CHCS II Nurse Lesson Plan

COMPOSITE HEALTH CARE SYSTEM II

February 2005
Rev 2.2

Change History			
Date	**Name**	**Change Description**	**Source:**
10-25-2004	Kathleen Chapman	Created	Consolidation of Services materials
11-5-2004	Kathleen Chapman	Updated	CITPO comments
12-01-2004	Juanita Stuckey	Revised	Service Comments
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01-11-2005	Juanita Stuckey	Revised	Service Comments
02-01-2005	Juanita Stuckey	Build Enhancement	Build 837.4 Release

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Preparation for Delivery

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

Materials Needed

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

Note: Training items are to be left in the classroom. The Evaluation Form is to be completed by each student and left with the instructor upon completion of the class.

Tasks to be Completed Prior to Class

- Set up classroom with one workstation per student and one for the instructor, each workstation loaded with the following:
    - CHCS II Training System (CTS)
    - Training Templates
    - CHCS II Nurse Course PowerPoint Presentation (instructor workstation only) updated with instructor name and current date.
- Reset data (**Encounter Data** button) for each CTS prior to starting class daily. **Note**: The entire database should be refreshed weekly after the last Nurse's class to ensure that CHCS II does not generate messages saying that templates created during class already exist because students created them in a previous class.
- Import training templates:
    - TRAINING—ECP—PREGNANCY TEST—VISIT
    - TRAINING—TRIAGE—COLD&COUGH—ENC
    - TRAINING—ECP—UTI—ENC
    - TRAINING—TRIAGE—DIARRHEA—ENC
    - TRAINING—TRIAGE—FEVER—ENC
- Become aware of local policies and variations with respect to such things as template naming conventions, pharmacy locations and other similar factors relevant to training. The site coordinator and the MTF's CHCS II training team are resources for this type of information
- From the lead instructor, find out how students can obtain copies of the CHCS II User Manual at each site.

- Review the release notes addendum (a.k.a. Disclaimer List).

Tasks to be completed at the end of class

- Distribute the 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.

Duration	Training Activities	Instructor Notes
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: CHCS II Nurse Training Course** ❑ **Slide 2: Logistics and Introductions**
	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 the 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 a transition to next slide:** One of the greatest benefits of CHCS II is that it is an electronic patient record. Not only does this help to meet the presidential directive for a "comprehensive, life-long medical record," but it also eliminates some of the risks and inefficiencies of paper-based medical records. ***Next Slide***	❑ **Slide 3: What is CHCS II?**
	Limitations of Paper Based Medical Records • Paper charts are lost • No automatic drug interaction alerts • Penmanship counts • Only one person can access a record at a time ***Next Slide***	❑ **Slide 4: Limitations of Paper Based Medical Records**

Duration	Training Activities	Instructor Notes

	CHCS II Benefits
	• Interfaces with MHS Standard systems, e.g. CHCS & ADM
	• Uses MEDCIN (a structured language that captures ICD-9 and CPT codes)
	• 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 simultaneous multi-user access
	• Supports problem-oriented health care
	• Accumulates data for reports and studies, such as clinical and population health
	• When fully implemented worldwide, CHCS II will provide access to patient records anywhere, anytime
	• Maintains security
	Next Slide
		❑ **Slide 5: CHCS II Benefits**
		Elaborate on each benefit.

	Security Security is a crucial requirement of patient medical records. • CHCS II security is multi-leveled and conforms to HIPAA/MHS security standards • User access to patient information is based on user role • Roles and privileges are tied to unique user name and password • The system administrator assigns passwords that may 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 ***Next Slide***	❑ **Slide 6: Security**

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 • Nurses shall be available to receive On-the-Job Training (OJT) • 100% of patient encounters shall be documented in CHCS II ***Next Slide***	❑ **Slide 7: Expectations**
	CHCS II Training Training is accomplished using Clinical scenarios appropriate to each user's role. In order to better demonstrate system functionality the clinical scenarios presented may not always follow clinical standards of care. Providers receive eight hours of Instructor-Led Training (ILT), while Nurses receive six hours of ILT. Providers and Nurses receive sixteen hours of OJT. Clerks and Support staff receive four hours of ILT and four hours of OJT. Records Reviewers receive two hours of ILT and two hours of OJT. ***Next Slide***	❑ **Slide 8: Training Schedule**

	Key Information Technology Training Resources
	
	• MTF CHCS II Team
	    • MTF Project Officer
	    • Facility Training Coordinator
	    • Clinical Champion/SuperUser
	• Unisys On-Site Team
		❑ **Slide 9: Key Information…**
		
		These resources are available during the training implementation.
		
		Note: Provide the names of

Duration	Training Activities	Instructor Notes
	• Site Training Coordinator ILT Trainers OJT Trainers ***Next Slide***	those filling these roles locally and an indication of how they might be contacted.

	System Demo	
	Go to Appendix B ***Next Slide***	❑ **Slide 10: Systems Demonstration** **Suggestion:** 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 CHCS II to document patient encounters. ***Next Slide***	❑ **Slide 11: Course Goal**
	CHCS II Training System **Explain:** • CTS desktop icon • Stand-alone practice version of CHCS II • Used for training only • Simulates CHCS II functionality • Patient data is fictitious • Very limited choices for labs, Rads and meds • Slight variations between the CTS and the live system • Users are automatically logged on as a Provider • Live system access may vary depending on roles ***Next Slide***	❑ **Slide 12: CHCS II Training System** **Elaborate on each bullet point** **Note:** Duties of staff vary from clinic to clinic.
	Training and MTF Business Rules • Training exercises do not imply that your clinical role or privileges change • Training scenarios represent user's role • Roles and privileges vary from MTF or clinic	❑ **Slide 13: Training and MTF Business Rules**

	• MTF and service-specific business rules are to be followed when using CHCS II ***Next Slide*** **Session One Course Agenda** • Navigation • Patient Search and Appointments • Telephone Consults • Patient Encounter • Previous Encounters • Medicomp Forms Tool • S/O Template Management ***Next Slide***	❑ **Slide14: Session One Course Agenda**

Lesson 1: Navigation

	Lesson Goal The goal of this lesson is to enable the user to access and navigate within the CHCS II application. **Learning Objectives** Upon completion of this lesson, the user will be able to: • Log onto the CHCS II application • Access modules quickly using Folder List • Open and close an application module • Lock CHCS II session • Exit the CHCS II application	❑ **Slide 15: Navigation Learning Objectives** **Note:** At a CHCS II workstation equipped with a CAC reader, users will have the option of using their personal CAC to log into CHCS II.
	Basic Navigation **Explain:** General layout of the screen (similar to Outlook) • Title Bar • Main menu • Action Bar • Folder List **Demonstrate:** Log on to the system, view the current list of appointments and open and close modules 1. Double-click the CHCS II Training System icon on the computer desktop. A Role identification screen will appear; the medical radial button is selected by default. 2. Click **OK**. 3. Press the escape key (Esc) on your keyboard twice to progress through the informational messages.	**Explain:** You will demonstrate each lesson first and after each lesson demonstration the class will practice these lessons by performing the exercises in the Student Guide. The Action Bar icons change according to the active module, providing quick access functionality for the module.

	4. Verify the Appointments module is open. 5. The list of current appointments will display. 6. Review the icons in the Action Bar for Appointments. Icons in the Action Bar are relevant to the module that is open. Icons that are used in one module might not be used in another, so what appears in the Action Bar changes. 7. Click the **Telephone Consults** folder in the Folders List to open the Telephone Consults module. The Telephone Consults module will display. 8. Click the **Close** icon on the Action Bar to close the Telephone Consults module. 9. To lock the CHCS II application, follow the Menu Path **File** > **Lock.** 10. The screen will minimize. 11. To reopen the application click the application located on the desktop tool bar area. 12. Click **OK**. **Point out that the in the live system user will have to enter their assigned password before reentering CHCS II.** **Note:** The CHCS II application restores to previously used screen. 13. Click the Close **X** button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display. 14. Click **Yes** to confirm the exit **Key Points:** • Module access • For navigating, the Folder List and Action Bar are the most efficient method	**Note:** Emphasize how the desktop can be customized.
	Exercises	
	• Complete the exercises • Check for understanding and answer participant questions	

	Security and Session Management **Explain:** • Passwords expire every 85 days – user is prompted at 80 days to change. • Password can be changed prior to expiration. • CHCS II password and CHCS verify codes are synchronized. • 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. **SUMMARY** • Navigation • Security ***Next Slide***	**Note**: Emphasize that passwords **must** be changed in CHCS II. **Note:** Reopen application and demonstrate this feature.
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 module in CHCS II. **Learning Objectives** Upon completion of this lesson, the user will be able to: • Search for a patient record	❑ **Slide 16: Patient Search and Appointments Learning Objectives**

	• Set search selections for the appointments modules • Change and save the column order • Create a walk-in appointment • Transfer an appointment to a provider • Add a Nurse to an appointment • Clear patient	

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

	Patient Search and Appointments **Demonstrate:** Open the CHCS II Application **NOTE:** By default the Appointment module displays CAPT. Paula Flanagan has come in today complaining of a cough. We need to search for CAPT Flanagan's record, set the appointment filters and create a new appointment.	

