for health studies worldwide

Add this brief comment as transition to next slide:

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

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❑ **Slide 3: What is CHCS II?**

Limitations of Paper Based Medical Records

- Paper charts are lost
- No automatic drug interaction alerts
- Penmanship counts
- Only one person can access a record at a time

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❑ **Slide 4: Limitations of Paper Based Medical Records**

Duration	Training Activities	Instructor Notes
	CHCS II Benefits	 Elaborate on each benefit.

	• Interfaces with MHS Standard systems, e.g. CHCS I & ADM
	• Uses a standard, structured language, which is MEDCIN, which has the ICD-9 and CPT codes tied to those structured terms.
	• Facilitates compliance through electronic capture of elements required for:
	   • JCAHO (Joint Commission on Accreditation of Healthcare Organizations)
	   • Evaluation & Management (E&M) coding
	• Supports team-based health care and clinic workflow, providing appropriate access for each team member and simultaneous multi-user access
	• Supports problem-oriented health care
	• Accumulates data for reports and studies, such as clinical and population health
	• When fully implemented world-wide, will provide access to patient records anywhere, anytime
	• Maintains security
	
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	Security	❑ **Slide 6: Security**
	Security is a crucial requirement of patient medical records. CHCS II security is multi-leveled and conforms with HIPAA/MHS Security standards. User access to patient information within the application is based on user role. • The system administrator assigns passwords that can be changed later by the user. • Users must have a CHCS account prior to registering for a CHCS II account. • The CHCS II password replaces CHCS verify code. • Roles and privileges are tied to unique user name and password. *Next Slide*	❑ **Slide 7: Expectations**

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

Duration	Training Activities	Instructor Notes

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

	System Demo	
	<center>Go to Appendix B</center> <center>*Next Slide*</center>	❑ **Slide 10: Systems Demonstration** **Note:** Invite class participation to assist with roles in demonstration.

Course Goal

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

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CHCS II Training System

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

- Click the caduceus icon on the desktop to start

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

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

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❑ **Slide 11: Course Goal**

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

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

Lesson 1: Navigation

	### Lesson Goal	❑ **Slide 15: Navigation Learning Objectives**
	The goal of this lesson is to enable the user to access and navigate within the CHCS II application.	

	Learning Objectives Upon completion of this lesson, the user will be able to: • Log in to the CHCS II application • Access modules quickly using Folder List • Open and close an application module • Exit the CHCS II application • Lock CHCS II session	
	Basic Navigation	
	Explain: General layout of the screen (similar to Outlook) • Title Bar • Main menu • Action Bar ## Demonstrate: • Logging on to the system • Viewing the current list of appointments • Opening and Closing modules 1. Double-click the CHCS II Training System icon on the computer desktop. 2. Press the escape key **Esc** on your keyboard twice to progress through the informational messages. 3. Verify the Appointments module is open. The list of current appointments will display. Point out Action Bar Icons. To demonstrate how the actions change depending on the active module: 4. Click **Co-signs** 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.	The Action Bar icons change according to the active module. **Note:** Emphasize how the desktop can be customized.

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

- For navigating, the Folder List and Action Bar are the most efficient method.

Exercises

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

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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.

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.)

Note: Emphasize that passwords **must** be changed in CHCS II.

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
    • Cancel an appointment
    • Transfer an appointment
	❑ **Slide 16: Patient Search & Appointments Learning Objectives**

Patient Search Module	

Pulling a Patient Record features:
 	
    ▪ Different search methods available
 	
    ▪ Patient must have a record in CHCS
 	
    ▪ "Search CHCS" is an option	

	Appointment Module	**Explain** specific *Appointment* screen features.
	Module specific screen features:	
	• Module title bar • Appointment list • Columns • Access to properties setup options: • Drop-down box • Options • Change selections	**Explain:** Scheduled (future) appointments are still made in CHCS and come over to CHCS II nightly and every 15 minutes throughout the day.
	Patient Search and Appointments	**Explain** the five setup options:
	# 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. Column Order 2. Clinic (Clinic assignments defined in CHCS) 3. Provider 4. Date 5. Status Selection
	1. Open the CHCS II Application. The application starts in the Appointments module.	
	2. Click **Search** in the Folders List to search for a patient. The Patient Search window will display.	**Explain:** Appointment types and statuses.
	3. Type *ALEXANDER* in the Last Name: field and click **Find** for a list of names.	Do not need to show all steps in Transfer and Add Provider—but, do point out these functions.
	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.	
	To set the appointment filters:	
	1. Click **Change Selections** button in the Appointment list workspace. The Appointment Search Selections window will display.	**Explain:** Live system, *Today plus Incomplete* pulls in old appointments from CHCS.
	2. Click the following radio buttons for the associated Field:	
	Clinics: This Clinic **Providers: Me** **Dates: Today Only** **Status Selection: Any Status**	Suggest using *Today Only* to view the current day's

