



CHCS II SuperUser Lesson Plan



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Rev 2.2

Change History

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10-5-2004	E. Chesnut	Created	
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Preparation for Delivery

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

Materials Needed

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

Note: Students can keep the Quick Reference Card (QRC); other training items are to be left in the classroom. The CHCS II Evaluation Form is to be completed by each student and left with instructor upon completion of class.

Tasks to be Completed Prior to Class

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

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

Tasks to be Completed at the End of Class

- Distribute the evaluation forms and collect them from the students before they leave the classroom. Ensure that the student included a comment if rated "3" or lower
- Explain to the class how assistance will be provided the first time they attempt to use their account in the live system

Duration	Training Activities	Instructor Notes
CHCS II Overview		
	<p data-bbox="296 253 594 293">What is CHCS II?</p> <p data-bbox="296 318 1535 386">CHCS II is a computer-based patient record (CPR) system selected by Department of Defense to meet the requirements of the Military Health System.</p> <p data-bbox="296 407 541 440">CHCS II provides:</p> <ul data-bbox="380 461 1346 651" style="list-style-type: none"> <li data-bbox="380 461 1226 493">• A Graphical user interface that networks with existing systems <li data-bbox="380 509 1346 542">• Efficient means of creating, managing and retrieving of medical records <li data-bbox="380 558 1272 591">• Anytime, anywhere delivery of patient records to the point of care <li data-bbox="380 607 1184 639">• Future access military records for health studies worldwide <p data-bbox="296 721 982 753">Add this brief comment as transition to next slide:</p> <p data-bbox="296 773 1549 878">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.</p> <p data-bbox="848 935 1016 984" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1583 282 1948 315">Slide 3: What is CHCS II?</p>
	<p data-bbox="296 1016 1014 1057">Limitations of Paper-Based Medical Records</p> <ul data-bbox="296 1078 932 1219" style="list-style-type: none"> <li data-bbox="296 1078 611 1110">• Paper charts are lost <li data-bbox="296 1118 810 1151">• No automatic drug interaction alerts <li data-bbox="296 1159 596 1192">• Penmanship counts <li data-bbox="296 1200 932 1232">• Only one person can access a record at a time <p data-bbox="848 1243 1016 1292" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1583 1045 1892 1151">Slide 4: Limitations of Paper Based Medical Records</p>

Duration	Training Activities	Instructor Notes
	<p data-bbox="296 180 579 215">CHCS II Benefits</p> <ul data-bbox="348 250 1530 773" style="list-style-type: none"> • Interfaces with MHS standard systems, e.g. CHCS & ADM • Uses a standard, structured language, which is MEDCIN which has the ICD-9 and CPT codes tied to those structured terms • Facilitates compliance through electronic capture of elements required for: <ul data-bbox="401 412 1402 480" style="list-style-type: none"> • JCAHO (Joint Commission on Accreditation of Healthcare Organizations) • Evaluation & Management (E&M) coding • Supports team-based health care and clinic workflow, providing simultaneous multi-user access • Supports problem-oriented health care • Accumulates data for reports and studies, such as clinical and population health • When fully implemented world-wide, CHCS II will provide access to patient records anywhere, anytime • Maintains security <p data-bbox="848 837 1014 873" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1583 207 1940 237">Slide 5: CHCS II Benefits</p> <p data-bbox="1583 261 1923 290">Elaborate on each benefit.</p>
	<p data-bbox="296 911 432 946">Security</p> <p data-bbox="296 976 1562 1076">Security is a crucial requirement of patient medical records. CHCS II security is multi-leveled and conforms with HIPAA/MHS security standards. User access to patient information is based on user role.</p> <ul data-bbox="348 1092 1440 1255" style="list-style-type: none"> • The system administrator assigns passwords that can be changed later by the user. • Users must have a CHCS account prior to registering for a CHCS II account. • The CHCS II password replaces CHCS verify code. • Roles and privileges are tied to unique user name and password. <p data-bbox="848 1287 1014 1323" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1583 938 1814 967">Slide 6: Security</p>

Duration	Training Activities	Instructor Notes
	<p data-bbox="300 180 594 220">CHCS II Training</p> <p data-bbox="300 240 1476 277">Classroom training is accomplished using Clinical Scenarios appropriate to each user's role.</p> <p data-bbox="300 347 1539 451">Providers have eight hours of Instructor-Led Training (ILT), while Nurses have six hours of ILT. Providers and Nurses have sixteen hours of OJT. Clerks and Support Staff receive four hours of ILT and four hours of OJT. Records Reviewer receive two hours of ILT and two hours of OJT.</p> <p data-bbox="306 524 1499 561">SuperUser's receive four days of Instructor-Led Training and one day of Training Workshop.</p> <p data-bbox="848 581 1016 630" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1587 240 1955 277">Slide 7: Training Schedule</p> <p data-bbox="1587 347 1969 529">Explain: That CHCS II system functionality is taught Day 1-4. Tools for assisting the user is taught Day 5. This includes ILT and OJT prep.</p>
	<p data-bbox="300 716 506 756">Expectations</p> <p data-bbox="300 781 1482 849">Upon completion of training, it is expected that service-directed expectations will be used as guidelines for each site as they ramp up to 100% productivity in CHCS II.</p> <p data-bbox="300 870 793 907">To accomplish this, it is expected that:</p> <ul data-bbox="348 927 1234 1049" style="list-style-type: none"> • 100% of CHCS II users shall attend scheduled classroom training • Users shall be available to receive On the Job Training (OJT) • 100% of patient encounters shall be documented in CHCS II 	<p data-bbox="1587 743 1877 781">Slide 8: Expectations</p>
	<p data-bbox="300 1276 1083 1317">Key Information Technology Training Resources</p> <ul data-bbox="348 1344 816 1466" style="list-style-type: none"> • MTF CHCS II Team <ul style="list-style-type: none"> • MTF Project Officer • Facility Training Coordinator 	<p data-bbox="1587 1304 1934 1341">Slide 9: Key Information</p> <p data-bbox="1587 1360 1969 1466">These resources are available during the training implementation.</p>

Duration	Training Activities	Instructor Notes
	<ul style="list-style-type: none"> • Clinical Champion/SuperUser • Unisys On-Site Team <ul style="list-style-type: none"> • Site Training coordinator • ILT Lead • OJT Lead • Trainers <p style="text-align: center;"><i>Next Slide</i></p>	<p>implementation.</p> <p>Note: Provide the names of those filling these roles locally and an indication of how they might be contacted</p>
	<p style="background-color: #e0e0e0; text-align: center;">Systems Demo</p> <p style="text-align: center;">Go To Appendix B</p> <p style="text-align: center;"><i>Next Slide</i></p>	<p>Slide 10: System Demonstration</p> <p>Note: Invite class participation to assist with roles in demonstration.</p>
	<p style="background-color: #e0e0e0; text-align: center;">Course Goal</p> <p>The goal of this course is to enable Nurses to access, navigate, and use the CHCS II application to document patient encounters in the clinic.</p> <p style="text-align: center;"><i>Next Slide</i></p>	<p>Slide 11: Course Goal</p> <p>Slide 12: CHCS II Training System</p>

Duration	Training Activities	Instructor Notes
	<p data-bbox="298 175 716 215">CHCS II Training System</p> <p data-bbox="298 233 1558 337">Instruct students to log into the CHCS II Training System. Explain that you will demonstrate each lesson and they should watch you, and then they will practice by performing the exercises in the Student Guide.</p> <ul data-bbox="352 386 877 418" style="list-style-type: none"> • Click the icon on the desktop to start <p data-bbox="346 461 466 493">Explain:</p> <ul data-bbox="346 505 1020 846" style="list-style-type: none"> • 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 from live CHCS II system • Users are automatically logged on as a Provider • Live system access may vary depending on roles <p data-bbox="846 1045 1014 1084" style="text-align: center;"><i>Next Slide</i></p> <p data-bbox="298 1183 848 1224">Training and MTF Business Rules</p> <p data-bbox="298 1292 541 1333">Refer to Slide</p>	<p data-bbox="1583 207 1919 272">Note: Duties of staff vary from clinic to clinic</p> <p data-bbox="1583 1200 1898 1265">Slide 13: Training and MTF Business Rules</p>

Duration	Training Activities	Instructor Notes
	<p data-bbox="848 183 1016 224" style="text-align: center;"><i>Next Slide</i></p> <hr data-bbox="296 383 1562 428" style="border: 1px solid black;"/> <p data-bbox="793 391 1066 431" style="text-align: center;">Day One Agenda</p> <p data-bbox="848 456 1016 496" style="text-align: center;"><i>Next Slide</i></p>	<p data-bbox="1587 277 1948 310">Slide 14: Day One Agenda</p>
Lesson 1: Navigation Skills		
	<p data-bbox="302 813 554 854">Lesson Goal</p> <p data-bbox="302 878 1556 911">The goal of this lesson is to enable the user to access and navigate within the CHCS II application.</p> <p data-bbox="302 967 705 1008">Learning Objectives</p> <p data-bbox="302 1032 1066 1065">Upon completion of this lesson, the end-user will be able to:</p> <ul data-bbox="348 1089 932 1300" style="list-style-type: none"> • Log in to the CHCS II application • Access modules quickly using Folder List • Open and close an application module • Lock CHCS II session • Exit the CHCS II application 	<p data-bbox="1587 797 1871 870">Slide 15: Navigation Learning Objectives</p> <p data-bbox="1587 943 1955 1154">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.</p>
	<p data-bbox="302 1341 569 1382">Basic Navigation</p> <p data-bbox="302 1406 1052 1438">Explain: General layout of the screen (similar to Outlook)</p>	<p data-bbox="1587 1341 1965 1438">Explain: You will demonstrate each lesson first and after each lesson</p>

Duration	Training Activities	Instructor Notes
	<ul style="list-style-type: none"> • Title Bar • Main menu • Action Bar <p>Demonstrate:</p> <p>Log on to the system, view the current list of appointments and open and close modules</p> <ol style="list-style-type: none"> 1. Double-click the CHCS II Training System icon on the computer desktop. A Role identification screen will appear, the medical radial button is selected by default. 2. Click OK. 3. Press the escape key (Esc) on your keyboard twice to progress through the informational messages. 4. Verify the Appointments module is open. 5. The list of current appointments will display. 6. Review the icons in the Action Bar for Appointments. Icons in the Action Bar are relevant to the module that is open. Icons that are used in one module might not be used in another, so what appears in the Action Bar changes. 7. Click the Co-signs folder in the Folders 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 11. To reopen the application click the application located on the desktop tool bar area 12. The simulated password will repopulate 13. Click OK <ul style="list-style-type: none"> • Note: CHCS II restores back to previously used screen 14. Click the Close X button on the upper right corner of the Title Bar to end CHCS II. A confirmation message will display. 	<p>demonstration the class will practice these lessons by performing the exercises in the Student Guide.</p> <p>The Action Bar icons change according to the active module, providing quick access functionality for the module.</p> <p>Note: Emphasize how the desktop can be customized.</p>

Duration	Training Activities	Instructor Notes
	<p>15. Click Yes to confirm the exit</p> <p>Key Points: Module access For navigating, the Folder List and Action Bar are the most efficient method.</p> <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p style="text-align: center;"><i>Next Slide</i></p>	
	<p>Security and Session Management</p> <p>Explain:</p> <ul style="list-style-type: none"> • 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. <p>Changing passwords: This cannot be demonstrated on the CHCS II Training System; you will be shown how to change your password in your OJT session.</p> <p style="text-align: center;">SUMMARY</p> <ul style="list-style-type: none"> • Navigation • Security <p style="text-align: center;"><i>Next Slide</i></p>	<p>Note: Emphasize that passwords must be changed in CHCS II.</p>

Duration	Training Activities	Instructor Notes
Lesson 2: Patient Search and Appointments		
	<p>Lesson Goals</p> <p>The goal of this lesson is to enable the user to locate a patient record and use the appointment functions in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the user will be able to:</p> <ul style="list-style-type: none"> ● Search for a patient record ● Set search selections for the appointments module ● Change and save the column order ● View and Add appointment comments ● Check-in a patient ● Create a walk-in appointment ● Transfer an appointment ● Add a nurse to an appointment 	<p>Slide 16: Patient Search & Appointments Learning Objectives</p>
	<p>Patient Search Module</p> <p>Pulling a Patient Record features:</p> <ul style="list-style-type: none"> ▪ Different search methods available ▪ Patient must have a record in CHCS ▪ “Search CHCS” is an option <p>Appointment Module</p> <p>Module specific screen features:</p> <ul style="list-style-type: none"> ● Module title bar ● Appointment list 	<p>Explain specific <i>Appointment</i> screen features.</p> <p>Explain: Scheduled (future) appointments are still made</p>

