CHCS II User's Manual

for the

Composite Health Care System II Block 1

Consistent with 2.1.832.7

Prepared For:

The CHCS II Program Office

and the

MHS Clinical Information Technology Program Office

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COMPOSITE HEALTH CARE SYSTEM II

Table 1: CHCS II Release 1 Changes

Section	Description of Change	Date
Desktop Navigation	Replaced Graphic 2-1 (graphic with no modules/ patients)	1/31/03
Desktop Navigation	Updated Current File Pull-down Menu options	1/31/03
Desktop Navigation	Updated Current Go Pull-down Menu options	1/31/03
Desktop Navigation	Updated Current Go Patient Sub-menu options	1/31/03
Desktop Navigation	Updated Tools Pull-down Menu options	1/31/03
Desktop Navigation	Updated Check-out information	1/31/03
Desktop Navigation	Updated Startup options	1/31/03
Desktop Navigation	Updated Actions Pull-down menu	1/31/03
Desktop Navigation	Updated Help Pull-down menu	1/31/03
Desktop Navigation	Changed Patient ID Line Options to Patient ID Bar	1/31/03
Desktop Navigation	Added the New Results Icon, Priority Results & Co-signs Icon and the Orders to Sign Icon	1/31/03
Workflows	Updated Sign Orders	1/31/03
Patient Search	Updated graphic 4-2 Folder List	1/31/03
Patient Search	Updated graphic 4-3 Select Patient Using Patient Pull-down Menu	1/31/03
Appointments	Added graphic 5-1	1/31/03
Appointments	Changed Section 5.1 to read Overview of Appointments	1/31/03
Telephone Consults	Changed section 6.1 to read Overview of Telephone Consults	1/31/03
Telephone Consults	Updated graphic 6-1 Military Clinical Desktop – Telephone Consults Module	1/31/03
Demographics	Changed Section 7.1 to read Overview of Demographics	1/31/03
Demographics	Added graphic 7-1 Military Clinical Desktop – Demographics Module	1/31/03
Web Browser	Updated graphic 9-1	1/31/03
Web Browser	Changed Section 9.3 to Changing the Internet Home Page	1/31/03

Table 1: CHCS II Release 1 Changes

Section	Description of Change	Date
Health History	Updated graphic 10-1	1/31/03
Wellness	Updated graphic 11-1	1/31/03
Patient Immunizations	Added entire module	1/31/03
Immunization Admin	Added entire module	1/31/03
Readiness	Updated graphic 14-1	1/31/03
Allergy	Updated graphic 15-1	1/31/03
Medications	Updated graphic 16-1	1/31/03
Problems	Updated graphic 17-1	1/31/03
Clinical Notes	Updated graphic 18-1	1/31/03
Flowsheets	Updated graphic 19-1	1/31/03
Previous Encounters	Updated graphic 20-1	1/31/03
Previous Encounters	Updated graphic 20-4	1/31/03
Copy Forward	Added Section on Copy Forward from Previous Encounter	1/31/03
Laboratory	Added Graphic 21-1 Military Clinical Desktop – Laboratory Module	1/31/03
Radiology	Updated graphic 22-1	1/31/03
Patient Encounter Summary	Updated graphic 23-1	1/31/03
Screening	Updated graphic 24-1	1/31/03
Vital Signs	Updated graphic 25-1	1/31/03
Vital Signs	Updated graphic 25-3	1/31/03
S/O	Updated graphic 26-1	1/31/03
S/O	Updated Importing and Exporting S/O Templates	1/31/03
A/P	Updated graphic 27-1	1/31/03
A/P	Added section on Non-Provider Order Entry	1/31/03
Disposition	Updated graphic 28-1	1/31/03
Template Management	Updated graphic 31-1	1/31/03
Template Management	Updated Section 31.10 Importing/Exporting Templates	1/31/03

Table 1: CHCS II Release 1 Changes

Section	Description of Change	Date
Alert Review	Updated graphic 32-1	1/31/03
Co-Signs	Updated graphic 33-1	1/31/03
Co-Signs	Updated graphic 33-8	1/31/03
Consult Log	Updated graphic 34-1	1/31/03
List Management	Updated graphic 35-1	1/31/03
Patient List	Updated graphic 37-1	1/31/03
Reports	Updated graphic 38-1	1/31/03
Screening Notification	Updated graphic 39-1	1/31/03
Screening Notification	Changed Section 39.5 to read Notifying Patients About Screening Services	1/31/03
Rx Alternatives	Updated graphic 40-1	1/31/03
New Results	Updated graphic 41-1	1/31/03
Patient Questionnaire	Updated graphic 42-1	1/31/03
All Modules	Alphabetized User's Manual Sections	6/20/03
Appointments	Updated content and graphics to Build 831	7/9/03
A/P	Updated content and graphics to Build 831	7/9/03
Disposition	Updated content and graphics to Build 831	7/9/03
Patient Encounter Summary	Updated content and graphics to Build 831	7/9/03
Previous Encounters	Updated content and graphics to Build 831	7/9/03
Problems	Updated content and graphics to Build 831	7/9/03
S/O	Updated content and graphics to Build 831	7/9/03
Template Management	Updated content and graphics to Build 831	7/9/03
Vital Signs	Updated content and graphics to Build 831	7/9/03
Template Management	Added new screens for section 39.4	8/18/03
Drug Cost	Changed Drug Cost to Rx Alternatives	8/18/03
Order Sets	Added section on Creating Order sets within A/P	8/18/03
Couplers	Changed Couplers to PKC Couplers	8/18/03

CHCS II User's Manual
Table of Contents

1.0 GETTING STARTED

1.1 CHCS II Overview

As the target healthcare system of the Department of Defense (DoD), the Composite Health Care System (CHCS) II provides a structured framework for accessing and integrating medical information for patients. CHCS II is the Military Health System (MHS) Computer-based Patient Record (CPR). It provides the DoD with an enterprise-wide system; governed by universal standards integrating data from multiple sources and displaying the data at the point of care. Appropriate portions are easily accessible to authorized users when and where needed. The CPR facilitates the worldwide delivery of healthcare, assists clinicians in making healthcare decisions, and supports leaders in making operational and resource allocation decisions.

CHCS II provides the essential capabilities, as identified by the functional community, to support the creation of a CPR. CHCS II integrates the best of Government and commercial off-the shelf (COTS) products by interfacing the existing Military Health System (MHS) Automated Information Systems with new functionality.

1.2 Security Overview

CHCS II is installed in MTFs and clinics throughout the world. As the security of patient data is of paramount importance in the military's healthcare community, an elaborate and effective security methodology has been built into CHCS II. The system administrator strictly controls access to all parts of CHCS II User access to the system is based on the role of the user and is determined when registration is complete and the system administrator assigns a password. Thereafter, when the user logs in to CHCS II, access to all of the CHCS II components required in the performance of duties is granted. Access to all other components of the system is denied.

CHCS II Security Architecture is a flexible security framework that is designed to accommodate multiple levels of security needed throughout Health Affairs. The framework can accommodate growth, allowing the same framework to be used to centrally capture and store any access control information for all applications in the Enterprise.

An integral part of CHCS II security is the assignment of roles. Each user is assigned a CHCS II role. This role is determined by the user's job skill set. These roles are cumulative, allowing greater access to patient information as roles are added. Similar in concept to the CHCS user level, an individual's role determines what information can be accessed or changed.

1.3 Requesting a New Account

To request a new account within CHCS II, an existing account with CHCS must first be obtained from the System Administrator. After a CHCS account has been created, a new CHCS II account can be requested.

To request a new account:

1. Browse to the CHCS II User Account Registration page at enterprise.chcsii.com (see Figure 1-1: Account Registration Web Page).

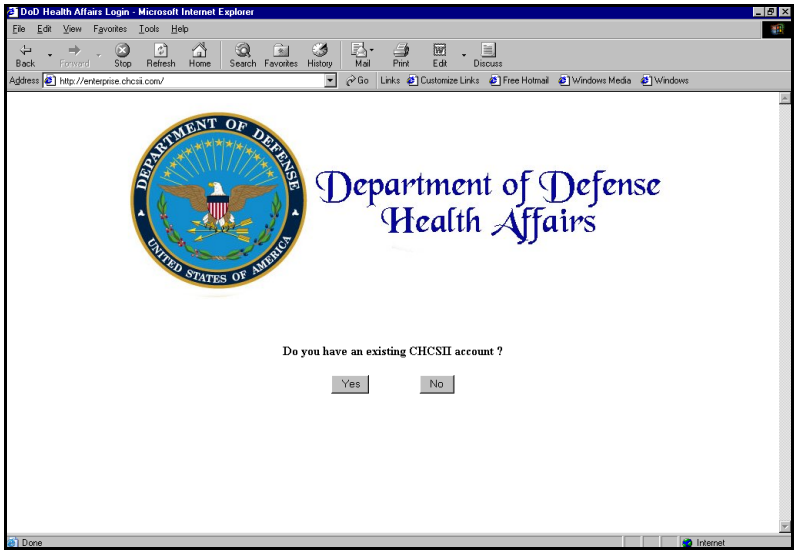

Figure 1-1: Account Registration Web Page

2. Click **No**.
3. Scroll to the Account Registration Information fields (see Figure 1-2: Account Registration Information Fields).

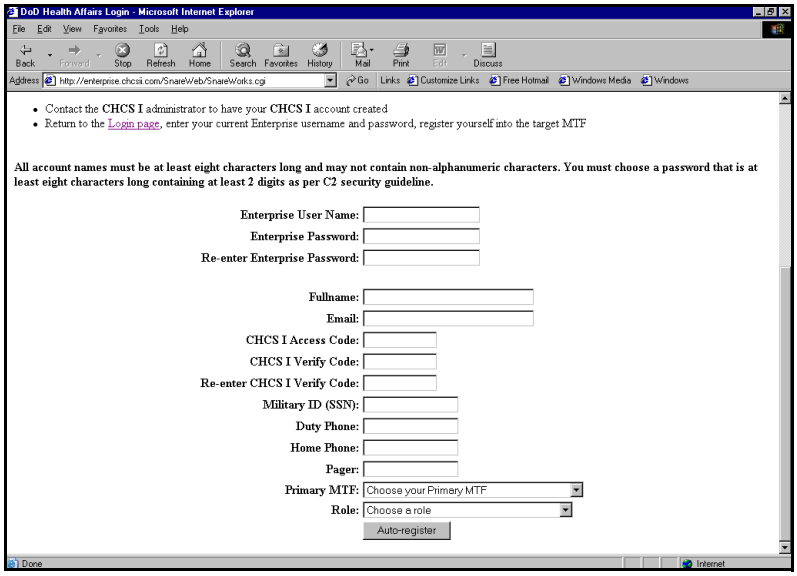

Figure 1-2: Account Registration Information Fields

4. Enter information in the applicable fields.
   - Enterprise User Name

- Enterprise Password
- Re-enter Enterprise Password
- Full Name
- E-mail
- CHCS Access Code
- CHCS Verify Code
- Re-enter CHCS Verify Code

Note: You can enter additional MTF accounts from within the account management page once the initial account information is entered and submitted for auto-registration.

- Military ID (SSN)
- Duty Phone
- Home Phone
- Pager
- Primary MTF
- Role

Note: You can request additional roles from within the account management page once the initial account information is entered and submitted for auto-registration.

5. From the File menu select Print, if desired.
6. Click **Auto-Register**.
7. Click **Logout**.

Note: Once the request has been submitted and verified, the System Administrator creates the new account granting access to the functions necessary for the role of the user.

1.3.1 Updating User Profile Information

To update user profile information:

1. Browse to the CHCS II User Account Registration page at enterprise.chcsii.com.
2. In the Enterprise User Name field, enter the username.
3. In the Enterprise Password field, enter the associated password.

4. Click **Proceed**.
5. In the view/update section, select your MTF
6. Click **View/Update**.
7. Enter new update information including e-mail, duty phone, home phone, and pager.
8. Click **Submit Change**. A confirmation message appears advising of successful update at the MTF specified.

1.4 Logging In to CHCS II

To login to CHCS II:

1. Double-click the **CHCS II** icon located on the Windows Desktop (see Figure 1-3: CHCS II Icon). The SnareWorks security warning window opens.

Figure 1-3: CHCS II Icon

2. Review the information in the window and click **OK** to accept the security message. The Login window opens (see Figure 1-4: CHCS II Login Window).

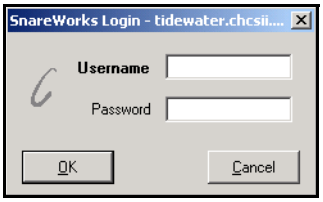

Figure 1-4: CHCS II Login Window

3. In the Username field, enter the assigned Username.
4. In the Password field, enter the assigned password.
5. Click **OK**. Upon successful login, the Military Clinical Desktop displays, configured as it was upon the last exit.

Note: The system administrator determines each user's level of access and job skill set.

1.5 Changing a Password

CHCS II passwords must be changed in SnareWorks. SnareWorks is the system that controls the user identifications and passwords. When a password is nearing invalidation, the system displays an informational message window stating that the password

needs to be changed. Click **Yes** to change the password and view the SnareWorks Authentication Services Window.

Note: A Change Password option is available under the File menu. If this option is selected, an informational window appears, directing the use of SnareWorks.

To change a password:

1. In the CHCS II desktop Status bar, click **SnareWorks**.

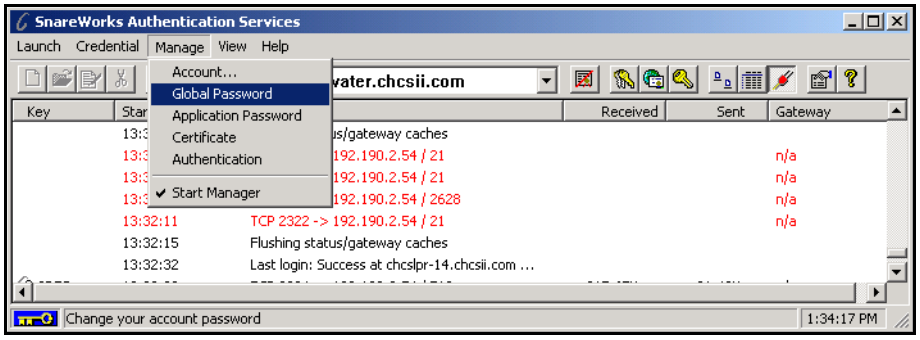

Figure 1-5: SnareWorks Authentication Services Window

2. In the Manage menu, click **Global Password** (see Figure 1-5: SnareWorks Authentication Services Window). The Change Password window opens with the current user's name (see Figure 1-6: Change Password Window).

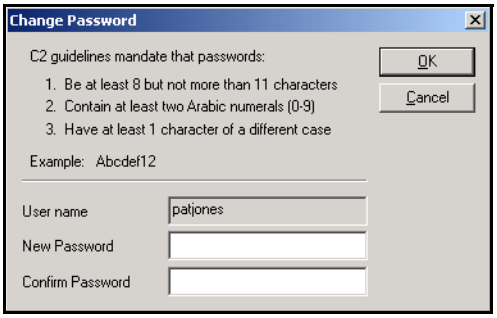

Figure 1-6: Change Password Window

3. Enter the new password.

Note: Passwords must be 8 characters in length and contain at least:

- 2 numbers
- 2 capital letters
- 2 lower case letters

4. In the Confirm Password field, re-enter the password.

5. To save the new password, click **OK**.

Note: When the password is updated in CHCS II, the Verifying Code is also updated in CHCS. Therefore, passwords must be changed only in CHCS II.

1.6 Exiting CHCS II

To exit CHCS II:

- On the File menu, click **Exit**.

OR

- In the upper right hand corner, click the '**X**' like any Windows application.

1.7 Protecting Sensitive Material

Do not provide data to persons contacting you by phone. Keep patient reports and confidential materials in a secure location. Report suspicious or malicious activity to your supervisor.

1.8 Protecting Your Assigned Username and Password

Change your password every 90 days. Create a password that avoids obvious words and combinations such as your spouse's name, birthday, or telephone number. Do not use job titles. Use a maximum of eight characters, mixing letters and numbers. Never disclose your password to others. Memorize your password, do not write it down.

1.9 Protecting Your Workstation

Never leave your workstation unattended. Do not use password-protected screensavers—you must log off. Position your workstation monitor so that it cannot be observed by passers-by. Never use a disk of unknown origin. Do not load unauthorized software onto the workstation. Make no changes to any workstation settings unless directed to do so by your supervisor.

1.10 Break the Glass Privileges

CHCS II provides authorized individuals with "Break the Glass" privileges to access sensitive patient information.

There are three types of users involving the "Break the Glass" privilege:

- Users that do not have the privilege at all.
- Users that do have the privilege.

- Users that already have the authority to see sensitive data and do not need the privilege.

If you have “Break the Glass” privileges, you receive a warning when trying to access sensitive data.

To accept the warning message and view the sensitive results, click **Yes**. CHCS II logs and audits this access.

If you do not want to accept the warning message, click **No**. You cannot view the sensitive information.

2.0 CHCS II NAVIGATION

2.1 Navigation Basics

The appearance and navigation functions within CHCS II are very similar to the appearance and navigation systems employed in other Windows operations (see Figure 2-1: Military Clinical Desktop). Many of the common icons for Windows are also used by CHCS II. For example, the icons in the top right hand corner of the screen are Minimize, Maximize, and Close. The Plus (+) and Minus (-) signs are called expand and collapse icons and are used to show that there are more folders above or below the folder that is currently being used. Also note that when a topic is selected, the icon text on the folder list becomes highlighted.

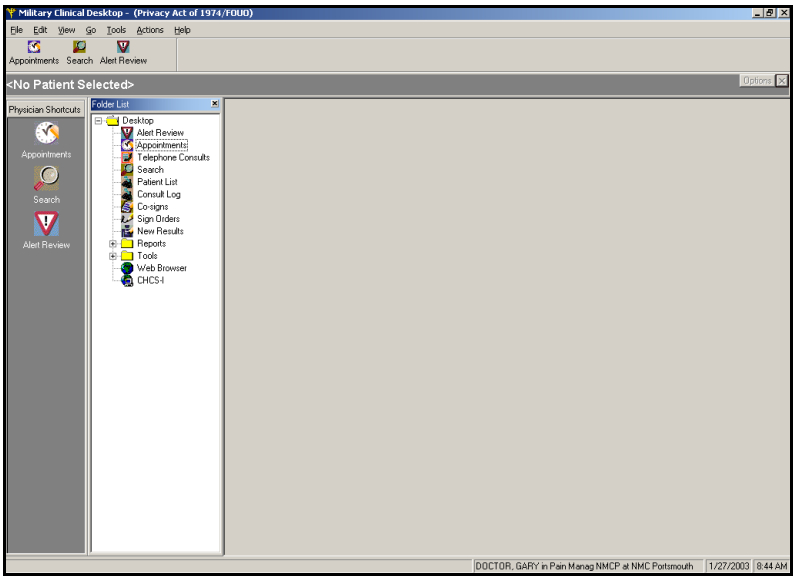

Figure 2-1: Military Clinical Desktop

As in all Windows applications, it is necessary to click on an icon or button using the cursor in order to select the icon or function. This is true in all cases except when using the Alt- functions on the Main menu. To use the Alt- functions, press and hold the **Alt** key and depress the underlined letter for the desired menu. Once the menu is open, press the letter of the underlined action. There is no need to press the **Alt** key a second time. If there exists more than one action per letter, the system stops on the first action. Continue to press the letter until the desired action is highlighted, then press enter.

Tip:
Once inside the encounter, modules associated with the encounter are typically accessed from the Patient Encounter window, not using these paths.

2.2 Accessing a Module

There are generally four ways to access individual modules.

1. In the **Folder List**, click the icon associated with the module you want to open.

2. On the **Shortcuts** bar, click the icon associated with the module you want to open.
3. On the **Action** bar, click the icon associated with the module you want to open.
4. Access the Go pull-down menu from the Main menu bar and select the desired module. All other modules can be found under the Tools pull-down menu.

Note: Icons on the Shortcuts and the Tool bar are only present if the desktop has been customized to include them.

2.3 Closing a Module

There are three ways to close a module. It is best to close each module before opening a new one. The modules are opened one on top of the other and use unnecessary memory.

To close a module:

1. Use the Actions pull-down menu and click **Close**.
2. On the Action bar, click **Close**.
3. In the upper, right corner of the workspace, click **X**.

2.4 Desktop Navigation

2.4.1 The Desktop

The Desktop includes the menu bar, the Tool bar, the Action bar, the Shortcuts, the Folder List and the Status bar. The desktop can be customized according to different needs by using the View pull-down menu.

2.4.2 Tool Bar

The Tool bar is located just under the Main menu bar and contains the modules that are on the desktop (see Figure 2-2: Tool Bar). The Tool bar can be customized to show words, icons, both, or nothing at all. Do this by accessing the View pull-down menu.

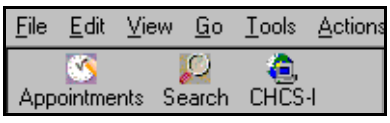

Figure 2-2: Tool Bar

2.4.3 Status Bar

The Status bar is located at the bottom of the desktop and shows details about the screen currently displayed (see Figure 2-3: Status Bar). The Status bar can be hidden using the View pull-down menu.

Figure 2-3: Status Bar

2.4.4 Action Bar

The Action bar is an extension of the Tool bar (see Figure 2-4: Action Bar). It contains functionality that pertains to individual modules. As modules are opened and closed, the items on the Action bar change.

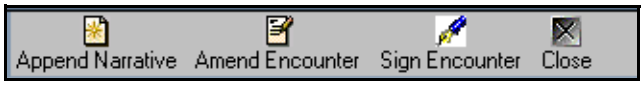

Figure 2-4: Action Bar

2.4.5 Folder List

The Folder List displays icons pertaining to the modules that are on the desktop in a hierarchical manner (see Figure 2-5: Folder List). It allows all of the folders within the system to be seen. The Folder List can be hidden using the View pull-down menu.

Figure 2-5: Folder List

2.4.6 Shortcuts

The Shortcuts menu contains the modules that can be accessed from the desktop (see Figure 2-6: Shortcuts). Clicking on a particular icon or label brings up the associated module. The Shortcuts can be customized to show words, picture icons, both, or neither by accessing the View pull-down menu.

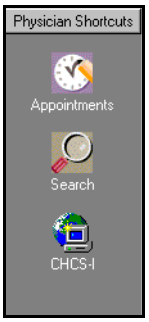

Figure 2-6: Shortcuts

2.5 Tool Bar

2.5.1 Customizing the Icons

To customize the icons:

1. Access the View>> Tool bar>> Customize option to view the Customize Tool bar window.
2. Select an icon from the Available Tool bar Buttons column and drag it to the Selected Tool bar Buttons column or click **Add**.
3. To remove an icon, select an icon from the Selected Tool bar Buttons column and drag it to the Available Tool bar Buttons column or click **Remove**.
4. Click **OK** when finished.

Note: The Tool bar displays a limited number of icons. When capacity has been exceeded, » denotes that more options exist. To view additional options in a drop-down list format, click ».

2.5.2 Customizing the Desktop View

To customize the desktop view:

1. Access the View Pull-down menu and click on the desired view. A checkmark denotes the selections that are shown.
2. Re-click to hide the options. No checkmark denotes those options that are not shown.

2.6 Main Menu Bar

2.6.1 File Pull-down Menu

Print	Prints either DD2766 (Adult Preventive and Chronic Care Flowsheet) or SF600 (Chronological Record of Medical Care).
Print Preview	Displays either DD2766 or SF600, as it would appear if it were to be printed.
Printer Setup	Enables user to set up default printer.
Change Location	Enables user to change the location of the workstation to another location within the same MTF.
Exit	Exits the system.

2.6.2 Edit Pull-down Menu

Cut	Removes selected text from present document and places it on the clipboard.
Copy	Copies selected text and places it on the clipboard.
Paste	Places the text or graphic from the clipboard into selected location.
Spell Check	Checks current document for incorrect spelling and offers correct suggestions.

2.6.3 View Pull-down Menu

To hide the Status bar, Shortcuts, or Folders, click on the title. A checkmark denotes the selections that have been made.

Refresh Data	Updates the current screen with the latest information.
Status Bar	Allows the Status bar to be seen or hidden.
Shortcuts	Allows the Shortcuts list to be seen or hidden.
Folders	Allows the Folders to be seen or hidden.
Tool Bar Menu	Displays options for viewing the Tool bar and Shortcuts.
Action Bar Menu	Displays options for viewing the icons on the Action bar that are associated with each module.

2.6.4 View>Tool Bar Pull-down Menu

When Tool bar is selected from the View Pull-down menu, additional options are available to customize the items on the Tool bar and Shortcuts.

Icons	Displays only icons in the Tool bar and Shortcuts.
Text	Displays only text in the Tool bar and Shortcuts.
Both	Displays both text and icons in the Tool bar and Shortcuts.
None	Hides the Tool bar.
Customize	Allows the customization of the Tool bar and Shortcuts through the selection of available icons.

Note: The Desktop Tool bar and Shortcuts can be viewed with different options. To view a specific option, click on the desired view (Icons, Text, Both, or None). A checkmark denotes the selection that has been made. Different icons can be added or deleted from the Tool bar and Shortcuts by clicking on the Customize Button.

2.6.5 View>Action Bar Pull-down Menu

If the Action bar option is selected within the View option on the menu bar, four more options are presented. These options allow the customization of the Action bar icons associated with each module. These icons match the items in the Action Pull-down menu for each module. Use the mouse or the Alt-function to access the actions.

Icons	Displays only icons in the Action bar.
Text	Displays only text in the Action bar.
Both	Displays both text and icons in the Action bar.
None	Hides the Action bar.

2.6.6 Go Pull-down Menu

The Go menu contains the majority of the modules within CHCS II. Patient specific modules are disabled until a patient's record has been loaded to the desktop.

Patient	Displays a sub-menu containing additional options.
Alert Review	Displays patient and caregiver alert messages.
Consult Log	Allows ordered and received consults to be tracked.

Immunization Admin	Opens the Immunization Admin module providing options related to the administration of an immunizations program
List Management	Allows providers to pre-select their most common diagnosis, procedures, chief complaints, and E&M Codes.
Reports	Allows customized, preventive, standard, and population health reports to be run.
Sign Orders	Enables providers to sign orders entered by users without order signing authority, on behalf of the provider.
A/P	Allows the diagnosis, procedures, order sets, and order entry for labs, radiology, and medications to be completed.
Allergy	Allows allergies to be displayed, edited, and printed.
Clinical Notes	Displays clinical notes for viewing, editing, and printing; these notes are not associated with a specific encounter.
PKC Couplers	Allows the HEAR Questionnaire to be run along with a multitude of other questionnaires.
Demographics	Displays pertinent patient demographic information of which some data can be edited.
Diagnosis	Allows the diagnosis to be documented.
Disposition	Allows the disposition of selected patient.
Encounter Order Sets	Allows sets of laboratory, radiology, and medication items to be ordered based on the diagnosis.
Encounter	Allows the viewing of the current encounter documentation.
Flowsheets	Allows vital signs, lab results, and medications to be viewed in chart form.
Health History	Displays a condensed version of data contained in pre-selected modules and provides direct access to those modules.
Immunizations	Enables the vaccination record to be reviewed and immunizations to be documented.
Lab	Enables laboratory test result data to be reviewed.

Meds	Lists medications, current and past, for the patient and enables over the counter (OTC) and outside medications to be entered for the patient.
Order Entry Consults	Allows consults to the ordered.
Order Entry lab	Allows lab tests to be ordered.
Order Entry Med	Allows medications to be ordered.
Order Entry Rad	Allows radiology tests to be ordered.
Other Therapies	Allows instructions to be printed for patients.
Patient Questionnaires	Allows completed patient questionnaires to be reviewed
Previous Encounter	Allows previously completed encounters to be reviewed.
Problems	Allows patient problems to be displayed, entered, and printed.
Procedure	Allows the procedure to be documented.
Radiology	Allows radiology results to be viewed and printed.
Readiness	Allows care providers access to readiness information.
S/O	Allows the documentation of the history of present illness, physical exam, and review of systems.
Screening	Allows the reason for visit to be documented.
Vital Signs Entry	Allows patient's vital signs to be entered.
Vital Signs Review	Allows patient's vital signs to be displayed, edited, printed, or graphed.
Wellness	Provides the ability to track wellness care history and identify and manage wellness care needs such as immunizations, routine check-ups and procedures, etc.