	3. When the information has been completed, select the **Set Selections as Default** button to change the default settings. 4. To change column order, click and drag the **CheckedIn Time** column header to move next to the Appt. Date /Time column. 5. Click **Change Selections** button in the Appointment list workspace, select the **Set Column Order as Default** button to change the default settings. The Appointment List will re-display **To create new unscheduled appointment:** 6. Click **New Appt** on the Action Bar. A New Appointment confirmation window will display. 7. Click on *ACUTE APPT (ACUT$) 30* to select the appointment type. 8. Type *cough* in the Reason for Appointment field and click **OK** to complete the new appointment process for Col. Alexander. 9. Col. Alexander's appointment will now appear at the bottom of the Appointment list with a status of CheckedIn. **Key Points:** • Point out the **Transfer** icon.	appointments only.
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	
	SUMMARY • Patient search • Appointment list properties • Change display selections • Create a new appointment • Explained how to transfer a patient to another provider. *Next Slide*	

Lesson 3: Telephone Consults

Lesson Goals

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

Learning Objectives

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

- Set default search and display options for the telephone consults list
- Create a Telephone Consult
- Select and open a Telephone Consult
- Transfer a telephone consult to a different Provider
- Edit a call back phone number

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

Telephone Consults Module

Demonstrate:

You receive a call from retired **CAPT Clayton Williams (w8867).** He states that he needs a refill for his Hypertension medication, Lisinopril. You create a level one telephone consult for a Med refill. You ask CAPT Williams if the phone number listed in the callback field is correct. He indicates that he has moved and provides a new number: (123) 223-4444. You edit the Callback Phone Number.

To set the telephone consults filters:

1. Click **Telephone Consults** in the Folder List. The Telephone Consult window will display:

2. Click **Change Selections** button in the Telephone Consults list workspace. The Telephone Consults Search Selections window will display.

Telcons created in CHCS must be completed in CHCS.

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

3. Click the following radio buttons for the associated Field:

Clinics: This Clinic
Providers: Me
Dates: Today Only
Status Selection: Any Status

Click the **Change Selections** button to change the default settings.

To Create a Telcon and Edit the Callback Phone Number:

1. Click the **New Telcon** icon on the Action Bar. The Patient Search window will display:

2. Type (**w8867**) in the Quick Search Field and click the **Find** button. Highlight CAPT Clayton Williams' name in the Patient Name area.

3. Click **OK**. The New Telcon window will display.

4. Change the Callback Phone Number to (123) 223-4444.

5. Type *Med Refill* in the Reason for Telcon Consult field.

6. Type *Pt request refill, Lisinopril PO 20mg T* in the Notes field and click **OK**. The Telcon Quick Entry screen will display. Return to the Telephone Consults workspace. See Note.

7. Click **Cancel** in the Telcon Quick Entry screen.

8. Click **Close** on the Action bar to return to the Telephone Consults workspace.

To Transfer the Telcon:

9. In the Telcon list, highlight CAPT William's telcon.

10. Click the **Transfer** icon on the Action Bar.

11. Select **DOCTOR, DAVID** from the dropdown list.

Click **OK**. Notice that CAPT William's telcon is no longer in the list of telcons.

Key Points:

- Point out the **Transfer** icon.

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

NOTE: Since the user is logged in as a provider, the Telcon Quick Entry window displays. **Support/Clerk users are returned to Telephone Consults workspace.**

Also point out the **Edit Phone #** button on the Action bar.