Duration	Training Activities	Instructor Notes
	<ul style="list-style-type: none"> • Columns • Access to properties setup options: <ul style="list-style-type: none"> • Drop-down box • Options • Change selections 	<p>in CHCS and come over to CHCS II nightly and every 15 minutes throughout the day.</p>
	<p>Patient Search and Managing Appointments</p> <p>Demonstrate:</p> <p>Col. Violet Alexander has come in today complaining of a cough. We need to search for Col. Alexander’s record, set the appointment filters and create a new appointment.</p> <ol style="list-style-type: none"> 1. Open the CHCS II Application. <p>NOTE: By default the Appointment module displays</p> <ol style="list-style-type: none"> 2. Click Search in the Folders List to search for a patient. The Patient Search window will display 3. Click in the Last Name field and type ALEXANDER, then click Find for a list of names. Click on ALEXANDER, VIOLET W in the list of names and click OK. Col. Alexander’s information will appear on the Patient ID line and the Appointments List will display. 5. Click the Change Selections... button in the top left corner of the Appointments module. <ol style="list-style-type: none"> a. In the <i>Clinic</i> section, click the radio button for This Clinic b. In the <i>Provider</i> section, select the radio button Me. c. In the <i>Dates</i> section, select the correct radio button to show Today Only appointments. d. Click the Set Selections as Default button to save your changes. 6. To move a column: <ol style="list-style-type: none"> e. Scroll to the right just until the Type column is visible. f. Click the Type column heading and hold down the left mouse button. g. Drag the Type column horizontally right (or left). <p>Release the left mouse button when the Type column is between the Patient and Status columns. Practice moving columns until the <i>Appointments</i> screen is most useful for you.</p>	<p>Explain: Appointment display options:</p> <ul style="list-style-type: none"> • Column order • Clinic <p>(Clinic assignments are in CHCS)</p> <ul style="list-style-type: none"> • Provider • Date • Status Selection <p>Explain: Appointment types and statuses.</p> <p>Do not need to show all steps in Transfer and Add Provider—but, do point out these functions.</p> <p>Explain: Live system, <i>Today plus Incomplete</i> pulls in old appointments from CHCS.</p> <p>Suggest using <i>Today Only</i> to view current day’s appointments</p> <p>Explain: The Related to</p>

Duration	Training Activities	Instructor Notes
	<p>Practice moving columns until the <i>Appointments</i> screen is most useful for you.</p> <p>If you wish to save the new column arrangement, click the Change Selections button. Then click the Set Column Order as Defaults.</p> <p>You need to Create a New Unscheduled Appointment for Col. Alexander (a5743).</p> <ol style="list-style-type: none"> 7. Click New Appt. on the Action Bar. A New Appointment confirmation window will display. 8. Click Yes to complete the New Appointment information for Col. Alexander. 9. Click on ACUTE APPT (ACUTS) 30 to select the acute appointment type. 10. Type cough in the Reason for Appointment field and click OK to complete the new appointment process for Col. Alexander. (The Allergy synchronization simulation from CHCS will begin.) 11. Col. Alexander's appointment will now appear at the bottom of the Appointment list with a status of CheckedIn. <p>Key Points:</p> <ul style="list-style-type: none"> • 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) <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	<p>Injury/Accident checkbox, a HIPAA 837 compliant feature.</p>
	<p style="text-align: center;">SUMMARY</p> <ul style="list-style-type: none"> • Explained patient search module • Explained appointment list properties • Explained how to make appointment display selections • Created a new appointment • Pointed out function for transferring appointments to other Providers • Pointed out function for adding a Provider to an appointment 	

Duration	Training Activities	Instructor Notes
	<div data-bbox="842 224 1018 280" data-label="Text"> <p><i>Next Slide</i></p> </div>	
Lesson 3: Telephone Consults (Telcons)		
	<div data-bbox="296 532 581 574" data-label="Section-Header"> <p>Lesson Goals</p> </div> <div data-bbox="296 596 1352 631" data-label="Text"> <p>The goal of this lesson is to enable the user to use the Telcon function in CHCS II.</p> </div> <div data-bbox="296 682 709 727" data-label="Section-Header"> <p>Learning Objectives</p> </div> <div data-bbox="296 745 1016 781" data-label="Text"> <p>Upon completion of this lesson, the user will be able to:</p> </div> <div data-bbox="390 802 1369 1026" data-label="List-Group"> <ul style="list-style-type: none"> • Set default search and display options for the telephone consults module • Create a Telcon • View clerk notes from the Appointment screen • Select and open a Telcon • Transfer a Telcon to a different Provider • Edit a call back phone number </div>	<div data-bbox="1575 516 1862 623" data-label="Text"> <p>Slide 17: Telephone Consults Learning Objectives</p> </div>

Telephone Consults Module

Demonstration:

An end user 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 end user diagnosed a low-grade fever (a level one telephone consult). The end user told the mother to give the child Children's Tylenol and a cool bath. If the patient's temperature has not gone down by morning, the mother should make an appointment for Ester. Assist the end user in documenting this telephone call.

1. Click the **Telephone Consults** folder in the Folder List. The Telephone Consult window will display:
2. Click the **New Telcon** icon on the Action Bar. The Patient Search window will display:
3. Type CHANG in the Last Name Field and ESTER in the First Name field and click the **Find** button. The Patient Search window will re-display with Ester Chang's name in the Patient Name area.
4. Click on Ester's name and click **OK**. The New Telcon window will display for Ester. Type FEVER in the Reason for Telephone Consult field, type PT HAS A FEVER OF 100.2 DEGREES F. WITH NO OTHER SYMPTOMS in the Notes area and click on the **OK** button. the Allergy Synchronization box appears.
5. The Telcon Quick Entry screen will display.

NOTE: If the end user has the provider role assigned to their log on, they will receive the Quick Entry Screen after clicking OK. Any other end user will be taken back to the Telephone Consults module.

6. In the Provider Note area type **GIVE PT CHILDREN'S TYLENOL AND A COOL BATH. IF TEMPERATURE HAS NOT GONE DOWN BY MORNING, MAKE AN APPOINTMENT FOR PT.,** type **FEVER** in the Search field and click **Find Now**. A list of terms containing or related to fever will display.
7. Click on a fever (as a symptom) 780.6 to select it and click **ADD** 'a fever (as a symptom)',

Telcons created in CHCS must be completed in CHCS.

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

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

Lower case terms in diagnosis list are symptoms.

Review quick entry screen.

Explain: Rather than signing the note and designating a Physician as the cosigner, an end user could transfer the Telcon to the Physician for their signature using the Action Bar icon.

	<p>will display in the Selected Diagnosis field.</p> <ol style="list-style-type: none"> 8. Click the drop-down arrow on the right of the E&M field to get a list of possible E&M codes for the Telephone Consult. 9. Click to select 99371 Telcon: Lvl I, Simple/Brief, click the Save and Sign radio button (if not already selected) and click OK. The Sign Encounter window will display. 10. Click SIGN to sign the order and complete the process and return to the Telephone Consults window. The Telephone Consult for Ester Chang will indicate it is Complete. 11. Click the CLOSE icon on the Action Bar to close the module. 	
Exercises		
<ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 		
SUMMARY		
<ul style="list-style-type: none"> • Explained default search and display telephone consults appointment list options • Created a telephone consult appointment • Explained how to transfer a telephone consult to a different Provider • Edited a call back phone number 		
<div style="border: 1px solid gray; padding: 2px; display: inline-block;">Next Slide</div>		
Lesson 4: Demographics		
	<p>Lesson Goals</p> <p>The goal of this lesson is to enable the end-user to verify third-party insurance and demographic information in CHCS II.</p>	<p>Slide 18: Demographics Learning Objectives</p>

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

- Verify third party insurance information
- Verify patient demographic information

Demographics

Demonstration:

LCDR Eduardo Suarez informs you that he has moved since his last visit and you must edit his demographic information. He has also acquired additional health insurance for his family and this information also needs to be added.

1. Click **Appointments** from the Folder List
2. In the Appointment List, highlight LCDR Eduardo Suarez's Diabetes follow up appointment.
3. Open encounter for LCDR Eduardo Suarez, click on **Demographics** in the Folder List. The Demographics module will display:
4. Click **Edit** on the Action Bar to be able to edit the demographic information and complete the following information:

Module or Field	Data or [Description of Data]
Home Address	1234 My Street
City	Chantilly
State/Country	VA
Zip	20151
Home Phone	703-444-4848
Religion	Jewish

5. To enter the Third-Party Insurance information, click the **Enter Changes to Patient Insurance Information** button on the bottom of the window. The Patient Insurance Information window will display

Enter the following information:

6. Click the **Yes** radio button for 'Does Patient have health insurance other than Medicare or Champus?'
7. Click the **Yes** radio button for 'Has any health insurance information been changed since last

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

visit?’

8. Insurance Company Name: *Blue Cross Blue Shield*
9. Insurance Company Telephone: *888-888-8888*
10. Insurance Company Address: *234 Nowhere Street My Town, NJ 00220*
11. Insurance ID Number: *1311-2323-111*
12. Group Name: *CHCS II*
13. Group Number: *ABC 123*
14. Subscriber’s Name: *LCDR Eduardo Suarez*
15. Patient’s Relationship to Subscriber: *Self*
16. Effective Date: (Enter one month ago today)
17. Expiration Date: (Enter one year from Effective Date)
18. Person Capturing Information: (Enter your name)
19. Information Source: *Patient*
20. Click the **Save** on the bottom of the window to save the information.
21. The 3rd party Insurance window displays. Click **OK**
22. Click **Save** on the Action Bar to save the updates
23. Click the **Close** icon on the Action Bar to close the module.

Key Points

- Demographic and third party insurance information may currently be viewed in CHCS II, but any required changes should be done in the respective legacy (former) systems. Follow your MTF business rules.

Exercises

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

SUMMARY

- Explained how to verify third party insurance information
- Verify patient demographic information

Next Slide

Lesson 5: Patient List

Lesson Goals

The goal of this lesson is to enable the end-user to create a patient list in CHCS II.

Learning Objectives

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

- Add patients to a patient list
- Delete a patient from a patient list
- Delete the patient list

Slide 19: Patient List Learning Objectives

Patient List

Demonstration:

The end user would like to create a list of their frequently seen patients.

Creating a patient list

1. Click **Patient List** in the Folder List to open the Patient List. The Patient List window will display.
2. Click the **Add** icon on the Action Bar to open the Patient Search window.
3. Type **W8118** in the Quick Search field and click the **Find** button.

4. Highlight WUNDERLICH, ANNA W and click **Ok**.
5. Repeat steps 2-4 to add the whole Wunderlich family to the patient list.

Deleting a patient from the list

1. With the Patient List module open, highlight **WUNDERLICH, HERMAN**.
2. Click the **Delete** icon on the Action Bar. A Delete patient from list window will appear.
3. Click **Ok**. The Patient List module will redisplay with Herman Wunderlich’s name removed.

Deleting the entire patient list

1. With the Patient List module open, click the **Delete List** icon on the Action Bar.
2. A Delete All Patients window will appear asking if you want to delete all patients from the current list.
3. Click **Ok**. The Patient List module will redisplay with all the names removed.
4. Click **Close** on the Action Bar to close the Patient List module.
5. Clear Patient

Exercises

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

SUMMARY

- Add patients to a patient list
- Delete a patient from a patient list
- Delete the patient list

Next Slide

Lesson 6: Patient Encounter

Patient Encounter

The patient encounter consists of the processes indicated. We will be going over each of these steps in detail.

Lesson Goals

The goal of this lesson is to document the patient encounter in CHCS II and create electronic record.

Learning Objectives

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

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

Slide 20: Patient Encounter Learning Objectives

AutoCite Information

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

	<p>and deletions that are appropriate outside of encounters.</p> <p>AutoCite modules include:</p> <ul style="list-style-type: none"> a. Problems module b. Lab module c. Radiology module d. Medications module e. Allergies module f. Vital Signs module <p>Problems, Allergies, Medications, and Vital Signs are considered Health History modules and are located in the Health History Folder for the patient in the Folder List. AutoCite information for these modules appears in the AutoCite section of the SF600.</p> <p>The Lab module and the Radiology module are directly accessible in the patient’s folder. Information from these modules, when selected for AutoCite display, appears in the S/O section of the SF600.</p> <p>The AutoCite button on the SF600 refreshes all information selected for AutoCite display regardless of where it appears.</p>	<p>Briefly discuss. You will update autocite preferences in the next scenario.</p>
	<p>Screening and Vitals Modules</p> <hr/> <p>Screening and Vitals</p> <ul style="list-style-type: none"> Screening Vital signs <p>Once the patient has been checked in, it is now time to open an encounter document for the patient. Appointments with a status of Checked-in, indicates that the patient is ready for screening. The appointment, or encounter for the patient can be opened.</p>	<p>Review screen layout: SF600 features</p>
	<p>Screening and Vitals</p> <hr/> <p>Demonstration:</p>	

Anna Wunderlich (w8118) has come in for a pregnancy test, you create a new appointment. You begin screening along with verifying her allergy information and documenting her vitals.

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

Clinical data:

Field	Data
New Unscheduled Appointment/Telcon Visit	
Appointment Type	Acute Appt (ACUT\$) 30
Reason for Appointment	Pregnancy Test
	Click OK
To open appt.	Double-click the appointment
Encounter Summary Properties	
	Click the Options button
Active Problems	[Accept default]
Allergies	[Accept default]
Active Family History	[Select]
Active Medications	[Select]
	Click OK
Screening	
In the Search field	[Enter] Pregnancy Test and click Find
For Females Only	
[Birth Control]	[Select] None
Verified This Encounter	[Select to verify allergies]
Vitals	

Explain: Use of the Screening module to document:

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

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

In review, ask students in

Vitals	
Habits	
Tobacco	[Select] No
Alcohol	[Select] No
BP	130/70
Rt arm	[Select]
Adult cuff	[Select]
HR	80
Radial	[Select]
Regular	[Select]
RR	16
Temperature F	96.7 F
Oral	[Select]
Ht	[Click] the drop-down list next to Ht [Select] ft/in. [Enter] 5 ft 5 in
Wt	132
Pain Severity	
	[Select] 0 Pain Free
Where is pain located?	Note: Add comments when pain scale is Selected (other than “0 pain free”)
	Click Close (Action Bar Icon)
Save Vitals	
	[Select] Save Vitals (Action Bar Icon)
	[Select] Close (Action Bar Icon)

which module allergies are verified: *Screening, not Allergy.*

Key Points:

- Reason for Visit is a structured term and may be more accurate than Reason for Appointment
- Screening during the patient encounter is the only area where a patient’s allergies can be verified

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

- Allergy information, however, can be added without an open encounter

Exercises

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

Section Summary

- Open the encounter
- Setup AutoCite properties
- Document “reason for visit”
- Verify patient’s allergies
- Document patient’s vital signs

Next Slide

MEDCIN

MEDCIN

Medical terminology narrative engine used in S/O, A/P, Disposition, Template Management, Screening and Problems modules

Relates to the encounter

Over 250,000 terms with 5.5 million semantic links

Linked to ICD-9 and CPT codes in A/P

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.

