CHCS II Provider Lesson Plan

COMPOSITE HEALTH CARE SYSTEM II

Change History

Date	Name	Change Description	Source:
12-16-2004	Linda Armstead	New Release	Patch 837.2 Release Notes
02-01-2005	Juanita Stuckey	Build Enhancement	837.4 Release Notes

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Preparation for Delivery

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

Materials Needed

- CHCS II Sign-In Roster may (Electronically or Paper Form)
- CHCS II Provider Course Lesson Plan
- CHCS II Provider Presentation
- CHCS II Training Templates
- CHCS II Provider Training Student Guide (one per seat)
- CHCS II User Manual (one per classroom)
- Latest Release Notes
- 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 Provider Training Course 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 after the Provider class to ensure that CHCS II does not generate messages saying that templates created during class already exists because students created them in a previous class.
- Import training templates:
  - TRAINING--VISIT--URI MEDCIN
  - TRAINING--VISIT--RASH MEDCIN
  - TRAINING--URI ENCOUNTER
  - ENC—ASTHMA—TRAINING
  - AIM—FORMS--Ankle Pain
- Become aware of local policies and variations with respect to such things as template naming conventions, pharmacy locations and other similar factors relevant to training. The Site Training 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 latest release notes.

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 that users include comments for any line item rated "3" or lower.

Duration	Training Activities	Instructor Notes
Introduction		
	Welcome/Logistics	☐ **Slide 1: Provider Training Course**
	Next Slide	
	Logistics: Room location in building, fire escape routes, restrooms, kitchen facilities, smoking area	☐ **Slide 2: Logistics and Introductions**
	Workstations	
	Instructional material	
	Pagers and cell phones: Off or on vibrate mode	
	Breaks	
	Resources: Indicate how to obtain additional information regarding additional support on the system.	
	Parking Lot	
	Introductions	
	Instructor and students exchange personal introductions, providing relevant background information.	
	Next Slide	
CHCS II Overview		
	What is CHCS II?	☐ **Slide 3: What is CHCS II?**
	CHCS II is a computer-based patient record (CPR) system selected by the Department of Defense to meet the requirements of the Military Health System.	

Duration	Training Activities	Instructor Notes

	CHCS II provides:
	
	    • A graphical user interface that networks with existing systems
	    • Efficient means of creating, managing and retrieving medical records
	    • Anytime, anywhere delivery of patient records to the point of care
	    • Future access to military records for health studies worldwide
	
	Add this brief comment as transition to next slide:
	
	One of the greatest benefits of CHCS II is that it is an electronic patient record. Not only does this help to meet the presidential directive for a "comprehensive, life-long medical record," but it also eliminates some of the risks and inefficiencies of paper based medical records.
	
	Next Slide	

	Limitations of Paper Based Medical Records
	
	    • Paper charts get lost
	    • No automatic drug interaction alerts
	    • Penmanship counts
	    • Only one person can access a record at a time
	
	Next Slide
		❑ **Slide 4: Limitations of Paper Based Medical Records**

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

Duration	Training Activities	Instructor Notes
	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*	
	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 receiving a CHCS II account • The CHCS II password replaces CHCS verify code *Next Slide*	❑ **Slide 6: Security**
	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 • Providers shall be available to receive On-the-Job Training (OJT) • 100% of patient encounters shall be documented in CHCS II	❑ **Slide 7: Expectations**

Duration	Training Activities	Instructor Notes
	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
	  - Site Training Coordinator
	  - ILT Trainers
	  - OJT Trainers
	
	 Next Slide
		❑ **Slide 9: Key Information**
		
		These resources are available during the training implementation.
		
		Note: Provide the names of those filling these roles locally and an indication of how they might be contacted.

	System Demo	
	Go to Appendix A *Next Slide*	❑ **Slide 10: System Demonstration** **Suggestion:** Invite class participation to assist with roles in demonstration.

Duration	Training Activities	Instructor Notes
	Course Goal	☐ **Slide 11: Course Goal**
	The goal of this course is to enable Providers to access, navigate, and use the CHCS II application to document patient encounters.	
	Next Slide	☐ **Slide 12: CHCS II Training System**
	CHCS II Training System	
	Explain:	**Elaborate on each bullet point**
	• Click CTS desktop icon to log on to training system • 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 • Some variations between the CTS and the live system • Users are automatically logged on as a Provider • Live system access may vary depending on roles	**Note:** Duties of staff vary from clinic to clinic. **Note:** The scenarios used in this training may not fully reflect your actual clinic workflow or clinical practices. They are designed to teach the features in the software.
	Next Slide	
	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 • MTF and service-specific business rules are to be followed when using CHCS II	

Duration	Training Activities	Instructor Notes
	Next Slide	❑ **Slide 13: Training and MTF Business Rules**
	Session One Course Agenda	
	• Navigation • Patient Search and Appointments • Patient Encounter • Previous Encounters • S/O Template Management • Medicomp Forms Tool • List Management	
		❑ **Slide 14: Session One Course Agenda**
	Next Slide	

Lesson 1: Navigation

		❑ **Slide 15: Navigation Learning Objectives**
	Lesson Goal The goal of this lesson is to enable the user to access and navigate within the CHCS II application. **Learning Objectives** Upon completion of this lesson, the provider will be able to: • Log in to the CHCS II application • Access modules quickly using Folder List • Open and close an application module	**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.

Duration	Training Activities	Instructor Notes
	• Lock a CHCS II session • Exit the CHCS II application	
	Basic Navigation	**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.
	Explain: General layout of the screen (similar to Outlook) • Title Bar • Main menu • Action Bar • Folder List	**Review screen layout.** **Explain:**
	# 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** radio button is selected by default. 2. Click **OK**. 3. Press the escape key (Esc) on your keyboard twice to progress through the informational messages. 4. Verify the Appointments module is open. 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 used in one module might not be used in another, so what appears in the Action Bar changes. 7. Click the **Co-Signs** module in the Folder List to open the Co-Signs module. The Co-Signs module will display. 8. Click the **Close** icon on the Action Bar to close the Co-Signs module. 9. To lock the CHCS II application, follow the Menu Path **File** > **Lock.** 10. The screen will minimize.	Remind the students the importance of closing each module, this avoids stacking and will allow the user to move more freely within the system. Action Bar changes according to the module, providing quick access to navigation and functionality for the module.

Duration	Training Activities	Instructor Notes
	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 users will have to enter their assigned password before reentering CHCS II.	**Note:** Emphasize how the desktop can be customized.
	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	
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	
	Security and Session Management	
	Explain:	**Note**: Emphasize that passwords **must** be changed in CHCS II.
	• 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: Show File > Change Password. **Explain:** The complete steps for this task cannot be fully demonstrated on the CHCS II Training System; you will be shown how to change your password in your OJT session.	

Duration	Training Activities	Instructor Notes
	SUMMARY	
	 • Navigation • Security *Next Slide*	

Lesson 2: Patient Search and Appointments		

Duration	Training Activities	Instructor Notes
	## 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 provider will be able to: • Search for a patient record • Set search selections for the appointments module • Change and save the column order • Create a walk-in appointment • Add a provider to an appointment • Clear a patient's record.	❑ **Slide 16: Patient Search & Appointments Learning Objectives**
	Patient Search Module Pulling a Patient Record features: ▪ Different search methods available	

Duration	Training Activities	Instructor Notes

	▪ 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. 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.	**Explain:** Appointment display options: • Column order • Clinic (Clinic assignments are in CHCS) • Provider • Date • Status **Explain:** Appointment types and statuses. **Explain:** The Related to

Duration	Training Activities	Instructor Notes
	a. In the *Clinic* section, click the radio button for **This Clinic.**	Injury/Accident checkbox.
	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 status of **CheckedIn**.	
	Add an additional provider to an encounter	
	Doctor, David will be assisting you with the headache/physical appointment for **CAPT Clayton Williams (w8867)**.	
	1. Highlight CAPT Williams' name on the appointment list.	