	Flanagan's record, set the appointment filters and create a new appointment. 1. Click **Search** in the Folders List to search for a patient. The Patient Search window will display. 2. Click in the Last Name field and type **FLANAGAN**, then click **Find** for a list of names. Click on ***FLANAGAN, PAULA Z*** in the list of names and click **OK**. CAPT Flanagan's information will appear on the Patient ID line and the Appointments List will display. 4. 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. 5. To move a column: a. Scroll to the right just until the **Type** column is visible. b. Click the **Type** column heading and hold down the left mouse button. c. Drag the **Type** column horizontally right (or left). Release the left mouse button when the **Type** column is between the **Patient** and **Status** column. 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 **CAPT Flanagan (f1115)**. 1. Click **New Appt**. on the Action Bar. A New Appointment confirmation window will display. 2. Click **Yes** to complete the New Appointment information for CAPT Flanagan. 3. Click on ***ACUTE APPT (ACUT$) 30*** to select the acute appointment type. 4. Type **COUGH** in the Reason for Appointment field and click **OK** to complete the new appointment process for CAPT Flanagan. (The Allergy synchronization simulation from CHCS will begin.) 5. CAPT Flanagan's appointment will now appear at the bottom of the Appointment list with a	**Explain:** Appointment display options: • Column order • Clinic (Clinic assignments are in CHCS) • Provider • Date • Status Selection **Explain:** Appointment types and statuses. Do not need to show all steps in Transfer and Add Provider—but, do point out these functions. **Explain:** Live system, *Today plus Incomplete* pulls in old appointments from CHCS. Suggest using *Today Only* to view current day's appointments **Explain:** The Related to Injury/Accident checkbox.

	status of **CheckedIn**. **To Transfer and appointment** **Ret. VADM Olaf Berg's (b8943)** Provider had an emergency, so it is necessary to transfer her appointment to a different Provider. Use the **Transfer** icon on the Action Bar to transfer the appointment. 1. In the appointment list, select to highlight Col Alexander's appointment. 2. Click the **Transfer** icon on the Action Bar. 3. Select **DOCTOR, DAVID** from the dropdown list. 4. Click the **Refresh** icon on the Action Bar to refresh your screen. 5. Click **OK**. Notice that Col. Alexander's name disappears from your appointment list. **Add Nurse to an appointment** You will be assisting provider User, Test with the headache/physical appointment for **CAPT Clayton Williams (w8867)**. 1. Highlight CAPT Williams' name on the appointment list. 2. Check-in CAPT Williams by clicking the **Check-In** icon on the Action Bar. 3. Click the **Add Providers** icon on the Action Bar to open the *Providers and Roles* window. 4. Click the ellipsis **(…)** button next to Additional Providers #1 to perform a Clinician search for Nurse, Karen. 5. The Clinician search window will display. Enter **NURSE** in the **Last Name** field and click the **Find** button. **Note:** In the live CHCS II system a list of Nurses will appear. 6. Select **Nurse, Karen** if the name is not already highlighted. 7. Click the **Select** button to complete the process of adding Nurse Karen as the additional provider for CAPT Williams. The Clinician search window disappears. 8. The Providers and Roles window re-opens. Notice that Nurse, Karen is now added to the	

Additional Provider # 1 field.

9. Click the **Role** dropdown button to display the list of role options. Select **Nurse**.
10. Click **OK** to close the *Providers and Roles* window.

Note: The names of additional Providers for a visit are not shown on screens, but the Providers receive credit for the visit.

To Clear the patient from the Patient ID line.

1. Click **Go** on the Menu Bar to display the dropdown menu.
2. Select **Patient >** to display the sub-menu.
3. On the sub-menu, click **Clear Patient**.

Notice that the Patient ID displays *No Patient Selected* and the Folder List no longer displays the patient specific information.

Key Points:

- Locate a patient
- Manage appointments
- 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

- Search for a patient
- Set-up appointment list properties and display selections
- Created a new appointment
- Transferred an appointments to a provider
- Added a Nurse to an appointment

	• Cleared a patient from the patient ID line ***Next Slide***	

Lesson 3: Telephone Consults

Lesson Goals

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

Learning Objectives

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

- Set default search and display options
- Open and document a Telcon
- View clerk notes for an appointment
- Edit a call back phone number

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

Telephone Consults Module

Demonstrate:

To set Telcon display properties:

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

Telcons created in CHCS must be completed in CHCS.

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

	Anna Wunderlich (w8118) phones the clinic to report that she has lost her Zyrtec allergy medication. You review the appointment note and return her call. You speak to her, but need to phone her back after consulting the Provider. She indicates that she is leaving her office and wants her call returned at a different number: (123) 555-9999. You confer with the Provider and complete the Telcon according to the Provider's instructions. 1. Select **Anna Wunderlich's** Telcon appointment. 2. Click **Notes** on the Action bar. The Appointment Comment (Read Only) window opens. 3. Click **Cancel**. 4. Click **Edit Phone #** on the Action bar. 5. Change the Callback Phone Number to **(123) 555-9999**. 6. Click OK. Notice that the Callback phone number has changed in the type column. 7. Highlight Anna Wunderlich's Telcon appointment and click the **Open** icon to open her appointment. (The Allergy synchronization simulation from CHCS will begin.) 8. The Telcon Quick Entry window displays. 9. In the Provider Note field, enter **NURSE'S NOTE**: **PHYSICIAN CONSULTED REFERENCE PT LOSING MEDICATION. PT REQUESTS REFILL, ZYRTEC REFILL ENTERED PER PHYSICIANS ORDER**. 10. Select the **Problem List (Chronic)** radio button. 11. Select *ALLERGIC RHINITIS* and click **Add**. 12. Accept the default E&M value of 99371 Lvl I, Simple/Brief. 13. Select the **Save and Open A/P** radio button. 14. Click **OK**. The A/P module opens. 15. Click the **Order Med** tab. 16. In the **New Med Order** field, enter **ZYRTEC** and click **Search**. 17. Select CETIRIZINE (ZYRTEC)--PO 10MG TAB. 18. In the SIG field, enter **1 PO QD PRN #30 RF0** and press Enter on your keyboard. 19. Click the **Submit** button.	**Explain:** Reason for Telcon field and Note field. Both must be completed. Lower case terms in diagnosis list are symptoms. Review quick entry screen. **Explain:** Rather than signing the note and designating a Physician as the cosigner, an end user could transfer the Telcon to the Physician for their signature using the Action Bar icon. **Clarify**: 99371 code will convert to 99499 for non-credentialed providers. **Explain:** Some nurses may not have ordering privileges. May need to renew prescriptions by clicking "more detail" button in live system and select an ordering provider. **Explain**: When closing A/P

	20. A Drug Warning message appears: *One Drug Order warning returned*. 21. Click in the **Specify a reason for this override** field. Enter: **PT LOST MEDICATION.** 22. Click the **Accept override** button to submit the order. You are returned to the A/P module. 23. Click **Close** on the Action Bar. 24. You return to the encounter screen. 25. Click **Close** on the Action bar.	module, may get message regarding order not being associated with diagnosis. Instruct on how to correct this.
	Exercises • Complete the exercises • Check for understanding and answer participant questions **SUMMARY** • Explained default search and display telephone consults appointment list options • Edited a call back phone number • Opened and updated a telephone consult appointment • Explained how to transfer a telephone consult to a different Provider Next Slide	
Lesson 4: Patient Encounter		
	Lesson Goals The goal of this lesson is to document the patient encounter in CHCS II and create electronic record.	❑ **Slide 18: Patient Encounter Learning Objectives**

Learning Objectives

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

- Open the encounter
- Document "reason for visit"
- Verify patient's allergies
- Document patient's vital signs
- Document S/O using MEDCIN
- Document A/P
- Disposition and Sign Review Encounter

AutoCite Information

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

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

Inform that Provider's AutoCited selections are those that will show in the final SF 600.