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.

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

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

- 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 (-).

Next Slide

Subjective/Objective Module

Subjective/Objective

Most healthcare personnel are familiar with the SOAP format that is used in paper charting.

MEDCIN is organized into a SOAP format as well. To review:

- Subjective - what the patient told the end user
- Objective - what the end user observed during physical exam

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

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

Key Points:

- Standard visit templates are clinical note writers using MEDCIN terms
- E&M coding is done quickly and accurately using structured terminology.

Subjective/Objective

Demonstrate:

Anna Wunderlich's results were positive with a home pregnancy test, and she is now ready to be seen.

Reinforce to Users the criteria between HPI and ROS. This is typically not familiar to some Users.

Review screen layout

To load and unload an S/O template to document an encounter:

1. Click **S/O** on the SF600. The S/O module opens.
2. Click **Template Mgt** on the Action bar.
3. In the Name Contains field, enter TRAINING and click **Find Now**.
4. Select the TRAINING--ECP--PREGNANCY TEST--VISIT template. You can review the template in the Template Preview pane.
5. Click **Load** on the Action bar.
6. Add The reason for visit is: Pregnancy Test as a positive finding.
7. Click the **Notepad** icon, enter *HOME TEST RESULTS POSITIVE*. and Click **OK**.
8. Add *nausea* as a positive finding.
9. Click **Find Term** on the Action bar.
10. In the search field, enter *Fatigue* and click **OK**.
11. Add *feeling tired (fatigue)* as a positive finding.
12. Click the << **Go Back** button to return to the template.
13. Click **AutoNeg**.
14. Click the **PMH** tab.
15. Add reported home pregnancy test as a positive finding.
16. Add *taking vitamin supplements* as a positive finding.
17. In the Free Text field, enter *CALCIUM 500mg DAILY* and press Enter on your keyboard.
18. Expand *pregnancy history*.
19. Add age at first pregnancy years old as a positive finding.
20. In the **Value** field, enter 20 and press Enter on your keyboard.
21. Add *planning to become pregnant* as a negative finding.
22. Click **Find Term** on the Action bar.
23. In the **Search** field, enter DOWN SYNDROME and click **OK**.

Show how to:

- select/deselect
- expand/collapse

Explain: Documenting by exception is the common practice and crucial to the use and purpose of AutoNeg

24. Expand History of Diagnoses, Syndromes And Conditions.
25. Add history of *DOWN'S SYNDROME (TRISOMY-21 MONGOLISM)* as a positive finding.
26. Click the **FamHist** button on the Dashboard.
27. Click the << **Go Back** button to return to the template.
28. Click the **PE** tab.
29. Add Pain Level (0-10) as a positive finding.
30. In the **Value** field, enter 0 and press Enter on your keyboard.
31. Click the **Notepad** icon.
32. In the note field, enter **EDUCATION:** *Pt instructed to make OB appt. Pick-up prenatal vitamins from pharmacy. Pt instructed not to drink alcohol or take other medications* and click **OK**.
33. Click **Close** on the Action bar.

Explain: Reverse sensing terms

The patient does not appear well nourished.

After reviewing your S/O note, You noticed this statement and realized you failed to select the minus sign to document this as an abnormal finding, so AutoNeg emitted a normal term, if a reverse sensing term is not specifically noted as a (-). You must now open the S/O (*PE*) tab to correct this term in the note.

Explain:

This is a *reverse sensing* term. Abnormal conditions for these terms are documented by *explicitly* selecting the minus, rather than the plus.

There are around 300 reverse sensing terms; they usually describe a normal condition, like *well nourished* or *does not appear stressed*; rather than an abnormal one, like *headache* or *nasal congestion*.

For these terms, when a plus is selected, the condition is described as normal, and when no plus is selected, AutoNeg assumes a normal condition.

So, to document an abnormal condition, the minus must be explicitly selected.

In summary: When using AutoNeg, for reverse sensing terms, select nothing unless the condition described is a problem; then, explicitly select the minus rather than plus. When not using AutoNeg, select the plus when the condition is checked and found to be normal.

MEDCIN: Advanced Search Options

Explain:

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

Next Slide

Exercises

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

Section Summary

- Explained MEDCIN
 - Dashboard
 - Medcin Tree
 - Narrative Pane
- Searched, loaded and used a template
- Explained moving narrative from ROS to HPI
- Explained AutoNeg
- Explained reverse sensing terms

Next Slide

Assessment/Plan Module

Assessment/Plan

- Assessment – knowledge gained from the S/O determines diagnosis
- Plan – what needs to be accomplished to treat the patient

The Assessment and Plan module allows you to document your assessment of a patient's condition and the plan for treatment by entering diagnoses, procedures, patient instructions and order consults, laboratory and radiology procedures and medications.

A/P Processes

- Codes are captured with diagnoses and procedures
- Procedures, orders and other therapies must be associated to a logical diagnosis
- Consults, Labs, Rads and Meds can be submitted or saved to queue

ICD-9 and CPT codes are automatically included with the appropriate terms in MEDCIN. When a diagnosis is added to the encounter the associated ICD-9 code is also added. When a procedure is added, the associated CPT code is included.

Assessment/Plan

Demonstration:

1. Click **A/P** on the SF600. The A/P module opens.
2. In the **Search** field, enter *Pregnancy Test* and click **Find Now**.
3. Select **Pregnancy Test V72.9** and click **Add to Encounter**.
4. Click the **Order Lab** tab.
5. In the **New Lab Order** field, enter *HCG* and click **Search**.
6. Select *HCG QL*.

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

	7. Click Submit .	are similar to the ones in CHCS.
	Exercises	<ul style="list-style-type: none"> • Same drug-to-drug, drug and allergy, and duplicate order warnings as in CHCS.
	<ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	When adding diagnosis and procedures, point out ICD and CPT Codes.
	Section Summary	
	<ul style="list-style-type: none"> • Document A/P • Explained how codes are captured with diagnoses and procedures • Procedures, orders and other therapies must be associated to a logical diagnosis • Consults, Labs, Rads and Meds can be submitted or saved to queue <p style="text-align: center;">Next Slide</p>	Add diagnoses to the working diagnosis list. Explain Searches can be performed using:
	Disposition and Sign Module	WHO language
	Disposition and Signing <ul style="list-style-type: none"> • Release of the patient • Follow-up information • Items discussed • E&M code • Review the note • Sign the encounter 	ICD 9 Codes Partial Words Explain: User can delete a diagnosis, procedure or order that was documented in error. If orders were submitted they would be listed under the show orders area.
	Disposition and Sign	Discuss pros and cons of saving to queue.
	Demonstration: We are now ready to discharge the patient. In this case we want to release the patient without limitations and have them follow up as needed. All items were discussed with the patient who	<ul style="list-style-type: none"> • Point out you might lose orders if the system should fail; but you can delete

indicated an understanding of the items discussed. We want to see the effect of filters on the E&M code before signing the encounter.

1. Click **Disposition** on the Action bar.
2. Accept the default Disposition, **Released w/o Limitations**.
3. In the Follow Up area, select the **With PCM** checkbox.
4. In the Comments field, enter *Call tomorrow for pregnancy test results*.
5. In the **Meets Output Visit Criteria (Workload)?** select **Yes** (Default).
6. Accept the default E&M value.
7. Click **Sign** on the Action bar.

Exercises

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

Section Summary

- Complete Disposition
- Verify E&M code
- Sign Encounter

Next Slide

- from queued orders.
- Show how to delete before submitting queued.
- Recommend submit over save to queue.

Explain: Civilian (**Non-MTF**) consults continue to be completed in CHCS rather than in CHCS II.

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

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.

Lesson 7: Medicomp Forms Tool

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

Lesson Goal

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

Learning Objectives

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

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

Demonstration:

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** tab.
3. Click the **Template Mgmt** tab 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** on the Action Bar.
7. The AIM Form will load

Slide 21: Medicomp Forms Tools Learning Objectives

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. Select the **T** to indicate Local Tissue Swelling Right Ankle.
11. Click in the square beside the term you just selected. This will open up a dialog box to add free text or insert text to the note.
12. Type in the following: *Patient states she was playing tennis when she twisted her ankle and feels it is sprained.*

Note: You will notice 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.

13. Select the child terms – **Medial right ankle soft tissue swelling**, and Right ankle soft tissue swelling with black and blue discoloration, to be more specific with your documentation.
14. Next go to **PMH**.
15. Select **T** to indicate previous Ankle Fracture under the Previous Diagnosis section.
16. Once you complete documentation of the patient's HPI, PMH and ROS, click on the **Right Ankle Physical Exam Tab**
17. Document the Vital Signs reviewed
18. Select **F** in the In No Acute Distress box.
19. Click the **Note** box to the right of the statement.
20. A free text box will appear. In this box type in: *Pt. States ankle very painful to walk on.*
21. In the Examination of the Right Lower Leg section click **T** for each item in this section.
22. In the Appearance of the Right Ankle section select **F** for the first four entries. Leave the others blank.
23. In the Tenderness of the Right Ankle section check **F** Medial Palpation without Tenderness
24. In the Motion of the Right Ankle section check **F** Right Ankle without Abnormal Motion.
25. In the Pain of the Right Ankle section check **F** No Pain Elicited by Motion.
26. In the Examination of the Right Foot section check **F** Right Foot Not Swollen and **F** Right Foot Not Tender to Palpation.
27. In the Test Results section, under the Results of Right Ankle X-Ray, free text *Fractured*

	<p><i>right ankle.</i></p> <p>28. Select AutoNeg from the Dashboard to indicate a “normal” result for the rest of the history.</p> <p>29. Click Close to save and close the S/O Forms note.</p> <p>Exercises</p> <ul style="list-style-type: none"> • No Exercise (Student will follow along with demonstration). • Check for understanding and answer participant questions. <p>Summary</p> <ul style="list-style-type: none"> • Searched for a Form • Loaded Form • Documented the S/O using a Form <p><i>Next Slide</i></p>	
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Lesson 8: S/O Template Management

	<p>Lesson Goals</p> <p>The goal of this lesson is to locate available S/O templates in CHCS II and edit templates using MEDCIN.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the user will be able to:</p> <ul style="list-style-type: none"> • Search for Visit Template • Use Template Edit Mode • Use Find Term • Use Browse from Here 	<p>Slide 22: S/O Template Management Learning Objectives</p> <p>Explain: use of Favorites List when searching for and loading templates.</p> <p>Explain:</p> <ul style="list-style-type: none"> • Templates have pre-
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- Rename and Save the Template

S/O Template Management

Demonstration:

UTI encounters are among your most frequent clinic visit types. You decide to customize a UTI S/O template for your clinic.

1. Create an appointment for **CPT Heather Cloud (c0058)**.
 - Appointment Type: **ACUTE APPT (ACUT\$) 30**
 - Reason for Appointment: **Test Patient**
2. Open the encounter.
3. Click **S/O** on the SF600.
4. Click **Template Mgt** on the Action bar.
5. In the Name Contains field, enter *UTI* and click **FindNow**.
6. Highlight **VISIT--UTI**.
7. Click **Edit** on the Action bar.
8. In the right pane, under Review of Systems, highlight a *vaginal discharge*.
9. Click **ROS/HPI** on the dashboard. The term is flipped into the **HPI**.
10. Click **Find Term** on the Action bar.
11. In the search field, enter *incomplete emptying of bladder* and click **OK**.
12. Click **+** to add *incomplete emptying of bladder* to the template.

- positioned terms
- Benefits of using templates: streamline documentation
 - Folder location of templates in CTS versus the live system

Training system templates
The naming convention for templates used in the training system begins with TRAINING rather than BRANCH; and there are other training system templates you will use that do not follow either of these conventions.

- How to search for the template

Explain: Template preview screen (point out)

- Load the template. (Action Bar icon or double-click)

Explain: Template availability within S/O using drop-down

Explain: Service specific naming convention

Templates for all branches are stored together in the live

13. Click **Browse From Here** on the Action bar.
14. Click + to add *a vaginal discharge of urine*.
15. Click **Save As** on the Action bar.
16. In the Template Name field, enter **VISIT--UTI FEMALE--[Your Initials]** and click **Save**.
17. Click **Close** on the Action bar. To return to the S/O Template Management module.
18. Click **No** on the warning window.
19. Click **Close** on the Action bar to return to the S/O module.
20. Click **Close** on the Action bar to return to the SF600.

Next Slide

Exercises

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

Summary

- Explained S/O Template Management features
- Search for Visit Template
- Use Template Edit Mode
- Use FindTerm
- Use Browse from Here
- Save the Template

Next Slide

system. Each service uses a different naming convention to organize templates for browsing. For example:

BRANCH--ENC--URI--LDR

Key:

BRANCH=
 TYPE = Encounter (ENC), Visit, Education (EDU), Procedure (PROC), Consent, PE, and so on,
 SUBJECT = Allergy, URI, Asthma Followup, and so on,
 LDR = Personal initials (3) of the template owner

	Question and Answer and Summary	
	End of Day One	

DAY TWO

Slide 23: Day Two Agenda

Introduce Day Two lessons.