Duration	Training Activities	Instructor Notes
	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 Doctor, David.	
	5. The Clinician search window will display. Enter **DOCTOR** in the **Last Name** field and click the **Find** button.	
	6. Select **Doctor, David** if the name is not already highlighted.	
	7. Click the **Select** button to complete the process of adding Doctor David as the additional provider for CAPT Williams. The Clinician search window disappears.	
	8. The Providers and Roles window re-opens. Notice that Doctor, David is now added to the Additional Provider # 1 field.	
	9. Click the **Role** dropdown button to display the list of role options. Select **Assisting provider**.	
	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 **Transfer** icon.
	   • Point out the **Add Providers** icon. (Can add a Provider only to patient encounter with status of CheckedIn, Waiting, or In Progress)	

Duration	Training Activities	Instructor Notes
	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 • Explained how to transfer an appointments to a different provider • Added an additional provider to an appointment • Cleared a patient from the patient ID line *Next Slide*	
Lesson 3: Patient Encounter		
	# Lesson Goals The goal of this lesson is to document the patient encounter in CHCS II and create an electronic record. # Learning Objectives Upon completion of this lesson, the provider will be able to: • Open the encounter	❑ **Slide 17: Patient Encounter Learning Objectives**

Duration	Training Activities	Instructor Notes
	• Setup Autocite preferences • Document S/O using MEDCIN • Document A/P • Complete Disposition and verify E&M code • Sign Encounter	
	AutoCite Information	

	Explain: As encounters are completed for a patient, information from them is accessible through several modules from the Folders List. Information from some of these modules can be selected for display in the electronic SF 600 of a new encounter that is opened for the patient. These modules are referred to as AutoCite modules. You make selections for display of information from these modules in the *Encounter Summary Properties* window when you set up your system for personal use. Information in some of these modules can also be edited and modified by additions and deletions that are appropriate outside of encounters.
	
	AutoCite modules include:
	
	    • Problems module
	    • Lab module
	    • Radiology module
	    • Medications module
	    • Allergies module
	    • Vital Signs 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.
		Briefly discuss. You will update AutoCite preferences in the next scenario.
		
		The Provider's AutoCited preferences are selections that will show in the final SF 600.

	Introduction to MEDCIN	
	MEDCIN	

Duration	Training Activities	Instructor Notes
	• 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 • 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 (–).	Emphasize that use of structured documentation results in a more accurate code.
	MEDCIN: Advanced Search Options	
	Explain: • Dx (Diagnosis) Prompt generates a list of findings based on a diagnosis. This is helpful in selecting terms for a template built around a diagnosis. • List Size - There are three levels that create a broader list of findings. • Find Term • Browse From Here	

Duration	Training Activities	Instructor Notes

Subjective/Objective Module

Subjective/Objective

- Subjective - what the patient told the provider

- Objective - what the provider observed during physical exam

The Subjective portion of the note includes the History of Present Illness (HPI), Past Medical History (PMH) and Review of Systems (ROS). This information comes from the patient and is organized by the provider.

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

Key Points:

- Visit templates are clinical notes using MEDCIN terms
- E&M coding is done quickly and accurately using structured terminology.

Subjective/Objective

Demonstrate:

Since Col. Alexander has come in today complaining of a cough, we will document Col. Alexander's visit using a standard URI template. We need to document the following:

HPI

- Chief Complaint of URI symptoms

- Cough that has been occurring for 2 days, mainly at night

- Indicate that Col. Alexander went to the Urgent Care Clinic.

- Patient denies sore throat

Duration	Training Activities	Instructor Notes

ROS

- Sinus pain
- Headache
- No chest pain

PMH

- Col. Alexander smokes cigarettes and has been smoking 2 packs a day for 6 years (12 pack years)
- No history of Acute Bronchitis
- No history of Asthma
- Maternal History of Diabetes Mellitus Type II

PE

- Vital Signs (Reviewed)
- Nasal discharge
- Auscultation wheezing
- All other items are normal

Documenting the note:

Encounter Summary Properties	
	Click the Options button (on the Patient ID line.)
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family	[Select]
Active Medications	[Select]
	Click OK

Explain/Show:

Duration	Training Activities	Instructor Notes
		• select/deselect • expand/collapse • emitting
	1. Click the **S/O** button on the electronic version of the SF600 to open the S/O module. The S/O screen will display (the parts of the screen have been annotated for easy reference).	
	2. Click the **Template Mgmt** icon on the Action Bar.	
	3. In the Name Contains field, enter **URI** and click **Find Now**.	Reinforce to Providers the criteria between HPI and ROS. This is typically not familiar to some Providers.
	4. Select the VISIT—URI--MEDCIN template. You can review the template in the Template Preview pane.	
	5. Click **Load** on the Action bar.	
	Once the template is loaded, the S/O module starts with the **HPI** tab selected	
	6. Select **Chief Complaint is: URI symptoms** as a positive finding**.**	**Be sure to explain the parent-child relationship and that a parent term need not be selected if a child term is selected; for example, if the term cigarettes is chosen, no need to select smoking.**
	7. Select **a cough** as a positive finding.	
	8. Click on the Duration grid icon on the Dashboard	
	9. Select **2** and **Days**	
	10. Type *MAINLY AT NIGHT* in the Free Text area of the dashboard and press the [Enter] key	
	11. Select **sore throat** as a negative finding.	
	12. Click on the free text Note Pad icon in the S/O MEDCIN pane. The Preliminary Background HPI window for entering free text will display.	**Explain** AutoNeg—when to use and when not to use.
	13. Type **PT SAW DR AT UCC** in the Preliminary Background HPI area and click **Save and Close** to save the information.	
	14. Click the **PMH** tab.	
	15. Click + to expand **Smoking**	**Explain** "flipping" and the use of **ROS/HPI** button.
	16. Click + to expand **Cigarettes**	
	17. Click **Plus Sign** to select for ___ pack-years	Emphasize that use of structured documentation results in a more accurate code.
	18. Type **12** in the Value Field on the Dashboard and press **Enter**	
	19. Select **history of ACUTE BRONCHITIS** as a negative finding.	

Duration	Training Activities	Instructor Notes
	20. Select **history of ASTHMA** as a negative finding.	
	21. Click + to expand **history of DIABETES MELLITUS**	
	22. Click **Plus Sign** to select TYPE II	
	23. Click the **FamHist** drop down button on the Dashboard to select **Maternal History**	
	24. Click the **ROS** tab.	
	25. Select **sinus pain** as a positive finding.	
	26. Select **headache** as a positive finding.	
	27. Select **chest pain** as a negative finding.	
	28. Click the **PE** tab.	
	29. Select **vital signs (Reviewed)** as a positive finding.	
	30. Select **nasal discharge** as a positive finding.	
	31. Select **auscultation wheezing** as a positive finding.	
	32. Click **AutoNeg**.	
	33. Review the information in the narrative pane to ensure that everything is correct	
	34. Click on the **Close** icon 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.	

Duration	Training Activities	Instructor Notes

	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.
	
	Exercises
	
	- Complete the exercises.
	- Check for understanding and answer participant questions.
	
	Summary
	
	- Explained MEDCIN
	  - Dashboard
	  - MEDCIN Tree
	  - Narrative Pane
	- Searched, loaded and used a template
	- Explained moving text from ROS to HPI
	- Explained AutoNeg
	- Explained reverse sensing terms
	
	Assessment/Plan Module
	
	# Assessment/Plan
	
	- Assessment – knowledge gained from the S/O, Autocite and Vitals determines diagnosis
	
	- Plan – what needs to be accomplished to treat the patient and keep them healthy
	
	The Assessment and Plan module allows you to document your assessment of a patient's condition
		Explain:
		- CHCS II supports creating a problem-oriented medical record.
		- Procedures and orders must be associated with a diagnosis.
		- Association of orders and procedures supports problem-oriented healthcare.
		- Procedures and orders can be associated and disassociated with one or more diagnosis.
		- Order Entry selections are similar to the ones in CHCS.
		- Same drug-drug, drug-allergy, and duplicate order warnings as in CHCS.
		