AutoCite modules include:

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

	Problems, Allergy, Meds, and Vital Signs Review modules are located in the Health History Folder in the Folder List. AutoCite information for these modules appears in the AutoCite section of the SF 600. The Lab module and the Radiology module are directly accessible in the patient's folder. Information from these modules, when selected for AutoCite display, appears in the S/O section of the SF 600. The AutoCite button on the SF 600 refreshes all information selected for AutoCite display regardless of where it appears.	
	Screening and Vitals Modules **Screening and Vitals** • Screening • Vital signs Once the patient has been checked in, it is now time to open an encounter for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening. The appointment, or encounter for the patient can be opened.	**Review screen layout:** **SF 600 features**
	Screening and Vitals **Demonstrate:** **Sonya Jackson (j0201)** has come in for a pregnancy test, you create a new appointment. You begin screening along with verifying her allergy information and documenting her vitals. During this portion of the encounter, you will set the AutoCite properties, screen the patient	**Explain:** Use of the Screening module to document: • Appointment reason for

	including entry of the reason for visit and verifying allergies, enter the vital signs and review the results in the electronic SF 600. To get started: Clinical data:	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

Field	Data
New Unscheduled Appointment/Telcon Visit	
Appointment Type	Routine Appt (ROUT) 15
Reason for Appointment	Pregnancy Test
	Click OK
To open appt.	Click the **Open Appt** icon on Action
Encounter Summary Properties	
	Click the Options button
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family	[Select]
Active Medications	[Select]
	Click OK
Screening	
In the Search field	[Enter] Pregnancy Test and click Find
For Females Only	
[Birth Control]	[Select] None
Verify Allergy	[Select] No Known Allergies
	Click Close

	(Action Bar Icon)
Vitals	
BP Rt arm Adult cuff	130/70 [Select] [Select]
HR Radial Regular	80 [Select] [Select]
RR	16
Temperature F Oral	96.7 F [Select]
Ht	[Click] the drop-down list next to Ht [Select] ft/in. [Enter] 5 ft 5 in
Wt	127
Habits	
Tobacco	[Select] No
Alcohol	[Select] No
Pain Severity	
	[Select] 0 Pain Free
Where is pain located?	Note: Add comments when pain scale is selected (other than "0 pain free")
Verify Allergy	[Select to verify allergies]
	Click Close (Action Bar Icon)
Save Vitals	
	[Select] Save Vitals (Action Bar Icon)
	[Select] Close (Action Bar Icon)

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

Key Points:

- Reason for Visit is a structured term and may be more accurate than Reason for

Appointment

- Screening during the patient encounter is the only area where a patient's allergies can be verified
- Allergy information, however, can be added without an open encounter

Exercises

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

Summary

- Open the encounter
- Setup AutoCite properties
- Document "reason for visit"
- Verify patient's allergies
- Document patient's vital signs

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

Introduction to MEDCIN

MEDCIN

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

Explain: MEDCIN

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

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

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

	• Structure: Tree, hierarchy, parent-child relationships; navigational nodes, gender-specific aspects. Expand **head-related symptoms**, then **headache** for this. • Tabs: Move through and open and show terms. • Organization: Head to toe. • Location in application: Stored in and used in both S/O and A/P (diagnosis and treatment terms). • PMH hidden nodes: Diagnosis and therapy. • Use of terms: Demonstrate add/remove a term; change from plus (+) to minus (–).	.
	Subjective/Objective Module	
	Subjective/Objective Most Nurses are familiar with the SOAP format that is used in paper charting. MEDCIN is organized into a SOAP format as well. To review: • Subjective - what the patient told the end user • Objective - what the end user observed during physical exam The Subjective portion of the note includes the History of Present Illness (HPI), Past Medical History (PMH) and Review of Systems (ROS). This information comes from the patient and is organized by the end user. The Objective portion of the note includes the Physical Examination (PE) and is what the end user observes. **Key Points:** • Standard visit templates are clinical notewriters using MEDCIN terms • E&M coding is done quickly and accurately using structured terminology.	Reinforce to Users the criteria between HPI and ROS. This is typically not familiar to some Users. **Review screen layout**
	Subjective/Objective	

	Demonstrate: Sonya Jackson's results were positive with a home pregnancy test, and she is now ready to be seen. **To load and unload an S/O template to document an encounter:** 1. Click **S/O** on the SF 600. The S/O module opens. 2. Click **Template Mgt** on the Action bar. 3. In the Name Contains field, enter **TRAINING** and click **Find Now**. 4. Select the TRAINING--ECP--PREGNANCY TEST--VISIT template. You can review the template in the Template Preview pane. 5. Click **Load** on the Action bar. 6. Add the reason for visit is: Pregnancy Test as a positive finding. 7. Add *nausea* as a positive finding. 8. Click **Find Term** on the Action bar. 9. In the search field, enter **FATIGUE** and click **OK**. 10. Add *feeling tired (fatigue)* as a positive finding. 11. Click the **<< Go Back** button to return to the template. 12. Check note in right screen. Identify conflicting statements regarding menstrual period and thought of pregnancy and the need for correction. 13. Click **Plus** sign beside *did not miss the most recent menstrual period* to reverse this statement. 14. Click **Plus** sign beside *she did not think she was pregnant* to reverse this statement. 15. Click the **PMH** tab. 16. Add *reported home pregnancy test* as a positive finding. 17. Add *taking vitamin supplements* as a positive finding. 18. In the Free Text field, enter **CALCIUM 500MG DAILY** and press Enter on your keyboard.	**Show how to:** • select/deselect • expand/collapse

19. Expand *pregnancy history*.
20. Add *age at first pregnancy years old* as a positive finding.
21. In the **Value** field, enter **20** and press Enter on your keyboard.
22. Add *planning to become pregnant* as a negative finding.
23. Click **Find Term** on the Action bar.
24. In the **Search** field, enter **DIABETES** and click **OK**.
25. Expand History of Diagnoses, Syndromes And Conditions.
26. Add history of DIABETES *MELLITUS as* a positive finding.
27. Click the **FamHist** button on the Dashboard.
28. Click the **<< Go Back** button to return to the template.
29. Click the **PE** tab.
30. Add *Pain Level (0-10)* as a positive finding.
31. In the **Value** field, enter **0** and press Enter on your keyboard.
32. Click the **Notepad** icon.
33. In the note field, enter **EDUCATION**: **PT INSTRUCTED TO MAKE OB APPT. PICK-UP PRENATAL VITAMINS FROM PHARMACY. PT INSTRUCTED NOT TO DRINK ALCOHOL OR TAKE OTHER MEDICATIONS** and click **OK**.
34. Click **Close** on the Action bar.

Explain: Reverse Sensing terms

With a *reverse sensing* term, abnormal conditions 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 w*ell nourished* or *does not appear stressed*; rather than an abnormal one, like *headache* or *nasal congestion*. Reverse sensing terms are mostly found in the **General Appearance** section of the (*PE)* tab.

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.

Here's an example:

Under the S/O PE area in another note, you find the following statement.

"The patient does not appear well nourished."

You realized you failed to select the minus sign to document this as an abnormal finding, so AutoNeg emitted a normal term. This was a reverse sensing term that must be specifically noted as a (-). You must now open the S/O *(PE)* tab to correct this term in the note

MEDCIN: Advanced Search Options

Explain:

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

Exercises

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

Summary

- Explained MEDCIN

A/P-Explain:

- CHCS II supports creating a problem-oriented medical record.
- Procedures and orders must be associated with a diagnosis.
- Association of orders and procedures supports problem-oriented healthcare.
- Procedures and orders can be associated and disassociated with one or more diagnosis.
- Order Entry

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- Dashboard
- MEDCIN Tree
- Narrative Pane

Searched, loaded and used a template
Explained moving narrative from ROS to HPI
Explained AutoNeg
Explained reverse sensing terms

</td><td>
selections are similar to the ones in CHCS.
• Same drug-to-drug, drug and allergy, and duplicate order warnings as in CHCS.

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

Add diagnoses to the working diagnosis list.

Explain Searches can be performed using:
• WHO language
• ICD 9 Codes
• Partial Words

Explain: User can delete a diagnosis, procedure or order that was documented in error.
If orders were submitted they would be listed under the show orders area.
Discuss pros and cons of saving to queue.
• Point out you might lose orders if the system should fail; but you can
</td></tr>
<tr><td></td><td>Assessment/Plan Module</td><td></td></tr>
<tr><td></td><td>
<h2>Assessment/Plan</h2>

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.
</td><td></td></tr>
<tr><td></td><td>Assessment/Plan</td><td></td></tr>
<tr><td></td><td><h2>Demonstrate:</h2></td><td></td></tr>
</table>

	1. Click **A/P** on the SF 600. The A/P module opens. 2. In the **Search** field, enter **PREGNANCY TEST** and click **Find Now**. 3. Select **Pregnancy Test V72.9** and click **Add to Encounter.** 4. Click the **Order Lab** tab. 5. In the **New Lab Order** field, enter **HCG** and click **Search**. 6. Select *HCG QL*. 7. Click **Submit**. **Exercises** • Complete the exercises • Check for understanding and answer participant questions **Summary** • Document A/P • Explained how codes are captured with diagnoses and procedures • Procedures, orders and other therapies must be associated to a logical diagnosis • Consults, labs, rads and meds can be submitted or saved to queue	delete from queued orders. • Show how to delete before submitting queued. • Recommend submit over save to queue. **Explain**: Civilian **(Non-MTF)** consults continue to be completed in CHCS rather than in CHCS II. **Emphasize selection of Preventative Med types, when appropriate. Most often missed; results in inappropriate coding.**

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

Disposition and Signing

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

Disposition and Sign

Demonstrate:

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

1. Click **Disposition** on the Action bar.
2. Accept the default Disposition, **Released w/o Limitations**.
3. In the Follow Up area, select the **With PCM** checkbox.
4. In the Comments field, enter **CALL TOMORROW FOR PREGNANCY TEST RESULTS**.
5. In the **Meets Output Visit Criteria (Workload)?** Select **Yes** (Default).
6. The default E&M value, 99211 - Established Outpatient Minimal Service.
7. Click **Sign** on the Action bar.

8. Select the **Cosigner Required** checkbox.

9. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID.