Stress using structured text from a standardized medical language (MEDCIN). Documentation is facilitated by the creation and use of templates with appropriate terms for more common encounters.

Next Slide

Lesson 9: Encounter Templates and Order Sets

Lesson Goal

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

Learning Objectives

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

- Use an Encounter template
- Edit an Encounter template
- Create an Order Set in A/P
- Merge an Order Set with an Encounter template

Slide 24: Encounter Template Learning Objectives

Explain: Order sets currently in CHCS must be recreated for use in CHCS II.

Encounter Templates

Demonstrate:

CPT Heather Cloud (c0058) is calling the clinic because she is experiencing UTI symptoms. The Nurse taking the call needs to document the findings and assessment.

1. Click **Telephone Consults** on the Folder List.
2. Create a **New Telcon** appointment for **CPT Cloud (c0058)**.
 - Appointment Type: **TELEPHONE CONSULTS (TCON) 10**.
 - Reason for Telephone Consult: **UTI symptoms**.
3. Click **OK**. The Telcon Quick Entry window opens.
4. On the Telcon Quick Entry window, click **Cancel**. The SF600 opens.
5. Click **Templates** on the Action bar.
6. Expand the **My Favorites folder**.
7. Select the **TRAINING--ECP--UTI--ENC** template and click Add.
8. Click **OK**.
9. Click **S/O** on the SF600.
10. Add The Chief Complaint is: *UTI symptoms* as a positive finding.
11. Add *pain during urination (dysuria)* as a positive finding.
12. Click the **Duration grid** and then click **2** and **Days**.
13. Add feelings of *urinary urgency* as a positive finding.

Explain:

Purpose of the encounter template.
The use of the Template Management module to create an original encounter template
Mention that encounter templates can also be created from existing encounters and from previous encounters. Both require editing because actual patient encounters are tailored to the specific circumstances; so, they need to be generalized to be used as templates. (OJT).

14. Add *diarrhea* as a positive finding.
15. Click the **Duration grid** and then click **1** and **Days**.
16. Click **AutoNeg**.
17. Click the **PE** tab.
18. Add *Pain Level (0-10)* as a positive finding.
19. In the Value field, enter **4** and press Enter on your keyboard.
20. In the Free Text field, enter *As reported by patient* and press Enter on your keyboard.
21. Click the **PMH** tab.
22. Expand *sexually active*.
23. Add *trying to become pregnant* as a positive finding.
24. Click the **Notepad** icon.
25. In the Note field, enter *Pt. reports she has been previously diagnosed with a UTI* and click **OK**.
26. Add *Disposition of Patient* as a positive finding.
27. In the Free Text field, enter an **X** next to *WITHIN 24 HOURS*.
28. Click **A/P** on the Action bar.
29. Select urinary symptoms and click **Add to Encounter**.
30. Click the **Order Lab** tab.
31. In the New Lab Order field, enter *urinalysis* and click **Search**.

32. Select **URINALYSIS**.
33. Select the **ASAP** radio button.
34. Click **Submit**.
35. Click **Disposition** on the Action bar.
36. In the Follow Up area, click the **In Clinic** drop-down list and select **CHCS II Test Clinic**.
37. In the Comments field, enter *Walk in for UTI*.
38. In the E&M Codes area, select **99371 PHYSICIAN PHONE CONSULTATION**.
39. Click **Sign** on the Action bar.
40. Select the **Cosigner Required** checkbox.
41. Click the **Search** button to perform Clinician Search for DOCTOR, DAVID.
42. Select DOCTOR, DAVID
43. Click **Sign**.
44. Close the all open modules and return to the Appointments module.

To personalize an encounter template:

1. Expand Tools on the Folder List and select **Template Management**.
2. The **Search/Browse** displays by default.
3. Click **Search** on the Action bar.

Explain:

- Point out the five main components of the encounter template: diagnoses, notes templates (visit, S/O), other therapies, procedures and order sets.

<ol style="list-style-type: none"> 4. In Template Name type UTI and click Search. 5. Highlight the TRAINING-- ECP--UTI--ENC template. 6. Click View/Edit on the Action bar. The Template Details tab opens. 7. In the Diagnoses area, click Add. 8. In the Search Term field, enter <i>pain during urination</i> and click Search. 9. Select <i>pain during urination (dysuria) 788.1</i> and click Add Items. 10. Click Done. 11. In the Other Therapies area, click Add. 12. In the Search Term field, enter <i>frequent oral fluids</i> and click Search. 13. Select <i>Oral Fluids Frequent</i> and click Add Items. 14. Click Done. 15. In the Notes Template area, highlight [List] TRAINING--ECP-- UTI--VISIT and click Remove. 16. Click Add. 17. Click Search on the Notes Template Lookup. 18. In the Template Name field, enter VISIT--UTI FEMALE--TEST. 19. Click Search on the MEDCIN Template Search. 20. Select VISIT--UTI FEMALE--TEST and click Add Items. 	<ul style="list-style-type: none"> • Mention that the top four sections (Associated Reasons for Visit, Associated Appointment Types, Associated Problems, and Items to AutoCite into Notes) are not used. • Discussion of order sets will follow the building of the parts of the template mentioned above. <p>When adding diagnosis, show how to do multiple searches and select results before clicking the Done button.</p> <p>When adding therapies, show double-clicking to add, rather than using the Add Items button.</p> <p>When adding procedures, show entry of multiple selections pressing Ctrl key</p>
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21. Click **Done**.
22. Click **Save As** on the Action bar.
23. In the Template Name field, enter **ECP--UTI--ENC--TEST** and click **Save**.
24. Click **Close** on the Action bar.

To create an order set:

You have just personalized a UTI encounter template and you want to complete it by adding a UTI Order Set.

1. Click **A/P** on the SF600.
2. Click the **Order Lab** tab.
3. In the **New Lab Order** field, enter *Urinalysis* and click **Search**.
4. Select *URINALYSIS*.
5. Select the **ASAP** radio button.
6. Click **Save to Queue**.
7. In the **New Lab Order** field, enter *HCG QL* and click **Search**.
8. Select **HCG QL**.
9. Click **Save to Queue**.
10. In the **New Lab Order** field, enter *urine culture* and click **Search**.
11. Select *URINE CULTURE*.

12. Click **Save to Queue**.
13. Click the **Order Sets** tab.
14. Click **Save As Order Set**. The Save Encounter Template window opens.
15. In the **Template Name** field, enter **UTI--Orders--Test** and click **Save**.
16. Close the A/P module.
17. Click **Yes** on the A/P Warning window. You are returned to the SF600.

To merge an order set with an Encounter template:

1. Expand Tools on the *Folder List* and select **Template Management**.
2. Click Search on the Action bar.
3. In the Template Name field, enter UTI.
4. Click Search.
5. Press and hold Ctrl on your keyboard and select UTI--Orders-- Test and ECP—UTI ENC--TEST.
6. Click **Merge** on the Action bar.
7. Click **Save As** on the Action bar.
8. In the Template Name field, enter **ENC--UTI with Orders** and click **Save**.
9. Click **Cancel** on the Action bar to go back to the Search/Display window.
10. Click **Search** on the Action bar.
11. In the Template Name field, enter **ENC--UTI with Orders** and click **Search**.
12. Highlight **ENC--UTI with Orders** Template.
13. Click **View/Edit** on the Action bar to verify both templates merged.

14. Click **Close** on the Action bar to close SF600.

Exercises

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

Summary

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

Next Slide

Lesson 10: Health History Folder

Lesson Goal

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

Learning Objective

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

- Setup Health History patient data modules
- View patient's health history

Health History

Demonstration

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

1. Click the **Health History** folder in the Folders List.
2. The Health History Design Summary screen will display 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.
8. Click the **OK** button to view the results:
9. Click the **Close** icon on the Action Bar to close the module.

Slide 25: Health History Learning Objectives

Explain:

- Use this module to set up a display of selected patient health history information for quick review.
- Setup can be done from the **Options** button.
- Once set up, the same setup applies to all patient records.

	<p>Key Points:</p> <ul style="list-style-type: none"> • Can be changed to fit the current requirements <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p>Summary</p> <ul style="list-style-type: none"> • Explained Health History folder • Setup Health History patient data modules <p style="text-align: center;">Next Slide</p>	
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Lesson 11: Problems Module

	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end-user to add and update patient problems in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of this module, the end-user will be able to:</p> <ul style="list-style-type: none"> • Add a problem, family history, or historical procedure • Update a problem, family history, or historical procedure • Set and reset the viewing options • Display all information in all categories at once <p>Problems</p> <p>Demonstration:</p> <p>After seeing LCDR Eduardo Suarez for his chest pain, we documented he had a tonsillectomy in</p>	<p>Slide 26: Problems Learning Objectives</p>
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	<p>2003. This information is not currently in the patient’s record and needs to be added to the patient’s Historical Procedure list. His diabetes is now under control so we need to inactivate this problem.</p> <p>Add a Historical Procedure</p> <ol style="list-style-type: none"> 1. Highlight LCDR Eduardo Suarez’s name. 2. Click on Problems in the Folder List. The Problems window will display 3. Click on the Historical Procedures header and click the Add icon on the Action Bar. The Select Procedure window will display. 4. Click the Search tab and type TONSILLECTOMY in the MEDCIN Search field and click the Search button. Tonsillectomy terms will populate the search results area. 5. Click on TONSILLECTOMY 42825 and click the OK button. The New Procedure area of the Procedures window will display. 6. Click the Procedure Date drop-down, and click on December and select June. 7. Then select 06/29/2003. 8. Click the Save button and tonsillectomy will be added to the historical procedures list. <p>Inactivate a Problem</p> <ol style="list-style-type: none"> 1. Select the Diabetes Mellitus Type II – Uncontrolled problem from LCDR Suarez’s Problem list. 2. Click the status drop-down and select Inactivate. 3. Click Close to close the problem list 4. Click Close to close the SF 600 5. Clear patient <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	<p>Default tab for adding items in problem list is <i>Clinic List</i>; select the <i>Search</i> tab for doing the search.</p> <p>Point out fields that are unchanged.</p> <p>Problems designated Acute/Active are automatically changed to Acute/Inactive when listed for over 180 days based on last date modified, or creation date if never modified.</p>
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	<p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> • Added a historical procedure. • Updated a problem. • Set and reset the viewing options • Display all information in all categories at once <p style="text-align: center;"><i>Next Slide</i></p>	
Lesson 12: Meds Module		
	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end user to view patient meds and discontinue or add OTC and prescription medications.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the student will be able to:</p> <ul style="list-style-type: none"> • Add over-the-counter medications • Change the temporary display filter • Discontinue a medication • Review the details of a selected medication <p>Meds</p> <p>Demonstration:</p> <p>During LCDR Eduardo Suarez’s examination, it was determined he has been taking an adult low dose aspirin everyday for the past year. He usually buys them in a 250-tablet bottle. We need to record this information in Mr. Suarez’s record:</p>	<p>Slide 27: Meds Learning Objectives</p> <p>Options are used to set the Medications Module properties. The purpose is to show the user how to set the properties. Outpatient Current is the default.</p>

1. Click the **Add** icon on the Action Bar to display the Select Type of New Medication window
2. Click on the **Record OTC/Outside Medication** button to display the New OTC Outside Medication window.
3. Click on the **Medications** button so you can search the Health Data Dictionary for the low dose aspirin. The Healthcare Data Dictionary Search window will display.
4. Type **Tums** in the search field and click **Search**.

- Click on Calcium Carbonate (TUMS) PO 500 MG TAB to select it and click **OK**. The New OTC Outside Medication window will re-display with the Tums included.
- Complete the following fields as shown:

Field	Data or [Description of Data]
SIG	<i>Take one tablet daily</i>
Ordering End user	<i>Self</i>
Order Start Date	<i>One year ago</i>

- Click **OK** to add the OTC medication to the Eduardo's record. The TUMS will display.
- Click the **Close** icon on the Action Bar to close the Meds module and return to the SF600.
- Click the **Autocite** button to refresh the AutoCite properties (the Refresh icon on the Action Bar will not refresh the AutoCite properties). The TUMS will be shown in the Active Medications area.
- Click **Close** to return to Appointment Screen
- Clear patient

Key Points:

- Accuracy is very important.

Explain:

- The list includes all over-the-counter, outside, and CHCS II-ordered medications.
- Current medications can be viewed, re-ordered, or modified and new medications can be added and ordered.
- Active medications appear in bold text.
- Inactive medications appear in regular text.
- Medications are listed based on the search filter you selected.