		Review Screen Layout

Duration	Training Activities	Instructor Notes
	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 ▪ 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. CHCS II will only allow you to select terms that have a code associated to them.	**Order sets currently in CHCS must be recreated for use in CHCS II.**
	Assessment/Plan	
	# Demonstrate: As a result of the physical examination, the provider has determined the patient has both an Upper Respiratory Infection as well as Acute Bronchitis. The primary diagnosis being the Acute Bronchitis. The provider also noticed with the Acute Bronchitis, the patient has bronchospasms, but is not in distress. The provider wants to order: ▪ A peak flow procedure associated with the Acute Bronchitis ▪ A CBC W/Auto diff associated with the Acute Bronchitis ▪ A chest x-ray with (PA) and lateral views. We want to rule out pneumonia and associate the chest x-ray with the Acute Bronchitis ▪ Order Amoxicillin to treat the Acute Bronchitis ▪ Have the patient take frequent oral fluids for the Acute Bronchitis and the Upper Respiratory Infection **Documenting the note:**	When adding diagnosis and procedures, point out ICD and CPT Codes. Add diagnoses to the working diagnosis list. Explain searches can be performed using: • WHO language • ICD Codes • Partial Words Explain that the user can delete a diagnosis, procedure or order that was documented in error.

Duration	Training Activities	Instructor Notes
	1. Click **A/P** on the SF 600.	
	2. In the **Search** field, enter **UPPER RESP** and click **Find Now**.	
	3. Select **UPPER RESPIRATORY INFECTION 465.9** in the list and click **Add to Encounter.**	
	4. In the **Search** field, enter **ACUTE BRONCH** and click **Find Now**.	
	5. Select **ACUTE BRONCHITIS 466.0** in the list and click **Add to Favorites List.**	
	6. Click **Add to Encounter**.	
	7. Click on the word **Comment** associated with Acute Bronchitis in the Diagnosis List.	
	8. Type *PT HAS BRONCHOSPASMS BUT IS NOT IN DISTRESS* in the Comments area and click **OK**.	**Explain**: Civilian **(Non-MTF)** consults continue to be completed in CHCS rather than in CHCS II.
	9. Highlight **ACUTE BRONCHITIS**. Select the Priority up arrow to move diagnosis to primary diagnosis.	
	10. Click the **Procedure** tab.	
	11. Click the **Favorites List** button to Select **Pulmonary Function Test Peak Flow 94150.**	
	12. Click the **Order Lab** tab.	
	13. In the search field type **CBC** and click **Search**.	
	14. Select **CBC W/Auto Diff**. Click the **Submit** button to associated with Acute Bronchitis.	
	15. Click the **Order Rad** tab	
	16. In the search field type **CHEST** and click **Search**.	
	17. Select **CHEST, PA AND LATERAL**.	If an order has been sent the Provider still must notify the receiving location because the deleted order is still at the receiving location.
	18. In the Clinical Impression field type **R/O PNEUMONIA.** Click Submit.	
	19. Associated Rad with Acute Bronchitis	
	20. Click the **Order Med** tab.	
	21. In the search field type **AMOX** and click **Search**	
	22. Select **AMOXICILLIN--PO 500MG CAP.**	If orders were submitted they

Duration	Training Activities	Instructor Notes
	23. In the SIG field, type **T 1 CAP PO QID X7 #28 RF0** and press **Enter**.	would be listed under the *show orders* area. These orders would also need to be deleted; so another user would not think the patient was given the order.
	24. Associate Med with Acute Bronchitis. Click **Submit**.	
	25. Click the **Show Orders** button and view the orders that have been submitted.	
	26. Click on the **Other Therapies** tab.	
	27. In the search field type **FREQUENT ORAL FLUIDS** and click **Find Now**.	
	28. Select **Oral Fluids Frequent** and click **Add** to associate with Acute Bronchitis.	
	29. As indicated in the scenario, we also want to associate Frequent Oral Fluids with the Upper Respiratory Infection diagnosis.	
	30. Select **UPPER RESPIRATORY INFECTION 465.9** in the Diagnosis List.	
	31. Select **Oral Fluids Frequent** in the Orders and Procedure List and click the **< >** (Associates/Unassociates Orders & Procedures) button to associated with the Upper Respiratory Infection diagnosis.	
	32. Click the **Close** icon on the Action Bar	
	33. Review encounter note.	
	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 • Labs, Rads and Meds can be submitted or saved to queue	
	Disposition and Sign Module	
	Disposition and Signing	

Duration	Training Activities	Instructor Notes
	• Release of the patient • Follow-up information • Items discussed • E&M code • Review the note • Assign a co-signer if required	**Important Notes**: Emphasize that verification of the E&M code is essential and that it can be changed, if necessary, based on documentation. This is especially important when using more free text then MEDCIN terminology.
	## 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 the **Disposition** button on the encounter note to open the Disposition module. 2. Enter the following data:	**Emphasize selection of Preventative Med types, when appropriate. Most often missed; results in inappropriate coding.**
		NOTE: Remind Users of Mental Health Clinics, they won't use the >50% time spent counseling box but will use the appropriate Procedure code because these sessions are designed as counseling sessions with this already factored in. They can be documented using the correct

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

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

Duration	Training Activities	Instructor Notes
	a. Change the Service Type drop down to ***Prev Eval/Mgt*** and observe the E&M code. Change the Service type back to ***Outpatient Visit*** to reset the code.	Procedure code.
	b. Click on the >50% time spent counseling or coordinating care and indicate > 50 minutes spent in total face to face floor time in minutes. Observe the new E&M code. Click to reset the >50% time spent counseling or coordinating care.	
	c. Change the Patient Status drop down to New Patient and observe the E&M code. Change the Patient status back to Existing Patient to reset the code.	
	3. Click the **Sign** icon on the Action Bar to initiate the signing process. The Sign Encounter window will display.	
	4. Review the note to ensure that everything is complete and accurate and click **Sign** to complete the patient encounter process.	
	5. Clear patient.	
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	
	Summary	
	Complete Disposition and verify E&M code Sign Encounter	
	Next Slide	

Duration	Training Activities	Instructor Notes

Lesson 4: Previous Encounters

Lesson Goal

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

Learning Objectives

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

- Append a narrative
- Amend a previous encounter
- Copy Forward a previous encounter

Previous Encounters

Demonstrate:

Appending a Narrative

The provider needs to annotate LCDR Eduardo Suarez's diabetes is now controlled by adding a note to his Diabetes Mellitus Type II – Uncontrolled encounter

1. From the list of appointments, click on any of LCDR Suarez's appointments to pull his record.
2. Click the **Previous Encounters** module in the Folder List.
3. Highlight the **Diabetes Mellitus Type II – Uncontrolled** encounter.
4. Click the **Append Narrative** icon on the Action Bar. The Encounter Note window will display.
5. Type *DIABETES* in the Note Category field.
6. Type *DIABETES CONTROLLED* in the Note Title field.
7. Type **BASED ON THE PT A1C, HIS DIABETES SEEMS UNDER CONTROL. PT WILL CONTINUE TO MONITOR HIS GLUCOSE LEVEL.** in the text area.

Instructor Notes:

❑ **Slide 18: Previous Encounters Learning Objectives**

The *Change History* section of the Encounter Note shows the original S/O note. This is the electronic equivalent of lining out the information in the paper medical record.

New findings can also be documented for the current encounter.

Explain: Amending an encounter allows information in the original note to be changed by the original Provider, co-signing Provider, or the original Provider's supervisor.

Duration	Training Activities	Instructor Notes
	8. Click the **Save and Sign** button. The Sign Appended Note window will display. 9. Click the **Sign** button to sign the encounter. Notice status has changed from completed to updated. 10. Click the **Close** icon on the Action Bar to close the module. **Amend a completed encounter:** The user would like to add the results of the Lipid Panel tests to LCDR Eduardo Suarez' completed encounter. 1. In the appointment list select LCDR Eduardo Suarez's Diabetes follow-up appointment to pull his patient record. 2. Click **Previous Encounters** in the Folder List. 3. Highlight the *Screening exam Lipoid Disorders* note. 4. Click **Amend Encounter** on the Action bar. Notice the SF 600 displays. 5. Open the **S/O** section. Click the **Edit Note** button. 6. Click on the **Test** tab. 7. Click the **Find Term** icon on the Action Bar. 8. In the Search String field type **cholesterol**. 9. Expand **Serum Lipoproteins** 10. Select **Total Cholesterol** as a negative finding. Enter **171** in the **Value** field on the Dashboard. 11. Click **Sign** on the Action Bar. Review Change History. 12. Click **Sign** button on Sign encounter window. Notice the encounter status has changed.	**NOTE:** Previous Encounters will only list/show encounters completed in CHCS II.