10. Select **DOCTOR, DAVID**

11. Click **Sign**.

Exercises

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

Summary

- Complete Disposition
- Sign Encounter

Next Slide

Lesson 5: Previous Encounters

Lesson Goal

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

Learning Objectives

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

- Display a previous patient encounter
- Append previous patient encounter
- Amend a previous patient encounter

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

Previous Encounters

Demonstrate:

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

To view a previous encounters:

1. From the list of appointments, click on Col. Violet Alexander's appointment to pull her record.
1. Click **Previous Encounters** on the Folder List.
2. Select the *ESSENTIAL HYPERTENSION* previous encounter. The encounter note populates below.

To append a previous encounter:

3. Highlight Col. Alexander's *ESSENTIAL HYPERTENSION* note and click **Append Narrative** on the Action bar. The Encounter Note window opens.
4. In the **Note Category** field, enter **NURSING NOTE.**

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.

	5. In the **Note Title** field, enter **PATIENT EDUCATION**. 6. In the note area, enter **PATIENT WAS EDUCATED ON LOW SODIUM DIET**. 7. Click **Save** and **Sign**. 8. Click **Sign**. **To amend a previous encounter:** 1. From the list of appointments, click on CAPT Clayton Williams' appointment to pull his record. 2. Click **Previous Encounters** in the folder list. 3. Highlight the Normal Examination note and click **Amend Encounter** on the Action bar. The Encounter Note window opens. 4. Open the A/P portion of the note. 5. Select diagnosis **NORMAL EXAMINATION V70.0** 6. Change diagnosis type from *New* to *Follow-up.* 7. Click the **Disposition** icon on the Action Bar to verify E & M and Click **Sign.** 8. Preview note and Change History. 9. Click the **Sign** button on Sign Encounter window. This returns you to the appointment module. Notice the encounter status has changed to Updated. 10. Clear Patient from the Patient ID line. **Key Points:** • Access to past encounters is available at any workstation that has CHSC II access. • Anyone with signing privileges can append a note. • Only the signer or cosigner of a particular note can amend that note.	**Explain:** Amending an encounter allows information in the original note to be changed by the original Provider, co-signing Provider.
	Exercises	
	• Complete the exercises	

	• Check for understanding and answer participant questions **Summary** • Display a previous patient encounter • Append a narrative to a completed encounter • Amend a completed encounter ***Next Slide***	

Lesson 6: Medicomp Forms Tool

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

Lesson Goal:

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

Learning Objectives:

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

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

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

1. In the list of appointments in the appointment module, highlight and open the encounter for Marie Alexander.
2. Click the **S/O** button.
3. Click the **Template Mgmt** icon on the Action Bar.
4. In the Name Contains field enter **ANKLE PAIN**.
5. The Name Search should provide one AIM Form for Ankle pain.
6. Highlight the form and click **Load** icon on the Action Bar.
7. The AIM Form will load.
8. Verify the right ankle History Tab is selected before documenting the Note.
9. Click the **T** under the Chief Complaint section to indicate right ankle pain.
10. In HPI, select the **T** to indicate *Local Tissue Swelling Right Ankle.*

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

11. Click the **Free Text** square to the right of the term you just selected. This will open up a dialog box to add free text or insert text to the note.
12. Type in the following: **PATIENT STATES SHE WAS PLAYING TENNIS WHEN SHE TWISTED HER ANKLE AND FEELS IT IS SPRAINED**.
13. Click **Insert Text.**
14. Click **Close.**

Note: You will notice an arrow with a question mark beside it. When you right mouse click on it the child terms under Local Tissue Swelling Right Ankle will appear.

15. Select the child terms **+ *Localized Soft Tissue Swelling Right Ankle Inside***, and **+ *Soft Tissue Swelling R Ankle with Black and Blue Discoloration***, to be more specific with your documentation.
16. Next go to **PMH.**
17. Select **T** to indicate previous **Ankle Fracture** under the Previous Diagnosis section.
18. Once you complete documentation of the patient's HPI, PMH click on the **Right Ankle Physical Exam** Tab.
19. Document the Vital Signs reviewed.
20. Select **F** in the In No Acute Distress box**.**
21. Click the **Free Text** square to the right of the statement.
22. A free text box will appear. In this box type in: **PT. STATES ANKLE VERY PAINFUL TO WALK ON.**
23. Click **Insert Text.**
24. Click **Close.**
25. In the **Examination of the Right Lower Leg s**ection click **T** for each item in this section.
26. In the **Appearance of the Right Ankle** section select **F** for the first four entries. Leave the others blank.
27. In the **Tenderness of the Right Ankle** section check **F** Medial Palpation without Tenderness
28. In the **Motion of the Right Ankle** section check **F** Right Ankle without Abnormal Motion.
29. In the **Pain of the Right Ankle** section check **F** No Pain Elicited by Motion.

30. In the **Examination of the Right Foot** section check **F** Right Foot Not Swollen and **F** Right Foot Not Tender to Palpation.
31. In the **Test Results** section, under the **Results of Right Ankle X-Ray**, enter ***FRACTURED RIGHT ANKLE*** in Free Text**.**
32. Select **AutoNeg** from the Dashboard to indicate a "normal" result for the rest of the history.
33. Click **Close** to save and close the S/O Forms note.
34. Close the module.

Exercises

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

Summary

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

Next Slide

Lesson 7: S/O Template Management

Lesson Goals

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

Learning Objectives

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

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

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

	• Search for Visit Template • Use Template Edit Mode • Use Find Term • Use Browse from Here • Rename and Save the Template	**Explain**: • Templates have pre-positioned terms • Benefits of using templates: streamline documentation • Folder location of templates in CTS versus the live system
	S/O Template Management	
	Demonstrate: UTI encounters are among your most frequent clinic visit types. You decide to customize a UTI S/O template for your clinic. 1. Create an appointment for **CPT Heather Cloud (c0058)**. — Appointment Type: **ACUTE APPT (ACUT$) 30** — Reason for Appointment: **Test Patient** 2. Open the encounter. 3. Click **S/O** on the SF 600. 4. Click **Template Mgt** on the Action bar. 5. In the Name Contains field, enter **UTI** and click **FindNow**. 6. Highlight **VISIT--UTI**. 7. Click **Edit** on the Action bar. 8. In the right pane, under Review of Systems, highlight *fever*.	**Training system templates** The naming convention for templates used in the training system begins with TRAINING rather than BRANCH. There are other training system templates you will use that do not follow either of these conventions. • How to search for the template **Explain:** Template preview screen (point out) • Load the template. (Action Bar icon or double-click) **Explain:** Template availability within S/O using drop-down

	9. Click **ROS/HPI** on the dashboard. The term is flipped into the **HPI**. 10. Click **Find Term** on the Action bar. 11. In the search field, enter **INCOMPLETE EMPTYING OF BLADDER** and click **OK**. 12. Click + to add *incomplete emptying of bladder* to the template. 13. Click **Browse From Here** on the Action bar. 14. Click + to add *urine odor*. 15. Click **Save As** on the Action bar. 16. In the Template Name field, ENTER **VISIT--UTI FEMALE--[YOUR INITIALS]** and click **Save**. 17. Click **Close** on the Action bar. To return to the S/O Template Management module. 18. Click **No** on the warning window. 19. Click **Close** on the Action bar to return to the S/O module. 20. Click **Close** on the Action bar to return to the SF 600. 21. Clear patient **Exercises** • Complete the exercises • Check for understanding and answer participant questions **Summary** • Explained S/O Template Management features • Search for Visit Template	**Explain:** Service specific naming convention Templates for all branches are stored together in the live system. Each service uses a different naming convention to organize templates for browsing. For example: BRANCH--ENC--URI--LDR **Key:** BRANCH= TYPE = Encounter (ENC), Visit, Education (EDU), Procedure (PROC), Consent, PE, and so on, SUBJECT = Allergy, URI, Asthma Follow-up, and so on, LDR = Personal initials (3) of the template owner

	• Use Template Edit Mode • Use Find Term • Use Browse from Here • Rename and Save the Template as "VISIT-- [name]--[your initials]" **END OF SESSION ONE** • Encounter Templates and Order Sets • Health History Folder • Readiness • Questionnaire Setup and Patient Questionnaires Next Slide	**Note: Remember to reset the database for the day and import the training templates** ❑ **Slide 22: Session Two Course Agenda** **NOTE: This is a flexible agenda. Topics/Time to be determined per site**
Lesson 8: Encounter Templates and Order Sets		
	Lesson Goal The goal of this lesson is to enable the user to create Encounter Templates and commonly used	❑ **Slide 23: Encounter Templates and Order Sets Learning**

	Order Sets. **Learning Objectives** Upon completion of this lesson, the user will be able to • Use an Encounter Template • Edit an Encounter Template • Create an Order Set in A/P • Merge an Order Set with an Encounter Template	**Objectives** **Explain:** Order Sets currently in CHCS must be recreated for use in CHCS II.
	Encounter Templates	
	Demonstrate: **CAPT Heather Cloud (c0058)** comes into the clinic because she is experiencing UTI symptoms. The Nurse needs to document the findings and assessment. 1. Create a **New Appointment** for **CAPT Cloud (c0058)**. — Appointment Type: **(ACUT $) 30**. — Reason for Appointment: type **UTI SYMPTOMS**. 2. Click **OK**. 3. Highlight CAPT Cloud's appt. and click **Open Appt**. on the Action Bar. 4. The Encounter note displays. Click **Templates** on the Action bar. 5. Expand the **My Favorites folder.** 6. Select the **TRAINING--ECP--UTI--ENC** template and click **Add**.	**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; therefore, they need to be generalized to be used as templates. (OJT).