Exercises	
• Complete the exercises. • Check for understanding and answer participant questions.	
SUMMARY	
• Explained search selections for telephone consults list • Created a telephone consult appointment • Explained how to transfer a telephone consult to a different Provider • Edited a call back phone number Next Slide	

Lesson 4: Demographics

# Lesson Goals The goal of this lesson is to verify the demographic information in CHCS II. # Learning Objectives Upon completion of this lesson, the user will be able to: • Verify patient demographic information	❑ **Slide 18: Demographics Learning Objectives**

Demographics

Demonstrate:

CAPT. Clayton Williams informs you that he has moved since his last visit, and you want to verify that you have his latest demographic information. Using his open encounter,

1. Click **Demographics** in the Folder List. The Demographics module will display.
2. Verify his home address as 877 Main Street.
3. Click the **CLOSE** icon on the Action Bar to close the module.

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 systems. Follow your MTF business rules.

Exercises

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

SUMMARY

- Verified patient demographic information

Next Slide

- Use the Demographic module to verify patient demographic information.
- Address and phone number information should not be updated in CHCS II. Changes in CHCS II do not write back to CHCS.
- To update this information, continue to follow current MTF policies.
- Insurance information does not write back from CHCS II to CHCS. Continue to follow your MTF policy for collecting third party insurance information.

Lesson 5: Patient Encounter	

	## Lesson Goals The goal of this lesson is to document the patient encounter in CHCS II and create electronic encounter/SF600. ## 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 A/P	❑ **Slide 19: Patient Encounter Learning Objectives**
	Screening and Vitals Modules	
	## Screening and Vitals ▪ Screening ▪ Vital signs Once the patient has been checked in, it is now time to document screening and vitals signs for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening.	**Review screen layout:** **SF600 features**

Screening and Vitals	

Demonstrate:

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

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

To get started:

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

BP
  Rt arm
   Pediatric cuff
	110/70
	[Select]
	[Select]

Explain: Use of the Screening module to document:

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

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

HR	95
Radial	[Select]
Regular	[Select]
RR	13
Temperature F	99 F
Oral	[Select]
Ht	[Enter] 52 in
Wt	70 lbs
Habits	
Tobacco	[Select] No
Alcohol	[Select] No
Pain Severity	
	[Select] 1 Hurts a little bit
Where is pain located?	Throat NOTE: Add comments when pain scale is selected (other than "0 pain free").
Save Vitals	
	[Select] Save Vitals (Action Bar Icon)
	[Select] Close (Action Bar Icon)

Key Points:

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

Exercises

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

Summary - Open the encounter - Setup AutoCite properties - Document "reason for visit" - Verify patient's allergies - Document patient's vital signs *Next Slide*	
Assessment/Plan Module	
# Assessment/Plan The Assessment and Plan module allows you to document procedures, as well as order laboratory and radiology tests. **A/P Processes** - Codes are captured with procedures - Labs and Rads can be submitted or saved to queue When a procedure is added, the associated CPT code is included.	.
Assessment/Plan	**Review screen layout.**
# Demonstrate: 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. Click the **Procedure** tab. 3. In the Search field, enter *Throat Culture* and click **Find Now.** The search results appear.	**Show how to:** - select/deselect - expand/collapse **Explain** Searches can be performed using: - WHO language - CPT Codes - Partial Words

	4. Expand ORAPHARYNX CULTURE. 5. Select STREPTOCOCCUS GROUP A BETA HEMOLYTIC 87081. 6. Click **Order Lab** tab. 7. In the New Lab Order field, enter *Throat Culture* and click **Search**. 8. Select THROAT CULTURE. 9. Click **Submit**. 10. Click the **Close** icon on the Action Bar so we can review the information on the SF600.	**Explain**: User can delete a diagnosis, procedure, or order that was documented in error. If orders were submitted they would be listed under the show orders area. Discuss pros and cons of saving to queue. • Point out you might lose orders if the system should fail; but you can delete from queued orders. • Show how to delete before submitting queued. • Recommend submit over save to queue.
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	
	Section Summary	
	• Document A/P • Explained how codes are captured with procedures • Labs and Rads can be submitted or saved to queue Next Slide	

Lesson 6: Previous Encounters

Lesson Goal

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

Learning Objectives

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

- Display a previous patient encounter

Previous Encounters

Demonstrate:

The user needs to view the previous encounter for LCDR Suarez.

1. From the list of appointments, click on any of LCDR Eduardo Suarez's appointments to pull his record.
2. Click **Previous Encounters** in the Folder List. The Previous Encounters window will display.
3. View the previous encounters for LCDR Suarez.
4. Click the **Close** icon on the Action Bar to close the module.