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

Duration	Training Activities	Instructor Notes
	Summary	
	• Append a narrative to a completed encounter • Amend a completed encounter • Copy Forward a previous patient encounter *Next Slide*	

Lesson 5: S/O Template Management

Duration	Training Activities	Instructor Notes
	# Lesson Goals The goal of this lesson is to locate available S/O templates in CHCS II and edit templates. # Learning Objectives Upon completion of this lesson, the provider will be able to: • Search for Visit Template • Use Template Edit Mode • Use FindTerm • Use Browse from Here • Rename and Save the Template	❑ **Slide 19: S/O Template Management Learning Objectives** **Explain**: • Templates have pre-positioned terms • Benefits of using templates: streamline documentation • Folder location of templates in CTS versus the live system Templates specific to the site imported to the CTS appear under the Favorites and Personal Templates; however, in the live system, for those in Family Practice or Primary Care these
	S/O Template Management	
	# Demonstrate: You have determined your patient Ret. VADM Olaf Berg, who has come in with reason for visit as Cold and Flu, actually has Allergic Rhinitis. You would like to edit, and then use the Allergic Rhinitis Template. **Edit a Visit template** 1. In the appointment list highlight the appointment for Ret.VADM Olaf Berg, **(b8943).** Click **Open**	

Duration	Training Activities	Instructor Notes

	Appt. on the Action Bar to open encounter note.
	
	2. Open the S/O.
	
	3. Click the **Template Mgt** icon on the Action Bar.
	
	4. In the Name Contains field type **Allergic**. Click **Find Now** button.
	
	5. Select the **Allergic Rhinitis** Visit template
	
	6. Click the **Edit** icon on the Action Bar.
	
	7. We would like to remove the following terms from the template:
	
	    a. cardiovascular symptoms (ROS)
	
	    b. gastrointestinal symptoms (ROS)
	
	    c. endocrine symptoms (ROS)
	
	    d. External Auditory Meatus (PE)
	
	8. We would like to add the following terms
	
	    a. swollen eyelids (HPI)
	
	    b. hoarseness (HPI)
	
	    c. reported a family history of allergies (PMH)
	
	    d. sinus pain (ROS)
	
	    e. Constantly Wiping Nose (PE)
	
	9. To remove the ROS term highlight **cardiovascular symptoms** in the right pane.
	
	10. Click **Plus Sign** to deselect cardiovascular symptoms in the left pane.
	
	11. To remove the ROS term highlight **gastrointestinal symptoms** in the right pane.
	
	12. Click **Plus Sign** to deselect gastrointestinal symptoms in the left pane.
	
	13. To remove the ROS term highlight **endocrine symptoms** in the right pane.
	
	14. Click **Plus Sign** to deselect endocrine symptoms in the left pane.
	
	15. To remove the PE term highlight **External Auditory Meatus** in the right pane.
		templates are found in the Clinic Templates folder; and, for those in other areas, use the search feature to locate them.
		
		• Service specific naming convention
		
		Templates for all branches are stored together in the live system. Each service uses a different naming convention to organize templates for browsing. For example:
		
		BRANCH--ENC--URI--LDR
		
		Where:
		TYPE = Encounter (ENC), Visit, Education (EDU), Procedure (PROC), Consent, PE, and so on,
		SUBJECT = Allergy, URI, Asthma Followup, and so on,
		LDR = Personal initials (3) of the template owner
		
		Discuss use of Favorites List when searching for and

Duration	Training Activities	Instructor Notes
	16. Click **Plus Sign** to deselect External Auditory Meatus in the left pane.	loading templates.
	17. To add the additional terms: Click the **DX Prompt** icon on the Action Bar	
	18. Enter **ALLERGIC RHINITIS** in the search window and click **OK**.	
	19. Select **ALLERGIC RHINITS** and click **OK**. Terms related to Allergic Rhinitis will display in the MEDCIN Tree pane.	
	20. Click the **HPI** tab.	
	21. Select **swollen eyelids** as a positive finding.	**Examples**:
	22. Select **hoarseness** as a positive finding.	BRANCH--ENC--URI--LDR
	23. Click the **PMH** tab.	• Training system templates
	24. Click the **List Size 1** button on the Dashboard to expand to **List Size 2**.	The naming convention for templates used in the training system begins with TRAINING rather than BRANCH; and there are other training system templates you will use that do not follow either of these conventions.
	25. Select **reported family history of allergies** as a positive finding.	
	26. Click the **ROS** tab.	
	27. Select **sinus pain** as a positive finding.	
	28. Click the **PE** tab.	
	29. Select **constantly wiping nose** as a positive finding.	
	30. Click the **Save As** icon on the Action Bar. The Save List Note Template window will display.	
	31. Type **VISIT--ALLERGIC RHINITIS**--**Your Initials** in the Template Name field leaving the Add to Favorites and Shared check boxes checked and click **SAVE**. The template will be saved with the name specified.	• How to search for the template
	32. To terminate the template building process, click the **Cancel** icon on the Action Bar. The Template Management window will re-display.	**Explain:** Template preview screen (point out)
	33. Click **Yes** to close the module.	Load the template. (Action Bar icon or double-click)
	34. Click **Close** on the Action Bar. This takes you back to the S/O documentation window.	
	35. Click **Close** on the Action Bar to return to the encounter note.	
	36. Close note.	**Explain:** Template

Duration	Training Activities	Instructor Notes
	Exercises	availability within S/O using drop-down
	• Complete the exercises. • Check for understanding and answer participant questions.	
	Summary	
	• Explained S/O Template Management features • Search for Visit Template • Use Template Edit Mode • Use FindTerm • Use Browse from Here • Rename and Save the Template	
	Next Slide	

Lesson 6: Medicomp Forms Tool

	Medicomp Form Tools is an alternative mode of documentation during an encounter. The Medicomp Form Tool also provides enterprise management capability for forms that emulates Template Management functionality within the S/O portion of the encounter.	❑ **Slide 20: Medicomp Forms Tool Learning Objectives**

Lesson Goal:

The goal of this lesson is to locate and use available 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

Duration	Training Activities	Instructor Notes
	Demonstrate:	

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 Mgt** 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.*

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.

Duration	Training Activities	Instructor Notes
	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	

Duration	Training Activities	Instructor Notes
	• 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	

Lesson 7: List Management		

	## Lesson Goal:
	
	The goal of this lesson is to enable the provider to create and manage Favorites Lists of diagnoses and procedures for streamlining selection in the Screening, Problems and A/P modules.
	
	## Learning Objectives:
	
	Upon completion of this lesson, the provider will be able to:
	
	• Create lists of favorites for use in the application:
	  • Diagnoses
	  • Procedures
	  • Clinic Favorites
	• Delete items from lists.
		❑ **Slide 21: List Management Learning Objectives**

Duration	Training Activities	Instructor Notes

List Management

Demonstrate:

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

1. To begin, click the **List Management** module in the Folder List The List Management screen will display.

2. To Delete Upper Respiratory Infection from the Diagnosis favorites list, click ⊞ to expand *My Favorites* (if not already expanded) and click ⊞ to expand *My Diagnosis* (if not already expanded). A list of favorite diagnoses will be displayed.

3. Click on *UPPER RESPIRATORY INFECTION* to select it and click the **Delete** icon on the Action Bar. Upper Respiratory Infection will be deleted from the Favorite List.

4. To add flu shot to the procedures favorites list, click to highlight *My Procedures* and click the **Add** icon on the Action Bar. The Select Procedure window will display.

5. Type *flu shot* in the Search field and click **Search**. Terms related to flu shot will be displayed.

6. Click ⊞ to expand *Vaccines Viral Influenza*

7. Click ⊞ to expand *Split Virus*

8. Click ⊞ to expand 3 years of age and above

9. Click *For Intramuscular Use 90658* to select it and click **OK**. The For Intramuscular Use procedure will be added to the Procedure Favorite List.