2.6.7 Go>Patient Pull-down Menu

When Patient is selected from the Go Pull-down menu, additional options are available. Patient specific modules are italicized. A patient must be selected to access these modules.

Appointments	Displays the appointment list.

Co-Signs Required	Displays the list of encounters needing co-signatures.
New Results	Displays the list of new, returned results for the provider.
Patient List	Displays a list of patients set up by individual providers.
Telephone Consults	Allows telephone consults to be documented.
Search	Conducts a search for a specific patient.
Clear Patient	Clears the current record in order to view another.
Numbered Patients	Selected numbers bring up specific patient records.

2.6.8 Tools Pull-down Menu

Properties	Lists the properties of the current module.
Update Check-Out Data	Displays the information available to patients upon check-out and allows for updates.
Startup Options	Allows the customization of the first window to be viewed upon login.
CHCS Access	Access Opens a KEA session.
Questionnaire Setup	Enables the user to create and manage patient questionnaires.
Rx Alternatives	Allows the viewing and management of medications.
Screening Notification	Enables the user to notify patients about scheduled screening services.
Template Management	Allows the creation and selection of encounter template.
Web Browser	Opens the Web Browser module that is a direct link to the Internet.

2.6.8.1 Updating Check out Information

To update check out information:

1. Select **Update Check-out Data** from the Tools Pull-down menu Check-out Form window
2. Edit any of the selections and click **Save** to retain the information.

2.6.8.2 Startup Options

To customize your startup options:

1. Select **Startup Options** to view the Startup Options window.
2. Select **None**, **Patient Search**, or **Module**.
3. If Module is selected, access the drop-down list to select the desired module. Appointments, Co-Signs, New Results, Patient List, Telephone Consults, Alert Review, Consult Log, List Management, Reports, Template Management, and Web Browser.
4. To save the selection, click **OK**.

Note: Patient specific modules cannot be selected as an option.

2.6.9 Actions Pull-down Menu

The Actions Pull-down menu is dependent upon the selected module. The menus contain actions that can be taken from each of the individual modules. Actions that are grayed out are not active and cannot be done. For example, Save and Cancel from the Demographics Actions menu are not active until Edit is selected.

2.6.10 Help Pull-down Menu

Help Topics	Lists the topics in the Help Directory.
About {Module Name}	Displays application information concerning the current open module.
About Clinical Workstation	Displays information about CHCS II.

2.7 Patient ID Bar

The patient ID Bar is located under the Main menu and includes Patient Demographic information and icons denoting Special Work Status, Command Interest, Command Security, and the presence of allergies.

The Patient ID Line is displayed when a patient has been selected.

- Work Status can be documented in the Screening, Demographics, or Disposition modules. The Work Status icons are only documented in CHCS II and do not interface with other systems.
- The Allergy icons are based on the entries from the Allergy module. Either No Known Allergies or the Allergy icon is present. If the allergies have not been addressed, as with a brand new patient, and unique icon appears.

- Command Interest and Command Security information is pulled from CHCS and is displayed on the Demographics window.

2.7.1 Patient ID Bar Icons

Diving Status	**Flying Status**
Jumping Status	**Mobility Status**
Military Police Status	**Personal Reliability Program Status**
Presidential Support Program	**Submarine Status**
Patient Has Allergies	**Allergies Have Not Been Addressed**
No Known Allergies	**Command Interest Status**
Security Command Interest Status	**New Results**
Priority Results and Co-Signs	**Orders to Sign Icon Group**

The Patient ID Line Icons displays on the line, if applicable to the patient.

2.8 CHCS Access

Some functions cannot be completed within CHCS II and need to be done in CHCS. Scheduling future appointments is a good example. CHCS II does contain the functionality to connect directly to CHCS through a telnet session. This window is independent of CHCS II.

To access CHCS:

1. In the Tools menu and select **CHCS Access**.
2. A KEA session opens, allowing tasks to be completed. CHCS II automatically logs the user onto CHCS using the user's access and verify codes.
3. Close the KEA session by clicking **X** in the top, right corner. When the confirmation window appears, click **Yes** to return to CHCS II.

3.0 WORK FLOWS

3.1 Basic Front Desk Clerk Work Flow

CHCS II Front Desk Clerk tasks typically include managing the appointments and demographic information. Other tasks can be included depending on the clinic and role of each individual clerk.

The basic front desk workflow may be:

1. Access the Appointments module.
2. Check-in a scheduled appointment OR
3. Create a new walk-in appointment using the Search module. The clerk is automatically shown the Demographics module.
4. Review the demographic information and make any modifications.
5. Close the Demographics module and return to the Appointments module to await the next patient.

Other modules the Front Desk Clerk can use include:

- Telephone Consults
- PKC Couplers (HEAR)
- Web Browser

3.2 Basic Support Staff Work Flow

CHCS II support staff tasks typically include entering the reason for visit in the Screening module and documenting the vital signs. Other tasks can be included depending on the clinic and role of each individual.

The basic support staff workflow may be:

1. Access the Appointments module.
2. Double-click the appointment from the list.
3. From the Patient Encounter module, click **Screening** and enter the reason for visit.
4. On the Action bar, click **Vital Signs**. Enter the Vital Signs.
5. Close the Vital Signs module and the Patient Encounter module.
6. Return to the Appointments module to wait for the next patient.

Other modules the support staff can use include:

- Wellness
- Web Browser

- Allergy
- Clinical Notes
- Health History
- Reports
- Immunizations
- Medications
- Readiness

3.3 Basic Provider Work Flow

CHCS II Provider tasks typically include selecting an encounter template, documenting the subjective and objective portion, the assessment and plan, and ordering appropriate medications and laboratory and radiology tests. Other tasks can be included depending on the clinic and role of each individual provider.

The basic provider workflow may be:

1. Access the Appointments module.
2. Double-click the desired appointment.
3. From the Patient Encounter module, click **Templates**.
4. Select a template to load into the encounter.
5. Click **S/O**.
6. Document the exam using the various tabs from the S/O module.
7. Click **A/P**. Document the diagnosis and procedures.
8. Order radiology and/or laboratory tests, medications, or consults. Associate any procedures and/or orders with a diagnosis.
9. Click **Disposition**.
10. Complete the disposition.
11. Click **Sign**.
12. Enter the password and click **Sign**.

Other modules the Provider can use include:

- Alert Review
- Co-Signs Required
- Medications
- List Management
- Laboratory
- Patient List
- Radiology

- Flowsheets
- Problems
- Web Browser
- Consult Log
- Reports
- Previous Encounters
- Clinical Notes
- New Results
- Order Sets
- Sign Orders

4.0 ALLERGY

4.1 Overview of Allergy

The Allergy module keeps track of a patient's reactions to specific allergens (see Figure 4-1: Military Clinical Desktop - Allergy Module). The Allergy module allows information to be stored using coded data from the healthcare Data Dictionary (HDD). A common list of allergens can also be specified to make entering data more convenient.

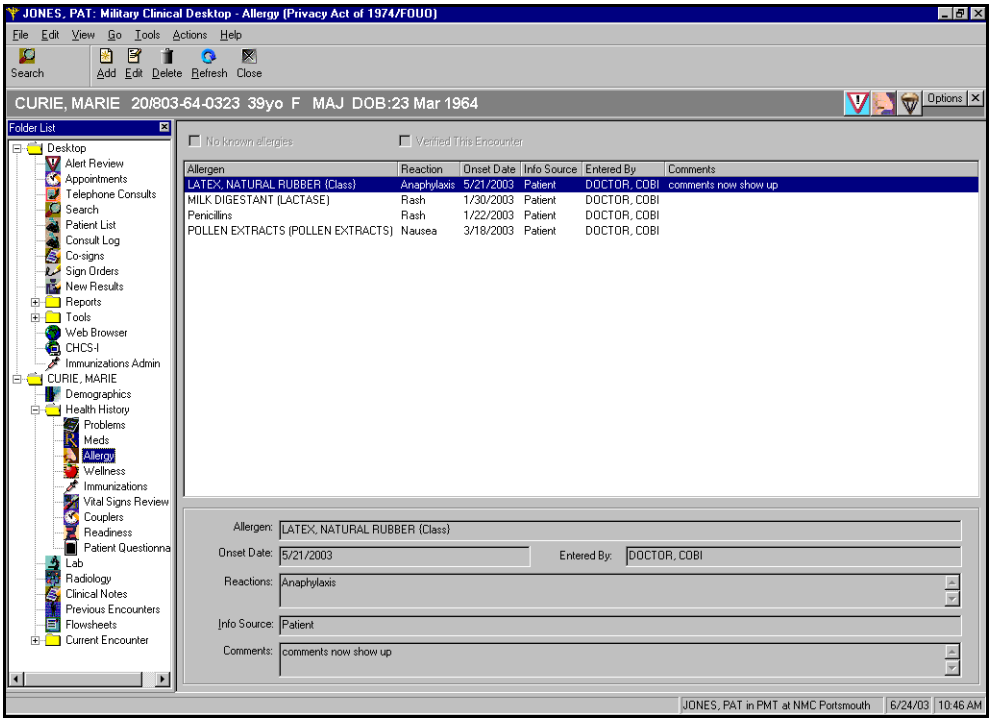

Figure 4-1: Military Clinical Desktop - Allergy Module

Note: When navigating in the Allergy module, it can take a few seconds for CHCS II to obtain allergy data from CHCS. A message displays, asking if you want to continue. If you click **Yes**, CHCS II obtains all allergy data from both CHCS II and CHCS. If you click **No**, CHCS II displays only the allergy data currently held in the Clinical Data Repository (CDR).

4.2 Action Bar Icons

	Add	Allows a new allergy to be added.
	Edit	Allows the highlighted allergy to be updated.
	Delete	Allows the highlighted allergy to be deleted.
	Refresh	Refreshes the list of allergies.
	Close	Closes the Allergy module.

4.3 Setting the Properties of the Allergy Module

The Properties window associated with Allergies allows for the creation of a list of allergens most often used. This list populates the drop-down list in the Allergen field on the New Allergy window. This eliminates the need to conduct a lengthy search. A default list is pre-populated when CHCS II is deployed; however, Clinical Team Members can create their own list.

To create a Common List:

1. Click **Options** on the Allergy window. The Properties window opens (see Figure 4-2: Allergy Module Properties Window).

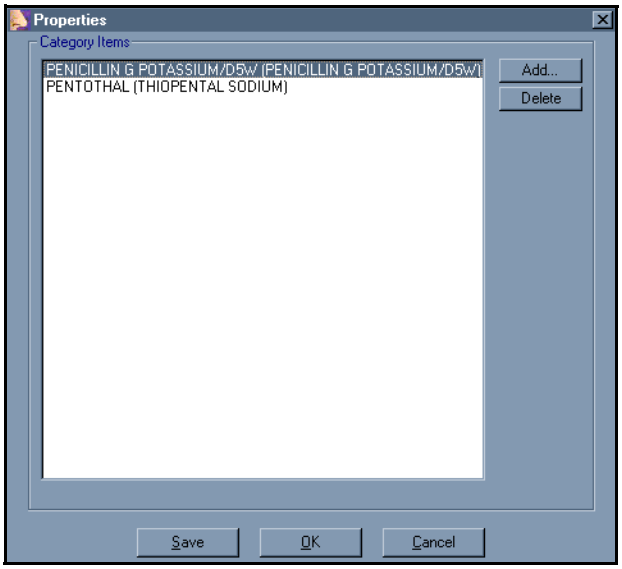

Figure 4-2: Allergy Module Properties Window

2. Click **Add**. The Add to Common List Items window opens (see Figure 4-3: Add to Common List Items Window).

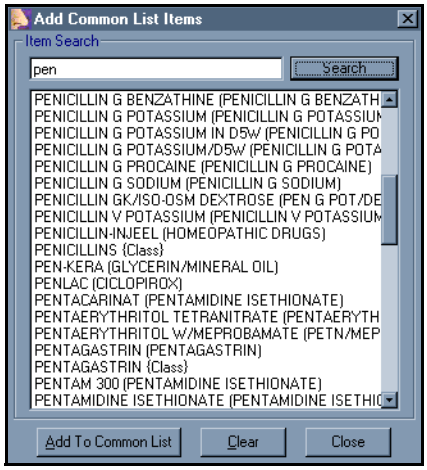

Figure 4-3: Add to Common List Items Window

3. Enter at least the first two letters of the allergen to be added.
4. Click **Search**. The search results are listed.
5. Select the desired item(s).
6. Click **Add to Common List**. Continue to add allergies to the list until all allergens you want have been selected.
7. Click **Close**. The Properties window displays the selected allergens.
8. Click **Save**.

Note: This list is combined with the pre-populated default list. To delete an allergen from the list, select the allergen and click **Delete**.

4.4 Adding an Allergy

If the patient has no allergies listed and the response to the question about whether they have an allergy is "no," the No Known Allergy option can be selected on the Allergy window. The checkbox for No Known Allergies at the top of the Allergy window is checked. Once an allergy is added, the check mark is removed. The "Verified Today" should be checked after asking the patient whether they have any allergies. This should be asked during each encounter.

To add a new allergy:

1. Click **Add** on the Action bar. The New Allergy window opens (see Figure 4-4: New Allergy Pane).

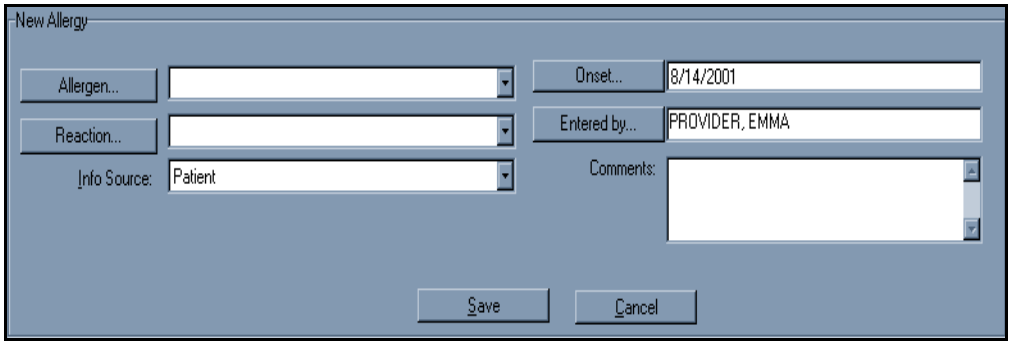

Figure 4-4: New Allergy Pane

2. Enter the appropriate information in the following fields:
   - **Allergen:** Select the desired allergen from the drop-down list. To search for an allergen that is not in the popular allergens list, click **Allergen**. The Health-care Data Dictionary window opens, allowing you to search and add allergens.
   - **Reaction:** Select the desired reaction from the drop-down list. To search for a reaction that is not on the popular reactions list, click **Reaction**. The Health-care Data Dictionary window opens, allowing you to search and add reactions.
   - **Info Source:** The Info Source is set by default to Patient and can be changed by selecting a different source from the drop-down list.
   - **Onset:** To change the onset date (defaults to current date), type a date in the date field (mm/dd/yyyy) or click **Onset** to use the Calendar.
   - **Entered By:** To change the associated clinician (defaults to clinician currently logged in), click **Clinician** to open the Clinician Search window allowing a clinician to be selected.
   - **Comment:** In the Comment area, type any needed notes.
3. Click **Save**. The new allergy is added to the patient's list of allergies.

4.5 Editing an Allergy

To edit an allergy:

1. Select the allergy to be modified.
2. Click **Edit** on the Action bar. The Edit Allergy window opens (see Figure 4-5: Edit Allergy Pane).

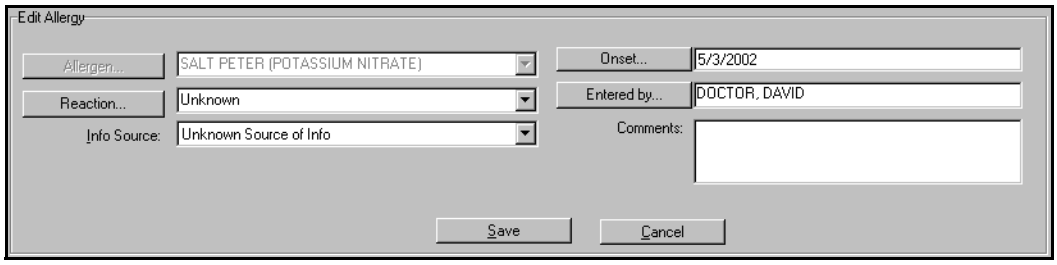

Figure 4-5: Edit Allergy Pane

3. Update the appropriate information in the following fields:
   - Reaction
   - Info Source
   - Onset
   - Comments

Note: The Allergen field is not editable.

4. Click **Save**.

4.6 Deleting an Allergy

To delete an allergy:

1. Select the allergy on the Allergy window.
2. Click **Delete** on the Action bar.
3. At the Confirm Deletion prompt, click **Yes**.

4.7 Verifying Allergies

To verify a patient's allergies:

1. In the Screening module, click **Verify Allergy** on the Action bar. You are transferred to the Allergies module.
2. Verify the patient's allergies in the Allergy window.

Note: You must have a patient encounter open to verify a patient's allergies during screening.

Note: You can only verify allergies through the Screening module.

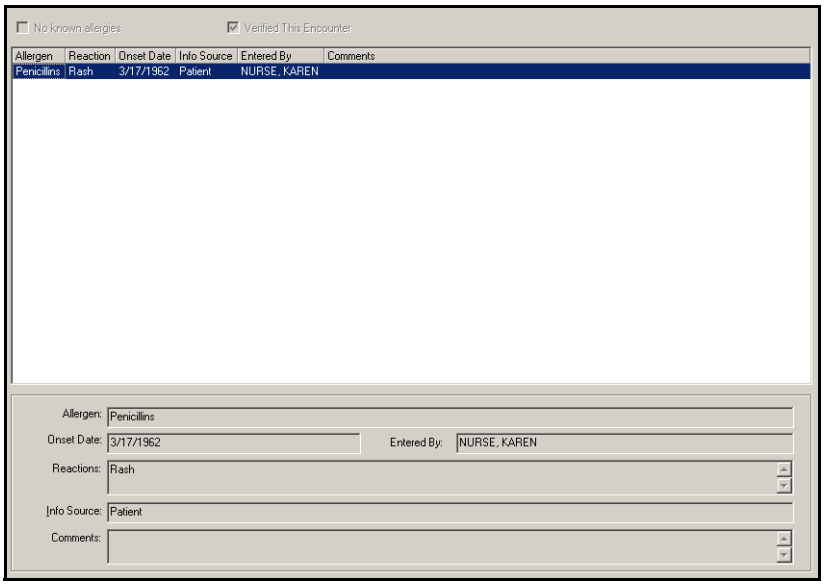

Figure 4-6: Verifying Allergies

5.0 ALERT REVIEW

5.1 Overview of Alert Review

The Alert Review module (see Figure 5-1: Military Clinical Desktop - Alert Review Module) displays items that need immediate attention. Unresolved alerts are in bold text and resolved alerts are in regular text. The gray and yellow colored alert icon in the patient ID bar signifies that an encounter needs to be cosigned, critical results, and priority results. The blue and white colored alert icon signifies modified encounters, new results, and orders to be signed.

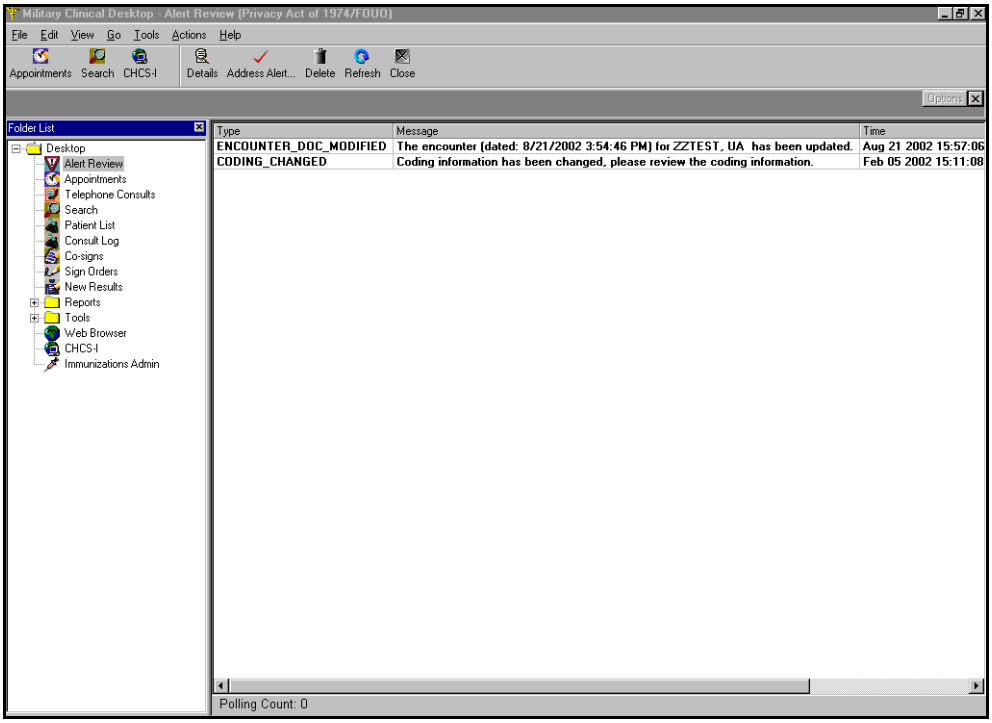

Figure 5-1: Military Clinical Desktop - Alert Review Module

5.2 Action Bar Icons

	**Details**	Displays the details of the selected alert.
	**Address Alert**	Allows the selected alert to be resolved.
	**Delete**	Allows the selected alert to be cleared.
	**Refresh**	Refreshes the window with updated information.
	**Close**	Closes the Alert module.

5.3 Addressing an Alert

Alerts that have not been addressed are indicated in bold text and alerts that have been resolved are indicated in non-bold text on the alerts list. An alert must be resolved within the module in which it resides. When you select an alert to address, you are navigated directly to the relevant module within CHCSII so the issue can be resolved.

To address an alert:

1. Select the bolded alert.
2. Click **Address Alert** on the Action bar. The module containing the alert opens.

Note: The Address Alert action can only be taken once. To view the source of the alert a second time, you must navigate to the associated module.

3. Address the alert by completing the tasks associated with the alert.
4. Click **Close**. The alert can now be deleted from the list.

5.4 Addressing New and Priority Result Alerts

New Result and Priority Result Alerts display as a result of actions performed in CHCS (such as lab tests). Priority Result Alerts are New Result Alerts that contain abnormal findings. Addressing these alerts navigates you to the New Results module of CHCSII.

To address new and priority result alerts:

1. Select the alert.
2. Click **Address Alert** on the Action bar. The New Results module opens.

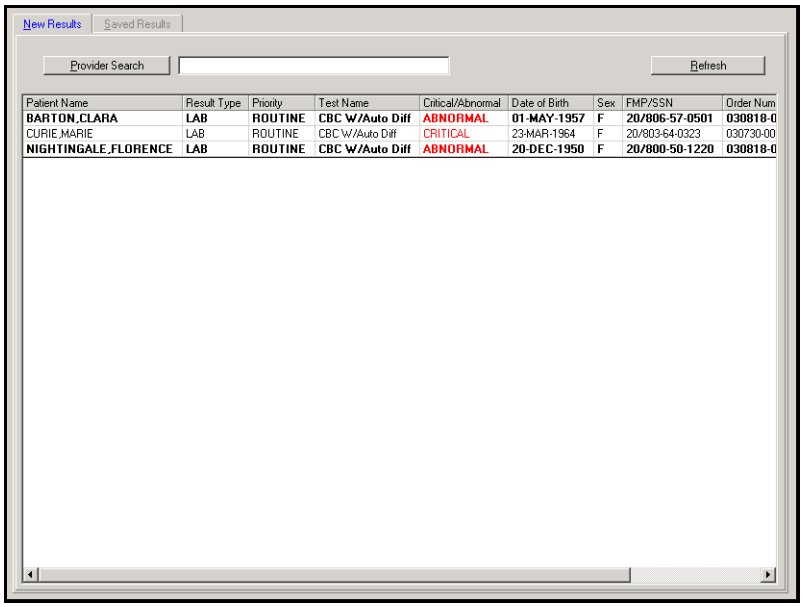

Figure 5-2: New Results Module

3. Select the **result** you want to review and click **View Result** on the Action bar.
4. Review the result information in the Lab module.
5. Close the module when complete.

5.5 Deleting an Alert

Only alerts assigned to a surrogate need to be deleted. Alerts completed by the primary provider are automatically deleted upon resolution. The alert must be resolved prior to deletion.

To delete an alert:

1. Select the alert.
2. Click **Delete** on the Action bar.

5.6 Viewing Details of an Alert

To view details of an alert:

1. Select the desired alert.
2. Click **Detail** on the Action bar. The Alert Details window opens (see Figure 5-3: Alert Details Window).

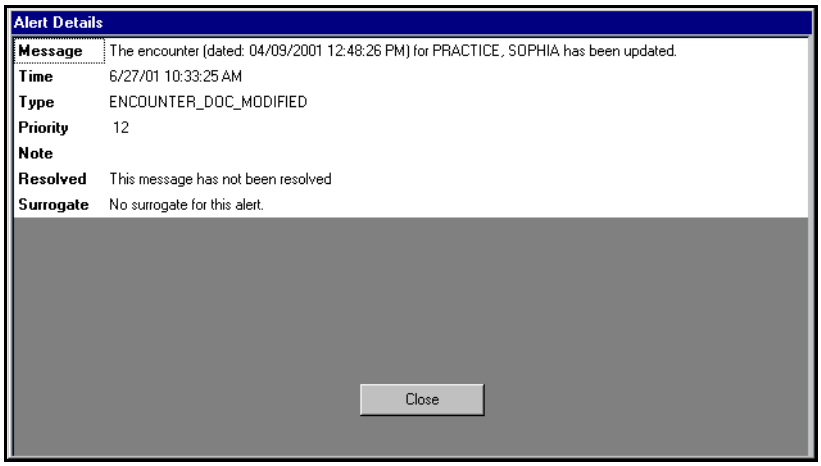

Figure 5-3: Alert Details Window

3. View detailed information on the selected alert.
4. Click **Close**.

6.0 APPOINTMENTS

6.1 Overview of Appointments

The Appointments module enables appointments that have been created in both CHCS and CHCS II to be viewed according to clinics, providers, dates, or statuses (see Figure 6-1: Military Clinical Desktop - Appointments Module).