Key Points:

- Access to past encounters is available at any workstation that has CHSC II access.

Exercises

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

❑ **Slide 20: Previous Encounters Learning Objectives**

Previous Encounters will only list encounters completed CHCS II.

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.

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	Summary	
	▪ Display a previous patient encounter	
	Next Slide	

Lesson 7: Health History Folder

Lesson Goal

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

Learning Objective

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

- Setup Health History patient data modules
- View and modify patient Problems information
- View and copy Lab results into an encounter
- View and copy Radiology results into an encounter
- View and modify patient Allergy information
- Setup and review the properties for Vitals Signs Review

❑ **Slide 21: Health History Learning Objectives**

Health History

Students follow along:

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

1. Click the **Health History** folder in the Folders List. A message appears to select the modules for display.

2. Click the **OK** button to remove the message.

3. Click the **Options** button on the Patient ID line. The Health History Design Summary screen will display.

4. Click the check box next to the Problems, Allergy and Lab. As the modules are selected, they are stacked on top of each other.

5. Click in the center of the Lab box in the Design Summary window and drag it to the upper left of the design area.

6. Click and drag the Allergy box to the center left of the design area.

7. Click and drag the Problems box to the lower left of design area.

8. Click the **Align** button to view the format

9. Click the **OK** button to view the results

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

AutoCite Information

Explain: As encounters are completed for a patient, information from them is accessible through several modules from the Folders List. Information from some of these modules can be selected for display in the electronic SF600 of a new encounter that is opened for the patient. These modules are referred to as AutoCite modules. You make selections for display of information from these modules in the *Encounter Summary Properties* window when you set up your system for personal use. Information in some of these modules can also be edited and modified by additions and

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Explain:

- Use this folder to set up a display of selected patient health history information for quick review.
- The first time you access the folder, you will need to select (and organize) the modules you want displayed.
- Setup can be done from either the Tools menu or from the **Options** button.
- Once customized, the same setup applies to all patient records.

deletions that are appropriate outside of encounters.

AutoCite modules include:

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

Problems, Allergies, Medications, and Vital Signs are considered Health History modules and are located in the Health History Folder for the patient in the Folder List. AutoCite information for these modules appears in the AutoCite section of the SF600.

The Lab module and the Radiology module are directly accessible in the patient's folder. Information from these modules, when selected for AutoCite display, appears in the S/O section of the SF600.

The AutoCite button on the SF600 refreshes all information selected for AutoCite display regardless of where it appears.

Problems Module

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

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

Students follow along:

1. Select (highlight) CAPT Williams' name in the list of appointments. The patient's name must show in the ID line.

2. In the Folder List, click the **Problems** module located under Health History.

3. Complete the following:

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

Lab Module

Set the Scene: Provider Test User is out of the office till this afternoon. He tells you he has just talked to patient LCDR Suarez and wants to see him to discuss his previous Lab and Rad results. Dr. User asks you to add the results to the patient encounter he wants you to create.

Students follow along:

1. Create a new appointment for LCDR Suarez.

   Note: Loading the patient name to the patient ID line is sufficient for viewing lab results. An appointment is created in this exercise to illustrate additional features of CHCS II.

2. Open the encounter.

3. Click **Lab** in the Folder List.

   Review what appears based upon the default settings.

4. Provider User is specifically interested in the results of a urinalysis test. Change the properties and the filter to locate this test. (**Hint:** Change **Time** to **All time periods**)

5. Highlight the urinalysis lab result. The result details display in the lower section of the screen. Use the **Display Criteria** check boxes and radio buttons to select the optimal view of the test

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Explain: Review screen layout and quickly review default options.

10. Click the **Options** button to set the Lab Results Properties.).
11. Select the *Filter* tab radio button: *All labs*.
In the Preferences tab.
12. Time Options section, select Default Time*: All Time Periods.*
13. Click the **OK** button.
14. Click the **OK** button to display the list of labs.

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

results.

6. Highlight the result details and right-click. Note the two options:
   Copy: puts the results onto the clipboard and they can be pasted into another document
   Copy to Note: enters the results onto the patient encounter in the S/O portion

7. Select **Copy to Note**.

8. Close the **Lab** module and the highlighted urinalysis results appear in the S/O portion of the encounter note.

Do not close SF 600.

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

9. Close Lab Module and review lab results copied to the encounter note.

Review the screen layout.