10. To move the electrocardiogram procedure to the bottom of the Procedures favorites list, click *Electrocardiogram* in the Procedures favorites list.

11. Click the **Move Down** icon on the Action Bar. Electrocardiogram will be moved to the bottom of the list.

Duration	Training Activities	Instructor Notes
	Exercises	
	- Complete the exercises. - Check for understanding and answer participant questions.	
	Summary	
	- Delete items from lists. - Create lists of favorites for use in the application *Next Slide* **END OF SESSION ONE**	
	Session Two Agenda - Encounter Templates and Order Sets - Telephone Consults - Health History Folder - Alerts, New Results, Co-Signs and Sign Orders - Clinical Notes	❑ **Slide 22: Session Two Course Agenda**
Lesson 8: Encounter Templates and Order Sets		
	## Lesson Goal The goal of this lesson is to enable the provider to create encounter templates and commonly used Order Sets. ## Learning Objectives Upon completion of this lesson, the provider will be able to	❑ **Slide 23: Encounter Templates and Order Sets Learning Objectives** **Note**: Remember to reset the database for the day and import the training templates.

Duration	Training Activities	Instructor Notes

	• Use an encounter template
	• Edit an encounter template
	• Create an Order Set in A/P
	• Merge an encounter template with an order set
	
	## Encounter Templates
	
	# Demonstrate:
	
	Using an Encounter Template
	
	Heather Cloud is being seen today because of pain in the lower portion of her back. There is an Encounter Template for *Low Back Pain* that you would like to use.
	
	1. Create a new appointment for **CAPT Heather Cloud (c0058)**.
	
	    –Appointment Type: **ACUTE APPT (ACUT$)30**
	
	    -Reason for Appointment: **lower back pain**
	
	2. Open CAPT Cloud's appointment for lower back pain, which now appears at the bottom of the appointment list.
	
	3. Click the **Templates** icon on the Action Bar.
	
	4. The *Templates Selections* tab will display by default.
	
	5. Expand the **My Favorites** folder
	
	6. Select the **ENC—LBP** template. Click the **Add** button to load the template into the current encounter.
	
	7. Click **OK**. Notice the encounter note (SF 600).
	
	8. Open **S/O** to document this portion of the note. Notice the LBP template automatically populates. View the contents of the tabs in S/O.
		When adding diagnosis, show how to do multiple searches and select results before clicking the **Done** button.
		
		When adding therapies, show double-clicking to add, rather than using the **Add Items** button.
		
		When adding procedures, show entry of multiple selections pressing **Ctrl** key.
		
		Explain:
		
		• Purpose of the encounter

Duration	Training Activities	Instructor Notes

	9. Document the following:
	
	HPI
	
	    The Chief Compliant is: **Back Pain**
	
	    Expand Back Pain
	
	    Select **in the lower back**
	
	    Pt. denied other symptoms
	
	PMH
	
	    No past history reported
	
	    Expand **Exercise habits**
	
	    Select **Regular**
	
	PE
	
	    Select **vitals signs (Reviewed)**
	
	    Select **Patient appeared uncomfortable**
	
	    Expand **Tenderness on palpation**
	
	    Select **lower**
	
	10. Click the **A/P** button on the Action Bar.
	
	11. The Diagnosis tab displays with LBP—ENC items populated.
	
	12. Select **LUMBAGO**, click **Add to Encounter**.
	
	13. Click the **Procedures** Tab.
	
	14. Select **Modalities Heat Hot Packs 97010**.
	
	15. Click the **Order Rad** Tab.
		template.
		• The use of the Template Management module to create an original encounter template Mention that encounter templates can also be created from existing encounters and from previous encounters. Both require editing because actual patient encounters are tailored to the specific circumstances; so, they need to be generalized to be used as templates. (OJT).
		
		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*

Duration	Training Activities	Instructor Notes
	16. Type *CT, LUMBAR SPI WITH AND WITHOUT CONTRAST GP* in the New Order field, click **Search**. 17. Select *CT, LUMBAR SPI WITH AND WITHOUT CONTRAST GP* in Procedure Name field. 18. In the Clinical Impression field type ***R/O Ruptured Disk.*** 19. Select ASAP 20. Click **Submit** button. 21. Click the **Meds** Tab. 22. Type ***Motrin*** in the **New Med** search field. 23. In the Item Name, select *IBUPROFEN (MOTRIN) 800 MG (U/D)-PO 800MG*. 24. Sig: ***T1 PO TID PRN #40 RF0***, then press enter on the keyboard. 25. Click **Submit**. 26. Click the **Other Therapies** Tab. 27. Select *Heat/Cold Application*, then click **Add**. 28. Click the **Disposition** button on the Action Bar. 29. Select: *Release w/o Limitations (Default selection), PCM, All items Discussed.*	*Visit, Associated Appointment Types, Associated Problems,* and *Items to Autocite into Notes*) are not used and if populated, they should be removed. • Discussion of order sets will follow the building of the parts of the template mentioned above.

Duration	Training Activities	Instructor Notes
	30. Click the **Sign** icon on the Action Bar.	
	31. The Sign Encounter window displays. View note.	
	32. Click the **Sign** button to complete the encounter.	
	Edit an Encounter Template	
	1. In the Folders List Open the **Tools** Folder and select **Template Management**.	
	2. Click the Search icon on the Action Bar.	
	3. In the Template Name field type in **LBP**.	
	4. Click **Search** at the bottom of the screen.	
	5. Highlight the **LBP** encounter template.	
	6. Select **View/Edit** icon on the Action Bar to edit this template.	
	7. In the Diagnosis area select SCIATICA 724.3, click **Remove** button to remove item from template.	
	8. Click the **Save As** button on the Action Bar.	**Explain**: • Created separately because of local ~~variations~~
	9. Use the proper naming convention and save the encounter template as the **LBP** encounter.	

Duration	Training Activities	Instructor Notes

10. Click **Save.**

11. Click **Close.**

Create an Order Sets

You need an order set for the LBP encounter template you are building.

1. Create a new **ACUTE** appointment for **CAPT Heather Cloud (c0058)**.

2. Open the encounter. Open **A/P**.

3. **Order Lab**

   Search: **Urinalysis**

   Save to queue

4. **Order Rad**

   Search: **Lumbar**

   Select: ***CT, LUMBAR SPI WITH AND WITHOUT CONTRAST GP***

   Clinical Impression: R/O LBP

   Save to Queue

5. **Order Med**

   Search: **Lumbar**

   Select: ***IBUPROFEN (MOTRIN) 800 MG (U/D)-PO 800MG***

   Sig: **T1 PO TID PRN #40 RF0**

   Save to queue

   Search: **Flexeril**

   Select: **CYCLOBENZAPRINE (FLEXERIL) –PO 10MG TAB**

   Sig: **T1 PO TID PRN #20 RF0**

Instructor Notes:

variations.
Order sets cannot be imported from other bases because of differences in Lab/Rad/Med availability.

- Created in A/P using a test patient and test clinic.
- Merged with appropriate encounter template.
- Can be loaded and used independently.

Duration	Training Activities	Instructor Notes
	Save to queue	
	6. Click the **Order Set** Tab.	
	7. Click the **Save as Order Set** button.	
	8. Save template as: **ORDERS—LBP.**	
	9. Close A/P warning box, click **Yes.**	
	10. **Close.** The encounter.	
	Merging two templates	
	1. Click **Template Management** in the Folder List.	
	2. Click the **Search** icon on the Action Bar	
	3. Type **LBP** in the search field.	
	4. Press and hold the **Ctrl** key and click to select:	
	Orders—LBP	
	ENC--LBP	
	5. From the Action Bar, click the **Merge** icon.	
	6. Notice the orders are now added.	
	7. Click **Save As** on the Action Bar.	
	8. Enter **ENC—LBP with orders** and click **Save.**	
	9. Close the module.	
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	
	Summary	

Duration	Training Activities	Instructor Notes
	• Use an encounter template • Edit an encounter template • Create an Order Set in A/P • Merge an encounter template with an order set Next Slide	
—Lesson 9: Telephone Consults		
	## Lesson Goals The goal of this lesson is to enable the provider to create and document Telephone Consults in CHCS II. ## Learning Objectives Upon completion of this lesson, the provider will be able to: • Set search selections for the Telephone consults module • Create a Telcon • Select, open and document a Telcon **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.	❑ **Slide 24: Telephone Consults Learning Objectives** Point out that the *Urgency* section is the only difference from *Appointment Search Selections* screen. Telcons created in CHCS must be completed in CHCS. Telcons must be created in CHCS II in order to be completed in CHCS II. Indicate that the Provider sees the Notes not the Reason for the appointment.