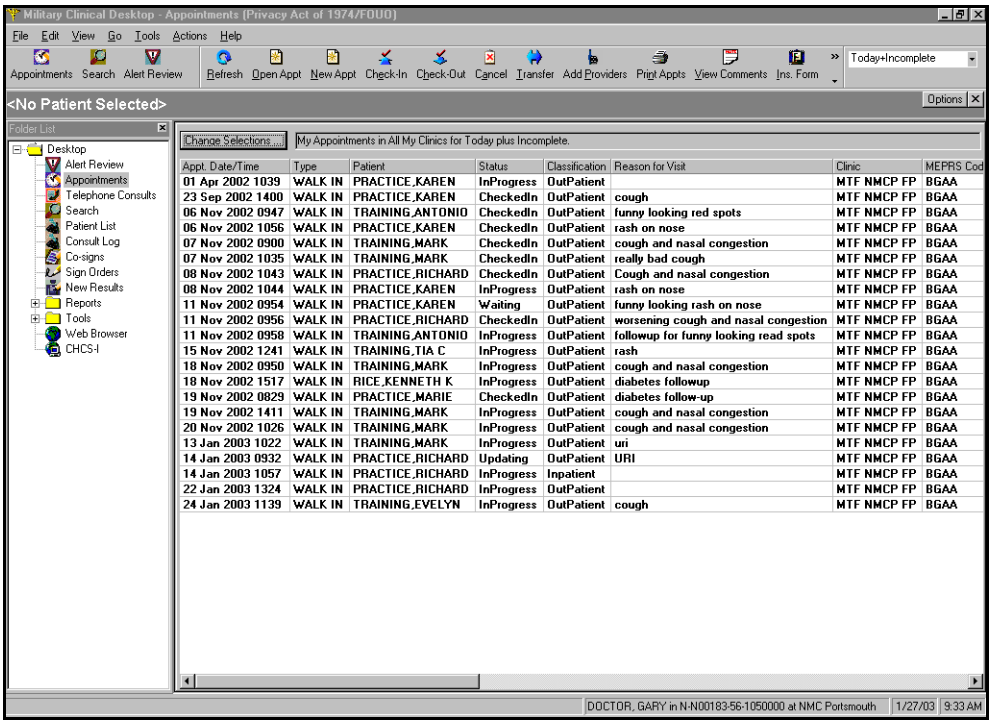

Figure 6-1: Military Clinical Desktop - Appointments Module

Appointments can be selected to check in, transfer, cancel, and check-out. Only an Unscheduled Visit (USV) type can be created in CHCS II. The USV type is defaulted to Walk-in, but can be changed to either Sick Call or Telephone Consult. Scheduled appointments must be created in CHCS. CHCS II pulls scheduled appointments from CHCS on a nightly basis.

6.2 Action Bar Icons

	**Refresh**	Refreshes the window with updated information.
	**Open Appt**	Opens the encounter.
	**New Appt**	Allows a new appointment to be created.
	**Check-In**	Allows a patient to be checked-in.
	**Check-Out**	Allows a patient to be checked-out.
	**Cancel**	Allows an appointment to be cancelled.
	**Transfer**	Allows appointments to be transferred.
	**Add Providers**	Allows an additional provider to be added to the encounter.
	**Print Appts**	Allows the appointment list to be printed.
	**View Comments**	Allows notes associated with the appointment to be viewed.
	**Ins. Form**	Allows the insurance information to be printed allowing the patient to review the information and make any changes. The front desk clerk can then go back and update the information in CHCS II.
	**Undo Cancel**	Allows a canceled appointment to be undone.
	**Close**	Closes the Appointments module.

6.3 Setting the Properties of the Appointments Module

In the Appointment Search Selections window, information regarding the list of appointments is displayed. The window displays information by clinic, provider, date, and/or appointment status.

To set the properties of the Appointments module:

1. On the Appointments window, click **Change Selections**. The Appointment Search Selections window opens (see Figure 6-2: Appointment Search Selections Window).

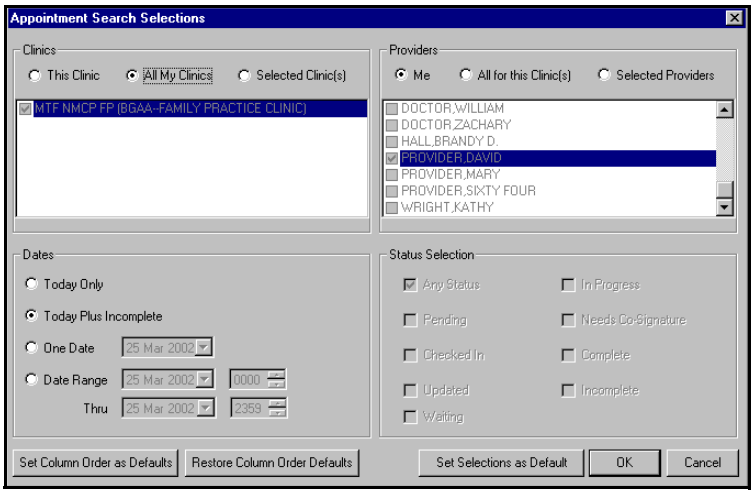

Figure 6-2: Appointment Search Selections Window

2. In the Clinics area, click the radio button for the associated clinic(s) you want to view.

Note: If you select the **Selected Clinics** option, select the applicable clinic(s) from the list.

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3. In the Providers area, click the radio button for the associated provider(s) you want to view.

Note: If you select the **Selected Providers** option, select the applicable provider(s) from the list.

---

4. In the Dates area, click the radio button for the selected appointment search date.

Note: If you select the **Date Range** option, select the applicable date range(s) from the drop-down lists.

---

5. In the Status Selection area, click the radio button for the selected appointment search status. All appointments meeting the above criteria are listed on the Appointments window.
6. Click **Set Selections as Default**. The settings are now your default settings for the Appointment window.

6.4 Filtering the List of Appointments

The Appointments window allows you to filter the list of appointments (see Figure 6-3: Filter Drop-down List).

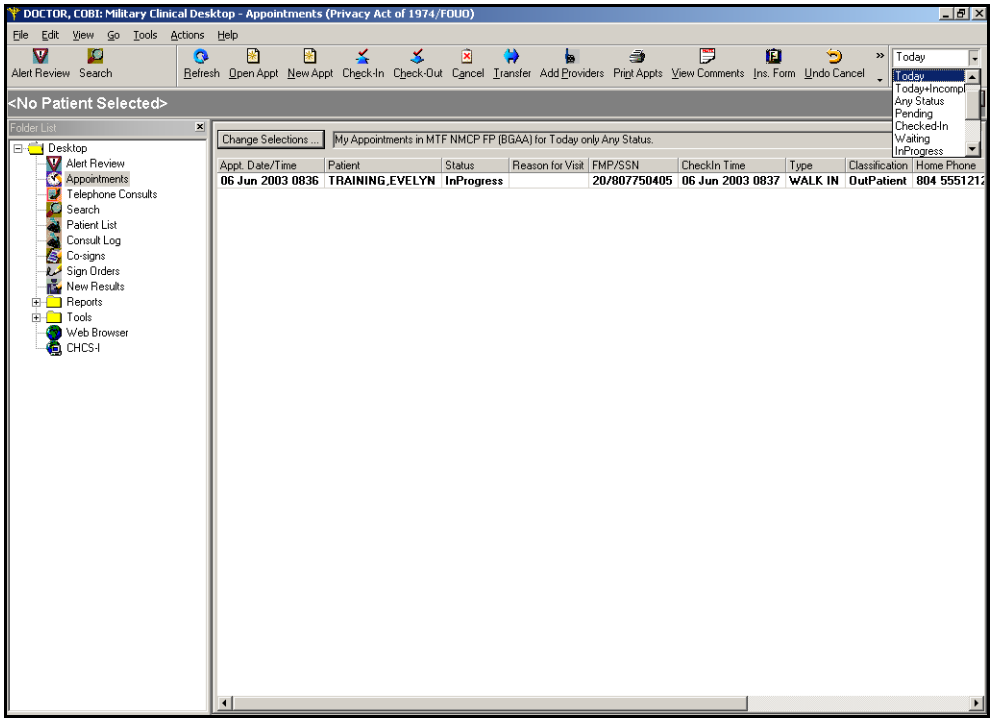

Figure 6-3: Filter Drop-down List

To filter a list of appointments:

- On the Appointments window, select a filter from the drop-down list in the upper-right corner.
  - — **Default:** The Appointments filter default is set by clicking **Change Selections** and selecting the desired choice in the Dates and Status Selection field. To save the selections as default, click **Set Selections as Default** and then click **OK**.
  - — **Today:** Appointments for the present day.
  - — **Today + Incomplete:** Appointments for the present day and all appointments that have a status of incomplete that falls within the selection made in the Dates field on the Appointment Search Selections window.
  - — **Any Status:** All appointments regardless of their status that fall within the selection made in the Dates field on the Appointment Search Selections window.
  - — **Pending:** Appointments that have a status of pending which means they have not been checked in yet and meet the date criteria in the Appointment Search Selection window.

— **Checked-In:** Appointments that have been checked-in that meet the date criteria set in the Appointment Search Selections window.

— **Waiting:** Appointments that have been checked in but the patient is waiting to be seen by the provider and meet the date criteria set in the Appointment Search Selections window.

— **InProgress:** Appointments that have been checked-in and are in progress and meet the date criteria set in the Appointment Search Selections window.

— **Needs Co-Signature:** Appointments that must have a provider's co-signature in order to be give a completed status and meet the date criteria set in the Appointment Search Selections window.

— **Updated:** Whenever an appointment is amended or appended, its status is changed to updated. The updated appointments must meet the date criteria set in the Appointment Search Selections window.

— **Completed:** Appointments that have a completed status and meet the date criteria set in the Appointment Search Selections window.

— **Incomplete:** Appointments that are not complete and meet the date criteria set in the Appointment Search Selections window.

— **Checked-In or Pending:** Appointments with a status of Checked-In or Pending that meet the date criteria set in the Appointments Search Selections window.

6.5 Scheduling a New Appointment

Only new USV type appointments can be created. Pre-scheduled appointments are set up through CHCS. The appointment types available differ between clinics. Telephone Consults can also be scheduled here. Once scheduled, they can only be seen in the Telephone Consults module.

To schedule a new appointment:

1. On the Appointments window, click **New Appt** on the Action bar. The Patient Search window opens (see Figure 6-4: Patient Search Window).

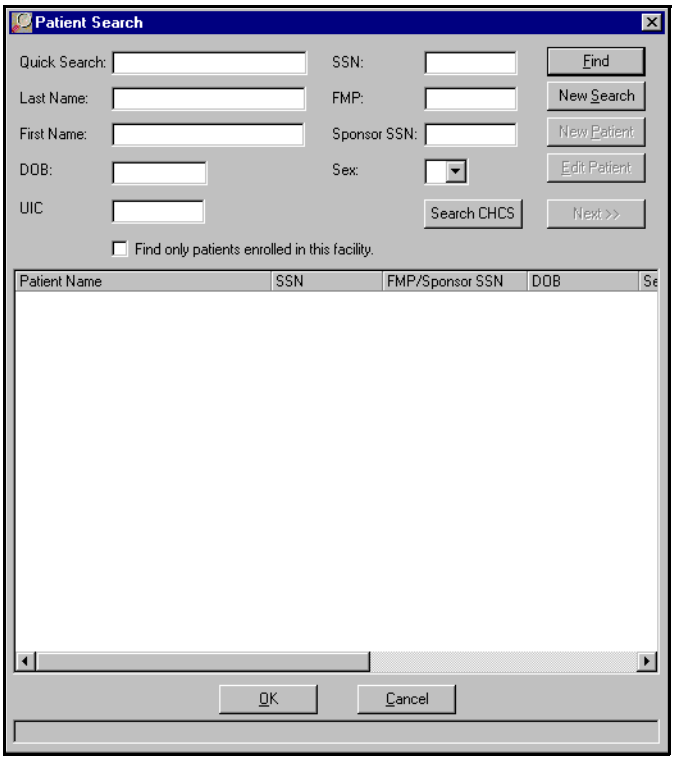

Figure 6-4: Patient Search Window

SEE RELATED TOPICS

- **27.0 PATIENT SEARCH**

2. Search for the patient for which you are scheduling the new appointment.
3. In the New Unscheduled Appointment/Telcon Visit window (see Figure 6-5: New Unscheduled Appointment/Telcon Visit Window), complete the following fields:
   - **Appointment Type:** Select an appointment type from the pick list.
   - **Assigned Clinic:** Select the clinic from the drop-down list.

Note: Clinical Team Members are only able to create appointments for providers assigned to the clinics to which they have access.

   - **Appointment Classification:** Default setting is Outpatient.
   - **APV/Observation**: Select Observation, if appropriate.
   - **Comments:** Enter any additional information, if needed.
   - **Call Back Number:** The patient's call back number used when scheduling a telephone consult.
   - **Date and Time:** Default is the current date and time.
   - **Meets Visit Criteria:** Depending on the Assigned Clinic, Provider, and Appointment Type, select Yes or No. If Count is enabled, it is defaulted but can be changed.

- **Provider:** Use the drop-down list to select the desired provider. The provider must be associated with the selected clinic.
- **Reason for Appointment:** Enter the reason why the patient needs to be seen.
- **Urgency:** This field is enabled when a telephone consult is selected. Low is the default setting. Select the radio button next to High or Medium, or accept the default (Low).
- **USV Type:** Click the radio button next to the appropriate USV type. The default is Walk-in.

4. Click **OK**. The patient is automatically checked in.

Tip:
Double-click on an appointment to begin documentation and open the encounter, if role allows.

Note: If you want to change the patient for which you are creating the new appointment, click **Change Patient**. The Patient Search window opens allowing you to search for the desired patient.

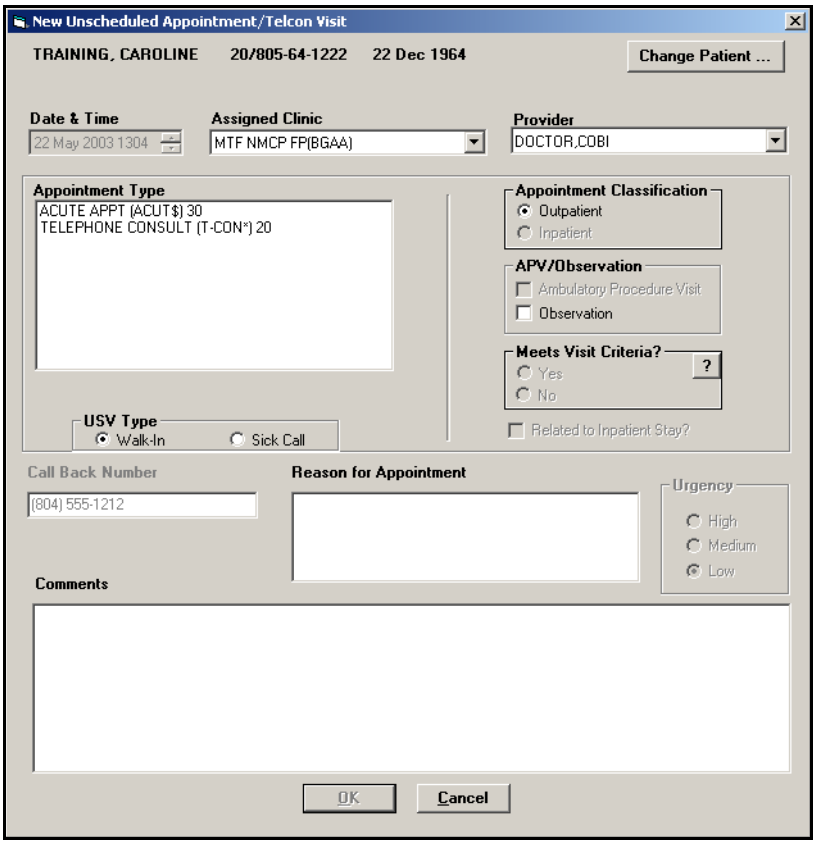

Figure 6-5: New Unscheduled Appointment/Telcon Visit Window

6.6 Checking In a Patient

In the Appointments window, individual patients that were scheduled in CHCS can be checked-in for their appointments. All USV type appointments are automatically checked in upon creating the appointment in CHCS II.

To check in a patient:

1. Select the appointment from the appointments list.
2. On the Action bar, click **Check-In**.

Note: You can only check-in patients which are in Pending status.

To check-in a group of patients, select an appointment from the appointments list and press **Ctrl** on your keyboard while selecting each additional appointment. Click **Check-In** on the Action bar.

Once a patient has been checked-in, an encounter is opened and the patient's name appears in bold on the appointment list.

6.7 Checking Out a Patient

The Appointment Check-Out window enables a patient to be checked out from the selected appointment. This does not change the status of the appointment. On this window, forms can be selected to print for the patient.

To check out a patient:

1. Select an appointment with a status of In Progress, Complete, or Updated from the appointments list.
2. On the Action bar, click **Check-Out**. The Check-Out window opens (see Figure 6-6: Check Out Window).

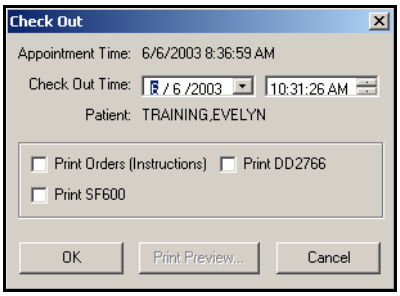

Figure 6-6: Check Out Window

3. Click the checkbox next to the associated print format.

Tip:
You can select more than one form. To view the forms before printing, click ***Print Preview****.*

Note: The **Print Preview** button becomes active once an associated print format is selected.

4. Click **OK**. The forms are sent to your designated printer.

6.8 Adding an Additional Provider Through Appointments

An additional provider can be added to an encounter to receive credit for work performed on a patient.

To add an additional provider through appointments:

1. On the Action bar, click **Add Providers**. The Providers window opens (see Figure 6-7: Providers Window).

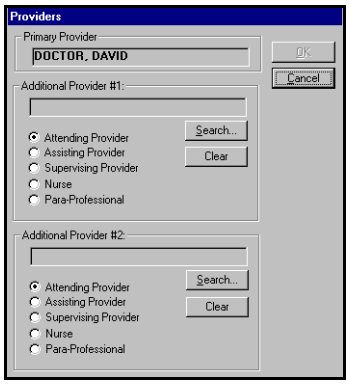

Figure 6-7: Providers Window

2. Select the type of clinician you want to add.
3. In the Additional Provider #1 area, click **Search**. The Clinician Search window opens (see Figure 6-8: Clinician Search Window).

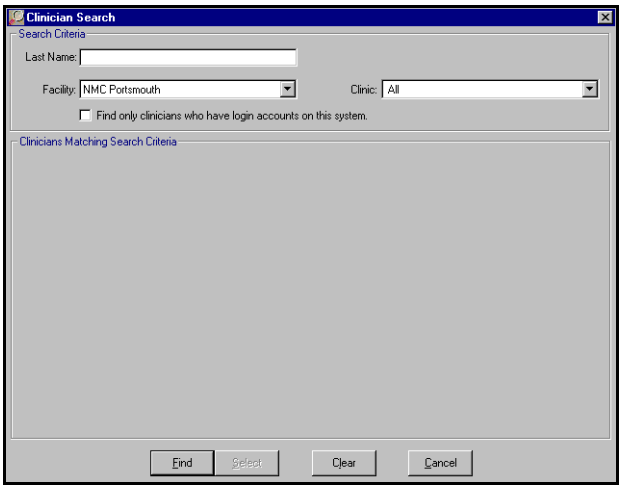

Figure 6-8: Clinician Search Window

4. In the Last Name field, enter the last name of the desired clinician.
5. Select a Facility from the drop-down list.
6. Select a Clinic from the drop-down list.
7. To view only providers associated with CHCS II, click the checkbox, if necessary.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the Additional Provider field on the Providers window.

Note: Repeat steps 2 - 10 if you want to add a second additional clinician.

11. Click **OK**. The clinician(s) is added to the appointment.

Tip:
If transferring multiple appointments, the patients must be from the same clinic.

6.9 Transferring an Appointment

The Appointment Transfer window enables an individual appointment or a group of appointments to be transferred to a different provider within the same clinic.

To transfer an appointment:

1. Select the appointment(s) to be transferred from the appointments list.
2. On the Action bar, click **Transfer**. The Appointment Transfer window opens (see Figure 6-9: Appointment Transfer Window).

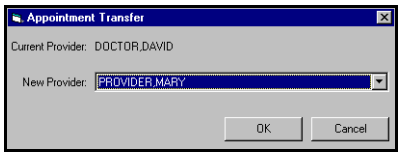

Figure 6-9: Appointment Transfer Window

3. Select the new provider from the drop-down list. Only providers assigned to the specific clinic are available.
4. Click **OK**. The appointment is added to the new provider's appointment list.

6.10 Canceling an Appointment

The Cancel Appointment window enables an appointment to be canceled. A reason for cancellation must be selected.

To cancel an appointment:

1. Select the appointment to be cancelled from the appointment list.
2. On the Action bar, click **Cancel**. The Cancel Appointment window opens (see Figure 6-10: Cancel Appointment Window).

Figure 6-10: Cancel Appointment Window

3. Select a Reason for Cancellation.
4. Click **OK**.

Note: This completes the encounter and the cancelled appointment appears in the Previous Encounter module indicating the appointment was cancelled.

6.11 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Demographics module.

Note: This form defaults to the current date.

To print an insurance form for a patient, click **Ins. Form** on the Action bar. The form is sent to your designated printer.

Note: Basic Demographic information is included on the form with space to update the address and home and work phone numbers, current insurance information with spaces to update, and questions for the patient to answer regarding any changes.

6.12 Viewing a Comment Associated with an Appointment

If a comment was added on the New Appointment window, the full text of the comment can be viewed.

To view a comment associated with an appointment:

1. On the Action bar, click **View Comments**. The Appointment Comments window opens (see Figure 6-11: Appointment Comments Window).

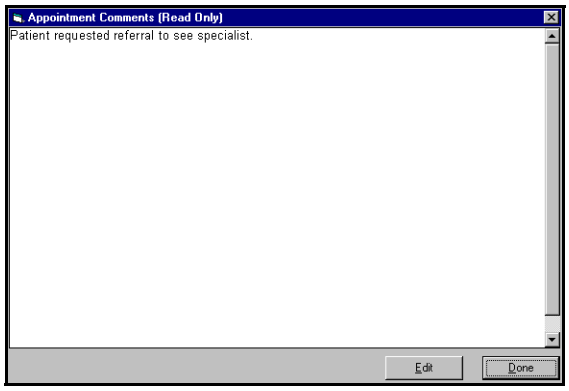

Figure 6-11: Appointment Comments Window

2. View the note.
3. Click **Done**.

Note: If you want to edit the note, click **Edit**. The Appointment Comments window changes from (Read Only) to (Edit Mode). Make the applicable changes and click **Done**.

7.0 ASSESSMENT AND PLAN (A/P)

7.1 Overview of Assessment and Plan

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, order consults, laboratory and radiology procedures, and medications (see Figure 7-1: Military Clinical Desktop - Assessment and Plan Module).

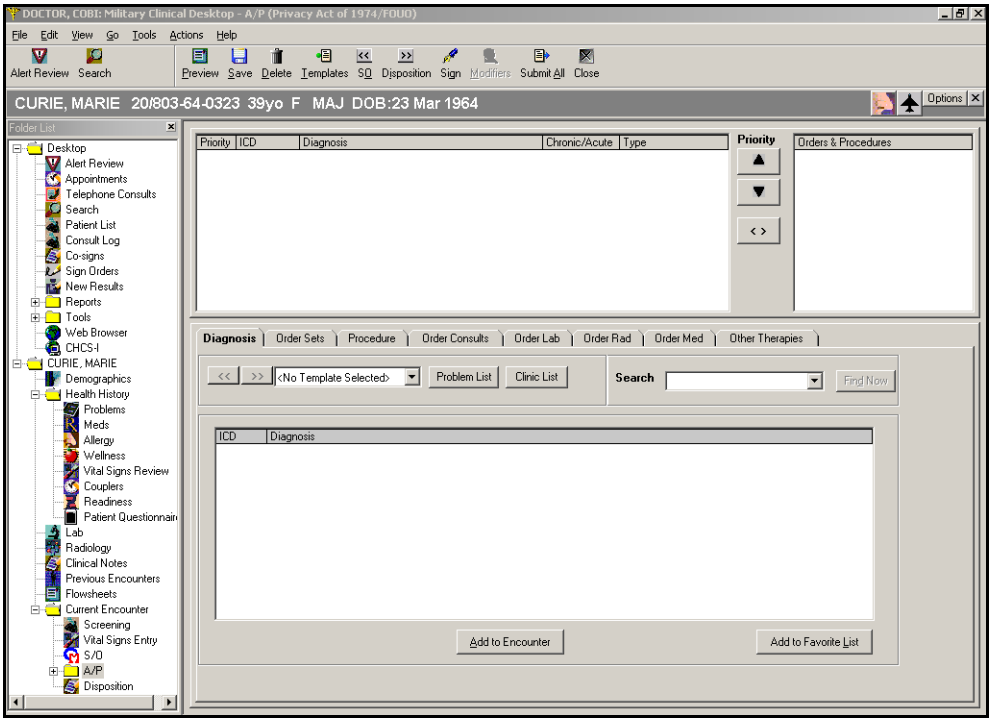

Figure 7-1: Military Clinical Desktop - Assessment and Plan Module

7.2 Action Bar Icons

	Preview	Allows the preview of the Assessment and Plan Summary.
	Save	Saves the current information.
	Delete	Deletes the highlighted item.
	Templates	Allows you to access the list of saved S/O templates.
	SO	Transfers you to the S/O module.
	Disposition	Transfers you to the Disposition module.
	Sign	Opens the Sign Encounter window, which allows you to sign the encounter.
	Modifiers	Allows you to indicate that a service was altered in some way from the stated CPT descriptor without changing the definition. The icon is only active once a Procedure has been added.
	Submit All	Submits all orders in queue.
	Close	Closes the Assessment and Plan module.

7.3 Associating Procedures, Orders, and Instructions

You can enter procedures, orders, and consults (patient instructions) without associating a diagnosis. If you enter one without associating a diagnosis and attempt to close the Assessment and Plan module, the system displays an alert (see Figure 7-2: A/P Warning Window).

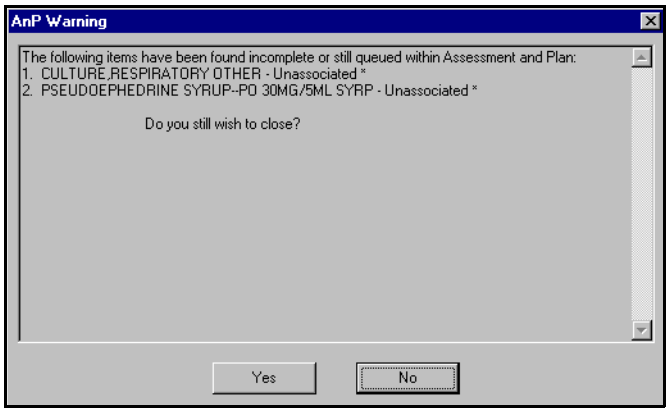

Figure 7-2: A/P Warning Window

All orders without a diagnosis receive a Count/No Count message if you attempt to sign the encounter without associating a diagnosis to a procedure, order, or consult.

7.4 Documenting a Diagnosis

The Diagnosis tab allows you to enter the patient's diagnosis for the encounter.

1. Click the Diagnosis tab. The Diagnosis tab displays (see Figure 7-3: Assessment and Plan Diagnosis Tab).

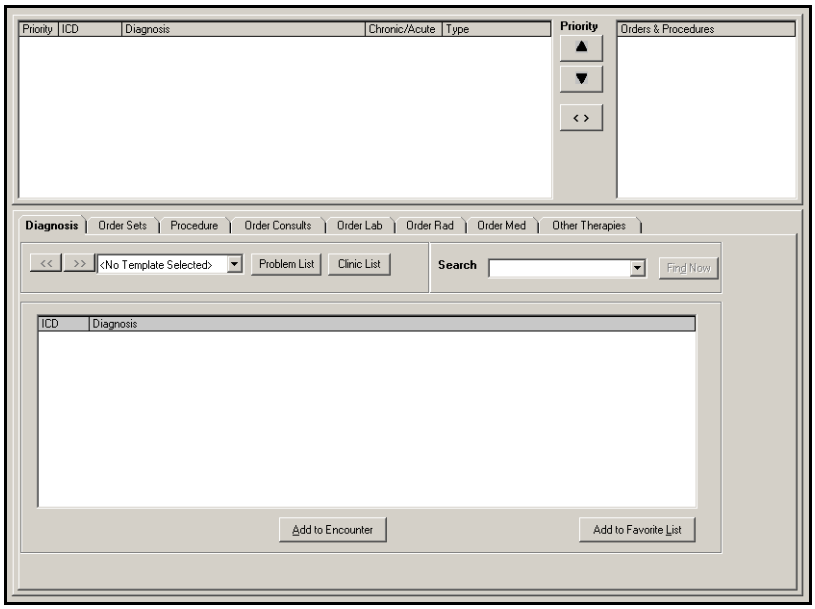

Figure 7-3: Assessment and Plan Diagnosis Tab

2. Do one of the following:
   - If you want to select a diagnosis from the template list, click the Template drop-down list and select a template.
   - If you want to view a list of the selected patient's acute or chronic problems, click the **Problem List** button.
   - If you want to select a diagnosis from the clinic list, click the **Clinic List** button.
   - If you want to search for a specific diagnosis:
     a. In the Search field, enter the diagnosis.
     b. Click **Find Now**. The result(s) displays in the Diagnosis area.
3. Select the diagnosis.
4. Click **Add to Encounter**. The diagnosis is added to the list above in the Diagnosis window (see Figure 7-4: Added Diagnosis).