	<p>Exercises</p> <p>Complete the exercises. Check for understanding and answer participant questions</p> <p style="text-align: center;">SUMMARY</p> <ul style="list-style-type: none"> ▪ Add over-the-counter medications ▪ Change the temporary display filter ▪ Discontinue a medication ▪ Review the details of a selected medication <p style="text-align: center;"><i>Next Slide</i></p>	
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Lesson 13: Allergy Module

	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the student to update patient allergy information in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of these modules, you will be able to:</p> <ul style="list-style-type: none"> • Review and verify allergy information • Add, edit, or delete patient allergy information • Search for and select common allergens • Delete allergens from the drop-down list <p>Allergy</p> <p>Demonstration:</p> <p>After talking to LCDR Eduardo Suarez, you discover he is allergic to peanuts, but this is not annotated in his medical record. He also states the last time he came into contact with iodine he had a reaction of hives (urticaria) instead of a rash. He is also allergic to Sulfu drugs. Add the</p>	<p>Slide 28: Allergy Learning Objectives</p> <p>Note: If participants closed the <i>Folder List</i> for the previous lesson and it is still closed, direct them to open it (From the View menu, select Folders).</p> <p>Point out the Allergy icon in the patient ID line.</p> <p>Allergy information is searched from within the</p>
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<p>had a reaction of hives (urticaria) instead of a rash. He is also allergic to Sulfa drugs. Add the allergy of peanuts and sulfa drugs to his allergen list and change the reaction with the iodine.</p> <p>Using the open encounter for LCDR Eduardo Suarez:</p> <ol style="list-style-type: none"> 1. Click on the Allergy folder in the Folder List. The New Allergy window will display: 2. To add a new allergen, click the Add icon on the Action Bar. The New Allergy window will display. 3. To search for a new allergen, click the Allergen button. The Healthcare Data Dictionary window will display. 4. Type PEANUT in the search field and click the button. Health Care Dictionary words containing peanut will be displayed 5. Click on PEANUT OIL (PEANUT OIL) to select it and click the OK button. The Allergy window will re-display with the Peanut Oil allergy noted. 6. Click the Reaction drop-down to get a list of common reactions: 7. Click on <i>Rash</i> to select it. The New Allergy window will re-display with the Rash noted. 8. Click the Onset button and select a date of one month ago. The new date will be displayed. 9. Click the Save button to save the information. The Allergy list will be re-displayed with the new allergen. 10. Add an Allergy with multiple reactions. 11. Click the Add icon on the Action Bar. The New Allergy window will display. 12. Click the <i>Allergen</i> drop-down to get a list of common allergies. 13. Click Sulfa-Drugs to select it. The New Allergy window will re-display with Sulfa-Drugs noted. 14. To annotate multiple reactions, click the Reaction button. The Healthcare Data Dictionary window will display. 15. Type NAUSEA in the search field and click the Search button. Health Care Dictionary words containing nausea will be displayed. 16. Type VOMITING in the search field and click the Search button. Health Care Dictionary words containing vomiting will be displayed. 17. Click on NAUSEA to select it and while holding down the control key click on VOMITING to select it. Click the Add >> button to move the terms to the right pane. 18. Click the OK button. The Allergy window will re-display with the nausea and vomiting reactions noted. 19. Click the Onset button and select a date of one week ago. The new date will be displayed. 20. Click the Save button to save the information. The Allergy list will be re-displayed with the new allergen. 	<p>Healthcare Data Dictionary (HDD).</p> <p>Explain</p> <ul style="list-style-type: none"> • By pressing the Shift or Ctrl key, multiple allergens from a single search can be selected before clicking the Add to Common List button. • Multiple searches can be done in succession to select allergens for the common list prior to clicking the OK button to close the <i>Properties</i> window. • Display the Allergen drop-down list with the addition. (May need to click the Add icon.) • To delete the Iodine Containing Agents allergy. • Click the Cancel button. • Highlight the Iodine Containing Agents allergy. • Click the Delete icon on the Action Bar. <p>Explain: Explain the edit capability.</p>
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Editing an Allergy

To edit the Iodine Containing Agents reaction:

1. From the Allergen list, click ***Iodine Containing Agents*** to select it and click the **Edit** icon on the Action Bar.

Note: the Allergen field is not editable

2. Click the Reaction drop-down to get a list of common reactions
3. Click Urticaria to select. The New Allergy window will re-display with Urticaria noted.
4. Click the **Save** button to save the information. The Allergy list will be re-displayed with the new reaction noted.
5. Close Allergy Module
6. Close SF 600

Key Points:

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

Exercises

Complete the exercises.

Check for understanding and answer participant questions

Summary

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

Next Slide

- Close the Allergy module.
- Refresh the AutoCite display.

Explain: Comments also write back to the SF600.

Lesson 14: Wellness Module

Lesson Goal

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

Learning Objectives

Upon completion of this module the student will be able to:

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

Wellness

Demonstration

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

Documenting a Due Reminder in the Due Reminders Tab

1. To start the Wellness module, click **Wellness** in the Folder List. The Wellness window will display.
2. Click the ***Due Reminders*** tab to select it. The Due Reminders window will display.
3. Scroll to the bottom of the list and click + to expand ***Counseling*** and click on ***Anti-Tobacco Counseling*** to select it.

Slide 29: Wellness Learning Objectives

4. Click **Document** on the Action Bar. The Document Anti-Tobacco Counseling window will display.
5. Select the **Completed** radio button for the Status (if not already selected).
6. Click the Coded: drop-down in the Comments area and click **Patient states Preventive Service Complete** to select it.
7. Click the **Date** button and enter a date of one month ago.
8. Click the Information Source drop-down and select **Patient** (may have to scroll down) to select and click **Save**. The Wellness window will re-display.
9. Click the **Documentation History** tab to see the completed Anti-Tobacco Counseling.

Adding a Reminder History in the Documentation History Tab

To add a reminder history in the Documentation History tab:

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

Adding a Wellness Schedule Reminder in the Wellness Schedule Tab

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

1. Click the *Wellness Schedule* tab. The Wellness Schedule Window will display.
2. Click **Add** on the Action Bar. The Add Wellness Schedule window will display.
3. From the **Select A Wellness Item** drop-down list Click *Total Cholesterol Screen* to select it.
4. Click **2** and click *years* using the *Specify A Patient Specific Schedule* drop-down lists and click **Save**.
5. The Total Cholesterol Screen will be added to LCDR Suarez's Wellness Schedule.

Activating/Inactivating a Wellness Reminder in the Wellness Schedule Tab

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

To inactivate a reminder in the Wellness Schedule tab:

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

Exercises

Complete the exercises.

Check for understanding and answer participant questions

Summary

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

Next Slide

Lesson 15: PKC Couplers

Lesson Goal

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

Learning Objectives

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

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

Next Slide

PKC Couplers

Demonstration

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

1. Click the **Couplers** folder in the Folder List. The **PKC Couplers** window will display with the Military tab selected.
2. In the Run New Coupler section, click on the HEAR questionnaire to select it (if not already selected) and click **Run Coupler**. The Coupler session will display.

Slide 30: PKC Couplers Learning Objectives

3. Press the [Enter] key or click in the space provided at the bottom of the window to begin. The HEAR Overview window will display.
4. Click the **CLICK HERE** area to begin the questionnaire. The HEAR Welcome window will display.
5. You can continue to the next page of the questionnaire by doing one of the following:
 - a. Clicking on the 'continue' bar
 - a. Pressing the [F10] key
 - b. Clicking the **Next** icon on PKC Couplers Military Action Bar.
6. Answer approximately 10 of the questions (the HEAR questionnaire is rather lengthy) and then click on the **Save** icon on the PKC Couplers Action Bar. The Coupler will be saved (the Coupler Save icon will become dim).
7. Click the **File/Couplers** button on the Coupler Menu bar. The File/Couplers drop-down will display.
8. Click **Exit and Return to CHCS II**. A save confirmation message will display:
9. Click **Yes** and the PKC Couplers module will re-display, with information about the HEAR Coupler just administered.
10. Click on the HEAR coupler just administered, and click **View**. The completed questionnaire is available for review.
11. Once the review is complete, click the **File/Couplers** button on the Coupler Menu bar. The File/Couplers drop-down will display.
12. Click the **Exit & Return to CHCS II** button on the drop-down. The PKC Couplers module will re-display.
13. Click the **Close** icon on the Action Bar to close the module.

Exercises

Complete the exercises.

Check for understanding and answer participant questions

Summary

- View a coupler
- Run a coupler
- Run a finding summary report

- Resolving a finding error summary report note.

Next Slide

Lesson 16: Vitals Sign Review Module

Lesson Goal

The goal of this lesson is to enable the end-user to record and graph vital sign information in CHCS II.

Learning Objectives

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

- Set and review properties
- Select appropriate screen options
- Enter vital signs and related information
- Graph vital signs

Slide 31: Vitals Signs Review Learning Objectives

Vitals Sign Review

Demonstration

After talking to LCDR 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 LCDR Eduardo Suarez's past vital signs:

1. Click either **Vital Signs Review** the folder in the Folder List. The Vital Signs Review window will display.
2. Highlight all of his past blood pressure **BP** and heart rate **HR** values (click in the upper left **BP** cell and drag the mouse to the lower right **HR** cell).
3. Click the **Graph Vitals** icon on the Action Bar. The Graph Vitals window will display a 2-D chart.

	<p>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.</p> <p>5. Click the Close icon on the Action Bar to complete the process</p> <p>6. Clear patient</p> <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions <p>Summary</p> <ul style="list-style-type: none"> ▪ Set and review the properties for the Vital Signs module ▪ Select appropriate screen options for the category of patient ▪ Enter vital signs and related information ▪ Graph vital signs <p style="text-align: center;"><i>Next Slide</i></p>	
	<p style="text-align: center;">Questions and Answers and Summary</p> <p style="text-align: center;">End of Day Two</p>	

DAY THREE

Next Slide

Slide 32: Day Three Course Agenda

Lesson 17: Readiness Module

Lesson Goal

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

Learning Objectives

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

- View the readiness module
- Edit the readiness information

Readiness

Demonstration

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

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

Slide 33: Readiness Learning Objectives

	<p>Exercises</p> <p>Complete the exercises. Check for understanding and answer participant questions.</p> <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> ▪ View the readiness module ▪ Edit the readiness information <p style="text-align: center;"><i>Next Slide</i></p>	
Lesson 18: Laboratory Results Module		
	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end-user to set Lab module properties and copy lab results in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of this module, the end-user will be able to:</p> <ul style="list-style-type: none"> ▪ Select lab results search criteria ▪ Select a default time period for searching ▪ Select preferences for display of abnormal results ▪ Select lab results display criteria ▪ Select various display criteria and preferences ▪ View laboratory test results ▪ Copy lab results into a patient encounter 	<p>Slide 34: Laboratory Learning Objectives</p> <p>Comment about “break glass” permissions; for example, user can’t view HIV lab results without “break glass” permissions.</p> <p>Note: You must open an encounter to use the Copy to Note function. The result is pasted directly into the patient encounter. If you (accidentally) copied more than once, it will show up in your note more than once.</p>

	<p>Laboratory</p>	<p>The Lab module is designed to display the results of laboratory tests. Results are viewed, not ordered, from this module. Lab results are pulled from CHCS. An alert is triggered when new results are received.</p>
<p>Demonstration</p> <p>We want to view LCDR Eduardo Suarez’s Lipid Panel Complete lab results and copy the result to his encounter.</p> <ol style="list-style-type: none"> 1. To start the Lab module, click the Lab folder in the Folder List. The Lab module window will display. 2. Click on Lipid Panel Complete. The Lab result will display in the Display Criteria section of the window. 3. Click the Ref Range/Units check box to display the reference ranges for the test. 4. Drag the mouse from Lipid Panel Complete in the upper left of the lab result area to the lower right of the area (this selects the entire lab result). 5. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note. 6. Since we want to copy these lab results to the note, click the Copy to Note button. 7. The lab result will re-display, with the lab result no longer highlighted (the result has been copied to the note). 8. Click the Close icon on the Action Bar <p>Key Points:</p> <ul style="list-style-type: none"> • Results can be copied to the clipboard for insertion into, for example, an MS Word document. 		
<p>Exercises</p>		
<p>Complete the exercises.</p> <p>Check for understanding and answer participant questions.</p>		

Summary

- Select lab results search criteria
- Select a default time period for searching
- Select preferences for display of abnormal results
- Select lab results display criteria
- Select various display criteria and preferences
- View laboratory test results
- Copy lab results into a patient encounter

Next Slide

Lesson 19: Radiology Results Module

Lesson Goal

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

Learning Objectives

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

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

Radiology

Demonstration

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

1. To start the Radiology module, click the **Radiology** folder in the Folder List. The Radiology

Slide 35: Radiology Learning Objectives

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

module window will display.

2. To view the ***Chest PA And Lateral Series Report***, click to select it. The result will display in the results section of the window.
3. Place the cursor in front of the word Report and drag the mouse to highlight the Report Text and Impression of the result.
4. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note.
5. Since we want to copy this radiology result to the note, click the Copy to Note button.
6. Click the **Close** icon on the Action Bar.
7. View the Rad result in S/O section of the SF600, under the S/O note.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

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

Next Slide

Lesson 20: Clinical Notes Module

Lesson Goal

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

Learning Objectives

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

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

Slide 36: Clinical Notes Learning Objectives

Clinical Notes

Demonstration

An end user specializing in Ear Nose and Throat (ENT) performed minor surgery yesterday on Klaus Wunderlich, who had an object lodged in his ear. The end user saw the patient today and examined his ear. He now wants to add the following note with graphic to the patient's record. Open Klaus Wunderlich's appointment for earache.

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

Creating a Clinical Note

1. Click on **Clinical Notes** in the Folder List. The Clinical Notes module will display:
2. Click the **New** icon on the Action Bar to create the new note. The New Clinical Note window will display.
3. Select **Physician Progress Notes:** from the Note Types drop-down list.
4. Select **CHCS II ITT** from the POC: drop-down list.
5. Type **3-YEAR-OLD MALE WITH PENCIL ERASER LODGED IN AUDITORY**
CANAL. REMOVED OBJECT YESTERDAY. SAW PATIENT TODAY. EAR

CANAL. REMOVED OBJECT YESTERDAY. SAW PATIENT TODAY. EAR HEALING WELL. WILL CONTINUE WITH FOLLOW-UP PLAN. in the documentation area. Press [Enter].