Duration	Training Activities	Instructor Notes
	4. In the Clinics area, select **This Clinic**.	
	5. In Provider area, select **Me**.	Lower case terms in diagnosis list are symptoms.
	6. In Dates area, select the **All Outstanding** checkbox.	
	7. Click **Set Selections as Default**.	Point out that all elements of a telephone consult are covered in the quick entry screen.
	To Create a Telcon	
	You just received a telephone call from Ester Chang's mother, stating that Ester has a fever of 100.2 F°. Ester's mother wants to know what to do. During the call, the mother indicated there were no other symptoms. Based on this information, the provider diagnosed a low-grade fever (low urgency telephones consult). The provider tells the mother to give the child Children's Tylenol and a cool bath. If the patient's temperature has not gone down by morning, make an appointment for Ester.	
	Assist the provider in documenting this telephone call.	
	1. Click the **Telephone Consults** module in the Folder List. The Telephone Consult window will display:	
	2. Click the **New Telcon** icon on the Action Bar. The Patient Search window will display:	
	3. Type **CHANG** in the Last Name Field and **ESTER** in the First Name field and click the **Find** button. The Patient Search window will re-display with Ester Chang's name in the Patient Name area.	
	4. Click on Ester's name and click **OK**. The New Telcon window will display for Ester.	
	5. In the Reason for Telephone Consult field type *FEVER*.	
	6. In the Notes area type *PT HAS A FEVER OF 100.2 F°. WITH NO OTHER SYMPTOMS* and click on the **OK** button. The Telcon Quick Entry screen will display.	
	7. In the Provider Note area type **GIVE PT CHILDREN'S TYLENOL AND A COOL BATH. IF TEMPERATURE HAS NOT GONE DOWN BY MORNING, MAKE AN APPOINTMENT FOR PT.,** type **FEVER** in the Search field and click **Find Now**. A list of terms containing or related to fever will display.	
	8. Click on a *fever (as a symptom) 780.6* to select it and click **ADD** *"a fever (as a symptom)"*, will display in the Selected Diagnosis field.	

Duration	Training Activities	Instructor Notes
	9. Click the **drop-down arrow** on the right of the E&M field to get a list of possible E&M codes for the Telephone Consult. 10. Accept the default E & M selection **99371 Telcon: Lvl I, Simple/Brief**, click the **Save and Sign** radio button (if not already selected) and click **OK**. The Sign Encounter window will display. 11. Click **SIGN** to sign the order and complete the process and return to the Telephone Consults window. The Telephone Consult for Ester Chang will indicate it is Complete. 12. Click the **CLOSE** icon on the Action Bar to close the module.	
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions.	—
	SUMMARY	
	• Set search and display telephone consults list options • Created and documented telephone consult — — Next Slide	

Lesson 10: Health History Folder

	# Lesson Goal The Health History module displays historical patient data from various modules in one window. The window can be customized to show different modules containing the patient's information. The goal of this lesson is to setup and customize the Health History module and enable the Provider to access, view and modify selected patient information accumulated from earlier encounters and outside the current encounter.	❑ **Slide 25: Health History Folder Learning Objectives** **Explain:** • Use this module to set up a display of selected

Duration	Training Activities	Instructor Notes
	## Learning Objective Upon completion of this lesson, the provider will be able to: - Setup Health History patient data modules - View Demographic information - View and modify problem information - View and copy lab results into an encounter - View and copy radiology results into an encounter - View and modify medication information - View and modify allergy information - Set and review the properties for the Vital Signs module - Select appropriate screen options for the category of patient - Graph vital signs	patient health history information for quick review. - There is no default setup. The first time you access the module; you need to setup the display. - Setup can be done from either the Tools menu or the **Options** button. - Once set up, the same setup applies to all patient records.
	### Health History	
	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.	

Duration	Training Activities	Instructor Notes
	Key Points:	
	• Can be changed to fit the current requirements	
	Problems Module	
	Explain: Information from the encounter for COL. Violet Alexander that you just completed documenting is now available in the Problems module. In this module, information from all previous encounters is accumulated and organized according to the problems that have been identified in encounters. Not only can you view this information, you can also add or delete problems, as appropriate.	—**Review the screen layout.**
	Set the scene: You want to review **COL Violet Alexander's (a5743)** problem list now that you have completed this new encounter. You want to add to her Problem List that she mentioned had childhood asthma.	
	## Demonstrate:	
	With **COL Alexander's (a5743)** name highlighted on the Appointments list.	
	1. In the Folder List, click the **Problems** module located under Health History.	
	2. Expand the Problem list to view **COL Alexander's** Acute/Chronic problems.	
	3. Click **Add** on the Action Bar	
	4. The Select Diagnosis window appears with Clinic List selected by default.	
	5. Select the **Search** tab.	
	6. Type *Asthma* in the Find field.	
	7. Select **ASTHMA 493.90**	
	8. Click **OK**.	
	9. In the Status field accept default: **Active**	
	10. In the chronicity field accept default: **Chronic**	
	11. In the Source field accept default**: Patient.**	

Duration	Training Activities	Instructor Notes
	Lab Module	—**Review the screen layout.**
	Set the Scene: LCDR Eduardo Suarez (s3217) is in for a follow-up appointment. While reviewing his Lab, you notice his elevated HGB A1C. You would like to include this information in the encounter note.	
	1. Create a **(ROUT) 15** appointment for **LCDR Eduardo Suarez (s3217)**. Open the encounter.	
	2. Click **Lab** in the Folder List.	
	Review what appears based upon the default settings.	
	3. Highlight the *Hemoglobin A1C* lab result. The result details display in the lower section of the screen. Use the **Display Criteria** to select **Ref Range/Units**.	
	4. 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	
	5. Select **Copy to Note**.	
	6. Close the **Lab** module. Notice the Hemoglobin A1C lab 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	
	Radiology Module	**Review the screen layout**.
	Set the scene: While reviewing **LCDR Suarez's (s3217)** radiology results, you noted his abnormal Sinus Series. You would like to include this information in the encounter note.	**Explain:** Point out temporary change options
	# Demonstrate:	

	1. Select the **Radiology** module from the Folder List.
	2. Set the properties (Options button).
	    Filter Name: **All Types**
	    Preferences tab, Time Options
	    Default Time: **All time periods**	

Duration	Training Activities	Instructor Notes
	3. Click the **OK** button. 4. Select: **Sinus Series Report**. 5. Highlight the impression portion of the report. 6. Copy the results to the note. 7. Click Close on the Action Bar. 8. Review results copied to encounter note. 9. Close encounter.	

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: LCDR Eduardo Suarez (s3217) tells you that she has added taking Tums each day for his heartburn.