7. Click **OK**.

8. Click **S/O** on the SF 600.

9. Add The Chief Complaint is: *UTI symptoms* as a positive finding.

10. Add *pain during urination (dysuria)* as a positive finding.

11. Click the **Duration grid** and then click **2** and **Days**.

12. Add *feelings of urinary urgency* as a positive finding.

13. Add *diarrhea* as a positive finding.

14. Click the **Duration grid** and then click **1** and **Days**.

15. Document f*ever* as a negative finding.

16. Document burning sensation during urination as a negative finding.

17. Click the **PMH** tab.

18. Expand *sexually active*.

19. Add *trying to become pregnant* as a positive finding.

20. Add URINARY TRACT INFECTION as a positive finding. Click History button on the Dashboard.

21. Click the **PE** tab.

22. Add *Pain Level (0-10)* as a positive finding.

23. In the Value field, enter **4** and press Enter on your keyboard.

24. In the Free Text field, enter **AS REPORTED BY PATIENT** and press Enter on your keyboard.

25. Click **A/P** on the Action bar.

26. Select urinary symptoms and click **Add to Encounter**.

27. Click the **Order Lab tab**.

28. In the New Lab Order field, enter **URINALYSIS** and click **Search**.

29. Select **URINALYSIS**.

30. Select the **ASAP** radio button.

31. Click **Submit**.

32. Click **Disposition** on the Action bar.

33. In the Follow Up area, click the **In Clinic** drop-down list and select **CHCS II Test Clinic**.

34. Verify the E&M code.

35. Click **Sign** on the Action bar.

36. Select the **Cosigner Required** checkbox.

37. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID.

38. Select DOCTOR, DAVID

39. Click **Sign**.

40. Close all open modules and return to the Appointments module.

Edit an Encounter Template:

	1. Expand Tools on the Folder List and select **Template Management**. 2. The **Search/Browse** displays by default. 3. Click **Search** on the Action bar. 4. In Template Name type **UTI** and click **Search.** 5. Highlight the **TRAINING-- ECP--UTI--ENC** template. 6. Click **View/Edit** on the Action bar. The Template Details tab opens. 7. In the **Diagnose**s area, click **Add**. 8. In the Search Term field, enter **PAIN DURING URINATION** and click **Search**. 9. Select *pain during urination (dysuria) 788.1* and click **Add Items**. 10. Click **Done**. 11. In the **Other Therapies** area, click **Add**. 12. In the Search Term field, enter **FREQUENT ORAL FLUIDS** and click **Search**. 13. Select *Oral Fluids Frequent* and click **Add Items**. 14. Select *Anticipatory Guidance Activities* and click **Remove Item.** 15. Click **Done**. 16. In the Notes Template area, highlight [List] **TRAINING--ECP-- UTI--VISIT** and click **Remove**. 17. Click **Add**. 18. Click **Search** on the Notes Template Lookup.	**Explain**: • Point out the five main components of the Encounter Template: diagnoses, notes templates (visit, S/O), other therapies, procedures and order sets. • Mention that the top four sections (Associated Reasons for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Notes) are not used. • Discussion of order sets will follow the building of the parts of the template mentioned above. When adding diagnosis, show how to do multiple searches and select results before clicking the **Done** button. When adding therapies, show double-clicking to add, rather than using the **Add Items** button.

	19. In the Template Name field, enter **UTI**. 20. Click **Search** on the MEDCIN Template Search. 21. Select **VISIT--UTI FEMALE--TEST** and click **Add Items**. 22. Click **Done**. 23. Click **Save As** on the Action bar. 24. In the Template Name field, enter **ECP--UTI--ENC--TEST** and click **Save**. 25. Click **Close** on the Action bar. **To create an order set:** You have just personalized a UTI Encounter Template and you want to complete it by adding a UTI Order Set. 1. Create an appointment for **CPT Heather Cloud (c0058)**. — Appointment Type: **ACUTE APPT (ACUT$) 30** — Reason for Appointment: **Test Patient** 2. Click **A/P** on the SF 600. 3. Click the **Order Lab** tab. 4. In the **New Lab Order** field, enter **URINALYSIS** and click **Search**. 5. Select *URINALYSIS*. 6. Select the **ASAP** radio button. 7. Click **Save to Queue**.	When adding procedures, show entry of multiple selections pressing **Ctrl** key.

	8. In the **New Lab Order** field, enter **HCG QL** and click **Search**. 9. Select **HCG QL**. 10. Click **Save to Queue**. 11. In the **New Lab Order** field, enter **URINE CULTURE** and click **Search**. 12. Select *URINE CULTURE*. 13. Click **Save to Queue**. 14. Click the **Order Sets** tab. 15. Click **Save As Order Set**. The Save Encounter Template window opens. 16. In the **Template Name** field, enter **UTI--ORDERS--TEST** and click **Save**. 17. Close the A/P module. 17. Click **Yes** on the A/P Warning window. You are returned to the SF 600. **To merge an order set with an Encounter Template:** 1. Expand Tools on the *Folder List* and select **Template Management**. 2. Click Search on the Action bar. 3. In the Template Name field, enter **UTI**. 4. Click Search. 5. Press and hold Ctrl on your keyboard and select UTI--ORDERS--TEST and ECP--UTI--ENC--TEST**.** 6. Click **Merge** on the Action bar.	

7. Click **Save As** on the Action bar.
8. In the Template Name field, enter **ENC--UTI WITH ORDERS** and click **Save**.
9. Click **Cancel** on the Action bar to go back to the Search/Display window.
10. Click **Search** on the Action bar.
11. In the Template Name field, enter **ENC--UTI WITH ORDERS** and click **Search**.
12. Highlight **ENC--UTI WITH ORDERS** Template.
13. Click **View/Edit** on the Action bar to verify both templates merged.
14. Click **Close** on the Action bar twice, to close the template and then the SF 600.

Exercises

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

Summary

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

Next Slide

Lesson 9: Health History Folder

Lesson Goal

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

❑ **Slide 24: Health History Folder Learning Objectives** outside the current encounter.

Learning Objective

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

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

Health History Set-Up

Demonstrate:

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

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

To customize the Health History folder:

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

Explain:

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

Key Points:

- Can be changed to fit the current requirements

Problems Module

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

Retired VADM Olaf Berg (b8943) 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.

1. Search for **Ret. VADM Olaf Berg** in the Search module to pull his patient record.
2. In the Folder List, click the **Problems** module located under Health History.
3. Expand the Problem list to view VADM Berg's Acute/Chronic problems.
4. Click **Add** on the Action Bar
5. The Select Diagnosis window appears with Clinic List selected by default.
6. Select the **Search** tab.
7. Type *Gallbladder cancer* in the Find field.
8. Select GALLBLADDER NEOPLASM MALIGNANT 156.0
9. Click **OK**.
10. Click the down arrow next to the Onset Date to display the date calendar.
11. Enter the Onset Date: **06 Dec 2000**.
12. Use the < > to select the December. Click on the year to display up/down arrows to select the year 2000. Click on day 6.
13. In the Status field accept default: **Active**
14. In the chronicity field accept default: **Chronic**
15. In the Source field accept default: Patient.

	Lab Module	
	Set the Scene: Dr. Test User tells you he has just talked to patient Col. Violet Alexander and wants to see her to discuss her previous Lab and Rad results. Dr. User has asks that when Col. Alexander arrives for her appointment he would like you to add the results to her encounter. 1. Create a **(ROUT) 15** appointment for Col. Alexander. Reason for visit is to *Review test results* 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 the *CBC w/o Diff*. 5. Highlight the *CBC w/o Diff* lab result. The result details display in the lower section of the screen. Use the **Display Criteria** to select **Ref Range/Units**. 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. Notice the Microalbumin, urine results appear in the S/O portion of the encounter note. Do not close SF 600. **Caution:** The system does not alert you when you have **Copied to Note**; however, results are copied. Selecting **Copy to Note** again results in multiple copies that cannot be deleted.	**Review Screen layout**
	Radiology Module	
	Set the Scene: Add the following Radiology results to Col. Alexander's encounter note. 1. In the Folder List, click the **Radiology** icon. The results of three tests appear. a. Point out the visual cue color code for normal/abnormal results. 2. Highlight the *L-Spine Series Report*. 3. Review what appears in the lower section. (Scroll down to view the results of selected test.)	**Explain:** Review screen layout and quickly review other options.

4. Left click and hold on **Report Text:** Drag mouse to bottom of report to highlight. Right-click and copy to note.
    - Point out you can also copy and paste results to the Add Notes section of the encounter.
5. Close the Radiology module
6. Close the encounter.

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

In the Preferences tab.

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

Meds Module

Explain:

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

Set the Scene: Col Violet Alexander (a5743) tells you that she has added taking Motrin each day to her daily routine as suggested earlier by Dr. David Doctor. Check her medication health history and update it with the new medication.