Radiology Module

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

Students follow along:

1. In the Folder List, click the **Radiology** icon. The results of three tests appear.

2. Click each test in turn; note that the Result Code appears in red when the results are not normal, but the color change is not visible when that report is selected.

3. In the Display Criteria section, select the Select **All Results** check box.

4. Scroll through the results that appear in the lower section of the window.

5. Clear the Select All Results check box. Press and hold the Ctrl key (on your keyboard) and select both the Sinus Series Report and the Chest PA and Lateral Series Report.

6. Review what appears in the lower section. (Scroll down to view the results of both of the selected tests.)

7. Use your mouse to highlight all, or a portion of, the test results and right-click. This allows you

to copy to an open encounter note, or copy to the clipboard and paste in another document.

8. Copy the note.

9. Close the Radiology module

10. Close the encounter.

Meds Module

Explain:

- The Medications module lists the patient's past and present medications.
- It includes all over-the-counter (OTC), outside, and CHCS II-ordered medications.
- Ordered meds appear once the prescription is filled at the pharmacy.

Set the Scene: Col Violet Alexander (a5743) has the cough that many of the clinic's patients are exhibiting. She tells you that she has added one enteric-coated aspirin each day to her daily routine as suggested earlier by Dr. David Doctor.

Check her medication health history and update it with the new medication.

Students follow along:

1. Make a new appointment for **Col Violet Alexander (a5743)**. Use Appointment Type, **ACUTE APPT (ACUT$) 30**.

2. Open the encounter and complete the screening.

3. In the *Folder List* under Health History, click the **Meds** icon. In the Meds module, the **Search Filter** field default is **Outpatient Current**.

4. Review the functions available using the Action Bar icons: **Add**, **Details**, **Discontinue**, **Modify** and **Renew**.

5. Click the drop-down arrow for the **Search Filter** field and review the options. Change the selection to **All**.

6. Select an existing medication and, on the Action Bar, click the **Details** icon.

7. Click Discontinue; click Refresh.

How can you view the discontinued medication? (Select **All Discontinued** in the **Search Filter**

Review the screen layout.

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

field.) Note that the **Status** column entry is now **(Out) Discontinued**.

8. Change the **Search Filter** selection back to **Outpatient Current**.

9. Click the **Add** icon to record the addition of aspirin.

10. Click the **Record OTC/Outside Medication** button.

11. Click the **Medications** button to begin searching for **Ecotrin** in the *Healthcare Data Dictionary Search* window.

12. Select ECOTRIN, 325 MG, CAPSULE EC, 105 ea. BOTTLE, SMITHK and click the OK button.

13. Complete all required fields (including the **Sig: 1 tab QD**) and add a comment that it was a suggestion by her doctor for secondary prevention for heart disease.

14. Click the **OK** button. Note the "**O"** in the **OTC** column to indicate this is an over-the-counter medication.

15. Close the Meds module.

16. Return to encounter and click **AutoCite** to view the added medication in encounter.

17. Close the encounter.

.

Allergy Module	
Explain:	**Review the screen layout.**

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

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

Students Follow along:

1. Search for MG Marcos' patient record and load her name to the patient ID line.

2. Open the **Allergy** module from the Folder List.

3. Click the **Add** button to display the *New Allergy* section.

4. Click the **Allergen** button and search for **wasp venom** in the *Health Care Dictionary Search for Allergens* window.

5. Double-click **WASP VENOM (WASP VENOM)** to add it as an allergen.

6. Click the **Reaction** button and search for **BRONCHOCONSTRICTION** as a reaction.

7. Highlight **BRONCHOCONSTRICTION** in the left column of the *Health Data Dictionary Search for Reactions* window and click the **Add>>** button to move it to the right column.

8. Click the **OK** button to close the window.

9. Enter the following information:

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

10. Click the **Save** button.

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

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

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

13. Click **Close**.

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

15. Click the **Add** button in the Action Bar, and review the **Allergen** drop-down list. Notice that

WASP VENOM (WASP VENOM) has been added.

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

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

Vitals Sign Review

Demonstrate:

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

Students follow along:

16. Open the **Appointment** module.

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

18. Verify that LCDR Suarez is now listed in the Patient ID line.

19. Open the **Vitals Sign Review** module from the Folder List.

20. Click the **Search Type** button to open the *Time Search* screen.

21. Select the **Sliding Time Range** radio button and select **2 months** as the time range.

22. Click **OK**.

23. Click the **Refresh** button to the right of the time period display. (This may not work correctly in the CHCS II Training System.)