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

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

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

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

5. Click **Discontinue** on the Action Bar.

6. An error box appears indicating this action requires an open encounter (for documentation). Click *OK*

7. The **Search Filter** selection changes back to **Outpatient Current**.

Instructor Notes: —**Review the screen layout.**

Duration	Training Activities	Instructor Notes
	8. Click the **Add** icon to record Motrin. 9. Click the Record OTC/Outside Medication button. 10. Click the **Medications** button to begin searching for **Tums** in the *Healthcare Data Dictionary Search* window. 11. Select *CALCIUM CARBONATE (TUMS) –PO 500MG TAB* and click the **OK** button. 12. Complete all required fields (including the **Sig: TAKING ONE TAB DAILY**) and add a comment *FOR HEARTBURN*. 13. Click the **OK** button. Note the checkmark in the **OTC** column, which indicates this is an over-the-counter medication. 14. Type *Patient* in the Ordering Provider field. 15. Order Start Date: **2 Weeks** 16. Close the Meds module.	
	Allergy Module	
	Explain: • Keeps track of a patient's reactions to specific allergens • Allergy icons: NKA, nose, and nose with question mark • Allergy synchronization occurs when the appointment is created and when the Allergy module opened • A common list of allergens can also be specified to make entering data more convenient **Set the scene: LCDR Suarez (s3217)** also indicated he is allergic to Latex. You need to document this. # Demonstrate: 1. Open **Allergy** from the Folder List. 2. Click the **Add** button to display the *New Allergy* section. 3. Click the **Allergen** button and search for **OTHER** in the *Health Care Dictionary Search for*	—**Review the screen layout.**

Allergens window.

4. Select **OTHER (Class)** to add it as an allergen.

5. Click the dropdown arrow next to the **Reaction** field and select **URTICARIA** as a reaction.

6. Enter the following information:

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

7. 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.

8. 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.

9. Click **Close**.

10. Click **Save**, then **OK** to **Close** the *Properties* window.

11. 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**.

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

13. Clear Patient

Duration	Training Activities	Instructor Notes
	Vitals Sign Review	
	# Demonstrate: After talking to Eduardo Suarez, you would like to view his past blood pressure and heart rate values. You need to graph them to get a better feel for the results. **Reviewing Vital Signs** To review Eduardo Suarez's past vital signs: 1. Click **Vital Signs Review** module in the Folder List. The Vital Signs Review window will display. 2. Highlight all of his past blood pressure *BP* and heart rate *HR* values (click in the upper left *BP* cell and drag the mouse to the lower right *HR* cell). 3. Click the **Graph Vitals** icon on the Action Bar. The Graph Vitals window will display a 2-D chart. 4. Click the *3-D Bar* radio button to display the results as a 3-D Bar Chart and click **OK** to close the graph window. 5. Click the **Close** icon on the Action Bar to complete the process	—**Review the screen layout.**
	Exercises	
	• Complete the exercises. • Check for understanding and answer participant questions	
	Summary	
	▪ Explained Health History folder	

Duration	Training Activities	Instructor Notes
	▪ Setup Health History patient data modules ▪ Viewed and modified problem information ▪ Viewed and copied lab results ▪ Viewed and copied radiology results ▪ Viewed and modified medications ▪ Viewed and modified allergy information ▪ Set and review the properties for the Vital Signs module ▪ Graph vital signs Next Slide	

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

	## Lesson Goal The goal of this lesson is to enable the provider to review and respond to notifications of diagnostic results and to orders and encounters requiring the provider's signature. ## Learning Objectives Upon completion of this lesson, the provider will be able to: - Access and Address alerts - Access the Lab or Radiology modules from New Results - Review, append and sign encounters requiring co-signatures - Sign non-Provider orders	❑ **Slide 26: Alerts, New Results, Co-Signs, Sign Orders Learning Objectives** **Point out icons on the Paitent ID line: Alerts, Sign Orders, etc…**
	Alerts Review	
	## Demonstrate: A provider needs to address the alert for a new result that has been posted. Review the result and	

Duration	Training Activities	Instructor Notes
	delete the alert.	
	1. Click either the **Alert Review** folder in the Folder List or the ! icon on the Action Bar. The Alert Review window will display.	
	2. Click to select the *New Result* alert and click the **Address Alert** icon on the Action Bar. The New Result window will open.	**Review Screen Layout**
	3. Click to select *Olaf Berg's Chem 7* result and click the **View Result** icon on the Action Bar. The Lab module will display.	
	4. View the result and click the **Close** icon on the Action Bar. The New Results window will re-display.	
	5. Click the **Toss** icon on the Action Bar. A confirmation message will be displayed.	
	6. Click **Yes** to confirm the Toss. The New Results window will be re-displayed less the New Result just tossed.	
	7. Click the **Close** icon on the Action Bar to close the New Results window. The Alert Review window will re-display indicating the New Results alert has been resolved.	
	8. Click on the New Result line to select it and click the **Delete** icon on the Action Bar. The Alert Review window will re-display with the New Result alert deleted.	
	9. Click the **Close** icon on the Action Bar to close the module.	
	New Results	
	# Demonstrate:	
	To view results:	
	1. Click the **New Results** folder in the Folder List. The New Results window will display.	**Review Screen Layout**
	2. Click to select the *New Results* tab if not already selected.	
	3. Click the *Lipid Panel Complete* lab test result for Eduardo Suarez. The line will be highlighted.	
	4. Click the **View Result** icon on the Action Bar to view the result. The Lab module will display the result.	
	5. When you are finished viewing the detailed result information in the Lab module, click the **Close** icon on the Action Bar. The New Results module window will re-display.	**Explain: The Purpose of the Results folder is to show a list of all results so that the Provider can use.**

Duration	Training Activities	Instructor Notes
	To discard results:	
	1. Click to select the *New Results* tab if not already selected.	
	2. Click the *Urinalysis* lab test result for Eduardo Suarez. The line will be highlighted.	
	3. Click the **Discard** icon on the Action Bar. A Discard confirmation window will display.	
	4. Click **Yes** to discard the Urinalysis lab test. The New Results window will re-display.	**Note**: Mention Discard vs Toss
		Explain: Discarded results can no longer be viewed from the results folder.
	To save results	
	1. Click the *Lipid Panel Complete* lab test result for Eduardo Suarez. The line will be highlighted.	
	2. Click the **Save** icon on the Action Bar. A CHCS II Results window will display, asking if you want to move this result(s) to your saved result list?	
	3. Click **Yes** to save the Lipid Panel Complete lab test. The New Results window will re-display and the Lipid Panel Complete result will disappear.	
	To forward a new result to a provider:	
	1. Click on the **Provider Search** button. The Clinician Search window will display.	
	2. Type *DOCTOR* in the Last Name field and click the **Find** button at the bottom of the window. Clinicians matching the search criteria will display.	
	3. Click to select *DOCTOR, DAVID* in the results area and click the **Select** button at the bottom of the window. The New Results window will be re-displayed.	
	4. Click to select the *CBC W/o Diff* lab test for Violet Alexander and click the **Forward** icon to forward the lab test result. A confirmation message will display.	
	5. Click **Yes** to forward the result. The New Results window will re-display.	
	6. Click the **Close** icon to terminate the process.	
	Note: The system creates a signature to confirm that a provider has viewed the new result information. You can discard results without viewing them (e.g., the result appears in your New Results list, but the result was forwarded to you for a patient from another provider). The discarded results are removed from your list without an electronic signature. To create an electronic	

Duration	Training Activities	Instructor Notes
	signature, view the result and then use the Toss functionality to remove the results from the list.	

Co-Signs

Demonstrate:

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

Review Screen Layout

Co-Sign an encounter

1. Click the **Co-signs** icon in the Folder List. The Co-Sign window will display.

2. Click to select the Allergic Rhinitis encounter or Anna Wunderlich. The encounter information will display in the encounter window.

3. Review the encounter.

4. Click **Sign Encounter** icon on the Action Bar.

5. Review the note again and click the **Sign** button to sign the encounter. The Co-Signs window will re-display

Amend an encounter

1. Click the **Co-signs** icon in the Folder List. The Co-Sign window will display.

2. Click to select the *HYPERLIPIDEMIA* encounter of Eduardo Suarez. The encounter information will display in the encounter window.