Note: Click **Add to Favorite List** if you want to add the selected diagnosis to your Favorites List. The diagnosis also display in the List Management module.

To change the priority of the diagnosis, highlight the diagnosis to be changed and click on either the ▲ or ▼ button to move the item up or down.

E codes can not be selected as a primary diagnoses. An information box displays if the user attempts to select E Code as a primary diagnosis.

The maximum number of diagnoses allowed is fifteen (15).

The Diagnoses are added in the order they are selected and priorities are also associated in the same order. The first 4 diagnoses are sent to SADR. This is similar to the "bubble sheet" process of selecting diagnoses in priority order of 1–4.

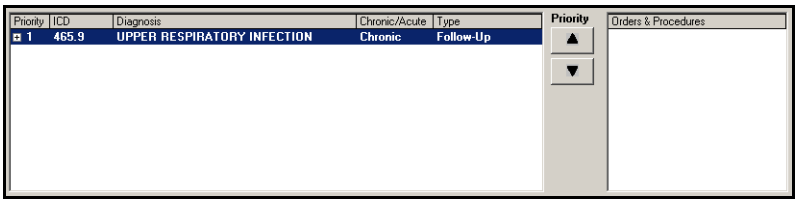

Figure 7-4: Added Diagnosis

Tip:
The diagnosis must have an associated code in order to be added.

5. Do one of the following:
   - If you want to add a comment to the diagnosis:
     a. Select a diagnosis that was added to the window.
     b. Click **Comment**. The Extended Comments window opens.
     c. In the Comments box, enter a comment.
     d. Click **OK**.
   - If you want to change the Chronic/Acute default setting for a diagnosis:
     a. Select the diagnosis that was added to the window.
     b. Click in the Chronic/Acute column.
     c. Select an option from the drop-down list.

Note: When an International Classification of Diseases (ICD) code is entered in the Search Field, the CHCSII displays an ***Acute*** list. If the ICD code is found, the diagnosis defaults to Acute/New.

Diagnoses selected from the patient's Problem list are defaulted to Chronic/ Follow-Up.

New problems that are not on the Acute List are defaulted to Chronic/New.

Problems on the Acute List added from a patient's Problems List default to Acute/Follow-up.

- If you want to change the diagnosis type:
  a. Select the diagnosis that was added to the window.
  b. Click in the Type column.
  c. Select an option from the drop-down list.

7.5 Using Order Sets

Order Sets are templates of Lab, Radiology, or Medication orders that you associated with an encounter template to streamline the ordering process. Order Sets are contained in Encounter Templates. You must select an **Encounter Template** and load it into an encounter to view and use the Order Sets within Assessment and Plan module.

To use order sets:

1. Click the Order Sets tab. The Order Sets tab displays the orders associated with the encounter template that are available (see Figure 7-5: Assessment and Plan Order Sets Tab).

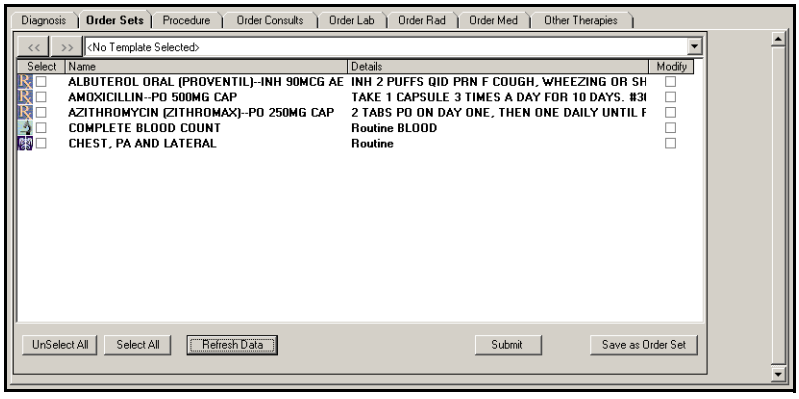

Figure 7-5: Assessment and Plan Order Sets Tab

2. Do one of the following:
   - If you want to select and submit all orders with no modifications, click **Select All**.

- If you want to select a specific order(s), click the checkbox in the Select column for the associated order you want to submit.
- If you want to save an order in the Order Set tab, right-click in the Order Set window and select Save as Order Set from the pop-up menu, or click the **Save as Order Set** button. Next, select the template to save the order set.

Note: Orders can be replaced in an existing Template/Order set with the newly saved orders, or can be added to orders already in an existing Template/Order set.

3. Click **Submit**.

Note: Orders that were selected but not modified are sent out automatically. For orders needing modification, the appropriate order entry window opens. Make the desired modifications and click **Submit** on the order entry window.

When an order set is created, it is placed in the appropriate Laboratory, Radiology, or Medications category, and the orders within each category are alphabetized.

To associate an order with a diagnosis, highlight the desired diagnosis and double-click the order.

7.6 Documenting a Procedure

The Procedure tab allows you to enter the procedures for the encounter. Multiple procedures can be added.

To document a procedure:

1. Click the Procedure tab. The Procedure tab displays (see Figure 7-6: Assessment and Plan Procedures Tab).

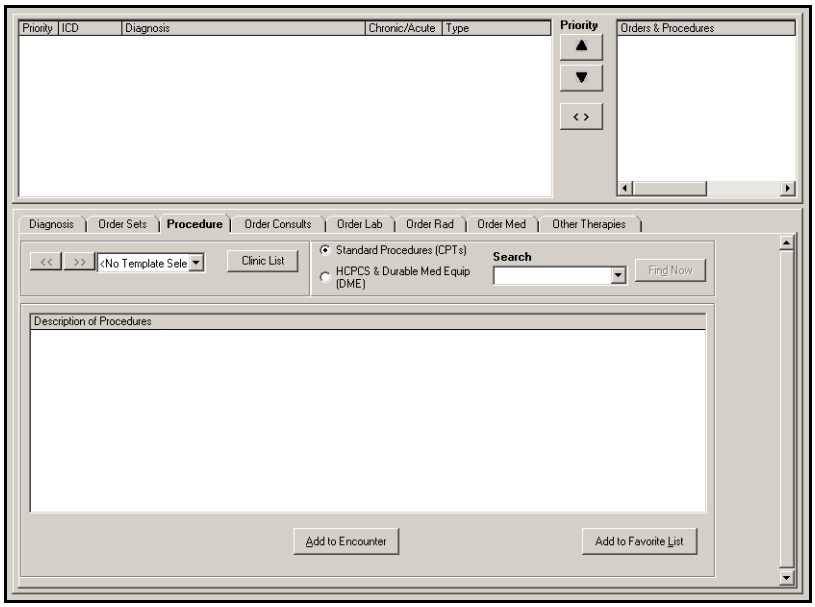

Figure 7-6: Assessment and Plan Procedures Tab

2. Do one of the following:
   - If you want to select the procedure from the template list, select a template from the Template drop-down list.
   - If you want to select the template from clinic list, click the **Clinic List** button.
   - If you want to search for a specific procedure:
     a. In the Search field, enter the procedure.
     b. Click **Find Now**. The result(s) displays in the Procedure area.
3. Select the procedure you want to add.
4. Click **Add to Encounter**. The procedure is added to the Orders and Procedures box (see Figure 7-7: Added Procedures).

Note: Click **Add to Favorite List** if you want to add the selected procedure to your Favorites List. The procedure also displays in the List Management module.

To associate a procedure with a diagnosis, select the diagnosis and double-click the procedure. You can assign the same procedure to more than one diagnosis.

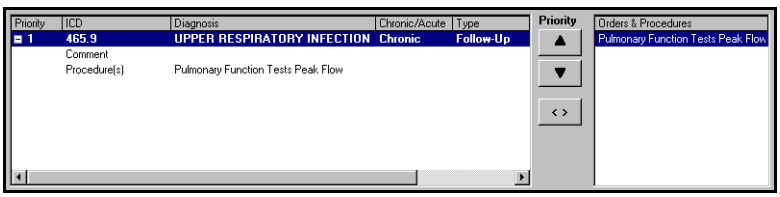

Figure 7-7: Added Procedures

7.7 Ordering a Consult

The Order Consults tab allows you to enter a consult request for a specific encounter.

To order a consult:

1. Click the Order Consults tab. The Order Consults tab displays (see Figure 7-8: Assessment and Plan Order Consults Tab).

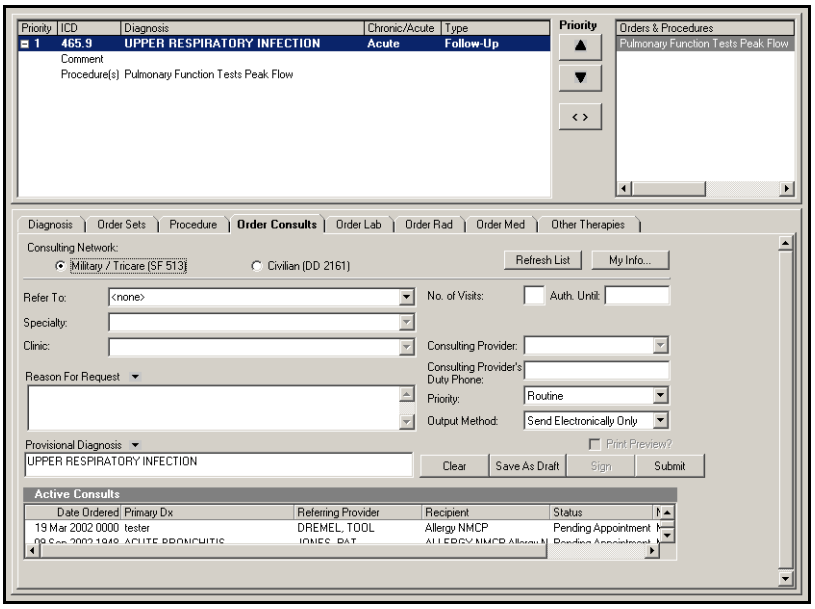

Figure 7-8: Assessment and Plan Order Consults Tab

2. When placing an order for a consult, complete the required fields:

Note: The system requires an entry or selection for each field except the Consulting Provider's Duty Phone.

- **Consulting Network:** Click the appropriate radio button. The Consulting Network group of radio buttons includes Military/TRICARE (SF513) and Civilian (DD2161). The default is Military/TRICARE Medical Care (SF513).
- **Refer To:** Select the recipient of the consult from the drop-down list. The associated specialty or clinic is automatically displayed in the corresponding fields.
- **Specialty:** Defaults with the associated specialty from the item selected in the Refer To field.
- **Clinic:** Defaults with the associated clinic from the item selected in the Refer To field.
- **Reason for Request:** The system enables the referring provider to enter a free-text description. Click inside the text box and type the reason.

- **Provisional Diagnosis:** A provisional diagnosis is the referring provider's best estimate of the patient's actual diagnosis. Often the patient is being referred because the diagnosis is uncertain, hence Provisional. If the Diagnosis code has been completed, it automatically populates the Provisional Diagnosis field. If the diagnosis has not been documented, enter the provisional diagnosis in the Provisional Diagnosis field.

Note: CHCSII defaults the provisional diagnosis field to the diagnosis selected.

- **No. of Visits:** This number refers to the recommended number of visits to complete the consult. Enter the desired number.
- **Auth Until:** The date until which this consult order is active. It is pre-filled with a date 30 days from the current date. Enter the appropriate date.
- **Consulting Provider:** Select the consulting provider from the drop-down list.
- **Consulting Provider's Duty Phone:** If a clinic provider was selected, the phone number displays here. The number is taken from information entered during the initial registration.
- **Priority:** Select the desired priority from the drop-down list.
- **Output Method:** Select an output method from the drop-down list. The Output Method refers to how the results of the consult should be communicated. The choices include Send Electronically Only, Send and Print, and Print Only. The default is Send Electronically Only.

3. After you enter the required information, click one of the following:
   - **Submit:** The system submits the newly created consult orders to CHCS for routing and scheduling with the selected specialty. The status is then changed to Submitted. The consult is also added to the Assessment and Planning window in the upper right corner with the list of procedures and is associated with the highlighted diagnosis. To re-associate the consult with a different diagnosis, highlight the desired diagnosis and double-click the consult.
   - **Save As Draft:** The consult request status is Saved in draft form because the request has not been submitted and can be edited.
   - **Clear:** Cancels the information entered for the consult.
   - **Sign:** Allows you to sign a consult.

Note: The Active Consults area at the bottom of the window lists consults by other providers for this patient as well as the ones ordered by you. The statuses for these consults include:

- Pending Results
- Updated
- Draft
- Pending Appointment
- Pending Review

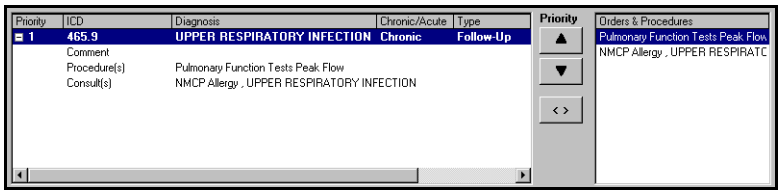

Figure 7-9: Added Consults

7.8 Ordering a Laboratory Test

The Order Lab tab allows you to enter a laboratory test for a specific encounter in the Assessment and Plan module.

To order laboratory tests:

1. Click the Order Lab tab. The Order Lab tab displays.

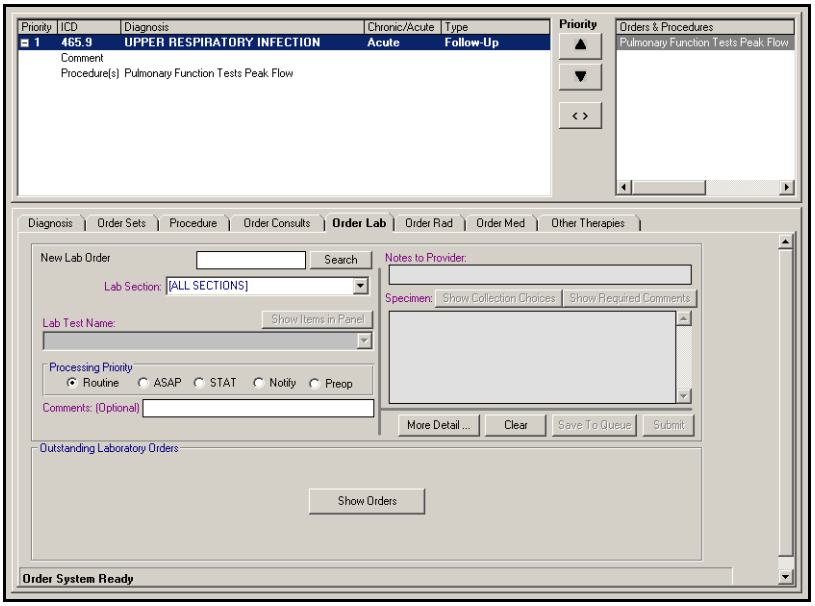

Figure 7-10: Assessment and Plan Order Lab Tab

2. Complete the following sections:
   - **Search:** Enter the name of the desired lab test and click **Search**. The results populate the Lab Test Name drop-down list.
   - **Lab Section:** Select the departments for the desired procedure. This narrows the results of the search, but is not necessary. To see all departments available select **All Sections**.
   - **Lab Test Name:** The results of the search populate the drop-down list. Select the desired laboratory test.

Note: If the pre-verify process identifies any conflicts regarding the order, the Lab Override window opens. To override the warning message, type a reason for the override in the Warnings window and click **Accept Override**. To ignore the warning override, click **Cancel Order** and select an alternative order.

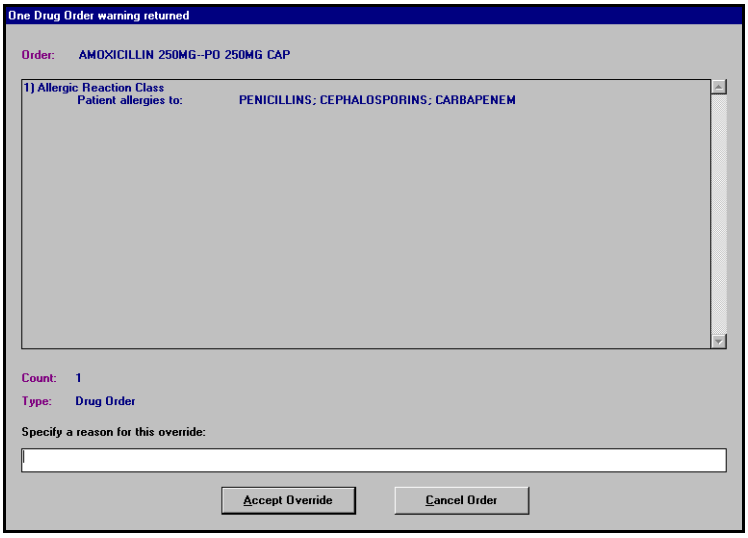

Figure 7-11: Lab Override Window

Note: The CHCS pre-verify process also identifies the laboratory test specimen, type, and container requirements. If there is more than one option, the Lab Collection Choices window opens and allows you to select preferences.

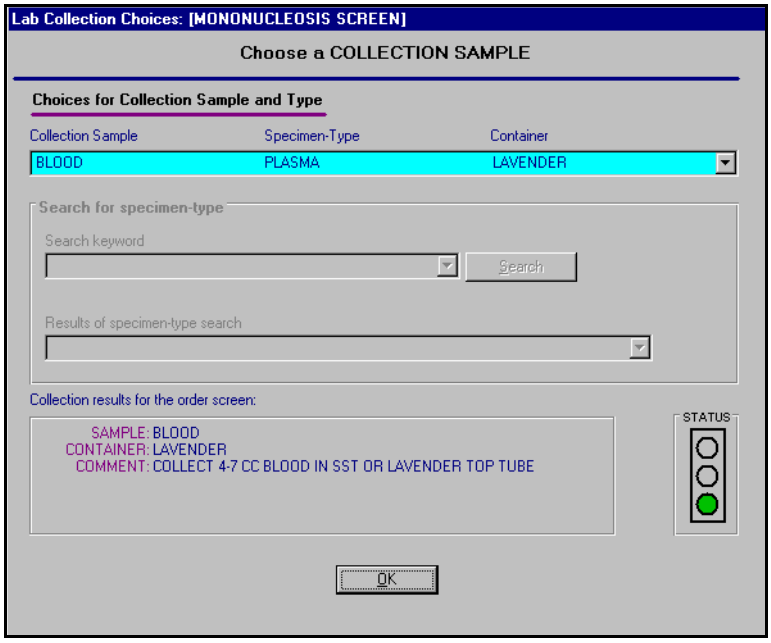

Figure 7-12: Lab Collection Choices

- **Showing Panel Contents:** If a laboratory test is associated with two or more subtests, the **Show Items in Panel** button is enabled. Click the button to display the Lab Panel Elements window for the selected laboratory test. Click **OK** to return to the Lab Orders tab.
- **Processing Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
- **Comments or Instructions:** In the Comments field, enter comments.

Note: Lab free-text comments persist in the Comments field during an Order Entry session.

- **Show Collection Choices:** If a laboratory test has two or more collection options, the Lab Collection Choices window opens displaying the available choices. Click **Show Collection Choices** to select specimen collection methods.
- **More Detail:** Click **More Detail** to view options for Schedule, Collection Priority, Collection Method, and Requesting Location. Once you click **More Detail**, the button changes to Less Detail.
- **Schedule:** Click the **One-Time** or **Continuous** radio buttons. The default is One-Time and Continuous is grayed out if the option is not appropriate for the selected test. If **Continuous** is selected, the Timing, Start Date, Frequency, and Duration fields become active. These fields have default values depending on the test selected.

- **Timing:** Use the drop-down list to change the time.
- **Start Date:** In the Start field, enter the desired date (or use the arrow keys in the field to select a date). The start date may only be the current date or a date in the future.
- **Frequency (for Continuous tests only):** Use the drop-down list to change the frequency.
- **Duration (Days) (for Continuous tests only):** In the Duration (Days) field, enter the preferred number of days.
- **Collection Priority:** Use the drop-down list to select a priority. The default is Routine.
- **Collection Method:** Use the drop-down list to select a collection method. The default is Send Patient to Lab.
- **Requesting Location:** Use the drop-down list to select a requesting location. The default is the location of the workstation.

3. Do one of the following:
   - If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Laboratory Orders area.
   - If you are not ready to submit the order, or if you have other orders you need to add before submitting, Click **Save to Queue**. This saves the order so you can submit it later.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

To associate an order with a diagnosis, select the desired diagnosis and double-click the lab order.

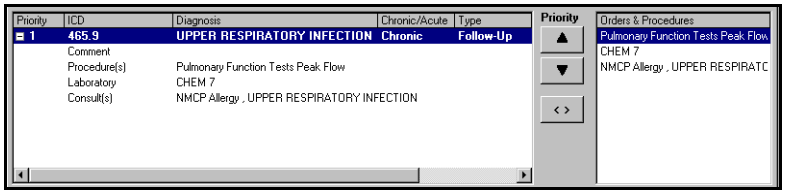

Figure 7-13: Added Laboratory Test

7.8.1 Anatomic Pathology Worksheets

Anatomic Pathology worksheets display for lab tests requiring additional pathology information than what is needed in ordering other lab tests. The worksheet displays when you search for a specified anatomic pathology lab test on the Order Labs tab in the A/P module. There are five Anatomic Pathology worksheets:

- Autopsy
- Bone Marrow
- Cytologic Gyn
- Cytologic Non-Gyn
- Tissue Exam

Note: The results for ordered Anatomic Pathology tests can be viewed in the Clinical Notes module. To view results, open the Clinical Notes module for the selected patient. Click **Filter** to access the Filter tab on the Properties window and select **Specific Note Types**. Click **Add** to access the Healthcare Data Dictionary Search for Clinical Note Types and search for Anatomical Pathology Reports. Add this as your filter to view results for ordered anatomic pathology tests.

7.8.1.1 Completing Autopsy Worksheets

The Autopsy worksheet window appears when you order an anatomic pathology lab test in the A/P module (see Figure 7-14: Autopsy Worksheet).

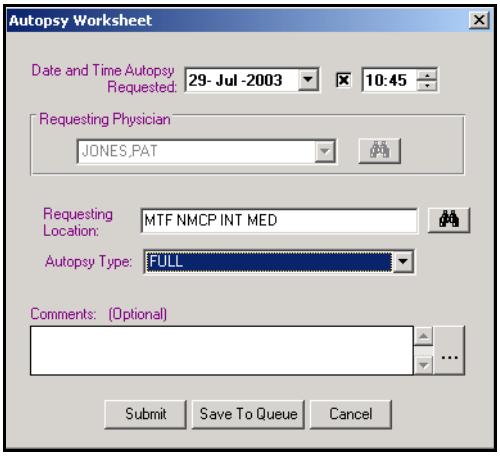

Figure 7-14: Autopsy Worksheet

To complete an Autopsy worksheet:

1. Select a date and time for the requested autopsy. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
1. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
2. Select the **Autopsy Type** being performed from the drop-down list.
3. If necessary, enter any comments in the Comments field.

4. If all necessary information has been added and you want to submit the order, click **Submit**.
   - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

7.8.1.2 Completing Bone Marrow Worksheets

The Bone Marrow Worksheet window appears when you order an anatomic pathology lab test in the A/P module (see Figure 7-15: Bone Marrow Worksheet).

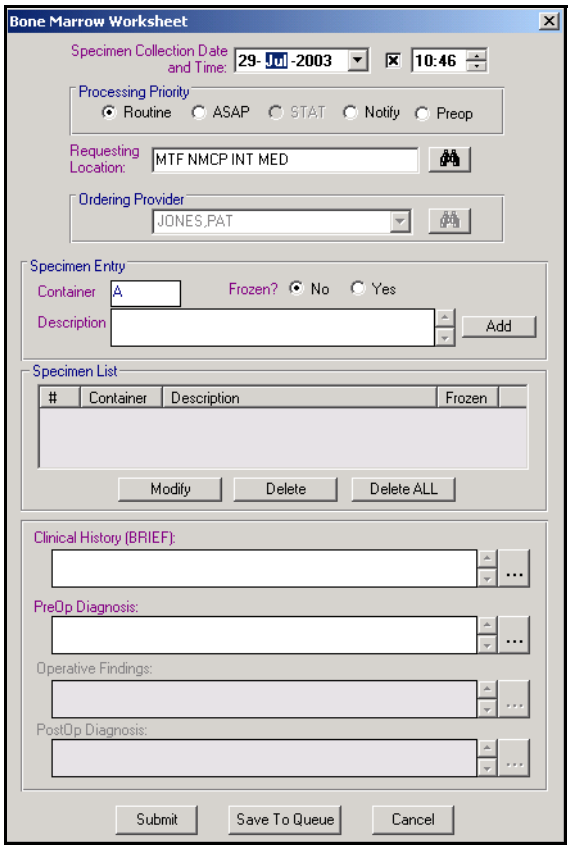

Figure 7-15: Bone Marrow Worksheet

To complete a bone marrow worksheet:

1. Select a date and time for the bone marrow specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
1. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
2. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
3. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.

4. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specific information, if necessary.

5. Enter a brief clinical history for the specimen.
6. Enter a brief PreOp diagnosis for the specimen.
7. If all necessary information has been added and you want to submit the order, Click **Submit**.
   - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

7.8.1.3 Completing Cytologic Gyn Worksheets

The Cytologic Gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module (see Figure 7-16: Cytologic Gyn Worksheet).

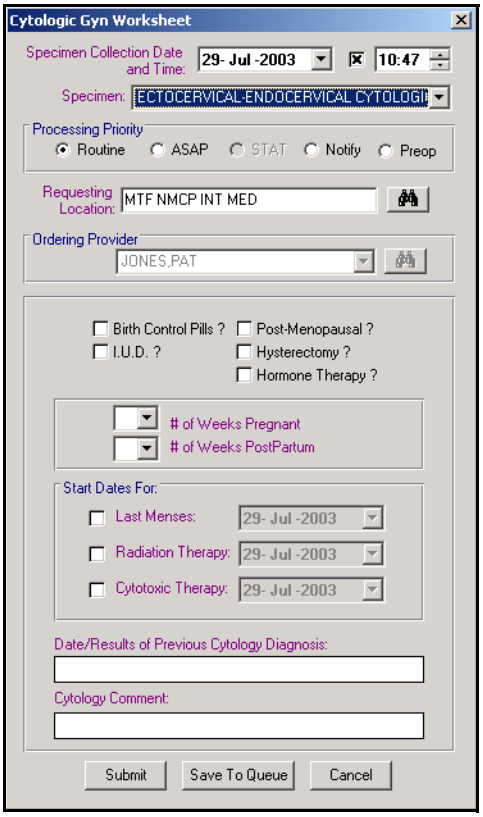

Figure 7-16: Cytologic Gyn Worksheet

To complete a Cytologic Gyn worksheet:

1. Select a date and time for the cytologic gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
1. Select a **Specimen** from the drop-down list.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Indicate if the patient is taking any of the following forms of birth control:
    - Birth Control Pills
    - IUD
    - Post-Menopausal
    - Hysterectomy
    - Hormone Therapy
5. If the patient is pregnant or recently gave birth, select the number of weeks from the drop-down list.
6. Indicate the start dates for any of the following:
    - Last Menses
    - Radiation Therapy
    - Cytotoxic Therapy
7. Enter any related results or previous cytology diagnoses.
8. Enter any related cytology comments.
9. If all necessary information has been added and you want to submit the order, click **Submit**.
    - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

7.8.1.4 Completing Cytologic Non-Gyn Worksheets

The Cytologic Non-Gyn Worksheet window appears when you order an anatomic pathology lab test in the A/P module (see Figure 7-17: Cytologic Non-Gyn Worksheet).