24. Highlight a single line and click the **Graph Vitals** icon on the Action Bar to open the *Graph Vitals* window.

25. Select each of the **Graph Options**, **Chart Types**, and **Vitals Keys** in turn to review their functions.

Note: The graphs can be printed from the live CHCS II system.

26. Click **OK** to exit and return to the Review role with LCDR Suarez' vitals.

27. Press the **Shift** key on your keyboard and select the entries in the **BP** and **HR** columns. Click the **Graph Vitals** button.

Review the display options available.

28. Return to the *Vital Signs Entry* screen.

29. Click the **Close** button twice to close the module and the encounter, respectfully.

Exercises

- No Exercises
  (Students practiced during instructor demonstration by following along).
- Check for understanding and answer participant questions

Summary

- Explained Health History folder
- Setup Health History patient data modules
- Viewed and modified problem information
- Viewed and copied lab results
- Viewed and copied radiology results
- Viewed and modified medications
- Viewed and modified allergy information
- Set and review the properties for the Vital Signs module
- Graph vital signs

Next Slide

Lesson 8: Questionnaire Setup & Patient Questionnaires

Questionnaire Setup

Lesson Goal:

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

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
- Administer a questionnaire

Explain:

- Questionnaire Setup allows you to create and modify questionnaires.
- Mark ready and Mark Obsolete
- An open encounter is not required to create or modify a questionnaire.

Creating a New Questionnaire

Students follow along.
1. Expand Tools, and select Questionnaire Set Up.
2. Click the New icon on the Action Bar.
3. In Name, enter Asthma.
4. Click the Add button. You can now create questions for your questionnaire.
5. In the Question text field, enter: How would you rate your asthma compared to your last visit?
6. From the Answer Type drop-down list, select Multiple Choice.
7. Next to Choice 1, enter Better and press Enter.

	8. Next to Choice 2, enter Worse and press Enter.	
	9. Next to Choice 3, enter Same. DO NOT press Enter this time.	
	10. Click the Add button.	
	11. Question #2: Do you have an asthma action plan?	
	12. From the Answer Type drop-down list, select Yes/No.	
	13. Click the Add button.	
	14. Question #3: How many times a week do you have a worsening of your asthma requiring use of your inhaler?	
	15. From the Answer Type drop-down list, select Number.	
	16. Min value: 0	
	17. Max value: 100	
	18. Click the Add button.	
	19. Question #4: What seems to trigger a worsening of your asthma?	
	20. From the Answer Type drop-down list, select Multi-select.	
	21. Next to Choice 1, enter Exercise and press Enter.	
	22. Next to Choice 2, enter Common cold and press Enter.	
	23. Next to Choice 3, enter Dust and press Enter.	
	24. Next to Choice 4, enter Animal fur and press Enter.	
	25. Next to Choice 5, enter Unknown. DO NOT press Enter this time.	
	26. Click the Add button.	
	27. Question #5: What date was your last asthma attack?	
	28. From the Answer Type drop-down list, select Date. DO NOT press Enter.	
	29. Click the Save icon on the Action Bar.	
	30. Click the Mark Ready icon on Action Bar.	
	31. Close the Questionnaire Setup module	

Complete a Questionnaire via Interview

Explain:	
• Use the interview when talking with the patient.	
• Answers are entered directly into the application.	
Explain while students follow along:	
32. Create a new appointment for **Edward Alexander (a5743)**, reason for appointment **Asthma follow up**. Open the encounter	
33. Expand the **Health History** folder, and select **Patient Questionnaires**.	