3. Click the **Amend Encounter** icon on the Action Bar. The ENCOUNTER will display.

Duration	Training Activities	Instructor Notes
	4. Click the **Lab** folder in the Folder List. The Lab module window will display.	
	5. Click on *Lipid Panel Complete*. The Lab result will display in the Display Criteria section of the window.	
	6. Click the *Ref Range/Units* check box to display the reference ranges for the test.	
	7. Drag the mouse from Lipid Panel Complete in the upper left of the lab result area to the lower right of the area (this selects the entire lab result).	
	8. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note.	
	9. Since we want to copy these lab results to the note, click the **Copy to Note** button.	
	10. The lab result will re-display, with the lab result no longer highlighted (the result has been copied to the note).	
	11. Click the **Close** icon on the Action Bar.	
	12. View the lab result in S/O section of the ENCOUNTER, under the S/O note.	
	13. Click the **Sign** icon on the Action Bar. The Co-Sign Encounter window will display.	
	14. Review the note again and click the **Sign** button to sign the encounter. The Appointments window will re-display.	
	15. Close module	
	Sign Orders	
	## Demonstrate: The provider notices the **Sign** icon in the Patient ID line. Assist the provider in signing the orders for Eduardo Suarez. The provider would also like to cancel the Chem 7 Panel ordered for Clayton Williams. **Signing non-provider orders** 1. Click either the **Sign** icon in the Patient ID line, or **Sign Orders** in the Folder List to open the Sign Orders process. The Sign Orders window will display	**Review Screen Layout**

2. Click the check boxes to the left of Eduardo Suarez's name for the Liver Panel test.

3. Click either the Sign Selected Orders icon on the Action Bar or Sign Selected Orders button. The window will re-display with the sign orders removed.

Canceling a Non-Provider Order

1. Click the check box to the left of Clayton William's name.

2. Click either the Cancel Selected Orders icon on the Action Bar or Cancel Selected Orders button. The window will re-display with the canceled order removed.

3. Close module

Summary

- New results
- Encounters needing to be co-signed
- Encounters modified
- Orders to sign

Lesson 12: Clinical Notes

Lesson Goal

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

Learning Objectives

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

❏ **Slide 27: Clinical Notes Learning Objectives**

Duration	Training Activities	Instructor Notes
	• View a clinical note • Add a clinical note • Edit a clinical note • Save a clinical note **Clinical Notes** # Demonstrate: A provider specializing in Ear Nose and Throat (ENT) performed minor surgery yesterday on Klaus Wunderlich, who had an object lodged in his ear. The provider saw the patient today and examined his ear. He now wants to add the following note with graphic to the patient's record. The provider would also like to insert a graphic of the ear. He asked you to show him how to do that. Assist the provider in performing these tasks. Search for Klaus Wunderlich to "pull" his chart. **Creating a Clinical Note** 1. Click on the **Clinical Notes** folder in the Folder List. The Clinical Notes module will display: 2. Click the **New** icon on the Action Bar to create the new note. The New Clinical Note window will display. 3. Select *Physician Progress Notes:* from the Note Types drop-down list. 4. Select *CHCS II ITT* from the POC: drop-down list. 5. Type **2-YEAR-OLD MALE WITH PENCIL ERASER LODGED IN AUDITORY CANAL. REMOVED OBJECT YESTERDAY. SAW PATIENT TODAY. EAR HEALING WELL. WILL CONTINUE WITH FOLLOW-UP PLAN**. in the documentation area. Press [Enter]. 6. Click the **Insert Image** button on the bottom of the window. Locate and load the ear image into the Clinical Note. **7.** Click either **Save** the icon on the Action Bar or the **Save** button to save the information. The Clinical Note Window will re-display with the updated information.	**Clinical Notes are notes that are entered on the patient but are not attached to the SF 600.**

Duration	Training Activities	Instructor Notes
	Copying a Clinical Note	Add Note: Notes that are attached to the patient's SF 600
	1. Klaus Wunderlich has come in for his appointment and the provider would like to add the Clinical Note to his encounter	
	2. You need to create an appointment for Klaus Wunderlich (for this example).	
	3. Highlight and opened the appointment	
	4. Go to Clinical Notes from his Health History Folder.	
	5. Highlight the Clinical Note you just created.	
	6. Select **Edit** to open the note.	
	7. Highlight the contents of the note, including the image.	
	8. Perform the copy process by using [Ctrl] C.	**Explain**:
	9. Click the **Close** icon on the Action Bar to close the module.	You can also use [Ctrl] V to paste to the note.
	10. Click the **Add Note** icon on the Action Bar.	
	11. Select **New Note** on the Select Note field.	
	12. With cursor in the documentation area, right click and select paste.	
	13. Click **Note Complete** button.	
	14. Review the ENCOUNTER.	
	15. Click the **Close** icon on the Action Bar to close the ENCOUNTER.	
	Key Points:	
	• Graphical images can be inserted into clinical notes.	
	Exercises	
	• Complete the exercises.	

Duration	Training Activities	Instructor Notes
	• Check for understanding and answer participant questions.	
	Summary	
	▪ View a clinical note ▪ Add a clinical note ▪ Edit a clinical note ▪ Save a clinical note	
	Next Slide	

Course Summary

Duration	Training Activities	Instructor Notes
	Briefly summarize the course and open to questions and answers. • Overview of the system, the training, the expectations • Basic skills: navigating through documenting • Patient Encounter • MEDCIN Templates and Forms • Previous Encounters • Health History folder • Alerts, New Results, Co-Signs, Sign Orders • Clinical Notes Next Slide	❑ **Slide 28: Course Summary**
	What Do I Do If I Encounter a Problem While Working with CHCS II?	❑ **Slide 29: 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	

Duration	Training Activities	Instructor Notes
	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 and click. You can also perform a right mouse click and select **Paste** or from the Edit menu, select **Paste**. 4. Save the screen capture to the appropriate folder on the workstation. In many clinics, there is a specific folder on a shared network drive for storing these files. Ensuring Patient Data is concealed in the Screen Capture 1. In PowerPoint, use the drawing tools to conceal any patient-specific information on the screen. 2. From the View menu, select **Slide Show**. 3. On the workstation keyboard, press **PrtScrn**. 4. Exit the slide show to return to the normal view by pressing **Esc** on the workstation keyboard. 5. On the PowerPoint toolbar, click the new presentation icon (i.e., the blank piece of paper). 6. To paste the screen capture into the new presentation, on the workstation keyboard, press **right mouse and click**. You can also perform a right mouse click and select Paste or from the Edit menu, select Paste. 7. Save the screen capture (in the new presentation) to the appropriate folder location on the workstation. 8. Close the original screen capture without saving the document.	

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Duration	Training Activities	Instructor Notes
	Other Help Resources	
	• CHCS II User Manual. Should be available in each clinic. • Student Guide. Can be used during class and also can be accessed online after class. • Application Help menu. Detailed information on use of modules Step-by-step procedures **Explain:** Both are readily available within the application help files. Help is structured like other Windows application help files. *Next Slide*	❑ **Slide 30: Other Help Resources** Remind the class that the student guide is not to be removed from the classroom, and inform them about the process for obtaining their own copies at the site. **Emphasize the use of Help in the application.**
	Questions and Answers *Next Slide*	❑ **Slide 31: End of Main Course**
Appendix A: System Demo		

Duration	Training Activities	Instructor Notes

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	**Acute Appt (ACUT$) 30**
	Reason for Appointment	*Turned Rt ankle*
	Injury/Accident Related	[Select] [Select] **Other Accident**
	Appointments Module	
CHCSII Provider Lesson Plan		[Select] CPT Cloud's walk-in appt. and open encounter note (SF 600).
	ENCOUNTER NOTE (SF 600)	

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Duration	Training Activities	Instructor Notes
	Appendix B: Immunizations	

Duration	Training Activities	Instructor Notes
	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 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.	❑ **Slide 32: Immunizations Learning Objectives**
	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.	

Duration	Training Activities	Instructor Notes
	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:	
	8. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays	
	9. Select a User Defined Group.	
	10. Select a vaccine from the Available vaccine list. (Have input from class).	
	11. Click the **Right Arrow** button to move the vaccine to the Assigned Vaccines list.	
	Vaccination Management	
	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.

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

Duration	Training Activities	Instructor Notes
	9. Close Vaccines in Stock Information window. **Key points:** o Explain how to view the Vaccine Lot Number List o Point out how to delete a provider from administering immunizations o 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	
	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	

Duration	Training Activities	Instructor Notes

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.

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:

13. **Print Worksheet:** Use this function to print required immunizations for the selected patient.

14. **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

Duration	Training Activities	Instructor Notes

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.**

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

Duration	Training Activities	Instructor Notes
	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	