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

1. Search for **Col Violet Alexander (a5743)** to pull her patient record.
2. In the *Folder List* under Health History, click **Meds**. In the Meds module, the **Search Filter** field default is **Outpatient Current**.
3. Review the functions available using the Action Bar icons: **Add**, **Details**, **Discontinue**, **Modify** and **Renew**.
4. Click the drop-down arrow for the **Search Filter** field and review the options. Change the selection to **All**.
5. Select an existing medication and, on the Action Bar, click the **Details** icon.

Review the screen layout.

6. Click **Discontinue** on the Action Bar.
7. An error box appears indicating this action requires an open encounter (for documentation). Click ***OK***

8. The **Search Filter** selection changes back to **Outpatient Current**.
9. Click the **Add** icon to record Motrin.
10. Click the Record OTC/Outside Medication button.
11. Click the **Medications** button to begin searching for **Motrin** in the *Healthcare Data Dictionary Search* window.
12. Select *IBUPROFEN (MOTRN) 800 MG, (U/D)--PO, 800 MG* and click the **OK** button.
13. Complete all required fields (including the **Sig: 1 TAB QD**) and add a comment that med was a suggestion by her doctor for muscle aches.
14. Click the **OK** button. Note the checkmark in the **OTC** column, which indicates this is an over-the-counter medication.
15. Close the Meds module.
16. Clear Patient

Review the screen layout.

Allergy Module

Explain:

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

Set the Scene: During her appointment CAPT Flanagan request that her allergy record be updated. She broke out in hives last month after wearing latex gloves.

1. Search for CAPT Flanagan's patient record and load her name to the patient ID line.
2. Open **Allergy** from the Folder List.
3. Click the **Add** button to display the *New Allergy* section.
4. Click the **Allergen** button and search for **OTHER** in the *Health Care Dictionary Search for Allergens* window.

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, however, in the live system, medication can be ordered, renewed and modified from the Meds module. To do this, an encounter must be open.

5. Select **OTHER (Class)** to add it as an allergen.
6. Click the dropdown arrow next to the **Reaction** field and select **URTICARIA** as a reaction.
7. Enter the following information:

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

8. 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.

1. Click **Options** to open the *Properties* window.
2. 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.
3. Click **Close**.
4. Click **Save**, then **OK** to **Close** the *Properties* window.
5. 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**.

6. Close the **Allergy** module and return to the **Appointments** module.
7. Clear Patient

Review the screen layout.

Vitals Sign Review

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

1. Open the **Appointment** module.
2. Click once to highlight LCDR Suarez Diabetes follow-up visit in the appointment list to pull his patient record.
3. Verify that LCDR Suarez is now listed in the Patient ID line.
4. Open the **Vitals Sign Review** module from the Folder List.
5. Click the **Search Type** button to open the *Time Search* screen.
6. Select the **Sliding Time Range** radio button and select **2 months** as the time range.
7. Click **OK**.
8. Click the **Refresh** button to the right of the time period display.
9. Highlight a single line and click the **Graph Vitals** icon on the Action Bar to open the *Graph Vitals* window.
10. Select each of the **Graph Options**, **Chart Types**, and **Vitals Keys** in turn to review their functions.
11. Click **OK** to exit and return to the Review role with LCDR Suarez' vitals.
12. Highlight the **BP** and **HR** columns. Click the **Graph Vitals** button.
13. Click **OK** after review graph.
14. Click **Close** on the Action Bar to close module.

Key Points:

- Add/Inactivate Problems
- Copy Lab and Rad Results to encounter
- Add/Discontinue Meds
- Add/Delete Allergies
- Review and graph Vitals

Exercises

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

	Summary • Explained Health History folder • Setup Health History Folder • Viewed and modified problem information • Viewed and copied lab results • Viewed and copied radiology results • Viewed and modified medications • Viewed and modified allergy information • Set and review the properties for the Vital Signs module Next Slide	**Review the screen layout** **Show the Ctrl-Rt mouse option to turn graph in 3-D mode.** **Show how to:** • select/deselect • expand/collapse
Lesson 10: Readiness		
	Lesson Goal	❑ **Slide 25: Readiness Learning Objectives**

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

Learning Objectives

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

- View the readiness module
- Edit the readiness information

Readiness

Demonstrate:

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

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

Exercises

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

Summary

- View the readiness module
- Edit the readiness information

Next Slide

Lesson 11: Questionnaire Setup & Patient Questionnaire

Questionnaire Setup/Questionnaire

Lesson Goal:

The goal of this lesson is to enable the user to set-up and run Patient Questionnaires in CHCS II.

❑ **Slide 26: Questionnaires Learning Objectives**

Learning Objectives

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

- Create and release a Questionnaire
- Change the status of a Questionnaire
- Interview a patient

Explain:

- Allow you to create and modify Questionnaires
- Once created, you can modify, copy, delete, and mark Questionnaires obsolete
- An open encounter is not required for Questionnaires to be created or modified
- As you add each question, you also specify the format of the answers and enter the answers you want for each question

With this module, you can format your answers as multiple choice, multi-select (patient can select more than one of the provided answers), yes or no, number, and date (patient can only select one of the provided answers.)

Creating a New Questionnaire

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

1. In the *Folder List* in the Tools folder, click the **Questionnaire Setup** icon.
2. On the Action Bar, click the **New** icon to create a new questionnaire.
3. In the Name field, enter: **HEADACHE – INITIAL VISIT**.
4. In the Instructions to Display field, enter these instructions: **PLEASE COMPLETE ALL QUESTIONS**.
5. Click the drop down arrow next to the Level field and select **Clinic**.
6. Click the drop down arrow next to the Owner field and select **CHCS II Test Clinic**
7. Click the **Add** button.
8. In the **Question Text** field, add each question below, click the **Answer Type** field drop-down arrow to select the answer type, and enter each possible answer in the space provided.

    Note: Do not hit **Enter** after last answer selection. Click **Add** for next question. Do not click **Add** after last question/answer.

Question	Answer Type	Possible Answers
Do you have a headache right now?	Yes/No	Yes No
When was the last time you had a headache?	Multiple Choice	Less than 1 month 1-6 months
Have the headaches gotten worse or better?	Multiple Choice	Worse Better
Are you taking any medication for the headaches?	Yes/No	Yes No

Are you taking any medication for the headaches?	Yes/No	Yes No
Does the medication help the headaches?	Yes/No	Yes No
Have you seen a medical provider regarding these headaches within the last year?	Yes/No	Yes No
Does anyone else in your family suffer from headaches?	Yes/No	Yes No
If so, who suffers from headaches?	Multi Select	Mother Father Sibling Grandparent No One
Is there a lot of stress in your normal day?	Yes/No	Yes No

9. Click **Save** icon on the Action Bar.
10. Highlight the Questionnaire just saved and click the **Mark Ready** icon.
11. Close the Questionnaires Setup module.

Using a Questionnaire for your Patient

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

Complete a Questionnaire via Interview

Explain:

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

We will now complete the Headache Initial Visit Questionnaire with CAPT Clayton Williams. Answer each question as if you were completing the Questionnaire for CAPT Williams:

1. Highlight CAPT Clayton William's Headache/physical appointment in the Appointment list to pull his record.
2. In the **Health History** folder, select **Patient Questionnaires**.
3. Click the **Interview** icon on the Action Bar to begin the Questionnaire. The questionnaire window will display.
4. To locate the questionnaire:
   a. Click ⊞ to expand Clinic.
   b. Click ⊞ to expand Questionnaires.
   c. Click ⊞ to expand CHCS II Test Clinic.
   d. Click ***Headache Initial Visit*** to select it. The Questionnaire will be displayed.
5. Click **Select** to start the Questionnaire.
6. Click the **Options** button and show Properties. In the Questions drop down box, select **Single Question View**.
7. Click **OK**.
8. Answer each question and click ***Next Question.***
9. When the last question is displayed, answer the question.
10. The Patient Questionnaire window will be re-displayed showing the questionnaire that has just been completed.
11. Mark Questionnaire as **Done**.
12. Click the **Encounter** button in the Action bar

	13. Show how to link Questionnaires to a specific Encounter 14. Close the Patient Questionnaires module 15. Close encounter note.	
	Exercises • Students follow along with the instructor • Check for understanding and answer participant questions **Summary** • Create and release a Questionnaire • Edit an existing Questionnaire • Change the status of a Questionnaire **Next Slide**	**Note**: Before Closing, point out the Encounter icon on the Action bar that allows you to associate Questionnaires with an encounter. Will also associate via Provider AutoCite settings.
Course Summary		
	Briefly summarize the course and open to questions and answers. • Overview of the system, the training, the expectations • Basic skills: navigating through documenting • Patient Search and Appointments • Telcons • Patient Encounter • Previous Encounters • MEDCIN and Templates management • Health History Folder	❑ **Slide 27: Course Summary** **Summarize course based on modules taught**

	• Questionnaires	
	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 **USE FOR REFERENCE ONLY** **Capturing Screens** To capture screens: 1. On the workstation keyboard, press **PrtScrn**. 2. Open PowerPoint. 3. To paste the screen capture into PowerPoint, on the workstation keyboard, right mouse click and select **Paste.** 4. Save the screen capture to the appropriate folder on the workstation. In many clinics, there is a specific folder on a shared network drive for storing these files. **Ensuring Patient Data is concealed in the Screen Capture** 1. In PowerPoint, use the drawing tools to conceal any patient-specific information on the screen. 2. From the View menu, select Slide Show. 3. On the workstation keyboard, press PrtScrn. 4. Exit the slide show to return to the normal view by pressing Esc on the workstation keyboard. 5. On the PowerPoint toolbar, click the new presentation icon (i.e., the blank piece of paper). 6. To paste the screen capture into the new presentation, on the workstation keyboard, right	❑ **Slide 28: What Do I Do If I Encounter a Problem While Working with CHCS II?**

	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
	• CHCS II User Manual. Should be available in each clinic
	• Application Help menu
	  • Detailed information on use of modules
	  • Step-by-step procedures
	Explain: Both are readily available within the application help files. Help is structured like other Windows application help files.
	Next Slide
	Questions and Answers
		❑ **Slide 29: Other Help Resources**
		Remind the class that the student guide is not to be removed from the classroom, and inform them about the process for obtaining their own copies at the site.
		Emphasize the use of Help in the application.