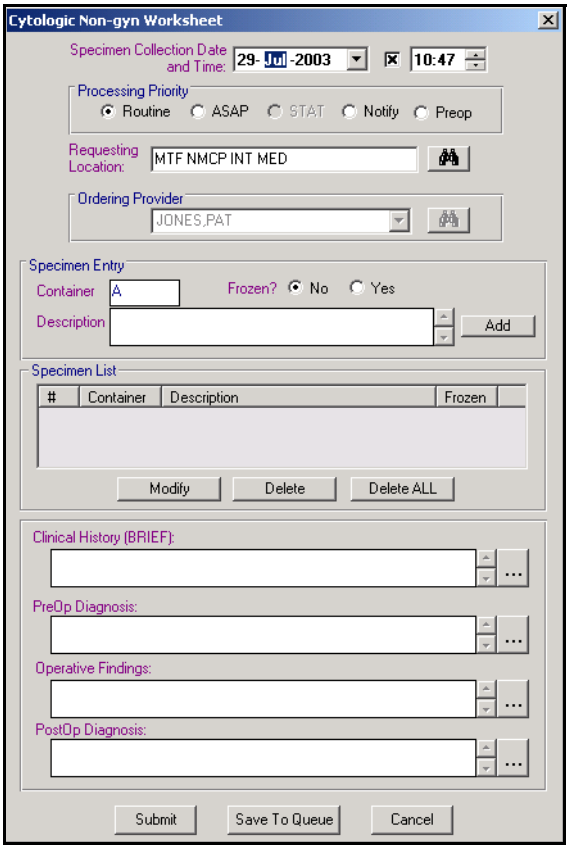

Figure 7-17: Cytologic Non-Gyn Worksheet

To complete a Cytologic Non-Gyn worksheet:

1. Select a date and time for the cytologic non-gyn specimen collection. The current date and time are defaulted to the user's workstation date and time, and the check-box is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.
4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

---

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.

9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
    - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

7.8.1.5 Completing Tissue Exam Worksheets

The Tissue Exam Worksheet window appears when you order an anatomic pathology lab test in the A/P module (see Figure 7-18: Tissue Exam Worksheet).

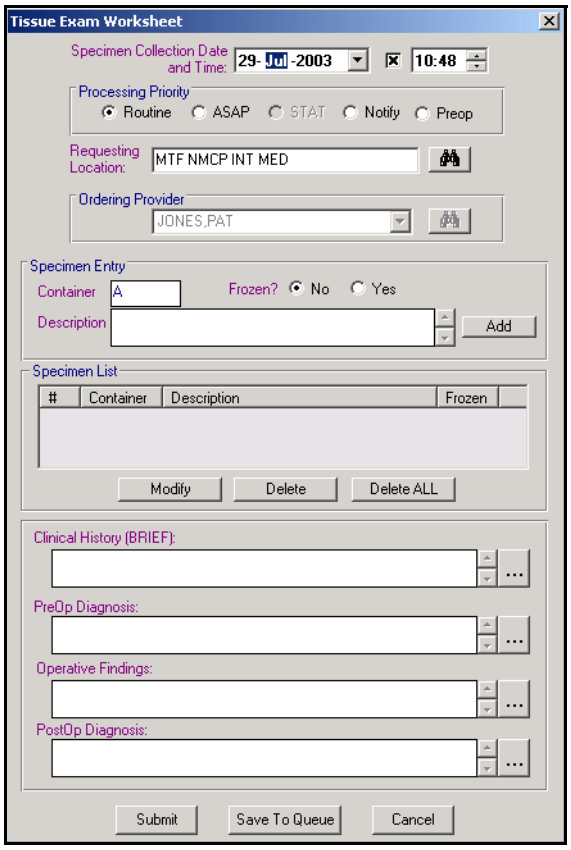

Figure 7-18: Tissue Exam Worksheet

To complete a tissue exam worksheet:

1. Select a date and time for the tissue specimen collection. The current date and time are defaulted to the user's workstation date and time, and the checkbox is automatically selected.
2. Select the **Processing Priority** for the specimen. Routine is selected as the default priority.
3. Select the **Requesting Location** from the drop-down list. The location defaults to your selected clinic.

4. Enter the container label and description for the specimen being collected. If the specimen is frozen, select **Yes**.
5. Click **Add**.

Note: The specimen information displays in the Specimen List area. You can modify or delete specimen information, as necessary.

6. Enter related Clinical History information for the specimen.
7. Enter related PreOp diagnoses for the specimen.
8. Enter related Operative Findings for the specimen.
9. Enter related PostOp diagnoses for the specimen.
10. If all necessary information has been added and you want to submit the order, click **Submit**.
    - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

7.9 Ordering a Radiology Procedure

The Order Rad tab allows you to order a radiology procedure for a specific encounter. To order a radiology procedure in the Assessment and Plan module:

1. Click the Order Rad tab. The Order Rad tab displays (see Figure 7-19: Assessment and Plan Order Rad Tab).

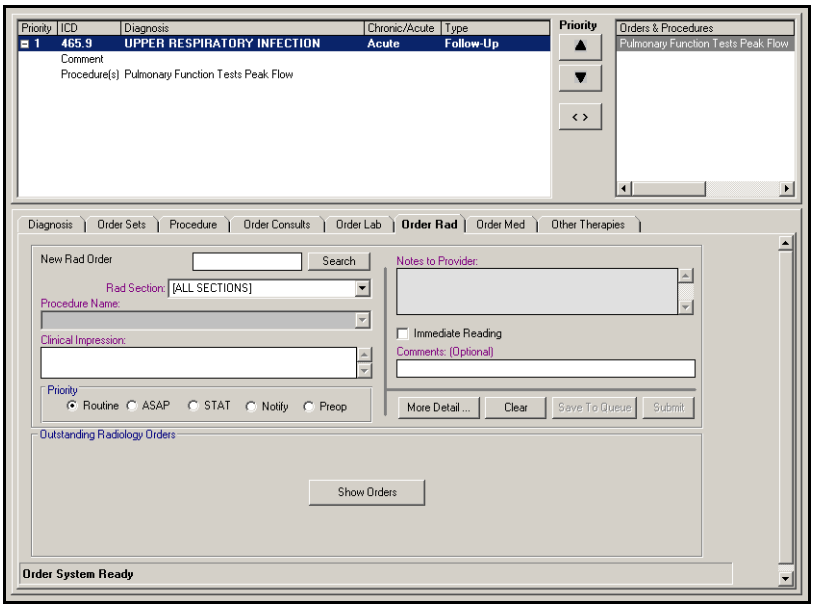

Figure 7-19: Assessment and Plan Order Rad Tab

2. Complete the following fields:
    - **New Rad Order:** In the Search field, enter the name of the desired radiology test and click **Search**. The results populate the Procedure Name drop-down list.
    - **Rad Section:** Select the departments for the desired procedure from the drop-down list. This narrows the results of the search but is not necessary. To see all departments available select **All Sections**.

Note: The pre-verify process identifies and displays warnings regarding the Radiology order. To override the warning, type a reason for the override in the Warnings window and click **Accept Override**. Otherwise, click **Cancel Order** and select an alternative order.

- **Procedure Name:** Select the desired test from the drop-down list.
- **Clinical Impression:** Enter the reason(s) for ordering the radiology procedure. This is a mandatory field.

Note: The previous clinical impression can carry over to the next radiology order, by selecting Yes in the dialog box.

- **Priority:** Click the radio button in the Processing Priority area to select a different processing priority. Options include Routine, ASAP, STAT, Notify, and Preop.
- **Immediate Reading:** Click the **Immediate Reading** check box to denote that the test should be read immediately.
- **Comments or Instructions:** Enter any comments or instructions related to the radiology procedure.
- **More Detail:** Click **More Detail** to view options for Schedule, Patient Mobility, and Requesting Location. After you click **More Detail**, the button changes to **Less Detail**.
- **Schedule:** Select **one-time** or **continuous**.

Note: **Timing**, **Frequency** and **Duration** are only available if the continuous radio button is checked in **Schedule**.

- **Timing:** Select either **AM** or **HS** from the drop-down list.
- **Start Date:** Click the drop-down arrow to open the calendar window. Select the start date.
- **Frequency:** Click the drop-down list and select the frequency.
- **Duration (Days):** Enter the duration.

- **Patient Mobility:** Select the option that best defines the patient's mobility from the drop-down list.
- **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.

3. Do one of the following:
   - If all necessary information has been added and you want to submit the order, click **Submit**. The order is seen in the Outstanding Radiology Orders area.
   - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order, allowing you to submit it at a later time.

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

To associate the procedure to a diagnosis, select the desired diagnosis and double-click the procedure.

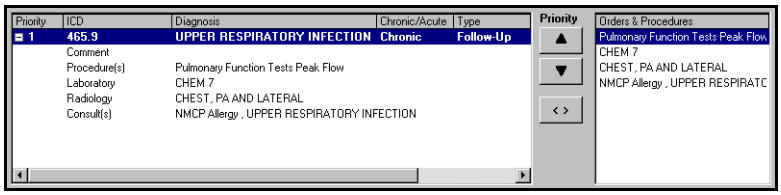

Figure 7-20: Added Radiology Test

7.10 Ordering a Medication

As you submit an outpatient medication order, the order is verified in CHCS to ensure that you have the proper privileges and the selected medication is available. You can submit new orders and modify, renew, discontinue or change the status of previously processed orders. CHCS validates each order as it is submitted and alerts you to any requirements (such as co-signature required) or limiting circumstances (such as availability or patient allergies).

To order a medication:

1. Click the Order Med tab. The Order Med tab displays (see Figure 7-21: Assessment and Plan Order Med Tab).

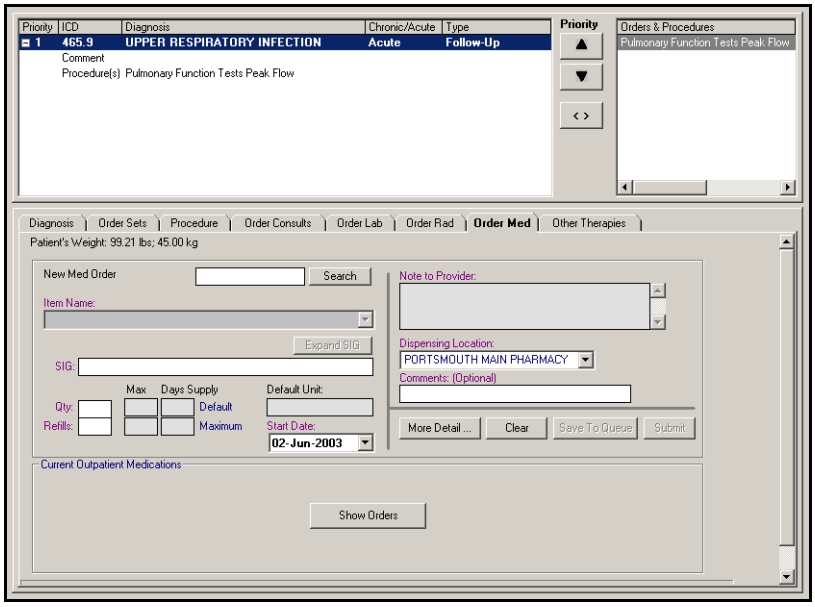

Figure 7-21: Assessment and Plan Order Med Tab

2. Complete the following sections:

   - **New Med Order:** In the Search field, enter the medication name and click **Search**. The results populate the Item Name drop-down list.
   - **Item Name:** Select the desired medication from the drop-down list populated by the search function.
   - **SIG:** Enter a new SIG or use the one returned by the pre-verify process. To view an expanded version of the displayed SIG code, click **Expand SIG**. The expanded SIG field provides a detailed explanation of the SIG codes returned from CHCS.
   - **Quantity:** Enter the quantity to be dispensed. Use the unit of measure shown in the Default Unit field on the right side of the tab or the quantity shown with the name/description of the medication. Default = 30-days' supply, calculated from the SIG, Quantity, and Refill fields.
   - **Refills:** Enter the number of refills. (Look in the Maximum field for the maximum number of refills allowed.) An error message displays if the number of refills is greater than the maximum (Maximum = maximum number of days' supply allowed).
   - **Start Date:** Enter the date the medication is to start (or use the arrow cursor in the field to select a date). The start date can only be the current date or a date in the future.
   - **Child Resistant Cap:** If you do not want a child resistant cap, deselect **Child Resistant Cap**.
   - **Comment:** Enter comments you want associated with the medication.

- **More Detail:** Click **More Detail** to view options for the dispensing and requesting locations After clicking **More Detail**, the button changes to **Less Detail**.
- **Requesting Location:** Select a requesting location from the drop-down list. The default is the location of the workstation.
- **Dispensing Location:** Defaults to the associated pharmacy. Use the drop-down list to select another location.

3. Do one of the following:
   - If all necessary information has been added and you want to submit the order, click **Submit**. You can see the order in the Current Outpatient Medications area.
   - If you are not ready to submit the order, or if you have other orders you need to add before submitting, click **Save to Queue**. This saves the order allowing you to submit it at a later time.

CHCS pre-verifies the order against patient and medications records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. In addition, CHCS II now provides connectivity to the Pharmacy Data Transaction System (PDTS), a central data repository containing patient medication profiles for all beneficiaries. In order entry – meds, in the Assessment and Plan (A/P) module, PDTS will provide the CHCS II user with:

- Excessive and insufficient dose warnings
- Interaction, overlap and duplicate warnings, and warning override capabilities
- Warning overrides on renew and modify orders

If the pre-verify process identifies warnings regarding the order, the CHCS and PDTS warnings will display in the same window (See Figure 7-22: CHCS and PDTS Warning Window). To override the warning, select a reason for override with the **Warning Override Reasons** radio buttons. To cancel an order, select a radio button under the **Order Cancellation Reasons**.

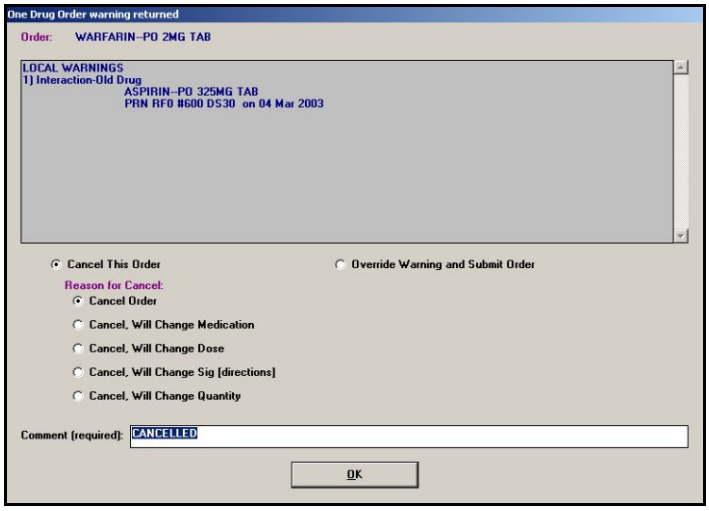

Figure 7-22: CHCS and PDTS Warning Window

Note: If the order is underlined, it is in a queue and has not been submitted. If the order is underlined and bolded, it is in a queue but has not been associated with a diagnosis or submitted. Click **Submit All** to submit orders in a queue. Orders without a diagnosis cannot be submitted unless you add a diagnosis.

To associate the order with a diagnosis, select the desired diagnosis and double-click the order (See Figure 7-23: Added Medications).

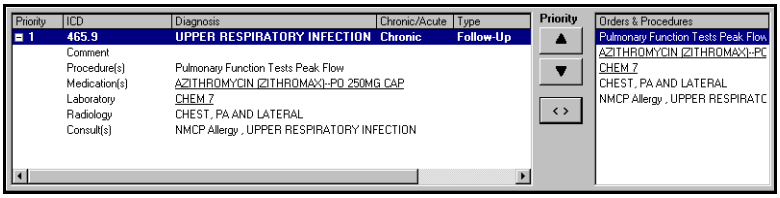

Figure 7-23: Added Medications

7.11 Adding Patient Instructions

Patient instructions enables you to select a short description for the instructions given to the patient during a specific encounter. These instructions are not associated with patient handouts that can be provided to the patient.

To add patient instructions:

1. Click the Other Therapies tab. The Other Therapies tab displays (see Figure 7-24: A/P Other Therapies Tab).

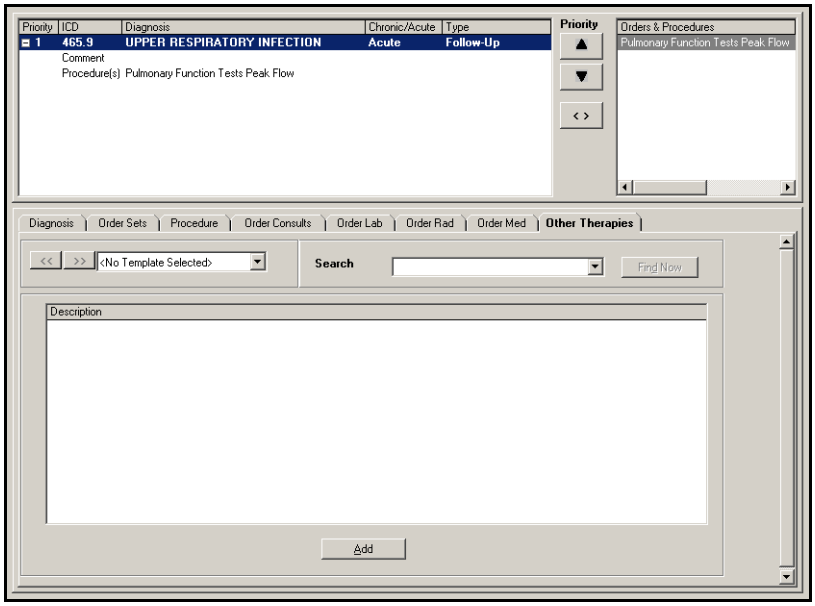

Figure 7-24: A/P Other Therapies Tab

Tip:
If the instruction was not automatically associated to the diagnosis, highlight the appropriate diagnosis and select the instruction.

Multiple instructions can be added using the same procedure.

2. Do one of the following:
   - If you want to view all of the possible selections for instructions, grouped by category, click **Browse**. The results display in the Patient Instruction area.
   - If you want to search for a specific template:
     a. In the Search field, enter the instruction.
     b. Click **Find Now**. The result(s) displays in the Patient Instruction area.
3. Select the instruction.
4. Click **Add**. The instruction is added to the Orders and Procedures box and associated with the highlighted diagnosis. To re-associate the instruction with a different diagnosis, select the desired diagnosis and double-click the instruction.
5. Click **Close** on the Action bar. The completed A/P is autocited in the Patient Encounter window.

7.12 Discontinuing an Order

To discontinue an order:

1. From the Current Orders window at the bottom of the Order Entry window, select the order to be discontinued.
2. Click **Discontinue**.

7.13 Placing an Order on Hold

To place an order on hold:

1. From the Current Orders window at the bottom of the Order Entry window, select the order.
2. Click **Hold**. The status of the order is changed to Hold.

7.14 Showing the Details of an Order

To show details of an order:

1. From the Current Orders window at the bottom of the Order Entry window, select a specific order.
2. Click **Show Detail** to view the Detail window.
3. Click **OK** to return to the Order Entry window.

7.15 Renewing/Modifying an Order

To renew an order:

1. From the Current Orders area at the bottom of the Order Entry window, select the desired order.

2. Click **Renew**. The order is resubmitted exactly as it was previously ordered.

To modify and renew an order:

1. From the Current Orders area at the bottom of the Order Entry window, select the desired order.
2. Click **Renew & Modify**. The Enter Reason for Action window opens. Enter a reason for action and click **OK**.
3. Make the changes you want, then click **Submit**.

8.0 CLINICAL NOTES

8.1 Overview of Clinical Notes

The Clinical Notes module (see Figure 8-1: Military Clinical Desktop - Clinical Notes Module) displays patient-specific notes that are not associated with an encounter.

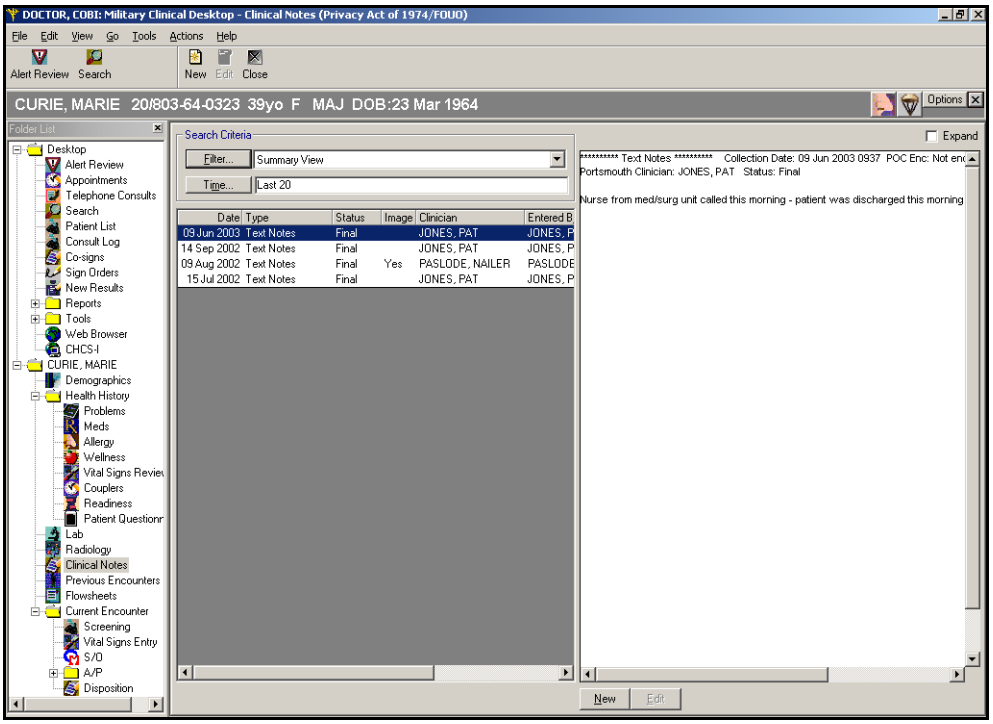

Figure 8-1: Military Clinical Desktop - Clinical Notes Module

8.2 Action Bar Icons

	**New**	Allows you to create a new clinical note.
	**Edit**	Allows you to edit a clinical note that you have created. This button is not available for notes that you did not create.
	**Save**	Allows you to save the information entered in the clinical note.
	**Cancel**	Allows you to cancel any information entered in the clinical note.
	**Insert**	Allows you to insert an image file (.bmp, .tiff, .wmf) in the clinical note.
	**Load**	Allows you to load a text file (.txt, .rtf, .html) in the clinical note.
	**Close**	Closes the Clinical Notes module.

8.3 Setting the Filter Properties for the Clinical Notes Module

The Filter tab enables the filter name, note type, and associated clinician to be selected.

To set the filter properties for the Clinical Notes module:

1. Click **Filter** on the Clinical Notes window (see Figure 8-2: Clinical Notes Properties Window (Filter Tab)). The Properties window opens with the Filter tab defaulted.

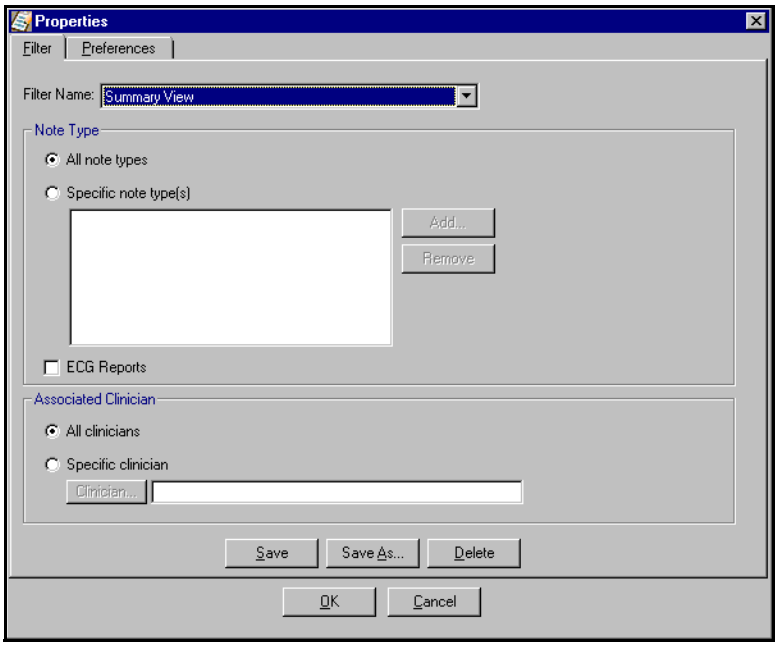

Figure 8-2: Clinical Notes Properties Window (Filter Tab)

2. Select a filter name from the drop-down list.
3. Do one of the following:
   - If you want to view a list of all note types, click the **All Note Types** radio button.
   - If you want to view selected note types:
     a. Click the **Specific Note Type(s)** radio button.
     b. Click **Add**. The healthcare Data Dictionary Search for Clinical Note Types window opens (see Figure 8-3: healthcare Data Dictionary Search for Clinical Note Types Window).

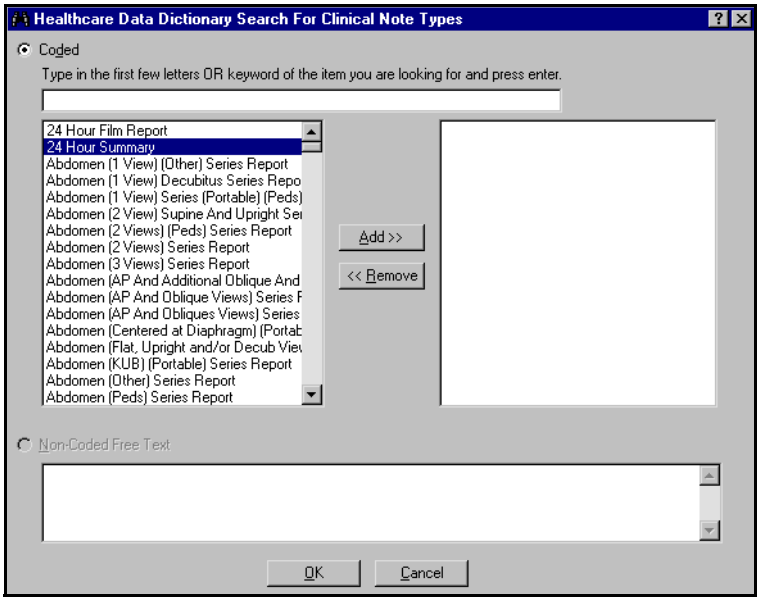

Figure 8-3: healthcare Data Dictionary Search for Clinical Note Types Window

c. Select the report(s) you want to add.

d. Click **Add**.

e. When you have finished adding the selected report(s), click **OK**. The selected reports display in the specific note type(s) area.

4. Do one of the following:

   - If you want to view clinic notes for all clinicians, click the **All Clinicians** radio button.
   - If you want to view clinic notes for selected clinicians:

     a. Click the **Specific Clinician** radio button.

     b. Click **Clinician**. The Clinician Search window opens (see Figure 8-4: Clinician Search Window).