6. Click the **Insert Image** button on the bottom of the window. Locate and load the ear image into the Clinical Note.
7. Click either **Save** the icon on the Action Bar or the **Save** button to save the information. The Clinical Note Window will re-display with the updated information.

Copying a Clinical Note

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

Key Points:

- Graphical images can be inserted into clinical notes.

Exercises

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

	<p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> ▪ View a clinical note ▪ Add a clinical note ▪ Edit a clinical note ▪ Save a clinical note <p style="text-align: center;"><i>Next Slide</i></p>	
Lesson 21: Previous Encounters Module		
	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end-user to use the Previous Encounters module in CHCS II.</p> <p>Learning Objectives</p> <p>Upon completion of these modules, the end-user will be able to:</p> <ul style="list-style-type: none"> ▪ Display a previous patient encounter ▪ Append a narrative to a completed encounter ▪ Amend a completed encounter ▪ Copy Forward <p>Previous Encounters</p> <p>Demonstration</p> <p>The end user needs to annotate LCDR Eduardo Suarez’s diabetes is now controlled by adding a note to his Diabetes Mellitus Type II – Uncontrolled encounter</p> <p>Appending a Narrative</p> <ol style="list-style-type: none"> 1. From the list of appointments, click on any of LCDR Eduardo Suarez’s appointments to pull his record. 	<p>Slide 37: Previous Encounter Learning Objectives</p> <p>The <i>Change History</i> 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.</p> <p>New findings can also be documented for the current encounter.</p>

2. Click the **Previous Encounters** icon in the Folder List. The Previous Encounters window will display.
3. Click the **Append Narrative** icon on the Action Bar. The Encounter Note window will display.
4. Type **DIABETES** in the Note Category field.
5. Type **DIABETES CONTROLLED** in the Note Title field.
6. Type **PATIENT HAS HIS DIABETES MELLITUS TYPE II UNDER CONTROL.** in the text area.
7. Click the **Save and Sign** button. The Sign Appended Note window will display.
8. Click the **Sign** button to sign the encounter. The Previous Encounters window will re-display.
9. Click the **Close** icon on the Action Bar to close the module.

To amend a previous encounter:

1. Highlight the DIABETES MELLITUS TYPE II - UNCONTROLLED note and click **Amend Encounter** on the Action bar. The SF600 opens.
2. Click **Lab** on the Folder List.
3. Click **Time**. The Time Search window opens.
4. Select the **All Time Periods** radio button.
5. Click **OK**.
6. Select the *Hemoglobin A1c* report. The report details populate below.
7. Highlight the report by left-clicking and dragging over the text with your mouse.
8. Perform a right-click and select **Copy to Note**.
9. Click **Close** on the Action bar.
10. Click **Close** on the Action bar to return to the Previous Encounters module.

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. If they are the originator of the note,

11. Clear Patient form the Patient ID line.

Copy Forward a Previous Encounter

1. Select the *diabetes/diabetes follow-up* appointment for LCDR Eduardo Suarez.
2. Click the **Open Appt** icon on the Action Bar. LCDR Eduardo Suarez's SF600 will open.
3. Click the **Previous Encounter** icon in the Folder List. The Previous Encounters window will display.
4. Highlight Mr. Suarez's *Diabetes Mellitus Type II* encounter.
5. Right click on the highlighted appointment.
6. Click the **Copy Forward** button. The Previous Encounters window will close.
7. Click the SO button on the SF600. The copy forward template will display.
8. Since none of Mr. Suarez's symptoms or findings has changed we can quickly document the abnormal and normal findings in all tabs by clicking the **AutoEnter** button.
9. Click the **Close** icon on the Action Bar to close the SF600.

Key Points:

- Access to past encounters is available at any workstation that has CHSC II access.
- Only the signer or cosigner of a particular note can amend that note.
- Anyone with signing privileges can append a note.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Display a previous patient encounter

- Amend a completed encounter
- Append a narrative to a completed encounter

Next Slide

Lesson 22: Alerts Review Module

Lesson Goal

The goal of this lesson is to enable the end user to review and respond to notifications of diagnostic results and to orders and encounters requiring the end user's signature.

Learning Objectives

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

- Access alerts:
Folder List
Alerts icon
- Address an alert
- Delete alerts

Alerts Review

Demonstration

An end user needs to address the alert for a new result that has been posted. Review the result and delete the alert.

1. Click either the **Alert Review** folder in the Folder List or the ! icon on the Action Bar. The Alert Review window will display.
2. Click to select the **New Result** alert and click the **Address Alert** icon on the Action Bar. The New Result window will open.
3. Click to select **Olaf Berg's Chem 7** result and click the **View Result** icon on the Action Bar. The Lab module will display.
4. View the result and click the **Close** icon on the Action Bar. The New Results window will re-

Slide 38: Alerts Review Learning Objectives

	<p>display.</p> <ol style="list-style-type: none"> 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. <p>Exercises</p> <p>Complete the exercises. Check for understanding and answer participant questions.</p> <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> • Access alerts: <ul style="list-style-type: none"> • <i>Folder List</i> • Alerts icon • Address an alert from the Alert Review module • Delete alerts that have been resolved 	
	<p style="text-align: center;">Questions and Answers and Summary</p> <p style="text-align: center;"><i>Next Slide</i></p> <p style="text-align: center;">End of Day Three</p> <p style="text-align: center;"><i>Next Slide</i></p>	<p>Slide 39: Day Four Course Agenda</p>

DAY FOUR

Lesson 23: New Results Module

Lesson Goal

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

Learning Objectives

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

- Access the labs or Rads modules
- Discard a lab or Rad result
- Toss a new lab or Rad result
- Save a new lab or Rad result
- Move a new result into saved results
- Forwarding new results to another provider

New Results

Demonstration

To view results:

1. Click the **New Results** folder in the Folder List. The New Results window will display.
2. Click to select the **New Results** tab if not already selected.
3. Click the **Lipid Panel Complete** lab test result for LCDR 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

Slide 40: New Results Learning Objectives

the result.

5. When you are finished viewing the detailed result information in the Lab module, click the **Close** icon on the Action Bar. The New Results module window will re-display.

To discard results:

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

To save results

1. Click the ***Lipid Panel Complete*** lab test result for LCDR 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 an end user:

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

	<p>6. Click the Close icon to terminate the process.</p> <p>Note: The system creates a signature to confirm that an end user has viewed the new result information.</p> <p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. <p>Summary</p> <ul style="list-style-type: none"> • Access the labs or Rads modules from the New Results module to view new results • Discard a lab or Rad result • Toss a new lab or Rad result • Save a new lab or Rad result • Move a new result into saved results • Forwarding new results to another provider 	
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Lesson 24: Co-Signs Module		
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	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end user to review and refine encounters requiring the Provider’s signature.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the end-user will be able to:</p> <ul style="list-style-type: none"> • Review encounters needing co-signatures • Co-sign an encounter completed by another Provider • Append a narrative to an encounter prior to co-signing <p>Co-Signs</p> <p>Demonstration</p> <p>The end user notices three encounters requiring their co-signature. The Allergic Rhinitis encounter</p>	<p>Slide 41: Co-Signs Learning Objectives</p>
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needs a co-signature. The encounter for LCDR Eduardo Suarez's hyperlipidemia visit, is missing the lab result within the encounter. Assist the end user in amending this encounter to include this report. The end user is then ready to sign the encounter.

Co-Sign an encounter

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

Amend an encounter

1. Click the **Co-signs** icon in the Folder List. The Co-Sign window will display.
2. Click to select the ***HYPERLIPIDEMIA*** encounter of LCDR Eduardo Suarez. The encounter information will display in the encounter window.
3. Click the **Amend Encounter** icon on the Action Bar. The SF600 will display.
4. Click the **Lab** folder in the Folder List. The Lab module window will display.
5. Click on ***Lipid Panel Complete***. The Lab result will display in the Display Criteria section of the window.
6. Click the ***Ref Range/Units*** check box to display the reference ranges for the test.
7. Drag the mouse from Lipid Panel Complete in the upper left of the lab result area to the lower right of the area (this selects the entire lab result).
8. [Right Click] on the highlighted area. A window will appear containing options to Copy and Copy to Note.
9. Since we want to copy these lab results to the note, click the **Copy to Note** button.
10. The lab result will re-display, with the lab result no longer highlighted (the result has been copied to the note).

	<p>11. Click the Close icon on the Action Bar.</p> <p>12. View the lab result in S/O section of the SF600, under the S/O note.</p> <p>13. Click the Sign icon on the Action Bar. The Co-Sign Encounter window will display.</p> <p>14. Review the note again and click the Sign button to sign the encounter. The Appointments window will re-display.</p> <p>15.</p>	
	<p>Exercises</p>	
	<ul style="list-style-type: none"> • Complete the exercises. • Check for understanding and answer participant questions. 	
	<p style="text-align: center;">Summary</p>	
	<ul style="list-style-type: none"> • Review encounters needing co-signatures • Co-sign an encounter completed by another Provider • Append a narrative to an encounter prior to co-signing 	


Lesson 25: Sign Orders

	<p>Lesson Goal</p> <p>The goal of this lesson is to enable the end user to access, review and sign orders created by non-providers.</p> <p>Learning Objectives</p> <p>Upon completion of this lesson, the end-user will be able to:</p> <ul style="list-style-type: none"> • Display details of non-Provider orders needing signing: <ul style="list-style-type: none"> ○ One at a time ○ All at once • Sign non-Provider orders: <ul style="list-style-type: none"> ○ One at a time 	<p>Slide 42: Sign Orders Learning Objectives</p>
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- Several selected orders at one time
- All at one time
- Cancel non-Provider orders

Sign Orders

Demonstration

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

Signing non-end user orders

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

Canceling a Non-End user Order

1. Click the check box to the left of Clayton William's name.
2. Click either the **Cancel Selected Orders** icon on the Action Bar or **Cancel Selected Orders** button. The window will re-display with the canceled order removed.
3. Click **Close** on the Action Bar to close the Sign Orders module.

Exercises

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

Summary

- Cancel non-Provider orders

- Sign non-Provider orders:
- Display details of non-Provider orders needing signing:

Lesson 26: List Management

Lesson Goal:

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

Learning Objectives:

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

- Create lists of favorites
 - Diagnoses
 - Procedures
 - Clinic Favorites
- Delete items from lists

Slide 43: List Management Learning Objectives

List Management

Demonstration

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

1. To begin, click the **List Management** folder in the Folder List The List Management screen will display.
2. To Delete Upper Respiratory Infection from the Diagnosis favorites list, click to expand **My Favorites** (if not already expanded) and click to expand **My Diagnosis** if not already

- expanded. A list of favorite diagnoses will be displayed.
3. Click on ***UPPER RESPIRATORY INFECTION*** to select it and click the **Delete** icon on the Action Bar. Upper Respiratory Infection will be deleted from the Favorite List.
 4. To add a flu shot to the procedures favorites list, click to highlight ***My Procedures*** and click the **Add** icon on the Action Bar. The Select Procedure window will display.
 5. Type ***flu shot*** in the Search field and click **Search**. Terms related to flu shot will be displayed.
 6. Click **+** to expand ***Vaccines Viral Influenza***
 7. Click ***For Live, Intranasal Use 90660*** to select it and click **OK**. The For Intranasal Use procedure will be added to the Procedure Favorite List.
 8. To move the electrocardiogram procedure to the bottom of the Procedures favorites list, click ***Electrocardiogram*** in the Procedures favorites list.
 9. Click the **Move Down** icon on the Action Bar. Electrocardiogram will be moved to the bottom of the list.

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

- Delete items from lists.
- Create lists of favorites for use in the application

Lesson 27: Questionnaire Setup/Questionnaire

Questionnaire Setup/Questionnaire

Lesson Goal:

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

Learning Objectives

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

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

Slide 44: Questionnaire Setup/Questionnaires Learning Objectives

Questionnaires

Demonstration

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


Building the Questionnaire

1. Click **Questionnaire Setup** in the Folder List (you may have to expand the Tools folder). The Questionnaire Setup window will display.
2. Click the **New** icon on the Action Bar to create a new questionnaire. The Questionnaire Setup window will re-display with the [New] in the Name: field and in the large, center window.
3. For level select personnel from drop down box
4. Overtyping [New] in the Name field with **HEADACHE INITIAL VISIT** in the Name: field. The name will appear in the large, center window.

5. Click the **Add** button on the right side of the window. The input area for question one will display.
6. In the Question Text area, overwrite [New Question] with ***DO YOU HAVE A HEADACHE RIGHT NOW?*** click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display.
7. In the Question Text area, overwrite [New Question] with ***WHEN WAS THE LAST TIME YOU HAD A HEADACHE?*** click ***Date*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display.
8. In the Question Text area, overwrite [New Question] with ***HOW LONG HAVE YOU BEEN HAVING HEADACHES?***, click ***Multiple-Choice*** in the Answer Type drop-down. In the Multiple-Choice area type:
LESS THAN 1 MONTH and press the [Enter] key
1-6 MONTHS and press the [Enter] key
7-12 MONTHS and press the [Enter] key
GREATER THAN 1 YEAR and click **Add** to add a new question.
The Questionnaire input area will re-display.
9. In the Question Text area, overwrite [New Question] with ***HAVE THE HEADACHES GOTTEN WORSE OR BETTER?***, click ***Multiple-Choice*** in the Answer Type drop-down. In the Multiple Choice area type:
WORSE and press the [Enter] key
BETTER and click **Add** to add a new question.
The Questionnaire input area will re-display.
10. In the Question Text area, overwrite [New Question] with ***ARE YOU TAKING ANY MEDICATION FOR THE HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down, type 7 in the Skip To field associated with No, and click **Add** to add a new question.
The Questionnaire input area will re-display.
11. In the Question Text area, overwrite [New Question] with ***DOES THE MEDICATION HELP THE HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display.
12. In the Question Text area, overwrite [New Question] with ***HAVE YOU SEEN A MEDICAL END USER REGARDING THESE HEADACHES IN THE LAST YEAR?***, click ***Yes/No*** in the Answer Type drop-down and click **Add** to add a new question. The Questionnaire input area will re-display.