Appendix A: Immunizations		
	Immunizations Admin & Patient Immunization Learning Objectives Upon completion of these modules, you will be able to: • Define vaccine groups • Track vaccines in stock • Add details to in-stock vaccines	❑ **Slide 30: Immunization Learning Objectives**

- Maintain groups
- Document patient vaccines

Overview of Immunizations Admin

The Immunization Admin Module is used to set-up an Immunization clinic by allowing the user to designate vaccines in stock, set-up user groups, maintain refrigeration temperature logs, reports and manage providers with clinic authorization. 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.

Vaccination Management

To add vaccines in stock for clinic:

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

Adding User Defined Groups

User defined groups are helpful when many individuals need to get the same immunizations. One example would be for a unit that is deploying.

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 as **GROUP A** (or as per class input).
4. Click **OK**.

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.	
	Vaccination Management	**Demonstrate accessing these different options.**

	To add vaccines in stock for clinic
	1. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays.
	To select a Default Vaccination Clinic
	2. Click the **Ellipsis** button next to the *Default Clinic* field. The Clinic List Edit window opens.
	3. 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 **TEST** and press **Enter** on your computer keyboard.
	4. Click **Set Default**. You are returned to the Vaccine Management area.
	Point out:
	• If you want to associate stocked vaccines to the default clinic:
	  • Select a vaccine from the list of available vaccines
	  • 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
	  • Click **Mfg/Lot Nbr** to open the Vaccines in Stock Information Window
	  • Click **Close** to return to the Admin tab	

	5. On Admin tab select a Vaccine from **Available Vaccines**. 6. Add the following Vaccines by selecting and clicking on **Right** arrow (>): Anthrax Hep A-Hep B Influenza MMR 7. Click **Mfg/Lot Nbr** button to add vaccine information. 8. Use drop-down lists to add Mfg name, Lot numbers, dosage and route.	**Must Ensure vaccines are in stock and have correct information for documentation.**

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
Anthrax	Ortho Diagnostics	OD13579	0.25 ml	IM
Hep A – Hep B	Abbott	44444	0.1 ml	IM
Influenza	Baxter	BA 12345	0.1 ml	IM
MMR	Merck	ME67890	0.5 ml	IM

9. Close Vaccines in Stock Information window.

Key points:
- Explain how to view the Vaccine Lot Number List
- Point out how to delete a provider from administering immunizations
- Print immunization reports

Exercises

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

Summary

- Defined vaccine groups
- Identified vaccines in stock

	• Added details to in-stock vaccines • Maintained groups	
	Patient Immunizations Module The Patient Immunizations Module is used 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. 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. Create an appointment for 2. 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. 3. Select a group name from the *Immunization Group* or *User-Defined Group* list. 4. 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. 5. Click **Close**. The selected groups appear on the Individual Immunization tab in the	

Vaccination Groups list.

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

Documenting a Vaccination Visit

1. Select New Appt on the Action bar.
2. Search for ***ALEXANDER, VIOLET***.
3. Select the Appt Type (Wellness$).
4. Select the Provider/Nurse authorized to sign SF 600.
5. Reason for Appt: Type **PATIENT REQUIRES VACCINATION S FOR MMR, HEP A, INFLUENZA, SMALL POX.**

A, INFLUENZA, SMALL POX.

6. Select OK.

Finishing the Documentation for Vaccination Visit:

1. Double click on ***ALEXANDER, VIOLET***
2. Select A/P module
3. Document Diagnosis
   a. MMR – V06.4
   b. HEP A – V05.3
   c. Influenza – V04.8
   d. Small Pox – V04.7
4. Document Procedures:
   a. MMR – 9707
   b. HEP A – 90632
   c. Influenza – 90659
   d. Small Pox – 90749
5. Select each Procedure code (as necessary) to add the modifier for **Units of Service**

Note: Use ICD-9 code V06.8 for other combinations of shots. Use V05.8 for other specific disease and Japanese Encephalitis. Use 90636 for Hep A and B together

6. Document Disposition/E&M Code of 99211

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 the **Click to Save Exemption** button.

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.

Point out:

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.

Exercises

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

Summary

- Defined vaccine groups
- Identified vaccines in stock
- Added details to in-stock vaccines
- Maintained groups

	• Documented patient vaccines	

Appendix B: System Demonstration

System Demonstration Scenario

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

Set the scene for the class, you will demonstrate the flow of the clinic for a 'walk-in' patient. You can play each role, the clerk who will check in the patient, the Support Staff who will triage the patient, the Nurse who will assist the provider with tests orders the Provider who will exam and disposition the patient.

Setting the scene
A patient comes to the clinic. The clerk creates a walk-in appointment for patient. The Support Staff screens patient, verifying allergies and enter vitals. The Nurse, assisting the Provider orders Lab and Rad tests STAT. Once test results are in, the Provider reviews the results and examines the patient. The Provider determines diagnosis then orders a medication. The Provider has the Nurse perform a procedure and issue medical equipment to the patient; The Nurse enters procedures in A/P and assigns herself as additional provider. The provider discusses diagnosis and treatment with patient, completes disposition and signs the encounter. The patient is checked out by the Clerk. The following day: The Records Reviewer has to view all encounters completed yesterday in CHCS II for this clinic.

Role/Function	Field	Data
CLERK: Creates a walk-in appointment for CPT Heather Cloud (c0058).	Patient Search	
	Quick Search	C0058
	New Unscheduled Appointment/Telcon Visit	
	Appointment Type Reason for Appointment Injury/Accident Related	**Acute Appt (ACUT$) 30** *Turned Rt ankle* [Select] [Select] **Other Accident**
SUPPORT STAFF: Documents screening, verifies allergies, and enters vitals.	Appointments Module	
		[Select] CPT Cloud's walk-in appt. and open encounter note (SF 600).
	ENCOUNTER NOTE (SF 600)	
	Screening	
	Search field Verify Allergy Comments	[Enter] *reported trauma ankle* and click **Find Now**. Expand *reported trauma ankle* scroll down to Expand *Right* Expand to [Select] *Turned in* Click **Add** to Encounter [Select] **No known Allergies** [Select] **Verified This Encounter** *Pt states not pregnant* [Click] **Close** on the Action Bar

	Vitals	
	BP Rt arm Adult cuff	125/77 [Select] [Select]
	HR Radial Regular	88 [Select] [Select]
	RR Temperature F Oral	21 98.6 F [Select]
	Ht	[Enter] 62 in
	Wt	124 lbs
	Habits	
	Tobacco	[Select] No
	Alcohol	[Select] Yes
	Pain Severity	
	Where is pain located?	[Select] **6** [Enter] *Rt. ankle* **NOTE:** Add comments when pain scale is selected (other than "0 pain free"). [Click] **OK**
		Return to encounter note [Click] **Close** Return to Appts. Module

<table>
<tr><td rowspan="6">NURSE:
Provider asks nurse to order Lab and Rad STAT for patient.</td><td colspan="2">Appointments Module</td></tr>
<tr><td></td><td>[Select] CPT Cloud’s walk-in appt. and open the encounter note (SF 600)</td></tr>
<tr><td colspan="2">ENCOUNTER NOTE (SF 600)</td></tr>
<tr><td colspan="2">A/P</td></tr>
<tr><td>Lab

Radiology

Receive A/P Warning</td><td>[Select] Lab Tab
[Enter] New Lab Order: CBC
Click Search
[Select] CBC W/AUTO DIFF
[Select] Processing Priority: STAT
[Select] Submit

[Select] Rad Tab
[Enter] New Rad Order: ankle
Click Search
[Select] ANKLE TRAUMA RT
[Enter] R/O ankle fracture
[Select] Processing Priority: STAT

[Select] Submit
[Click] Close on Action Bar
[Select] Yes</td></tr>
<tr><td></td><td>Return to encounter note
[Click] Close on Action Bar</td></tr>
<tr><td rowspan="2">PROVIDER:
Loads the Ankle Sprain Right visit template and examines the patient. Enters diagnosis, associates Lab, Rad orders and orders medication.</td><td colspan="2">Appointments Module</td></tr>
<tr><td></td><td>[Select] CPT Cloud’s walk-in appt. and open the encounter note (SF 600).</td></tr>
</table>