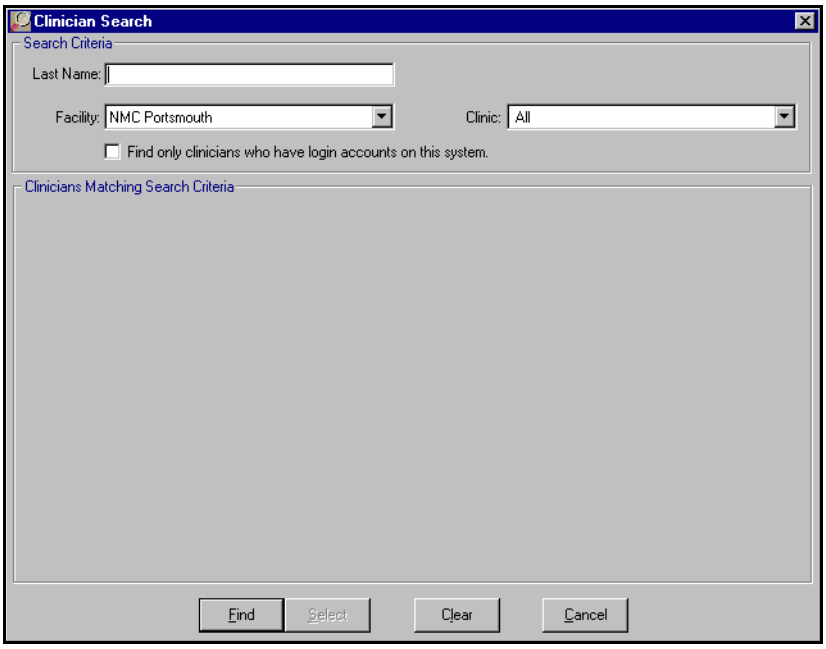

Figure 8-4: Clinician Search Window

c. Search for the clinician.

5. Click **Save**.

Note: If it is a new filter selection, click **Save As**, enter the name of the new filter and click **Save**.

---

6. Click **OK**.

8.4 Setting Time Preferences for the Clinical Notes module

The Preferences tab allows you to customize default times to be displayed on the Clinical Notes window (see Figure 8-5: Clinical Notes Properties Window (Preference Tab)).

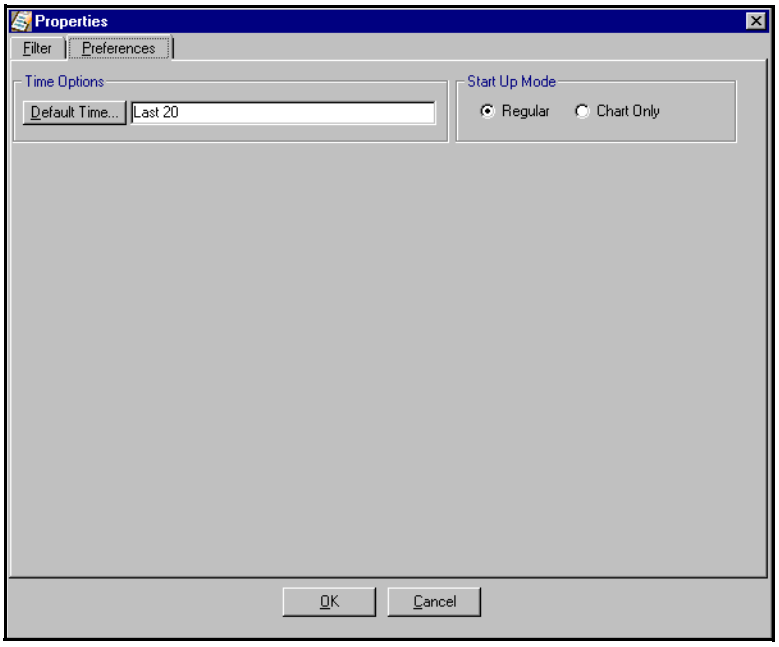

Figure 8-5: Clinical Notes Properties Window (Preference Tab)

Tip:
*You can also set time preferences by clicking **Time** on the Clinical Notes window.*

To set time preferences for the Clinical Notes module:

1. Click **Options** in the upper, right corner of the Clinical Notes window.
2. Click the Preferences tab.
3. Click **Default Time**. The Time Search window opens (see Figure 8-6: Time Search Window).

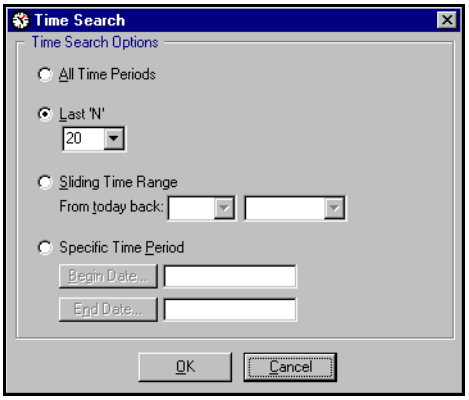

Figure 8-6: Time Search Window

4. Select a time search option.
5. Click **OK**.

Note: The data on the Clinical Notes window is refreshed according to the selected search option. All clinical notes meeting the criteria are listed on the Clinical Notes window. These become your default settings.

6. Click **OK** again to return to the Clinical Notes window.

8.5 Creating a New Note

To create a new clinical note for a patient:

1. Click **New** on the Clinical Notes window. The New Clinical Note window opens (see Figure 8-7: New Clinical Note Window).

Note: The Date field defaults to the current date. To change the date, enter a date or click **Date**. The Calendar window opens from which a date can be selected.

The Clinician field defaults to the name of the clinician who is currently logged on. To change the clinician, click **Clinician** to search for the clinician you want to add.

The POC field defaults to the facility name of the person logged on. Select a facility from the POC drop-down list to change the default facility.

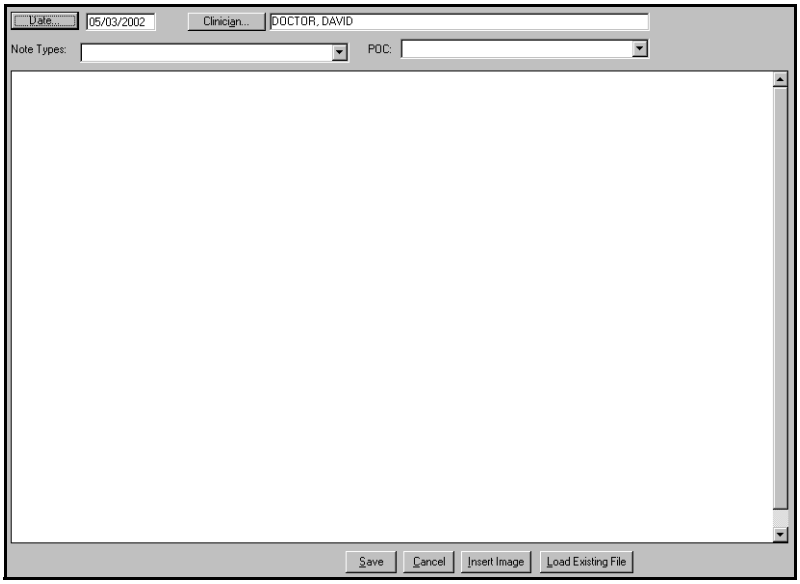

Figure 8-7: New Clinical Note Window

2. Select a note type from the drop-down list.

3. In the text field, enter the note.
4. Do one of the following:
   - If you want to insert an image file (e.g., .tif, .bmp, .wmf) in the note:
     a. Click **Insert Image**.
     b. Select the file from the Select Destination File window (see Figure 8-8: Select Destination File Window).

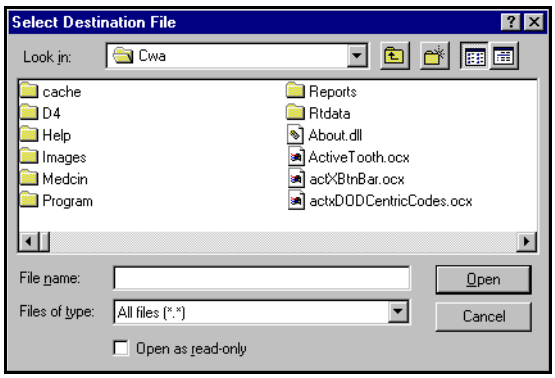

Figure 8-8: Select Destination File Window

     c. Click **Open**. The contents of the file are inserted in the note.

Note: Graphics that are imported must be 500K or less. If the file size is over this amount, the system gives you a message prompt.

   - If you want to insert an existing file (e.g., .txt, .rtf, .html) in the note:
     a. Click **Load Existing File**.
     b. Select the file from the Select Destination File window.
     c. Click **Open**. The contents of the file are inserted in the note.
5. Click **Save**. The note displays in the Clinical Notes window.

8.6 Editing a Note

Only the author of the note can modify clinical notes.

To edit a note:

1. Select the note from the list of notes on the Clinical Notes window. The text of the note displays in the text section of the window.
2. Click **Edit** on the Action bar. The Edit window opens.
3. Enter the applicable changes.
4. Click **Save**. The modifications display in the note.

9.0 CONSULT LOG

9.1 Overview of Consult Log

The Consult Log module displays all of your consults, both ordered and received (see Figure 9-1: Military Clinical Desktop - Consult Log Module). The log displays and continually updates statuses and other information for each consult as it progresses through its lifecycle. In this fashion, the system establishes a tracking log of all actions.

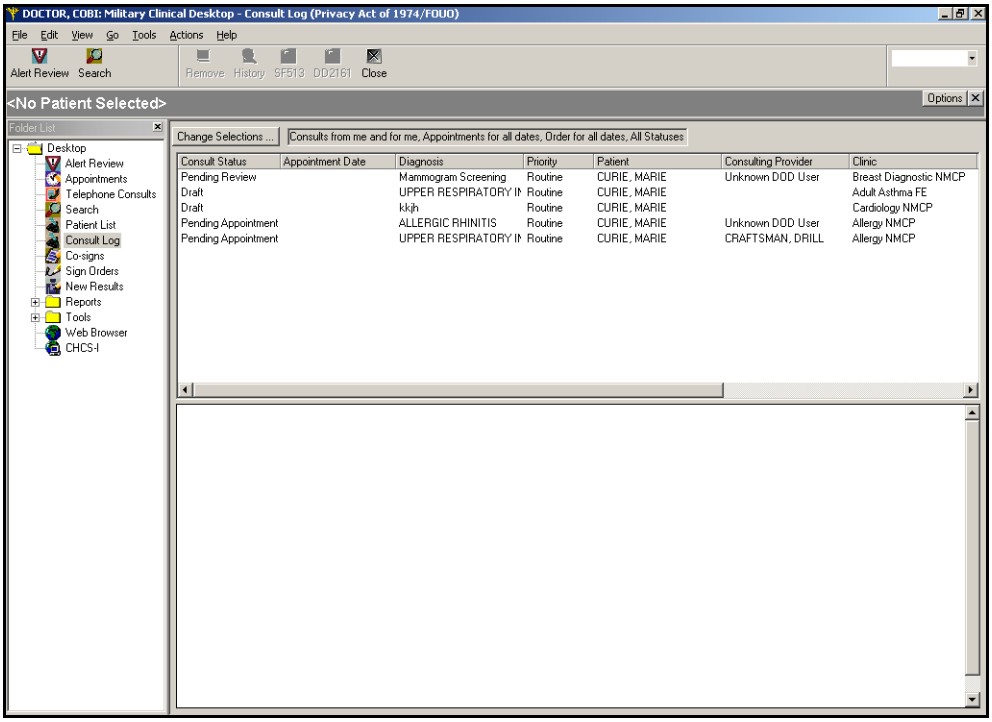

Figure 9-1: Military Clinical Desktop - Consult Log Module

9.2 Action Bar Icons

	Remove	Removes consults from the consult log.
	History	Allows you to view the history of the selected consult.
	SF513	Allows you to print the consult in SF513 format.
	DD2161	Allows you to print the consult in the DD2161 format.
	Close	Closes the Consult Log module.

Tip:
Use the scrollbar at the bottom of this area to view the additional Consult Log fields.

9.3 Setting the Consult Log Filter

The Consult Log can be viewed by Consults For Me, Consults From Me, or Both.

To set the Consult Log filter, select the filter from the drop-down list in the top, right corner of the Consult Log window. The Consults Log meeting the criteria appears in the Consults Log area on the Consults Log window.

9.4 Setting the Consults Change Selection Criteria

The Change Selections Criteria function allows you to select field criteria for the Consults Log that are displayed in the Consult Log window. These selections become the default settings.

To set the consults change selection criteria:

1. Click **Change Selections** on the Consult Log window. The Consult Log Selections window opens (see Figure 9-2: Consult Log Selections Window).

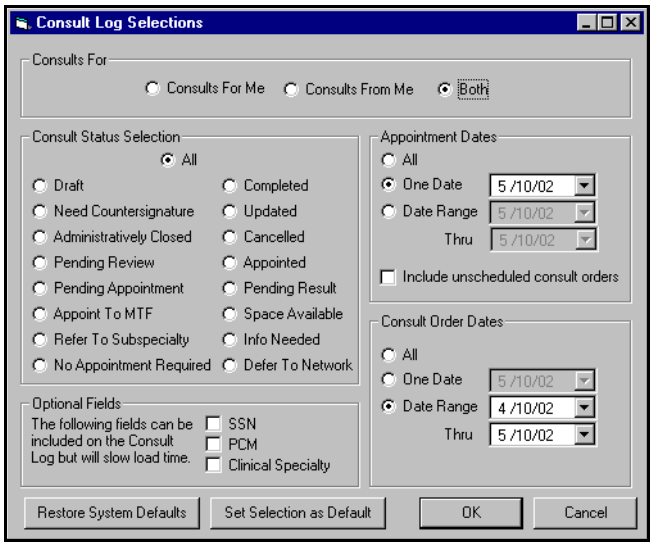

Figure 9-2: Consult Log Selections Window

2. Select an option in the Consults For area.
3. Select an option in the Consult Status Selection area.
4. Select an appointment date.
5. Select a consult order date. All consult logs meeting these criteria are listed on the Consult Log.
6. Click **OK** to set the selected search criteria. The data on the Consult Log is refreshed according to the search criteria.

Note: As each column header at the top of the window is clicked, the system re-sorts and re-displays the consults based on the column header chosen.

9.5 Printing a Consult

You have the capability to print a selected consult in an SF513 form.

To print a consult:

1. Select the consult you want to print from the consult log.
2. Click **SF513** or **DD2161** on the Action bar. A Print Preview window opens (see Figure 9-3: Consult Print Preview Window).

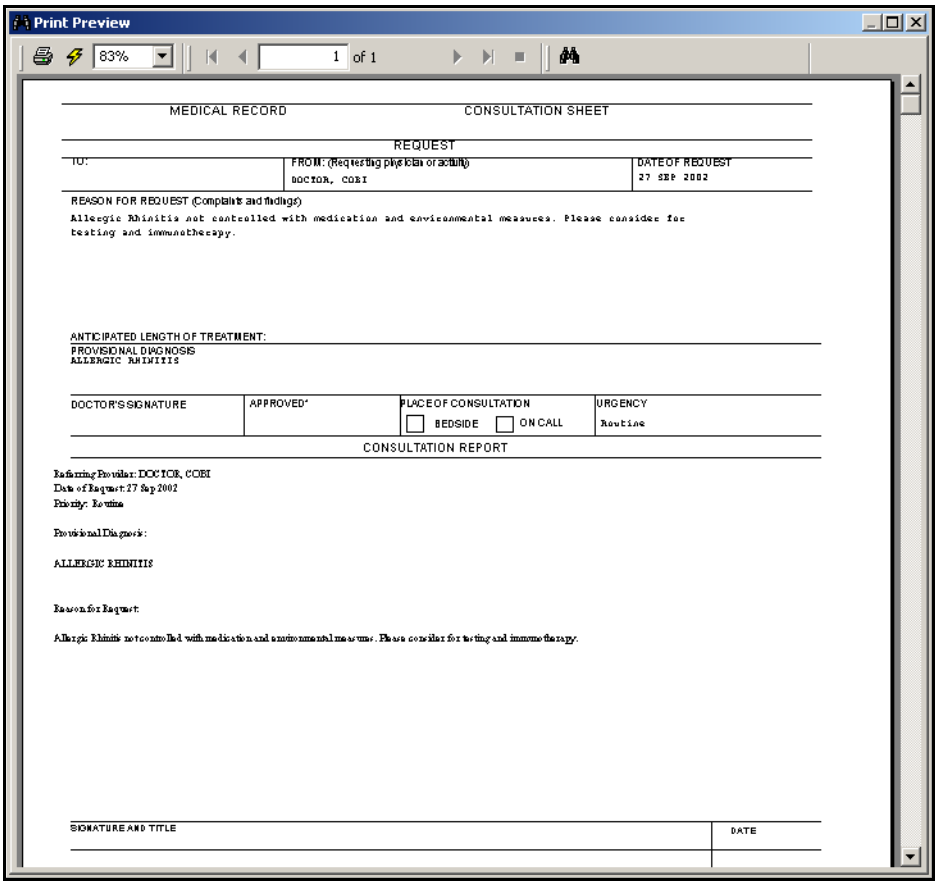

Figure 9-3: Consult Print Preview Window

3. View the form.
4. Click **Print Report**. The form is sent to your designated printer.

9.6 Removing a Consult

A consult with a status of Draft or Pending Appointment can be removed from the Consult Log by using the following procedure.

To remove a consult:

1. Select the consult from the consult log.
2. Click **Remove** on the Action bar (see Figure 9-4: Consult Status—Cancelled).

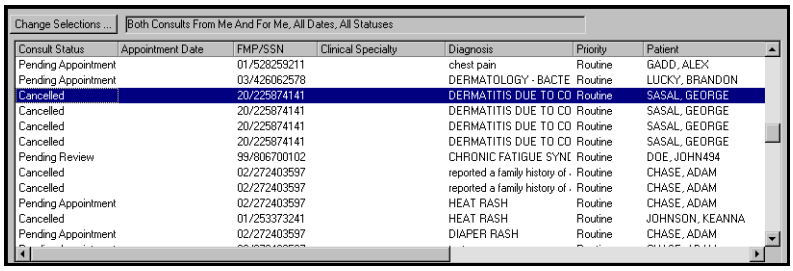

Figure 9-4: Consult Status—Cancelled

Note: Consults should be removed from the log when appropriate. This reduces the number of consults to be pulled from the database; therefore, reducing the amount of time it takes to open a consult log window.

9.7 Viewing the History of a Consult

Any actions that have occurred in reference to a consult listed in the Consult Log area of the Consults window can be viewed.

1. Select the appropriate consult from the consult log list.
2. Click **History** on the Action bar. The Consult History window opens (see Figure 9-5: Consult History Window).

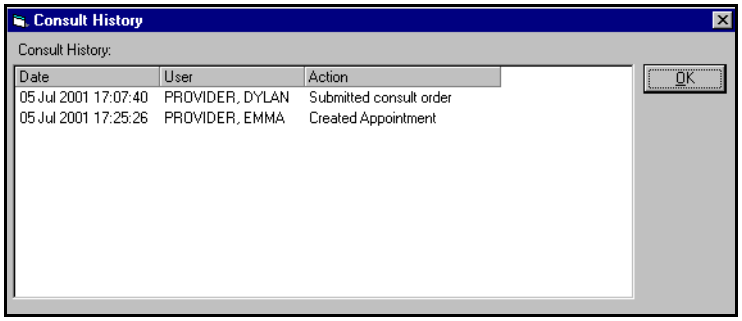

Figure 9-5: Consult History Window

3. View the information in the Consult History window.
4. Click **OK**.

10.0 PKC COUPLERS (HEAR)

10.1 Overview of PKC Couplers

The questionnaires associated with the PKC Couplers module automate the collection of demographic and health data for patients. The questionnaires provide the care provider a “snapshot” of the patient's health, habits and other factors that can affect their overall health. The data is then used to assess preventive service needs, identify services routinely used, and determine the appropriate level of medical expertise/care required for each patient. Couplers are patient specific. Accordingly, a patient’s record must be loaded to the Military Clinical Desktop before the PKC Couplers module is available. The functions available upon accessing the PKC Couplers module depends on security access roles. A user, normally with clerk privileges, is permitted to generate and print a patient password to be used by the patient to access a questionnaire at a kiosk. A user, normally with provider privileges, is permitted to display, run, and update completed questionnaires.

10.2 Action Bar Icons

	**Close**	Closes the PKC Couplers module.

10.3 HEAR Questionnaire

The Health Evaluation, Assessment, and Review (HEAR) questionnaire automates the collection of individual demographic and health data. It couples (hence the term Coupler) with a healthcare knowledge network and produces reports for the patient and the patient's primary care manager. The HEAR uses a commercial-off-the-shelf (COTS) product developed by Problem Knowledge Couplers, Inc. (PKC). The application is used by clinical staff to generate passwords for patients who are completing the HEAR and other questionnaires. In addition, providers use the application to view, and if necessary, update the patient's completed questionnaire, and to view related reports.

10.4 Running a New PKC Coupler

Two types of questionnaires can be administered, Military and All Others.

To run a new coupler:

1. On the PKC Couplers window, click either the **Military** or **All Others** tab (see Figure 10-1: Military and All Others Tab).

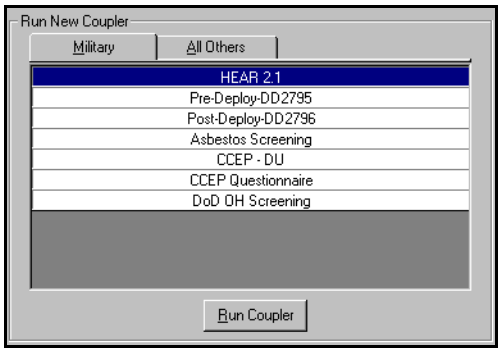

Figure 10-1: Military and All Others Tab

2. Select the desired questionnaire.
3. Click **Run Coupler**. The Couplers application begins with the selected questionnaire (see Figure 10-2: PKC Couplers Application).

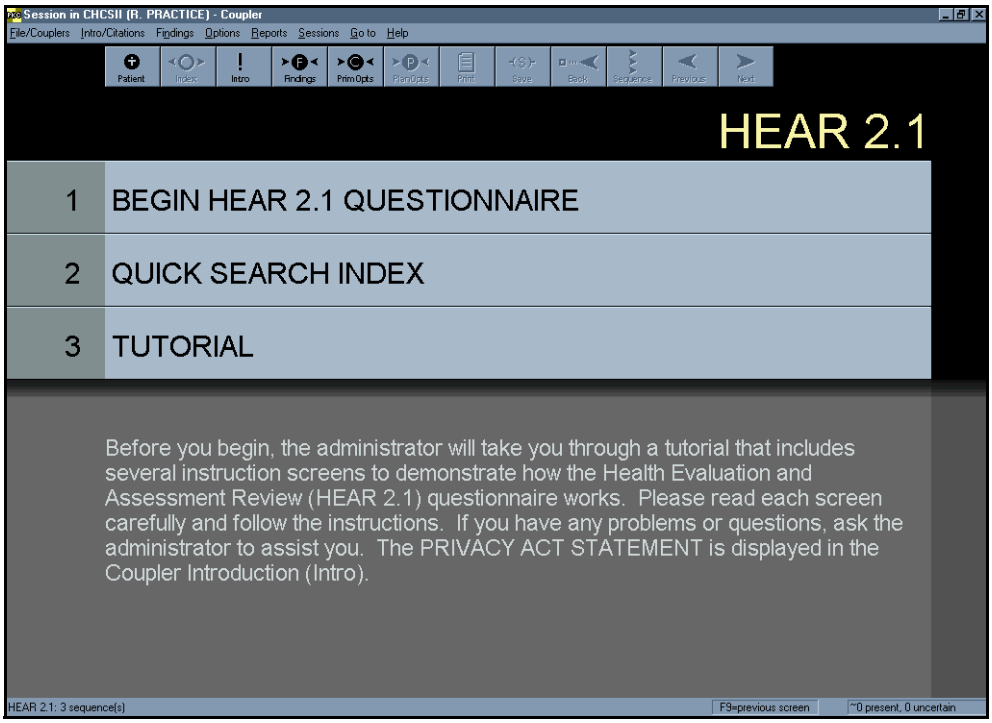

Figure 10-2: PKC Couplers Application

4. Do one of the following:
   - If the questionnaire is from the Military tab, the questionnaire begins with an opening sequence that presents options for running the questionnaire. To start the questionnaire:
     — Click **Begin Questionnaire**.
     — Answer the survey questions.
     — On your keyboard, press **F10**.

— On the tool bar, click the **Next Arrow** button.

Note: If answers are missing or are invalid, an error message appears. To correct the error, click **Yes**, click **No** to continue.

- If the questionnaire is from the All Others tab, the system begins with an overview of the subject areas presented in the questionnaire. To start the questionnaire:
  - — Click the applicable area.
  - — To answer a question, select a response. Click twice to mark a question as uncertain. Click a third time to clear the question.
  - — On the toolbar, click the **Next Arrow** button to move to the next window to respond to the next question.
  - — At the end of the questionnaire, on the File/Couplers menu, click **Exit & Return to CHCS II**.
  - — To save the findings and exit the questionnaire, click **Yes**.

10.5 Viewing a Completed PKC Coupler

The PKC Couplers window displays completed questionnaires and a list of questionnaires that can be administered. Each completed questionnaire can be viewed and updated.

To view a completed PKC Coupler:

1. Select the desired questionnaire to be viewed on the PKC Couplers window (see Figure 10-3: PKC Couplers Window).

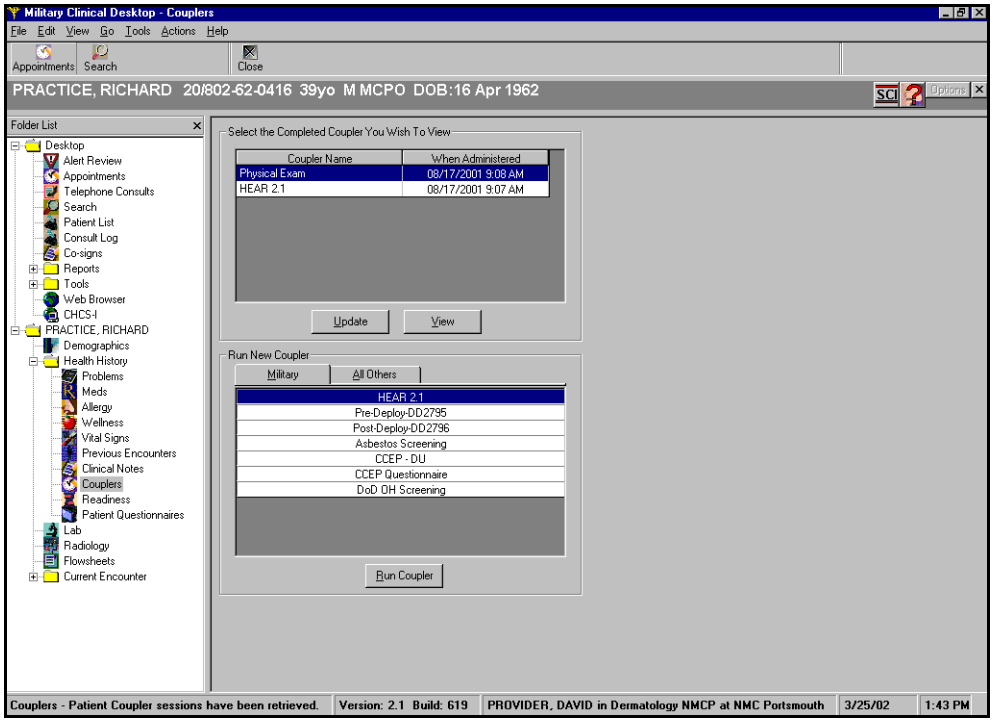

Figure 10-3: PKC Couplers Window

2. Click **View**. The PKC application begins and the completed questionnaire is available to review.

10.6 Updating a Completed PKC Coupler

Completed questionnaires can be updated if they have not been completed or if there are errors that need to be resolved.

To update a completed PKC Coupler:

1. Select the questionnaire to be updated.
2. Click **Update**. The PKC application opens to the completed questionnaire.
3. Update the questionnaire.
4. Save the questionnaire.
5. On the File/Couplers menu, click **Exit & Return to CHCS II**. The updated questionnaire is saved as a separate questionnaire. It does not replace the original questionnaire.