13. In the Question Text area, overtype [New Question] with ***DOES ANYONE ELSE IN YOUR FAMILY SUFFER FROM HEADACHES?***, click ***Yes/No*** in the Answer Type drop-down, type ***10*** in the Skip To field associated with no, and click **Add** to add a new question. The Questionnaire input area will re-display.
14. In the Question Text area, overtype [New Question] with ***IF SO, WHO SUFFERS FROM HEADACHES?*** click ***Multi-Select*** in the Answer Type drop-down and type the following in the Multi-Select area:
 - MOTHER*** and press the [Enter] key
 - FATHER*** and press the [Enter] key
 - SIBLINGS*** and press the [Enter] key
 - GRANDPARENTS*** and press the [Enter] key click **Add** to add a new question. The Questionnaire input area will re-display.
15. In the Question Text area, overtype [New Question] with ***IS THERE A LOT OF STRESS IN YOUR NORMAL DAY?*** click ***Yes/No*** in the Answer Type drop-down. Click the **Save** on the Action Bar (do not click the **Add** button to add another question) to save the questionnaire.
16. The questionnaire will appear in the list of questionnaires with a status of In Development.
17. Click the ***Headache Initial Visit*** questionnaire to select it and click the **Mark Ready** icon on the Action Bar. The questionnaire status will change from In development to Ready for Use.
18. Click **Close** on the Action Bar to complete the questionnaire setup process.

We will now complete the Headache Initial Visit questionnaire with LCDR Eduardo Suarez. Answer each question as if you were completing the questionnaire for Mr. Suarez:

1. Open the appointment
2. Click the Patient Questionnaires folder in the Folder List. The Patient Questionnaires window will display.
3. Click the **Interview** icon on the Action Bar to begin the questionnaire. The questionnaire will display.
4. To locate the questionnaire:
 - a. Click  to expand personnel

b. Click **Headache Initial Visit** to select it. The questionnaire will be displayed:

5. Click select
6. Click the Options button on the Patient ID line to select the Properties for administering the Patient Questionnaire. The Patient Questionnaire Properties window will display.
7. Click on **Single Question View** from the drop-down to select it and click **OK**. The questionnaire will re-display.
8. Answer each question and click **Next Question**
9. When the last question is displayed answer the question and click **Mark Questionnaire As Done**.
10. The Patient Questionnaire window will be re-displayed showing the questionnaire that has just been completed.
11. Click the **Close** icon on the Action Bar to close the module

Exercises

Complete the exercises.

Check for understanding and answer participant questions.

Summary

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

Lesson 28: Screening Notification

Screening Notification

Lesson Goal

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

Learning Objectives

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

- Select properties
- Set screening search properties
- Select or deselect search results

Slide 45: Screening Notification Learning Objectives

Screening Notification


Demonstration

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

To select Screening Notifications reminder search options:

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



click the  icon. Anti-Tobacco Counseling will display in the Selected Reminder(s) list.

Note: To select multiple reminders, select the reminders while pressing the [Ctrl] key on your keyboard and click the associated icon or individually select.

4. You can click to select the *PCM* radio button (if not already selected) and search for the end user.

Note: Performing a search for patients associated with an MTF may take an extended period of time.

5. Click **Letter** as the Method of notification from the drop-down list.
6. Click **OK**. The Screening Notifications window will re-display. Patients listed in the Screening Notifications window have a date in the corresponding wellness reminder column that determines when they need to be notified, either by e-mail, letter or both. To notify patients about future Screening Notifications.
7. Click **Select All** on the Action Bar to select all the patients. The check box associated with each patient, will be selected.
8. Click **Notify** on the Action Bar to notify the selected patients of the wellness reminder. A Notification Options window will display.
9. Click the **Print letter now** radio button to indicate use of a pre-printed letter. The Screening Notifications window will re-display.
Note: A Print Preview window opens when printing, displaying the letter for the patient(s) being notified.
10. Click the **Close** icon on the Action Bar to close the module.

Exercises

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

Summary

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

Lesson 29: Reports

Reports

Lesson Goal

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

Learning Objectives

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

- Run a report
- View a Report

Slide 46: Reports Learning Objectives

Reports

Demonstration

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

- Click the **Reports** folder in the Folder List. The Reports window will display.
- Click the **Report on:** drop-down to get a list of report types.
- Click on **Appointments** to select it. The Reports window will re-display.
- Complete the following fields:
 - With Scope of: - **Clinic/Lab**
 - From: field - One year prior to the To: field
 - Click to select the Display in separate window check box
 - Click to select the Provider check box
- Click the **Run Report** button. The report will be run and the result displayed in a separate window.
- Click the **Close** icon in the upper right of the screen to close the Print Preview window. The

	<p>Reports window will re-display.</p> <ul style="list-style-type: none"> • Click the Close icon on the Action Bar to close the module. <p>Exercises</p> <p>Complete the exercises. Check for understanding and answer participant questions.</p> <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> • Run a report • View a Report 	
Lesson 30: Immunizations		
	<p>Lesson Goal</p> <p>The goal of this lesson is to introduce the student to Immunizations Administration.</p> <p>Learning Objectives</p> <p>Upon completion of these modules the student will be able to:</p> <ul style="list-style-type: none"> • Define vaccine groups • Track vaccines in stock • Add details to in-stock vaccines • Maintain groups • Document multiple patient vaccines • Manage providers • Produce reports <p>Immunizations</p> <p>Immunizations</p> <ul style="list-style-type: none"> • Two separate modules 	<p>Slide 47: Immunizations Learning Objectives</p>

Immunization Admin

Immunizations

- Allows the documentation of immunizations for a patient.

CHCS II Immunization consists of two modules:

The Immunization Admin module is used to administer and manage vaccines, end users, reports, end user groups, and refrigeration temperature logs. The module is also used to document multiple vaccine entries for selected patients. The Immunizations Admin module can be accessed without having a patient's record open.

The Patient Immunizations Module is used to manage and track patient immunization records and vaccine history. The Immunization module is patient-specific; therefore, a patient's record must be loaded to the desktop to access this module.

Immunizations

Demonstration

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

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

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

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

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

MMR	Merck	ME67890	0.5 ml	IM
-----	-------	---------	--------	----

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

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

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

The screen will appear

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

Vaccine	Mfg Code	Lot Nbr	Dosage	Route
---------	----------	---------	--------	-------

Anthrax	Ortho Diagnostic	OD13579	0.25 ml	IM
Hep A – Hep B	Abbott	4444444	0.1 ml	IM
Influenza	Baxter	BA 12345	0.1 ml	IM
MMR	Merck	ME67890	0.5 ml	IM

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

Exercises

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

Summary

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

Next Slide

Question and Answer and Summary

End of Day Four

Next Slide

Slide 48: Day Five Course Agenda

Slide 49: Training Workshop

DAY FIVE

CHCS II Training Workshop

Training Methodology

- Prior to attending the T3 portion of the course, all participants will have attended the first four days of the Super-User course.
- This portion of the course has built-in flexibility depending on the background and expectations of the participants. For example: If they do not have a training background, the Training Adults lesson can be emphasized. If they are experienced trainers, focus on the Training Materials lesson. If they are technical staff responsible for keeping end-users up to speed on new functionality, emphasize the Release Process lesson. If they need to deliver end-user classes, allow more practice time.
- The part of the course is very different from the application driven part of the course. This T3 portion emphasizes the learning and training processes related to CHCS II implementation training rather than the content of the end-user courses. The participants are expected to voice opinions, engage in discussion, share ideas, and work together as a team to explore delivery techniques that will be most effective in their training efforts.

Instructor Checklist

Materials Needed

- T3 Course Lesson Plan
- T3 Course Student Binder (one per student). Binder includes:
 - T3 Student Guide
 - Lesson Plans and Instructor Guides for all appropriate end-user courses
 - OJT Checklists
 - Block I only: Excerpts from service clerk student guide for the intro and the first two topics (Administrative skills and Navigation.)
 - Executive Summary of the latest Release Notes
- T3 Student CD (one per site). CD includes all documents in T3 Student Binder plus:
 - T3 Course presentation
 - Student Guides, Exercises, handouts and presentations for all appropriate end-user courses
 - Service specific encounter and S/O templates
 - Latest Release Notes
 - Latest Quick Reference Guide

- Latest Quick Reference Cards
- Latest User's Manual
- T3 Course Instructor Binder (one per instructor). Binder includes everything in Student Binder plus:
 - T3 Instructor Guide
 - T3 Instructor/Student Guide (Student Guide with Instructor Notes visible)
 - Printed version of T3 Course Presentation (handouts - 3 slides per page)
- T3 Instructor CD (one per instructor). CD includes all files on T3 Student CD and in T3 Instructor Binder
- T3 Course PowerPoint Presentation should be loaded on the instructor's workstation
- Class Sign-in Roster
- Class Critiques

Tasks to Be Completed Before Class

- Classroom setup with one workstation per student and one projected workstation for the instructors loaded with Training System.
- Training System should not be reset prior to the start of the course. A reset is incorporated into course, in the Training Tools lesson.

To the Instructor

The Train-the-Trainer (T3) course is designed to teach trainers with CHCS II experience how to deliver end-user training. The course takes place in a classroom with access to the CHCS II Training System. Students should be provided with hard copies and electronic copies of the training materials for the T3 class as well as for the end-user classes. Do not reset the Training System; that is done in class with the participants.

The final day of the Super User course should be delivered by an instructor familiar with the CHCS II implementation training courses. The T3 instructor should also have experience training trainers and should be prepared to facilitate discussions about adult learning behaviors, classroom training techniques, challenges of one-on-one training, and how to manage on-the-job training. In addition, the T3 Trainer must be prepared to answer questions about various aspects of the CHCS II application.

When preparing to deliver this course, the instructor must realize that more so than most end-user classes, a train-the-trainer class must be flexible and must address the individual needs of each student. The trainer should conduct the class at an energetic pace to adequately cover each module while maintaining an interactive environment. The opportunity to ask questions and participate in discussion about these points is more important than clicking through the exercises. The instructor delivering the T3 course must thoroughly understand the big picture points of each lesson in this course as well as the concepts trained in the end-user courses. In addition, since adult learning theory is constantly evolving, the instructor might present some discussion topics as suggestions, not as facts.

The size of the audience can affect how the instructor can conduct certain exercises. Do not underestimate the impact of audience size on interactive exercises.

Instructor Guide Format

This guide is designed to provide you with the information you need to teach CHCS II Courses. Time spent reading the next few pages is important to the success of this course.

The instructor guide contains everything that appears in the student guide as well as instructor notes. Instructor notes are found in gray-shaded boxes throughout the document.

The following items appear throughout the course as items for you to use in preparing for the training delivery:

NOTES - Notes are intended to provide you with additional information or point out specific issues within the training delivery. Instructor Notes have been placed in callouts on the left side of the pages. Each note refers to a specific step or related information in the adjacent student guide text. Use these to amplify key points while taking students through the walkthroughs. Below is a sample.

Instructor Note
Use this to amplify
key points during
class.

SCREEN OVERVIEW - Every time you present a new screen, you should take a few seconds to provide the class with an overview of the screen. Point out how the screen is divided up into sections and if any fields are pre-populated, explain where the data comes from. Expect to do these screen overviews more frequently in the earlier lessons than the latter lessons.

HANDS ON - The Hands On sections guide you through a specific task. During the hands on section, you guide participants through each step of the task. The process steps are provided in both the student guide and instructor guide.

Overview of Course Content:

The Composite Health Care System II (CHCS II) Train-the-Trainer or T3 Course consists of six lessons. Each lesson is designed to provide the participant with content on a topic in some cases followed by performance-oriented tasks. Lessons are:

- Lesson 1 - Training Adults
- Lesson 2 - CHCS II Training Strategy
- Lesson 3- Training Materials
- Lesson 4- ILT Delivery
- Lesson 5- OJT Delivery
- Lesson 6- Release Process

Target Audience

This course is intended for two main groups:

- CHCS II Implementation training team members who are targeted to deliver end-user courses (internal trainers)
- Site personnel who are responsible to deliver CHCS II training after the Implementation training is complete (external trainers). The services and the sites differ in their philosophy for sustainment, or post-implementation, training. For example, at larger sites, there may be a dedicated CHCS training team that will take on responsibilities for CHCS II training. These trainers may or may not have a healthcare background. Smaller sites may use super-users and assign one trainer to each newcomer. These super-users may have extensive healthcare background but little or no training experience.

Course Summary

Briefly summarize the course and open to questions and answers.

Day One

Overview of the system, the training, the expectations
Basic skills: navigating through documenting

Day Two

MEDCIN and templates
Ancillary modules

Day Three

Alerts
Previous Encounters

Day Four

Provider modules
List Mgmt
Questionnaires

Next Slide

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

Slide 50: Course Summary

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

Slide 51: What Do I Do...