	S/O	
	Template Mgmt	[Select] on Action Bar [Enter] *ankle sprain* [Click] **Find Now** [Select] *Visit – Ankle Sprain – Right Side* [Click] **Load** icon on Action Bar
	HPI Structured Term Note Pad Structured Term Duration Grid	[Select] **+ CC: Possible ankle sprain right** [Select] **Note pad** icon to insert text: *Turned ankle while running* [Click] **OK** [Select] **+ localized soft tissue swelling right ankle** [Click] Duration Grid on Dashboard Duration x 1 day [Select] **- joint stiffness of the right ankle** **+ joint pain in the right ankle on the outer side**
	PMH	[Select] **+ past medical history** [Select] **– poor physical condition**
	ROS	[Select] **+ joint in the ankle worse with weight bearing** [Select] **+ limping**

	PE	[Select] **+ vital signs reviewed** **+ ankle tenderness on palpation right** **+ ankle swelling on the right anterior** AutoNeg
	Test Find Term	[Enter] *ankle fracture* [Click] **OK** [Select] **- X-Ray Ankle Fracture** **Right Talus** Click the **A/P** icon on the Action Bar
	A/P	
	Diagnosis Search field Injury/Accident Box	[Enter] *ankle sprain right* [Click] **Find Now** [Select] **ANKLE SPRAIN RIGHT 845.00** Click **Add to Encounter** [Enter] *Location of accident* [Click] **Find Now** Expand **Location of accident E849.9** [Select] **at home E849.0** Click **Add to Encounter** [Enter**] Date: 1 day prior** [Click] **OK**

	Associate Orders Order Med Tab New Med Order Sig	[Select] ANKLE SPRAIN [Select] **CBC W/AUTO DIFF** [Click] **< >** button to associate Lab with ANKLE SPRAIN [Select] **ANKLE, TRAUMA RT** [Click] **< >** button to associate Rad with ANKLE SPRAIN [Select] [Enter] *Tylenol* [Select] **Tylenol #3 (OR SUBT) -- PO TAB** [Enter] *T 1 Tab TID x 10 days #30 RF0* [Press] **Enter** on your keyboard [Click] **Submit** [Click] **Close**
		Return to encounter note
NURSE: Wraps patient's ankle and issues crutches. Nurse enters procedures in A/P and adds self as additional provider #1.	Appointments Module	
		[Select] CPT Cloud's walk-in appt. and open SF 600
	A/P	
	Associate Procedures Procedures Search field Modifiers	[Select] **ANKLE SPRAIN** [Enter] *strapping* [Click] **Find Now** Expand **Orthopedic Strapping 29799** [Select] **Ankle 29540** **Add to Encounter** [Click] **Modifiers** icon on Action Bar [Click] … button

	Additional Providers #1 Name Field	[Enter] Nurse and click **Find Now** [Select] **Nurse, Karen** [Click] **Role** dropdown arrow [Select] **Nurse** [Select] **Checkbox** next to Additional Provider #1 [Click] **OK** [Select] **HCPCS** [Enter] *crutches* [Select] **CRUTCHES E00112** **Add to Encounter** **Repeat Modifiers process** [Click] **Close**
PROVIDER: Discusses diagnosis and treatment with patient. Completes Disposition and Signs encounter.	Disposition Profile	Return to Encounter note [Click] Close on Action Bar [Select] **Release w/work/duty Limitations** *One Month against running and prolong standing.*
	Follow-up Discussed Items E & M Code Sign	[Select] **with PCM** [Select] **When** [Enter] **2 and weeks** [Select] **Diagnosis, Medication(s)/Treatment** Verify coding [Select] **Sign** on Action Bar Preview SF 600 [Click] **Sign** button
CLERK:	Appointments Module	

Clerk Checks out the patient		[Select] CPT Cloud's walk-in appt. [Select] Check out on Action Bar. Click OK on dialog box. In the menu line, [Select] **G0 > Patient > Clear Patient** to close CPT Cloud's medical record.
THE NEXT DAY		
RECORDS REVIEWER: Searches for CPT CLOUD in CHCS II to pull her patient record and view her Previous Encounter.	Patient Search Module	
	Last name First Name	[Enter] CLOUD [Enter] H [Click] **Find** button [Select] CLOUD, HEATHER and click **OK**
	Previous Encounters	
	Encounter	[Select] Turned Rt. Ankle Appt. to view/print encounter

	Lab Radiology Receive A/P Warning	[Select] Lab Tab [Enter] New Lab Order: *CBC* Click **Search** [Select] **CBC W/AUTO DIFF** [Select] Processing Priority: **STAT** **[**[Select] **Submit** [Select] Rad Tab [Enter] New Rab Order: *ankle* Click **Search** [Select] **ANKLE TRAUMA RT** [Enter] *R/O ankle fracture* [Select] Processing Priority: **STAT** [Select] **Submit** [Click] **Close** on Action Bar [Select] Yes
		Return to encounter note [Click] **Close** on Action Bar
PROVIDER: Loads the Ankle Sprain Right visit template and examines the patient. Enters diagnosis.	Appointments Module	
		[Select] Col Alexander's walk-in appt. and open the encounter note (SF 600).
	S/O	

Enters diagnosis, associates lab, rad orders and orders medication.	Template Mgmt	[Select] on Action Bar [Enter] *ankle sprain* [Click] **Find Now** [Select] *Visit – Ankle Sprain – Right Side* [Click] **Load** icon on Action Bar
	HPI Structured Term Note Pad Structured Term Duration Grid	[Select] **+ CC: Possible ankle sprain right** [Select] **Note pad** icon to insert text: *Turned ankle while running* [Click] **OK** [Select] **+ localized soft tissue swelling right ankle** [Click] Duration Grid on Dashboard Duration x 1 day [Select] **- joint stiffness of the right ankle** **+ joint pain in the right ankle on the outer side**
	PMH	[Select] **+ past medical history** [Select] **– poor physical condition**
	ROS	[Select] **+ joint in the ankle worse with weight bearing** [Select] **+ limping**

	PE	[Select] **+ vital signs reviewed** **+ ankle tenderness on palpation right** **+ ankle swelling on the right anterior** AutoNeg
	Test Find Term	 [Enter] *ankle fracture* [Click] **OK** [Select] **- X-Ray Ankle Fracture Right Talus** Click the **A/P** icon on the Action Bar
	A/P	

	Diagnosis Search field Injury/Accident Box Associate Orders Order Med Tab New Med Order Sig	[Enter] *ankle sprain right* [Click] **Find Now** [Select] **ANKLE SPRAIN RIGHT 845.00** Click **Add to Encounter** [Enter] *Location of accident* [Click] **Find Now** Expand **Location of accident E849.9** [Select] **at home E849.0** Click **Add to Encounter** [Enter**] Date: 1 day prior** [Click] **OK** [Select] ANKLE SPRAIN [Select] **CBC W/AUTO DIFF** [Click] < > button to associate Lab with ANKLE SPRAIN [Select] **ANKLE, TRAUMA RT** [Click] < > button to associate Rad with ANKLE SPRAIN [Select] [Enter] *Tylenol* [Select] **Tylenol #3 (OR SUBT) -- PO TAB** [Enter] *T 1 Tab TID x 10 days #30 RF0* [Press] **Enter** on your keyboard [Click] **Submit** [Click] **Close**
		Return to encounter note
NURSE:	Appointments Module	

Wraps patient's ankle and issues crutches. Nurse enters procedures in A/P and adds self as additional provider #1.		[Select] Col Alexander's walk-in appt. and opens SF 600
	A/P	
	Associate Procedures Procedures Search field Modifiers Additional Providers #1 Name Field	[Select] **ANKLE SPRAIN** [Enter] *strapping* [Click] **Find Now** Expand **Orthopedic Strapping 29799** [Select] **Ankle 29540** **Add to Encounter** [Click] **Modifiers** icon on Action Bar [Click] … button [Enter] Nurse and click **Find Now** [Select] **Nurse, Karen** [Click] **Role** dropdown arrow [Select] **Nurse** [Select] **Checkbox** next to Additional Provider #1 [Click] **OK** [Select] **HCPCS** [Enter] *crutches* [Select] **CRUTCHES E00112** **Add to Encounter** **Repeat Modifiers process** [Click] **Close**
		Return to Encounter note [Click] Close on Action Bar

PROVIDER: Discusses diagnosis and treatment with patient. Completes Disposition and Signs encounter.	Disposition Profile Follow-up Discussed Items E & M Code Sign	[Select] **Release w/work/duty Limitations** *One Month against running and prolong standing*. [Select] **with PCM** [Select] **When** [Enter] **2 and weeks** [Select] **Diagnosis, Medication(s)/Treatment** Verify coding [Select] **Sign** on Action Bar Preview SF 600 [Click] **Sign** button
CLERK: Clerk Checks out the patient	Appointments Module	
		[Select] Col Alexander's walk-in appt. [Select] Check out on Action Bar