10.7 Starting the HEAR Questionnaire

The HEAR questionnaire can be completed through a stand-alone kiosk. A Clinical Team Member generates a password for the patient to enter when using the kiosk. The password is linked to that specific patient and is active for 24 hours. The ability to

access the Generate Password window is a separate role within CHCS II and must be assigned before performing the following tasks.

To start the HEAR Questionnaire:

1. Access the PKC Couplers window. The Coupler Utility Application window opens (see Figure 10-4: Coupler Utility Application Window).

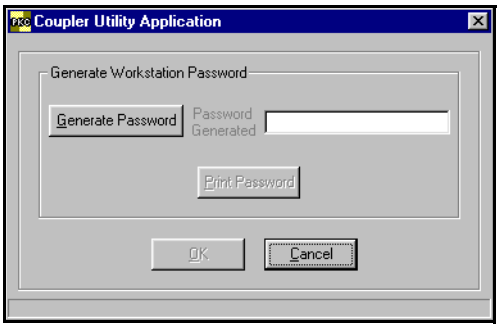

Figure 10-4: Coupler Utility Application Window

2. To create a password for the patient, click **Generate Password**.
3. To print the password for the patient, click **Print Password**.
4. Direct the patient to the kiosk. The patient only has access to the PKC Couplers module to complete the questionnaire.
5. The patient clicks **PKC/HEAR** to view the HEAR Questionnaire Login window (see Figure 10-5: Kiosk Questionnaire Login Window).

Figure 10-5: Kiosk Questionnaire Login Window

6. The patient types the given password and clicks **OK** to launch the questionnaire.
7. The system begins with an opening sequence that presents three options for running the questionnaire. To start, click **Begin Questionnaire**.
8. After answering a survey question, advance through screens in one of the following ways:
   - To continue, click the box marked **Press <F10>** or **Click Here**.
   - Press <**F10**>.
   - On the toolbar, click the **Next Arrow** button.

Note: Press <**F9**> or click **Previous** on the tool bar to see the previous screen.

If answers are missing or are invalid, an error message appears. Click **Yes** to correct the error, **No** to continue.

9. At the end of questionnaire, click **Exit** and Return to CHCS II on File/Couplers on the menu bar.
10. To save the findings and exit the questionnaire, click **Yes**.
11. The patient informs the Clinical Team Member that the questionnaire is complete. The Clinical Team Member returns to the PKC Couplers window and views the Coupler Utility Application window.
12. To import the coupler results, type the name of the stand-alone workstation in the Workstation Name field.
13. To import the results, click **Import to CDR**. When a Clinical Team Member views the PKC Couplers window, the imported questionnaire is available for review.

10.8 Finding Summary Report

This option allows the proctor or provider to access and review the Finding Summary report, which displays the patient's responses under specific headings, after the questionnaire is completed in the PKC application.

To find the summary report:

1. On the Findings menu, click **Finding Summary**. The Finding Summary report opens (see Figure 10-6: Couplers Finding Summary Report).

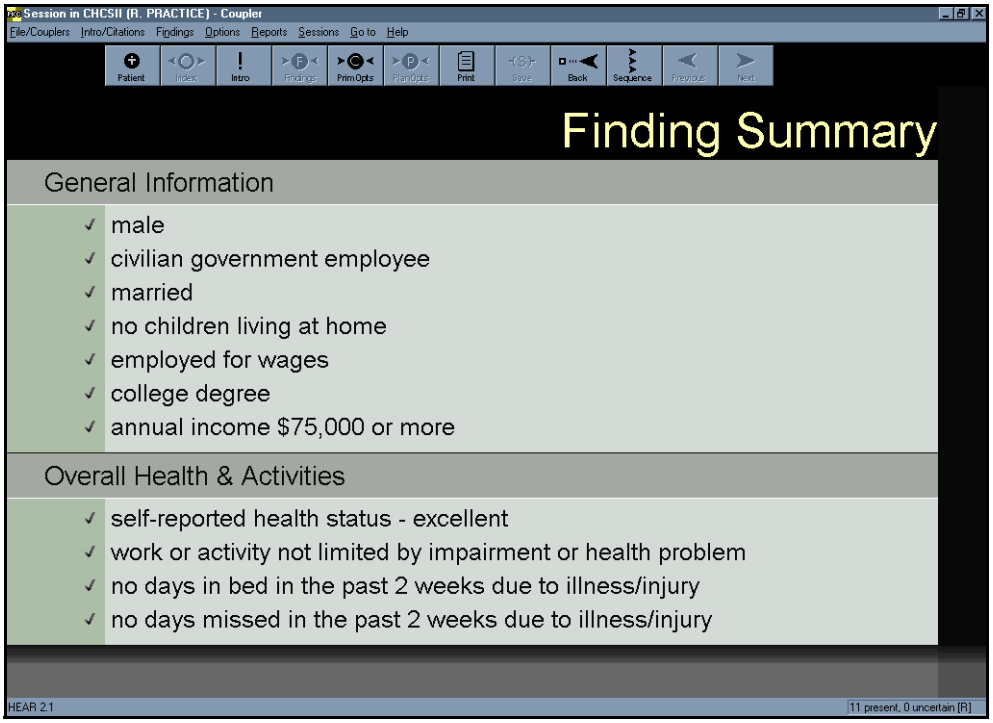

Figure 10-6: Couplers Finding Summary Report

2. View the answers that the patient entered. A checkmark indicates the question has been answered, a question mark indicates an uncertain answer.
3. Double-click an uncertain finding to return to the question in order to answer it completely and correctly.

10.9 Reviewing and Resolving the Finding Error Summary

This option allows the proctor or provider to access and review the Finding Error Summary Report. An error message is displayed whenever the rules of a question have been violated. The patient has the option of either correcting the error by answering the question, or moving forward without making the suggested corrections. All error messages that are not corrected are displayed in the Finding Error Summary Report. From this report, the error can be corrected.

To review and resolve the finding error summary:

1. When the questionnaire is completed, click **Finding Error Summary** on the Findings menu. The Finding Error Summary Report opens (see Figure 10-7: Couplers Finding Error Summary Report).

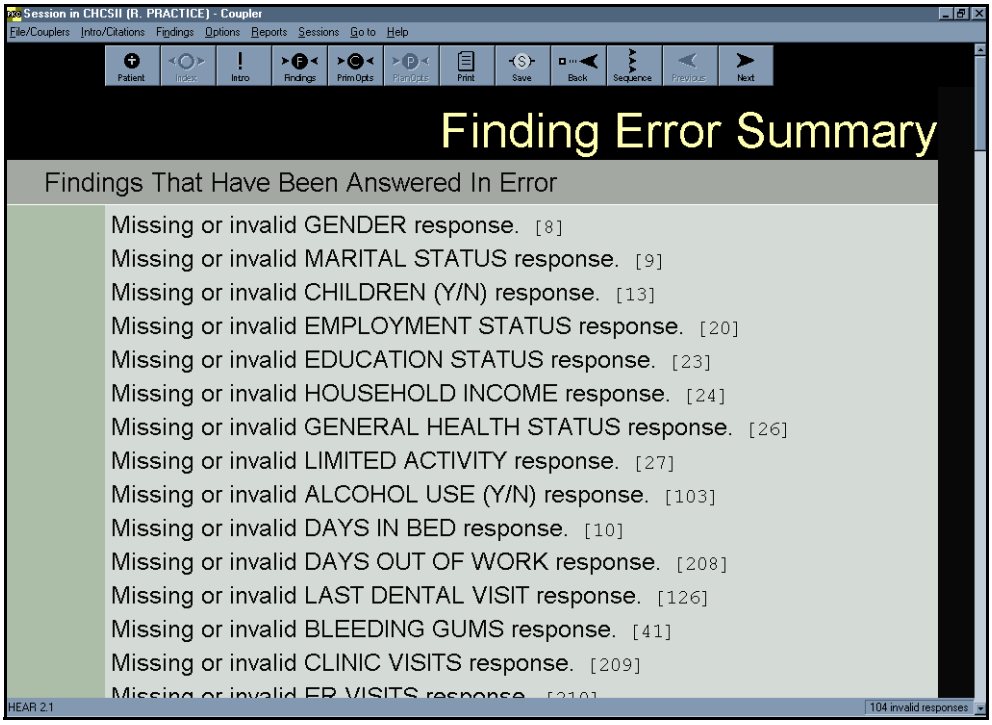

Figure 10-7: Couplers Finding Error Summary Report

2. To resolve any error messages:
   - At the end of the error message, click the number in brackets (e.g., [13]).
   - Correct the error.
   - Repeat steps until all error messages are resolved.
3. At the end of questionnaire, click **File/Couplers** on the menu bar.
4. Click **Exit**.
5. To save findings and exit the questionnaire, click **Yes**.

10.10 Printing or Previewing a Report

To print or preview a report:

1. Access the Reports pull-down menu and select Print Any Reports to view the Print Any Reports window.
2. Select the report to be printed by clicking in the check box next to the desired report.
3. Enter a Report Comment if necessary. If the comment needs to be saved, click **Save as Session Comment**.
4. Select necessary Details for Primary Options to be printed if Details for Primary Options is selected. Highlight the desired Primary Options for Plan Option if Primary Option Index is selected.

5. Click **OK** to print.
6. Click **Reset** to clear any changes made to the form.

Note: The Help button is not functional at this time.

11.0 CO-SIGNS REQUIRED

11.1 Overview of Co-Signs Required

The Co-Signs Required module displays a list of all of the encounters that an individual provider needs to co-sign. The provider can co-sign the appropriate encounters from this window as well as view encounter details, amend the encounter, and add a narrative. The top of the window displays a list of all the encounters requiring co-signatures for the provider logged in. View details of a specific encounter by clicking once on the desired encounter and viewing the details in the bottom half of the window.

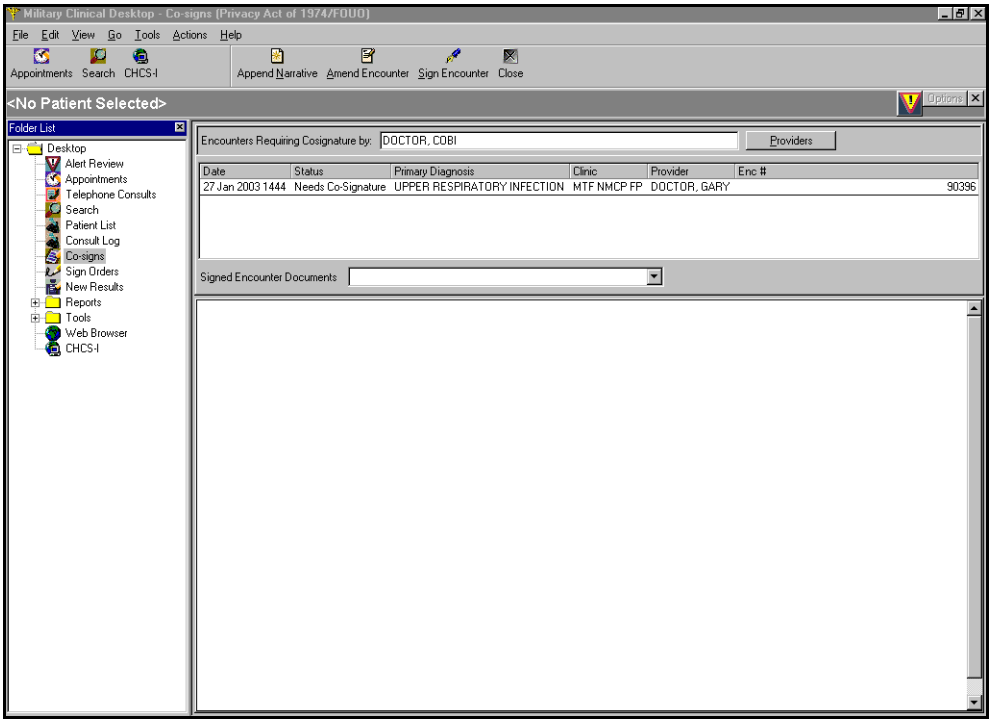

Figure 11-1: Military Clinical Desktop - Co-signs Module

11.2 Action Bar Icons

	Append Narrative	Opens the General Note window to allow a note to be added to the highlighted encounter.
	Amend Encounter	Opens the Patient Encounter window with the details of the highlighted encounter. Allows for changes in the encounter but requires a signature for each section that was amended.
	Sign Encounter	Opens the Sign Encounter Document window, so you can co-sign the selected encounter.
	Close	Closes the Co-Signs Required module.

11.3 Co-Signing an Encounter

All encounters needing co-signatures from the provider currently logged in are listed at the top of the Encounters Requiring Co-Signature window with the status of Needs Co-Signature. The system allows a provider with co-sign authority to access and subsequently co-sign encounter documents on another provider's co-sign list.

To co-sign an encounter:

1. Select the encounter you want to co-sign.
2. Click **Sign Encounter**. The Co-Sign Encounter window opens (see Figure 11-2: Co-Sign Encounter Window).

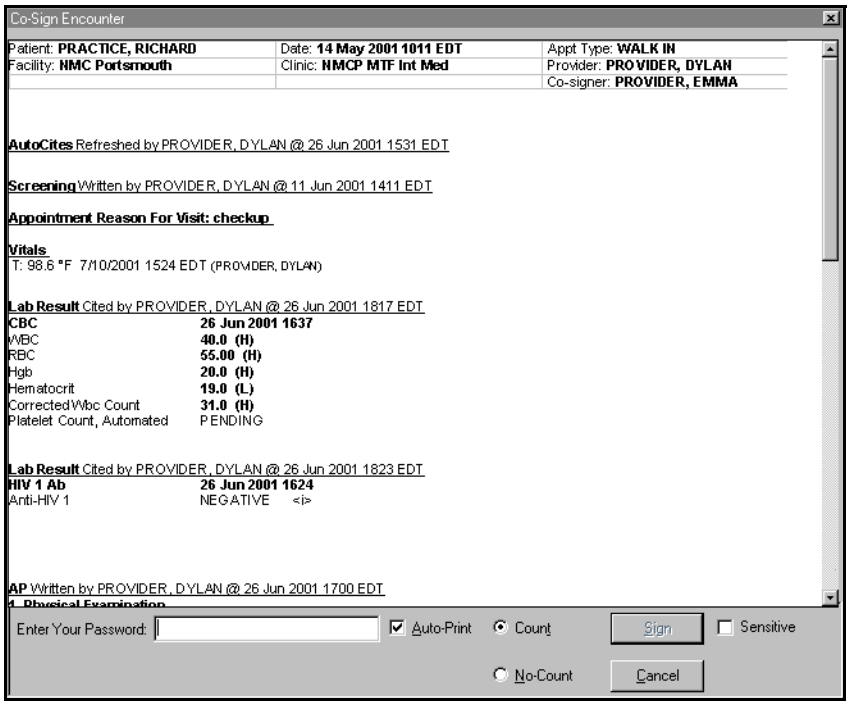

Figure 11-2: Co-Sign Encounter Window

3. In the Enter Your Password field, enter your password.
4. Click **Sign**.

11.4 Co-Signing an Encounter for Another Provider

To co-sign encounters for another provider:

1. Click **Providers** on the Encounters Requiring Co-Signature window. The Clinician Search window opens (see Figure 11-3: Clinician Search Window).

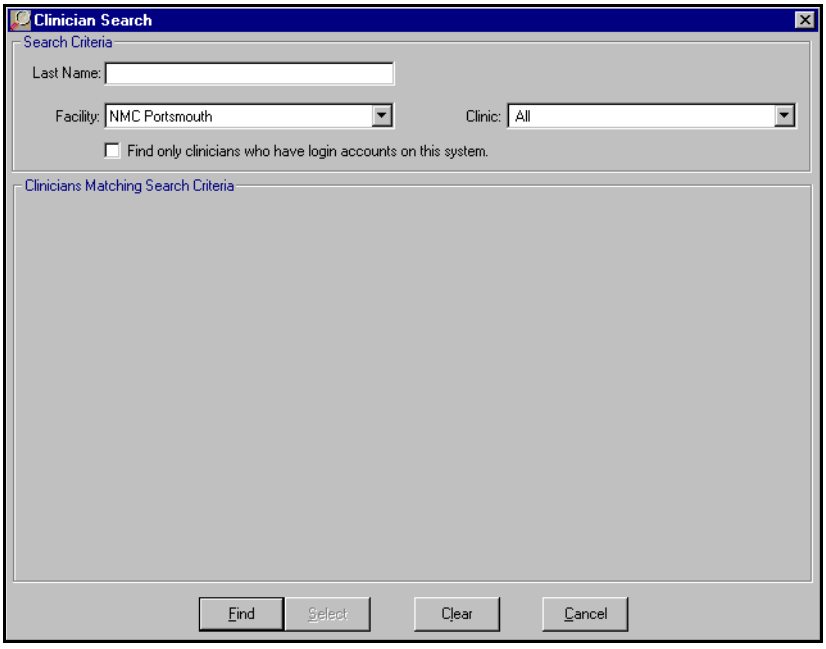

Figure 11-3: Clinician Search Window

2. Search for the clinician. The Co-Signs window displays the list of encounters requiring the selected provider's co-signature (see Figure 11-4: Co-Signs Window).

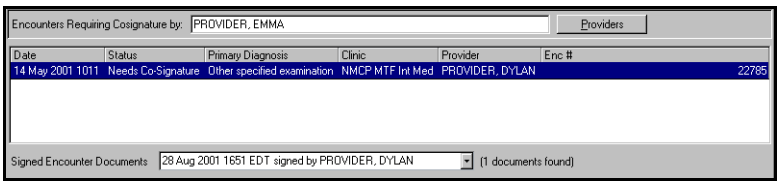

Figure 11-4: Co-Signs Window

3. Select the encounter to be co-signed.
4. Click **Sign Encounter**. The Co-Sign Encounter window opens.
5. In the Enter Your Password field, enter your password.
6. Click **Sign**.

11.5 Appending a Narrative

Information in the Co-Signs window cannot be modified. However, a narrative can be appended to an encounter document.

To append a narrative:

1. Select an encounter.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens (see Figure 11-5: Encounter Note Window).

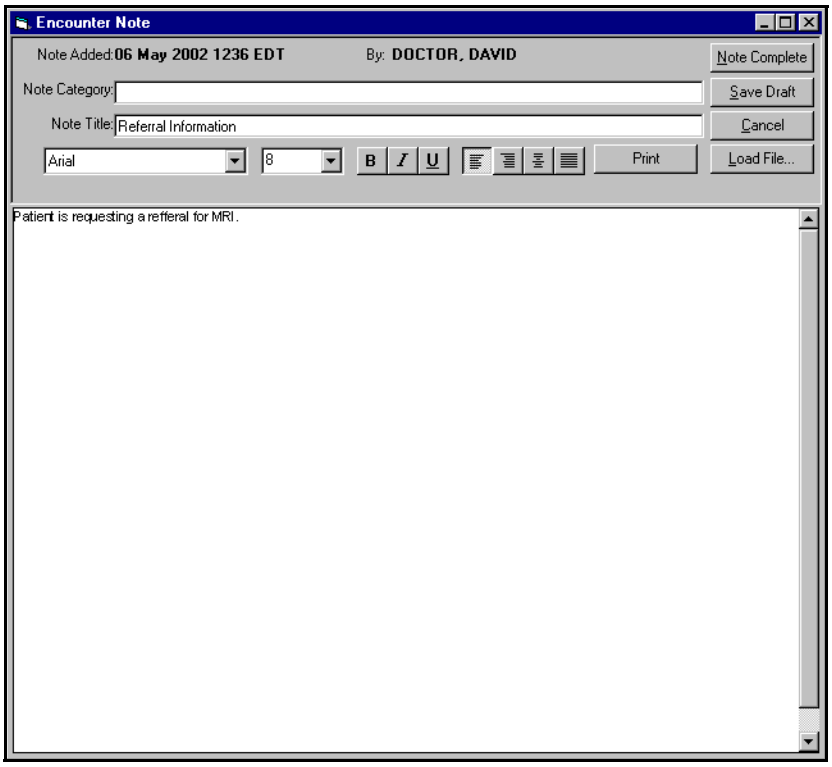

Figure 11-5: Encounter Note Window

3. Enter a note category, if necessary.
4. Enter a note title, if necessary.
5. Enter the note in the text box.
6. Do one of the following:
   - If you want to insert a file into the note:
     a. Click **Load File**. The Select Destination File window opens (see Figure 11-6: Select Destination File Window).

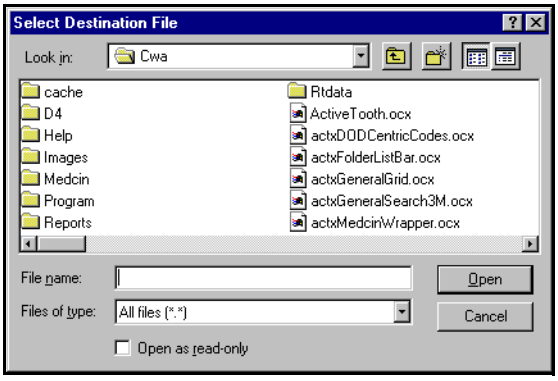

Figure 11-6: Select Destination File Window

b. Select the desired file to be added.

c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.

7. Click **Save and Sign**. The Sign Appended Note window opens, so you can review the narrative before signing (see Figure 11-7: Sign Appended Note Window).

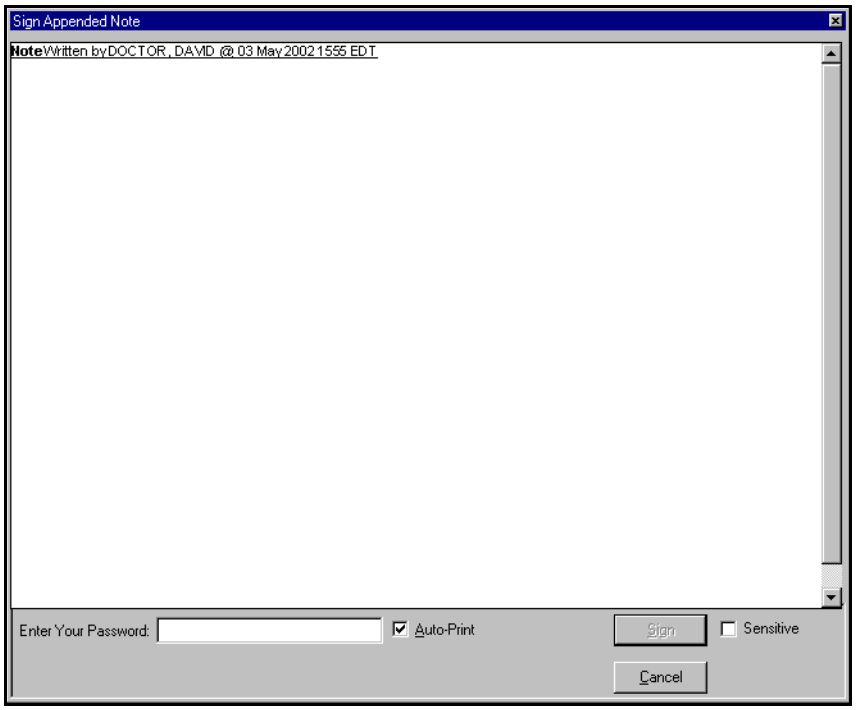

Figure 11-7: Sign Appended Note Window

8. In the Enter Your Password field, enter your password.

Tip:
Click the Sensitive checkbox if you want to mark the appended note as sensitive.

9. Click **Sign**.

Note: The narrative appears at the bottom of the encounter summary with the Time, Date, and Provider name next to the narration. The encounter must still be co-signed.

11.6 Amending an Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. Each section that is amended includes the co-signer's name and date stamp. A note is added to the document under Change History at the bottom of the encounter summary stating that the encounter has been amended.

To amend an encounter:

1. Select the encounter you want to amend.
2. Click **Amend Encounter** on the Action bar. The Patient Encounter window opens for the selected encounter (see Figure 11-8: Patient Encounter Summary).

Figure 11-8: Patient Encounter Summary

3. Update applicable sections of the encounter.
4. Once the changes have been made, you must sign the amended encounter document. Click **Sign** on the Action bar. The Sign Encounter window opens (see Figure 11-9: Sign Encounter Window).

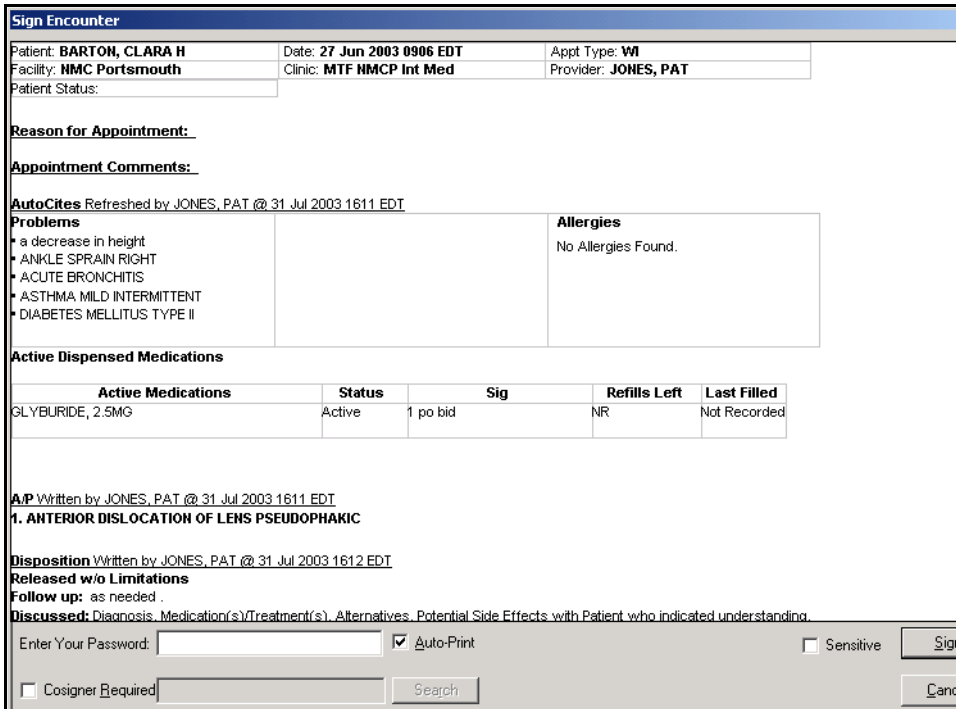

Figure 11-9: Sign Encounter Window

5. In the Enter Your Password field, enter your password.
   - If you do not want to Auto-Print the signed encounter, deselect the **Auto-Print** checkbox.
   - If a cosigner is required, click the **Cosigner Required** checkbox.
   - If the encounter is not being billed, deselect the **No-Count** radio button.
6. Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments.

12.0 DEMOGRAPHICS

12.1 Overview of Demographics

The Demographics module displays the patient's demographic information (see Figure 12-1: Military Clinical Desktop - Demographics Module).

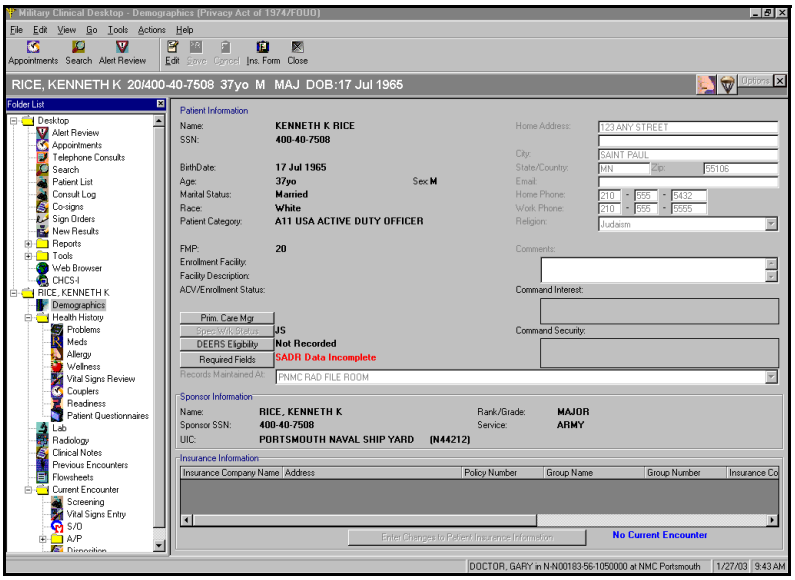

Figure 12-1: Military Clinical Desktop - Demographics Module

Certain demographic information can be updated in the Patient Demographics module. The patient's home address, city, state, zip code, country, home and work phone, religion, comments, and the location of the records can be modified in the Edit mode. Third-Party insurance information, Special Work Status, and Required Fields information can be viewed and modified. Information on a patient's primary care manager and the Defense Enrollment Eligibility Reporting System (DEERS) eligibility cannot be modified.