34. Expand **Questionnaires**.
35. Select the **Asthma** questionnaire.
36. Click the **Interview** icon on the Action Bar.
37. Click the **Options** button and show **Properties.** In the **Questions** drop down box, select **Single Question View.**
38. Click **OK.**
39. Select the appropriate answer for each question and follow the hyperlink **Next Question** to navigate through the questions.
40. Proceed to answer questions:
41. Answer #1: **Better**
42. Answer #2: **Yes**
43. Answer #3: **2**
44. Answer #4: **Animal fur**.
45. Click the **Add Comment** hyperlink to add the following comment: **Patient wheezes after being around cats.** Click **OK**.
46. Answer #5: **1st of month** using format dd mmm yyyy)
47. Click the **Done** icon on the Action Bar.
48. Click the **Encounter** button in the Action bar
49. Show how to link Questionnaires to a specific Encounter
50. Close the Patient Questionnaires module
51. In the open Encounter, click the **Options** button
52. In *Encounter Summary Properties* select the **Questionnaires** checkbox. Close Encounter Summary Properties.
53. Review the S/O note with the Questionnaire results.
54. Close the Encounter

Exercises

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

Summary

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

Course Summary

	Briefly summarize the course and open to questions and answers. • Overview of the system, the training, the expectations.	❑ **Slide 23: Course Summary** **Summarize course based on modules taught.**

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

	• Write down any error message received. • Remember what action was taken before the error message was received. • Take screen shots • Report the problem to your local Help Desk.	❑ **Slide 24: What Do I Do If I Encounter a Problem While Working with CHCS II?**

Demonstrate:

Capturing Screen Shots:

To capture screens:

1. On the workstation keyboard, press **PrtScrn**.

2. Open PowerPoint.

3. To paste the screen capture into PowerPoint, right mouse click and select **Paste.**

4. Save the screen capture to the appropriate folder on the workstation. In many clinics, there is a specific folder on a shared network drive for storing these files.

Ensuring Patient Data is concealed in the Screen Capture

1. In PowerPoint, use the drawing tools to conceal any patient-specific information on the screen.

2. From the View menu, select Slide Show.

3. On the workstation keyboard, press PrtScrn.

4. Exit the slide show to return to the normal view by pressing Esc on the workstation keyboard.

5. On the PowerPoint toolbar, click the new presentation icon (i.e., the blank piece of paper).

6. To paste the screen capture into the new presentation, right mouse click and select **Paste**.

7. Save the screen capture (in the new presentation) to the appropriate folder location on the workstation.

8. Close the original screen capture without saving the document.

Next Slide

Other Help Resources

- **QRC's**.
- **CHCS II User Manual** (should be available in each clinic)
- **CHCS II Help Menu**.

Emphasize the use of Help in the application.

Next Slide

Questions and Answers

Slide 25: Other Help Resources

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

Address all questions from users.

Course Evaluation Forms:

Ensure users include a comment for any item marked

		as "3" or lower.

Appendix A: Immunizations		
	# Overview of Immunizations Admin	❑ **Slide 27: Immunizations Learning Objectives**
	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:	
	30. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays	
	31. Click the **Ellipsis** button next to the *Default Clinic* field. The Clinic List Edit window opens	
	32. 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.	
	33. Click **Set Default**. You are returned to the Vaccine Management area.	

34. Do one of the following:

- If you want to associate stocked vaccines to the default clinic:

    1. Select a vaccine from the list of available vaccines.

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

- If you want to set the default typhoid product, select the typhoid product from the drop-down list.

- If you want to set the default body area where the vaccine is given, select the site from the drop-down list.

- If you want to view manufacturer and lot number information for the vaccines in stock:

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

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

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

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

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

Viewing the Vaccine Lot Number List

To view the Vaccine Lot Number List:

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

35. Select a manufacturer.

36. Click Details.

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

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

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

To add vaccines Mfg/Lot Nbr:

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

DTP	Smith Kline	022	.5 ml	IM
DTP-hib	Smith Kline	022A2	.5 ml	IM
Hep A	Smith Kline	11032L	.1 ml	IM
Hep B	Smith Kline	11032H	.1 ml	IM
Hib-HbOC	Merck	0528R	.5 ml	IM
Influenza	Unkn	005339	.5 ml	IM
IPPD	Aventis	C1601NA	.5 ml	IM
IPV	Avivon	12BH6578	.5 ml	IM
Measles	Unkn	123456	.5 ml	SC
Meningococcal	Wyeth	496590	.5 ml	IM
MMR	Merck	1082M	.5 ml	SC

Pneumoccoccal Conjug	Aventis	492540	.5 ml	IM
TD	Aventis	22AHA	.1 ml	ID
Tetanus	Unkn		.5 ml	IM
Typhoid	Unkn		.5 ml	Oral
Variccella	Unkn		.5 ml	
Smallpox				
Yellow Fever				

4. Select Close when completed.

To record a patient vaccines previously given:

1. Click **Rapid Data Entry** tab on Vaccine Management window.

2. Select vaccine by clicking on Add button.

3. Enter Immunization Date

4. Enter Immunization Providers

5. Click on **Rapid Data Entry** Button

6. Either read patient's ID bar code or enter required data.

7. Select OK

8. Select Close

Adding User Defined Groups

To add user defined groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays

2. Click **Add**. The Add User Defined Group window opens

3. Enter the name of the user group (have input from class)

4. Click **OK**.

Adding/Modifying a Refrigerator

To add/modify a refrigerator:

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

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

1. Complete the following fields:
   - Alias Name
   - Serial Number
   - Low Temperature
   - High Temperature
2. Click **A/M**.

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

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

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

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

Assigning Vaccines to User Defined Groups

To assign vaccines to User Defined Groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays

2. Select a User Defined Group.

3. Select a vaccine from the Available vaccine list. (Have input from class).

4. Click the **Right Arrow** button to move the vaccine to the Assigned Vaccines list.

Deleting Providers from Administering Immunizations

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

To delete a provider from administering immunizations:

1. Click **Provider Management** on the Admin tab. The Provider Management area displays (see Figure 12-9: Immunizations Admin—Provider Management).

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

3. Click **Delete**.

Entering Multiple Vaccines for a Patient

To enter multiple vaccines for a patient:

1. Select an Immunization Provider from the drop-down list on the Multiple Entry tab. *The Immunization Date field defaults to the current date. Type the applicable date in the field if the current date is not the correct date*.

2. Select the Unit in which the patient is located from the drop-down list.

   A list of patients assigned to the unit displays.

	3. Select the patient for which you want to enter multiple vaccines.lick the Select field for the associated patient and click the down arrow to select the patient. *Click Select All if you want to enter the same multiple vaccines for every patient in the list.* **4.** Click **Log Selected.**	

Printing Immunization Reports

To print immunization reports:

1. Click Reports on the Admin tab. The Reports area displays.

2. Select a report from the drop-down list.

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

3. Click Print.

4. Select a print range on the Print window.

5. Click OK.

Logging Refrigerator Temperatures

To log refrigerator temperatures:
1. Click **Temperature Log** on the Admin tab.
 The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.

4. Complete the following fields:
   - Temperature
   - Date
   - Time
5. Click **Add**.

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

Modifying Refrigerator Temperature Logs

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

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

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

Patient Immunizations Module

Overview of Patient Immunizations

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

Documenting a Vaccination Visit

- Select New Appt on the Action bar
- Search for Violet Alexander
- Select the Appt Type (Wellness$)
- Select the Provider/Support 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	

Have Provider/Support sign encounter Review	

Appendix B: System Demonstration

System Demo

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

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

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

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

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

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

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

	Order Rad Tab	
		[Select]Chest [Type] Chest in the new order field. [Click] Search [Select] Chest in the new order field.

	Clinical Impression
	  Routine
	  More Details
		[Enter] r/o pneumonia
		[Select]
		[Select] Ordering Provider
		
		[Click] Submit
		[Click] Close
		(Action Bar Icon)

	SF600	
		[Click] Close (Action Bar Icon) to return to Appts. module
NURSE:	**RESULTS ARE READY!!!**	
Reviews Results and copies results to encounter	Lab	
		Open module Highlight Result Copy to Note
	Rad	
		Open module Highlight Result Copy to Note
PROVIDER:	Apointments	
Returns to patient to discussed results and give a Diagnosis. He then completes the Disposition and Signs		[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF600

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

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

As the **CLERK:** Col. Violet Alexander walks into your clinic complaining of shortness of breath, she does not have an appointment but needs to see her PCM – Dr. Test User. You create an (Acute $) 30 walk-in appointment for the patient and enter the reason for appointment as shortness of breath.

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

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

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

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

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

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

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

Select + for History of Asthma

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

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

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

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

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

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

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

The **NURSE** then returns the signed encounter and double clicks it. This will take you to the previous encounter. The nurse highlights the encounter and selects the Append Narrative on the action bar. This will open the encounter note. The nurse will import the nebulizer treatment word document. The nurse will also indicate the second peak flow result after the treatment on the note. She/he saved the note and goes to sign the encounter. The nurse will add the provider as the co-signer of the note. The encounter will have the status of updating until the provider enters the countersignature. The status will change to updated.

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