Report the problem to your local Help Desk.

Capturing Screens

To capture screens:

1. On the workstation keyboard, press **PrtScrn**.
2. Open PowerPoint.
3. To paste the screen capture into PowerPoint, on the workstation keyboard, right mouse click and select **Paste**.
4. Save the screen capture to the appropriate folder on the workstation. In many clinics, there is a specific folder on a shared network drive for storing these files.

Ensuring Patient Data is concealed in the Screen Capture

1. In PowerPoint, use the drawing tools to conceal any patient-specific information on the screen.
2. From the View menu, select Slide Show.
3. On the workstation keyboard, press PrtScrn.
4. Exit the slide show to return to the normal view by pressing Esc on the workstation keyboard.
5. On the PowerPoint toolbar, click the new presentation icon (i.e., the blank piece of paper).
6. To paste the screen capture into the new presentation, on the workstation keyboard, right mouse click and select Paste.
7. Save the screen capture (in the new presentation) to the appropriate folder location on the workstation.
8. Close the original screen capture without saving the document.

Next Slide

Other Help Resources

- QRC's.
- CHCS II User Manual. Should be available in each clinic.
- Application Help menu.
 - Detailed information on use of modules
 - Step-by-step procedures

Slide 52: Other Help Resources

Explain: Both are readily available within the application help files. Help is structured like other Windows application help files.

Questions and Answers

Appendix A: Immunizations

Immunizations Admin & Patient Immunization Learning Objectives

Upon completion of these modules, you will be able to:

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

Overview of Immunizations Admin

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

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

Action Bar Icons

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

Close Closes the Immunization Admin Module.

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).

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

Vaccination Management

To add vaccines in stock for clinic:

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

Selecting a Default Vaccination Clinic

To select a Default Vaccination Clinic:

1. Click the **Ellipsis** button next to the *Default Clinic* field. The Clinic List Edit window opens.
2. 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.
3. Click **Set Default**. You are returned to the Vaccine Management area.
4. Do one of the following:
 - a. 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
 - b. If you want to set the default typhoid product, select the typhoid product from the drop-

down list

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

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

7. Add the following Vaccines by selecting and clicking on **Right** arrow (>):

Anthrax
Hep A-Hep B
Influenza
MMR

To add vaccines Mfg/Lot Nbr:

Must ensure vaccines are in stock and have correct information for documentation.

Need to have **Vaccine Management** highlighted and open.

- 1. Click **Mfg/Lot Nbr** button to add vaccine information.
- 2. 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

- 3. Close Vaccines in Stock Information window as well as Immunizations Admin Module when completed.

Viewing the Vaccine Lot Number List

To view the Vaccine Lot Number List:

1. Click **Reports** on the Admin tab.
The Reports area displays.
2. Click **Lot Numbers**.
The Vaccine Lot Number List window opens.
3. Select a vaccine from the drop-down list.
Manufacturer information displays for each manufacturer associated with the selected vaccine.
 - i. Select a manufacturer.
 - ii. Click **Details**.
All patients associated with the vaccine distributed by the selected manufacturer display.
 - iii. Click **Details** to edit the immunization history for the selected patient.
You can also click the drop-down arrow to view detailed information for manufacturers and patients.

Deleting Providers from Administering Immunizations

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

To delete a provider from administering immunizations:

9. Click **Provider Management** on the Admin tab. The Provider Management area displays.
10. Select a provider from the list in the *Provider Management* area.
11. Click **Delete**.

Printing Immunization Reports

To print immunization reports:

10. Click **Reports** on the Admin tab. The Reports area displays.
11. Select a report from the drop-down list.

	<p>Note: Information for the selected report displays in the Report area. The information displayed depends on what report you select.</p> <ol style="list-style-type: none"> 12. Click Print. 13. Select a print range on the Print window. 14. Click OK. 	
	<p>Exercises</p> <ul style="list-style-type: none"> • Complete the exercises • Check for understanding and answer participant questions. <p style="text-align: center;">Summary</p> <ul style="list-style-type: none"> • Defined vaccine groups • Identified vaccines in stock • Added details to in-stock vaccines • Maintained groups 	
	<p>Patient Immunization Module</p> <p>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.</p> <p>Editing Vaccination Groups</p> <p>All vaccination groups established for service type or occupational status are listed in the <i>Vaccination Groups</i> field.</p> <p>The patient receives vaccinations assigned to the selected group(s).</p> <p>To edit the Vaccination Groups:</p> <ol style="list-style-type: none"> 1. Click Edit Groups in the Individual Immunization tab. The Immunization Groups window opens. 	

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

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

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

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

Entering Historical Pediatric Vaccines

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

- Manufacturer
- Lot Number
- Provider

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

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

1. Click **Rapid Pediatrics Entry** on the Vaccine History tab.
The Transcribed window opens.
The Rapid Pediatrics Entry button is only visible for pediatric patients that are 18 years of age or younger.
2. Select the tab for which you want to enter vaccine information.
3. Enter the vaccine in the Vaccine field.

Double-click the vaccine field to open the Vaccines window to display a list of pediatric patient vaccines.

4. If you want to enter a vaccination date:
 1. Double-click the vaccine date. The Date Builder window opens.
 2. Select the date from the calendar.
 3. Click **OK**.

 5. If you want to enter the vaccine's manufacturer:
 - a. Double-click the manufacturer. The Manufacturer List window opens.
 - b. Select the manufacturer you want to use.
 - c. Click **Select**.
- Enter the word "Transcribed" in any field to signify that the information was not available when it was recorded from the patient shot record.*
6. Click **Save and Close**.
 7. There is an option to print the worksheet and the DD Form 2766C from the Individual Immunization window. The report is sent to your printer.
 - a. Print DD 2766C: Use this function to print a Vaccine Administration Record.
 - b. Print Worksheet: Use this function to print required immunizations for the selected patient.

Selecting the Immunization Exempt Type

To select the immunization exempt type:

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

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

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

	<p>Note: If you select Medical (Temp), Admin (PCS), or Admin (Temp) as an <i>Exemption Type</i>, an exempt date is required. The system formats that date.</p> <ol style="list-style-type: none"> 2. Click the Click to Save Exemption button. <p>To make a focused exemption for a specific vaccination in the Vaccine History tab</p> <ol style="list-style-type: none"> 1. Select the vaccination to be exempted. 2. Click Edit. <i>The Immunization History Edit</i> window opens 3. Select the exempt type from the <i>Exempt</i> drop-down list. <p>Note: Depending on the reason, an exempt date may be required. The system formats the date.</p> <ol style="list-style-type: none"> 4. Click Update. The Exempt Reason appears on the Vaccine History tab. 	
	<p>Giving a Vaccine</p> <p>To select an immunization:</p> <ol style="list-style-type: none"> 1. Click Give Vacc on the Individual Immunizations tab. The Select Immunization window opens 2. Select an Immunization. <p>Note: The <i>Immunizations Recommended</i> list is based on the vaccination groups to which the patient is assigned. The <i>Other Immunizations</i> list is a list of all vaccines.</p> <ol style="list-style-type: none"> 3. Click the right arrow to move the items from the <i>Immunizations Recommended</i> list or <i>Other Immunizations</i> list to the <i>Immunizations Selected</i> list. <p>Note: Click the double arrow to move the entire group of <i>Immunizations Recommended</i> to the <i>Immunizations Selected</i> list.</p> <ol style="list-style-type: none"> 4. Click the left arrow to remove the selected immunization from the <i>Immunizations Selected</i> list back to the <i>Immunizations Recommended</i> or <i>Other Immunizations</i> list. 5. Click OK. The Vaccine Select window opens displaying the selected vaccines 6. Select the vaccine(s). 7. Click OK. 	

Adding a Vaccination

Vaccinations can be added to a patient's record.

To add a vaccination:

1. Click the Vaccine History tab on the Immunizations window. The Vaccine History tab
2. Click **Add**. The Vaccines window
3. Select the vaccine you want to add.

Note: To view a list of all vaccines in stock, click the List All Immunizations checkbox. All vaccines in stock appear on the list. To edit the list of favorite vaccines, click **Edit List**. On the Edit Favorite Vaccine List window, select a vaccine from the *All Vaccines* list and click the right arrow to move the vaccine to the *Selected Vaccines* list. Click **Close**.

4. Click **Select**. The Add Vaccine window opens
5. Complete the following fields
 - **Vacc Date:** Enter a date, or click the **ellipsis** button and select a date from the calendar, to assign a vaccination date.
 - **Series Number:** Enter the series number of the vaccine, if necessary.
 - **Manufacturer:** Select a manufacturer from the drop-down list, if necessary.
 - **Lot Number:** Enter the lot number of the vaccine, if necessary.
 - **Dosage:** Select a dosage for the vaccine from the drop-down list, if necessary.
 - **Site:** Select an area of the body where the vaccine is given from the dropdown list, if necessary.
 - **Route:** Select the vaccine route from the drop-down list, if necessary.
 - **Next Vaccination Due:** Click **Recalc** to automatically calculate the next vaccination due date. The date is automatically entered.
 - **Exempt:** Select an exemption from the drop-down list, if necessary.
 - **Provider:** Select a provider from the drop-down list, if necessary.
6. Click **Update** to save the data and return to the **Vaccine History** tab.

	<p>Deleting Immunization History</p> <p>To delete an Immunization History:</p> <ol style="list-style-type: none"> 1. Select the immunization you want to delete. 2. Click Delete. <p>Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.</p> <p>Editing Immunization History</p> <p>To edit an Immunization History:</p> <ol style="list-style-type: none"> 1. Select the immunization you want to edit. 2. Click Edit. The <i>Immunization History Edit</i> window opens 3. Complete the following fields: <ul style="list-style-type: none"> • Series • Manufacturer • Lot Number • Dosage • Site • Route • Next Vacc Due • Exempt • Provider 4. Click Update to save the data and return to the Vaccine History tab. 	
	<p>Printing Immunization Records</p> <p>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.</p> <p>To print immunization records:</p> <ol style="list-style-type: none"> 1. Print Worksheet: Use this function to print required immunizations for the selected patient. 2. Print DD 2766C: Use this function to print a Vaccine Administration Record. 	

Reviewing Immunization Records

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

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

Immunization
Series
Date
Next Due
Vaccination Groups

Documenting a Vaccination Visit

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

Finishing the Documentation for Vaccination Visit:

1. Double click on *ALEXANDER, VIOLET*
2. Select A/P module

	<p>3. Document Diagnosis</p> <ul style="list-style-type: none"> a. MMR – V06.4 b. HEP A – V05.3 c. Influenza – V04.8 d. Small Pox – V04.7 <p>4. Document Procedures:</p> <ul style="list-style-type: none"> a. MMR – 9707 b. HEP A – 90632 c. Influenza – 90659 d. Small Pox – 90749 <p>5. Select each Procedure code (as necessary) to add the modifier for Units of Service</p> <p>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</p> <p>6. Document Disposition/E&M Code of 99211</p>	

Appendix B: System Demo

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 will play each role, the clerk who will check in the patient, the Tech who will triage the patient, the Provider who will exam and disposition the patient and the nurse who will provide patient education and submit the orders for the provider:

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

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

	HR Radial Regular	95 [Select] [Select]
	RR Temperature F Oral	13 99 F [Select]
	Ht	[Enter] 52 in
	Wt	70 lbs
Habits		
	Tobacco	[Select] No
	Alcohol	[Select] No
Pain Severity		
		[Select] 1 Hurts a little bit
	Where is pain located?	Throat NOTE: Add comments when pain scale is selected (other than "0 pain free").
Save Vitals		
		[Click] Save Vitals (Action Bar Icon) [Select] Close (Action Bar Icon) to retur to SF600
	SF600	[Click] Close and return to Appts. module
Appointments		

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

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

	Order Rad Tab	[Select]Chest [Type] Chest in the new order field. [Click] Search [Select] Chest in the new order field. [Enter] r/o pneumonia [Select] [Select] Ordering Provider
	Clinical Impression Routine More Details	[Click] Submit [Click] Close (Action Bar Icon)
	SF600	[Click] Close (Action Bar Icon) to return to Appts. module
NURSE: Reviews Results and copies results to encounter	RESULTS ARE READY!!!	
	Lab	
		Open module Highlight Result Copy to Note
	Rad	
		Open module Highlight Result Copy to Note
PROVIDER: Returns to patient to discussed results and give a Diagnosis. He then completes the Disposition and Signs	Apointments	
		[Select] Col Alexander's walk-in appt. Doubleclick appt. to open SF600

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

<p>CLERK:</p> <p>Clerk Checks out the patient and provides patient with a copy of the signed encounter.</p>		<p>[Select] Col Alexander's walk-in appt.</p> <p>[Select] Check out on Action Bar</p> <p>Print patient a copy of SF600</p>
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As the **CLERK:** Col. Violet Alexander walks into your clinic complaining of shortness of breath, she does not have an appointment but needs to see her PCM – Dr. Test User. You create an (Acute \$) 30 walk-in appointment for the patient and enter the reason for appointment as shortness of breath.

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

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

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

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

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

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

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

Select + for History of Asthma

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

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

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

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

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

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

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

The **NURSE** then returns the signed encounter and double clicks it. This will take you to the previous encounter. The nurse highlights the encounter and selects the Append Narrative on the action bar. This will open the encounter note. The nurse will import the nebulizer treatment word document. The nurse will also indicate the second peak flow result after the treatment on the note. She/he saved the note and goes to sign the

encounter. The nurse will add the provider as the co-signer of the note. The encounter will have the status of updating until the provider enters the countersignature. The status will change to updated.

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