Note: Any edits to the demographic information will be overwritten by the information held in DEERS.

12.2 Action Bar Icons

	Edit	Allows demographic information to be updated.
	Save	Saves the demographic information.

	Cancel	Cancels any changes.
	Ins. Form	Allows the insurance information to be printed, allowing the patient to review the information and make any changes. The front desk clerk can then go back and update the information in CHCS II.
	Close	Closes the Demographics module.

12.3 Editing Demographic Information

Certain demographic information can be updated in the Patient Demographics window. These fields include a patient's religion, home address, home and work phone, comments, and the location of the records. The rest of the information on the left is read only and can only be updated in CHCS.

To edit demographic information:

1. In the Appointments List, select a patient.
2. In the Folder List, click **Demographics**. The Patient Demographics window opens (see Figure 12-2: Patient Demographics Window).

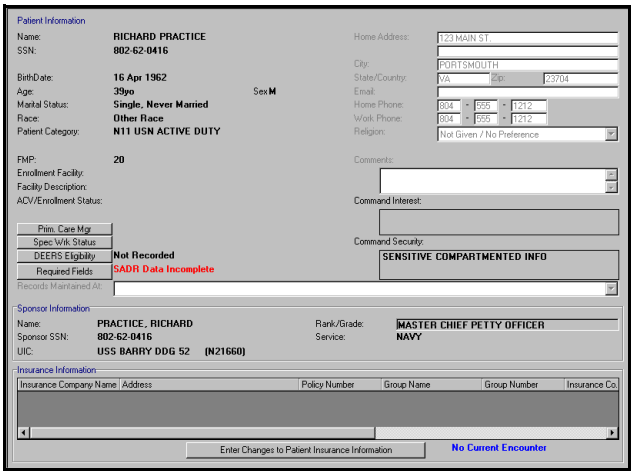

Figure 12-2: Patient Demographics Window

3. On the Action bar, click **Edit**.
4. Update the necessary fields in the Demographics window.
   - **Home Address, Phone Numbers, and E-Mail:** Enter necessary changes in the applicable fields. Tab or use the mouse to move to the next field.

Note: The Country field is limited to twelve characters including spaces.

- **Religion:** Use the drop-down list to select the desired religion.
- **Comments:** In the Comments text box, enter information applicable to the Demographics window.
- **Records Maintained At:** To change the location of the records, use the drop-down list to select the desired location. Use the scroll bar to view all options.

5. On the Action bar, click **Save**. Once the information is saved, it is visible upon returning to the Demographic window.

Note: Perform a right mouse click in any of the test fields to access the editing functions (cut, copy, paste).

12.4 Viewing Primary Care Provider Information

To view primary care provider information:

1. Click **Prim. Care Mgr**. The Primary Care Manager Information window opens containing read only information (see Figure 12-3: Primary Care Manager Information Window).

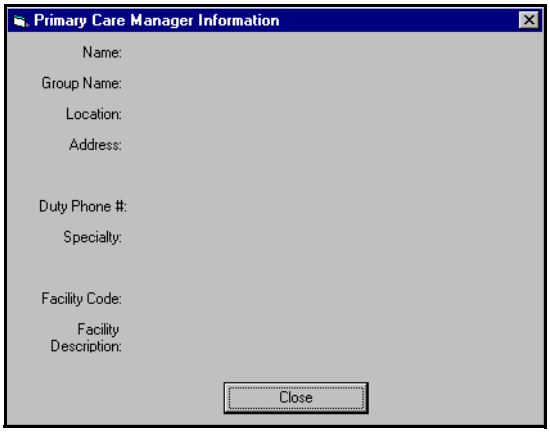

Figure 12-3: Primary Care Manager Information Window

2. To return to the Demographics window, click **Close**.

12.5 Modifying Special Work Status

To modify Special Work Status, an encounter must be open. If an encounter is not open, the **Special Work Status** button is disabled. When an encounter is open, the button is enabled and Special Work Status information can be modified. This information can be modified in the Demographics window, the Screening window and the Disposition window.

To modify special work status:

1. Click **Spec Work Stat**. The Special Work Status window opens (see Figure 12-4: Special Work Status).

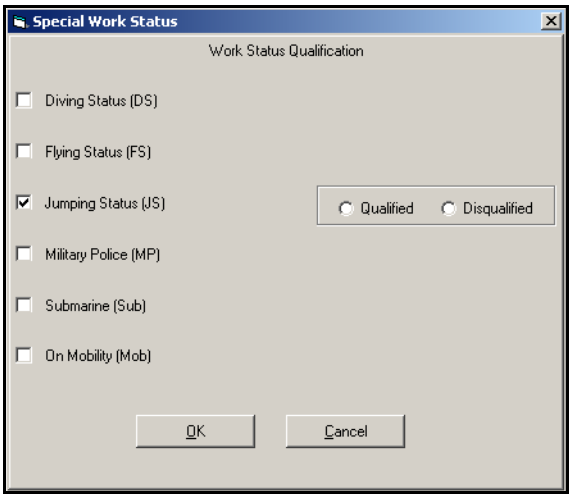

Figure 12-4: Special Work Status

2. Click the checkbox next to each applicable work status.
3. Select **Qualified** or **Disqualified** for the associated work status.

Note: A current encounter must be open to mark a work status as Qualified or Disqualified.

The icon associated with the selected status appears on the Patient ID Line.

---

4. Click **Save**.
5. Click **Close**. You are returned to the Demographics window.

12.6 Viewing DEERS Eligibility

To view DEERS Eligibility:

1. Click **DEERS Eligibility**. The DEERS Eligibility window opens (see Figure 12-5: DEERS Eligibility Window). This is a read-only window.

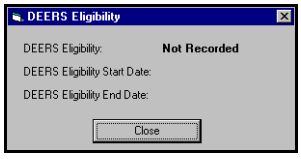

Figure 12-5: DEERS Eligibility Window

12.7 Updating Required Fields

If the fields that are required for each patient have not been completed, Standard Ambulatory Data Record (SADR) Data Incomplete appears in red beside the button.

To update required fields:

1. Click **Required Fields**. The Required Fields window opens (see Figure 12-6: Required Fields Window).

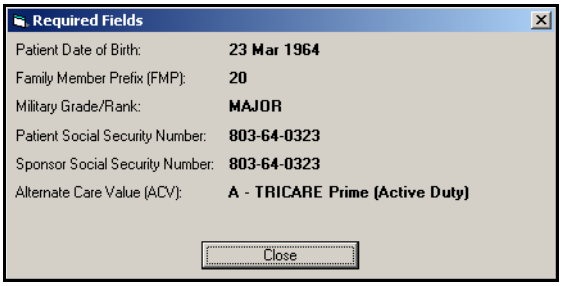

Figure 12-6: Required Fields Window

2. To update the record and open the Demographics window, click **Save Changes**. Once the SADR information is complete, SADR Data Complete appears beside the **Required Fields** button.

Note: Information updated in CHCS II also updates information in CHCS. When the Required Fields window is opened in the future, it is read-only.

12.8 Printing the Insurance Form

A copy of the patient's insurance information can be printed for verification or to note changes. The form can also be printed from the Demographics module.

Note: This form defaults to the current date.

To print the insurance form, click **Ins. Form** on the Action bar. The form is sent to your designated printer.

Note: Basic Demographic information is included on the form with space to update the address and home and work phone numbers, current insurance information with spaces to update, and questions for the patient to answer regarding any changes.

12.9 Entering New Third Party Insurance Information

To enter third party insurance information, an encounter must be open. If an encounter is not open, No Encounter Open displays next to the disabled **Enter Changes to Patient Insurance Information** button. When an encounter is open, the button is enabled and insurance information can be documented.

To enter new third party insurance information:

1. Click **Enter Changes to Patient Insurance Information** at the bottom of the Demographics window. The Patient Insurance Information window opens (see Figure 12-7: Patient Insurance Information Window).

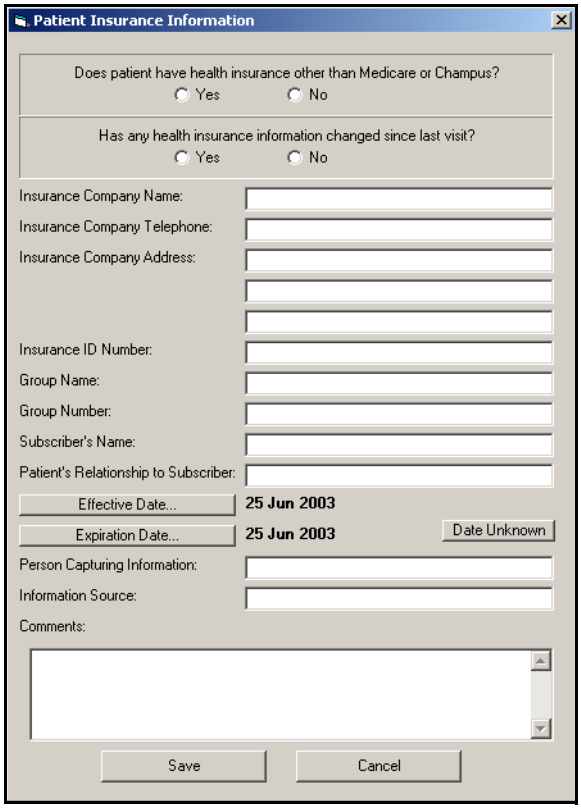

Figure 12-7: Patient Insurance Information Window

2. Click either **Yes** or **No** in response to the first two questions.
3. Enter the applicable information into the following fields:
   - **Insurance Company Name:** Enter the name of the insurance company.
   - **Insurance Company Telephone:** Enter the company's phone number.
   - **Insurance Company Address:** Enter the company's address.
   - **Insurance ID Number:** Enter the policy number.
   - **Group Name:** Enter the name of the group which the subscriber is associated.

- **Group Number:** Enter the group number.
- **Subscriber's Name:** Enter the name of the policy holder.
- **Patient's Relationship to Subscriber:** Enter the relationship of the patient to the person subscribed to the insurance policy.
- **Effective Date/Expiration Date:** To access the Calendar window, click these buttons to select the effective date and the expiration date for the insurance policy.

Note: The system defaults to the current date.

- **Person Capturing Information:** Enter the name of the person filling out this form.
- **Information Source:** Enter the source of the insurance information.
- **Comments:** Enter any comments for this entry.

4. Click **Save**.

13.0 DISPOSITION

13.1 Overview of Disposition

The Disposition window is used to document the disposition and E&M codes of an encounter (see Figure 13-1: Military Clinical Desktop - Disposition Module). In this module, you can record the discharge status of the patient from the clinic, follow-up information, and the patient's understanding of the assessment and plan. In addition, within the Disposition module the E&M codes are automatically calculated. The 1997 HCFA Documentation Guidelines are the basis for E&M coding; therefore, the CHCS II Disposition module pulls parameters from the encounter note. The most important parameters are History, Exam, and Medical Decision.

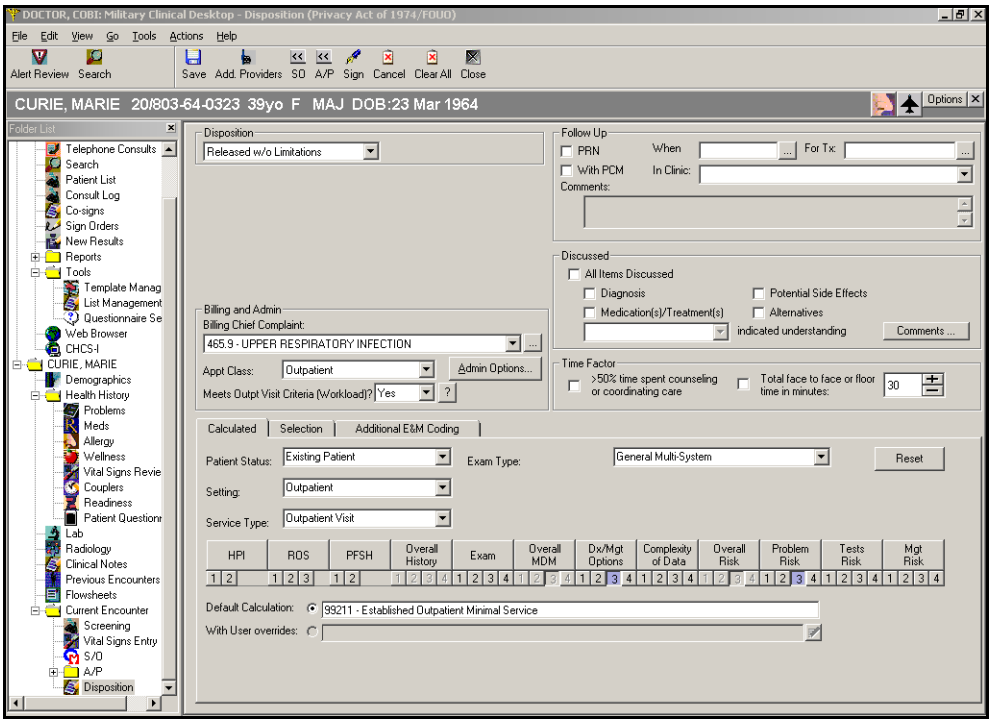

Figure 13-1: Military Clinical Desktop - Disposition Module

13.2 Action Bar Icons

	Save	Allows the current disposition information to be saved.
	Add Providers	Displays the Providers window, so you can add additional providers to the encounter.

	S/O	Saves the information in the Disposition window and takes you to the S/O module.
	A/P	Saves the information in the Disposition window and takes you to the A/P module.
	Sign	Opens the Sign Encounter window.
	Cancel	Closes the Disposition module without saving new information.
	Clear All	Clears the information from the Disposition module.
	Close	Closes the Disposition module and saves any information.

13.3 Completing the Disposition

Completing the disposition for a patient comprises several different sections, each completed in the upper-half of the main window of the Disposition module. After you're done documenting the disposition, you move on to the E&M code calculator--which is located in the bottom-half of the Disposition module.

The following steps walk you through each of these sections in more detail, but let's begin with a brief overview of the process and the description of the different sections.

You begin the Disposition by using the **Disposition list**--located in the upper-left of the window--to document how this patient is disposed. Based on the option you select from this list, you may have to document a time period, a profile, or provide comments explaining the disposition. If needed, appropriate buttons appear after you select a disposition option--simply click the button to document the option in more detail.

With the disposition documented, move down to the **Billing and Admin section**, where you can document the billing information for this visit. This area defaults the primary diagnosis, selected from the A/P module, as the Chief Billing Complaint.

To change the diagnosis used for billing, use the drop-down list to select any diagnoses entered earlier in the A/P module, or click the button associated with the Billing Chief Complaint field. To select the other option, use the provided lists. The Help button provides online help for count/no count criteria.

With the patient disposition documented, move to the right of the window to document the **follow-up information** for this patient. This section enables you to document that the patient should return as needed (PRN) or on a specific date for follow-up or treatment. A comments box enables you to document the specific reason for the follow-up.

Moving down the right side of the window, you next document the **topics you discussed** as part of the follow-up and with whom you discussed them.

To document these topics, either select the option for all of use the provided checkboxes to document specific topics--Diagnosis, Medication and Treatment, Potential

Side Effects, and Alternatives. Finally, use the list to document with whom you discussed these items.

To complete a disposition:

1. Select the patient's disposition from the Disposition drop-down list (see Figure 13-2: Disposition Drop-down List). You can only select one option.

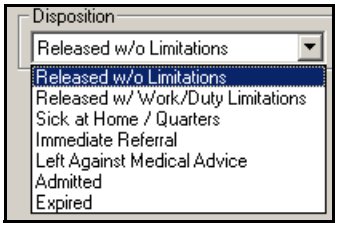

Figure 13-2: Disposition Drop-down List

2. Do one of the following:
   - If **Released w/o Limitations** is selected, go to step 3.
   - If **Released with Work/Duty Limitations** is selected, click **Profile** to document the limitation.
   - If **Sick at Home/Quarters** is selected, specify the correct time period (24, 48 or 72 hours).
   - If **Immediate Referral** is selected, enter the provider's name to whom the patient is being referred.
   - If **Left Against Medical Advice** is selected, click **Comments** to document detailed information on the patient's action.
   - If **Admitted** is selected, click **Comments** to document any information.
   - If **Expired** is selected, click **Comments** to document any information.
3. Select if the patient **Meets Outpt Visit Criteria (workload)**.
   - Select the **Meets Visit Criteria** by selecting Yes or No from the drop down box. An explanation of Count/No Count is instantly available by clicking the **?** button.
4. Select a **Follow Up** action.
5. Select disposition issues discussed with the patient.
6. Click the **Admin Options** button in the Billing and Admin pane. The Admin Options window opens (see Figure 13-3: Administrative Options Window)
7. Complete the information necessary in the Administrative Options window.

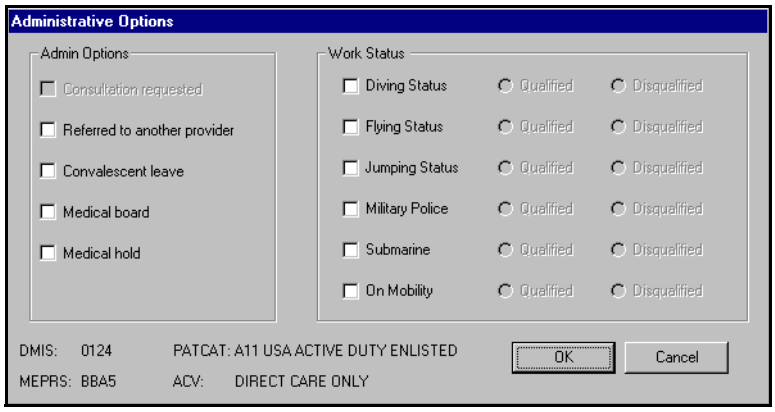

Figure 13-3: Administrative Options Window

- **Admin Options:** Place a check in the checkboxes to denote Referred to Another Provider, Convalescent Leave, Medical Board, or Medical Hold.
- **Work Status:** Click the appropriate checkbox to denote the patient's work status. Once a work status is selected, qualification fields become active allowing for the qualification or disqualification of the status. Select the appropriate radio button to denote qualification.

8. Click **Save** on the Action bar.

13.4 Calculating the E&M Code

If a visit is a count visit for billing purposes, the **E&M calculator** populates the bottom of the Disposition module. When you arrive at the Disposition module, the system calculates the E&M code based on your documentation in S/O and A/P. This code is also based on the Patient Status and Service type as well as default time factors for the visit.

To begin, let’s discuss the three lists provided in the Calculator--Patient Status, Setting, and Service Type.

These three lists are important for determining the E&M code. When you arrive at the Disposition module, these lists default to the values that either you selected or were determined based on the patient’s record when you created each appointment.

For example, if an existing patient comes into your clinic for an outpatient visit, and you selected these values when you created the appointment, Existing Patient, Outpatient, and Outpatient Visit populate the appropriate lists by default. A patient’s status defaults to new based on their patient record--if the patient has not visited your clinic or specialty in the past three years, she is assigned a status of New.

Patient status is very important--as the calculator factors the extra time needed for a new patient into its calculation.

Time factors are also important for calculating an accurate E&M code. In this section, you can document any time-related factors--including time spent counseling and time spent face-to-face with patient--that affect the E&M code for a visit. Time spent with patient defaults to the scheduled duration of the appointment.

To complete this section, simply select the option you want--and if documenting face-to-face time, select the amount of time in the provided list.

To calculate the E&M code:

1. E&M codes are automatically calculated based on selections made during the encounter (see Figure 13-4: Calculated Tab). If you want to override the defaulted calculations:

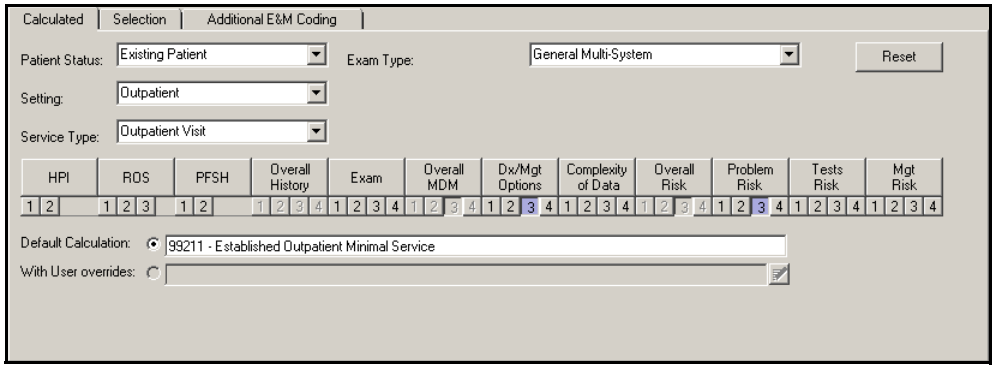

Figure 13-4: Calculated Tab

   a. Click the desired numerical button (see Figure 13-5: Calculated Tab - User Override Selected).

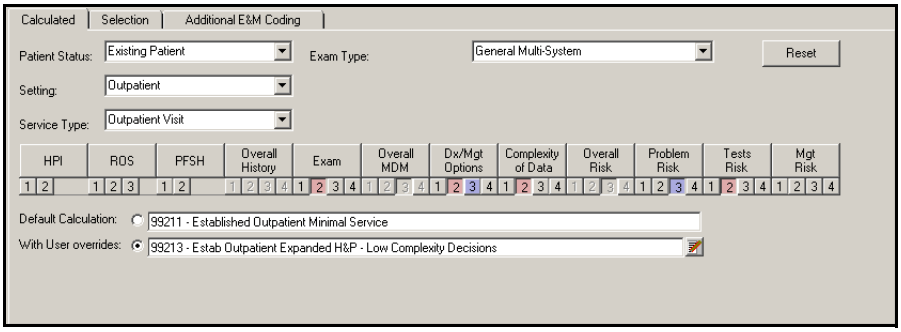

Figure 13-5: Calculated Tab - User Override Selected

   b. Select the **With User overrides** radio button.

   c. Make desired changes to any of the other defaulted entries on the Calculated tab.

Note: Patient Status will default to New Patient if the patient has not been seen in the same clinic/specialty within the past three (3) years.

The E&M calculator Face-to-Face time field defaults to the scheduled appointment duration.

The Total Face-to-Face time and >50% of time spent counseling are written in the Encounter Summary Document.

- If you want to manually select the code:
  a. Click the **Selection** tab (see Figure 13-6: Selection Tab).

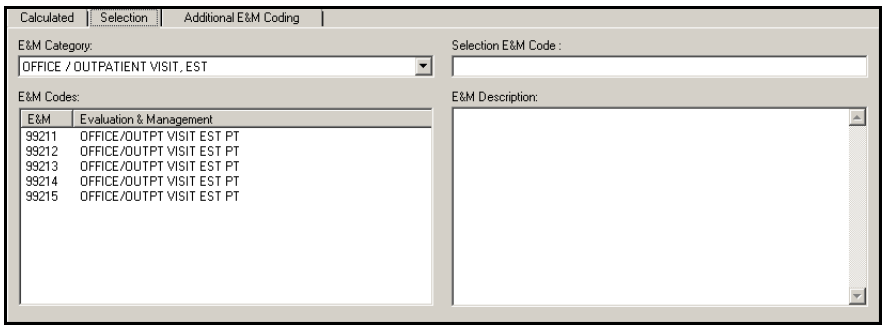

Figure 13-6: Selection Tab

  b. Select an **E&M Category** from the drop-down list.
  c. Select an E&M code from the results list for the associated E&M category. The E&M code and E&M help fields automatically populate with detailed code information.

Note: If this is a telephone consult, only categories for the telephone consults are listed.

- If you want to select coding modifiers:
  a. Click the **Additional E&M Coding** tab
  b. Select additional coding modifiers from the drop-down lists

Note: The Calculated and Additional E&M Coding tabs are only enabled if the Workload is set to count.

13.5 Adding a Provider During Disposition

An additional provider can be added to an encounter to receive credit for work done for a patient.

To add an additional provider:

1. Click **Add Providers** on the Action bar. The Providers window opens (see Figure 13-7: Providers Window).

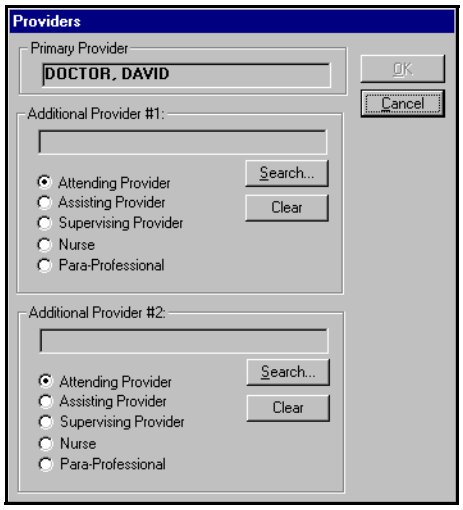

Figure 13-7: Providers Window

2. Click the applicable radio button for the type of clinician you want to add.
3. Click **Search** in the Additional Provider #1 area. The Clinician Search window opens (see Figure 13-8: Clinician Search Window).

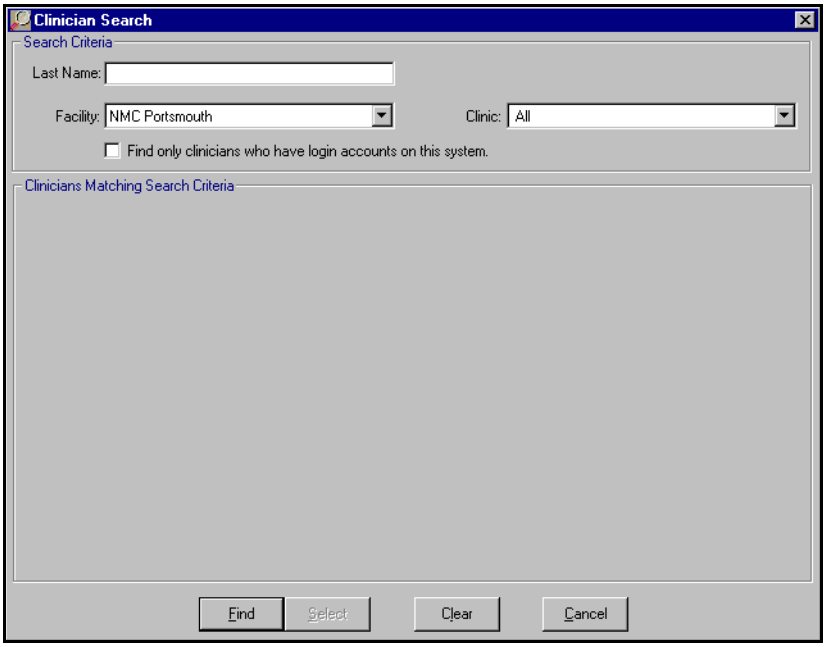

Figure 13-8: Clinician Search Window

4. In the Last Name field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the checkbox to view only providers associated with CHCS II, if necessary.

8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the Additional Provider field on the Providers window.

Note: Repeat steps 2–10 if you want to add a second clinician.

11. Click **OK**. The clinician(s) is added to the patient encounter.

14.0 RX ALTERNATIVES

14.1 Overview of Rx Alternatives

The Rx Alternatives module (see Figure 14-1: Military Clinical Desktop - Rx Alternatives Module) allows you to track the cost of primary and alternative medications. When you add the cost associated with a medication in this module, the information is used in populating population health drug cost reporting data.

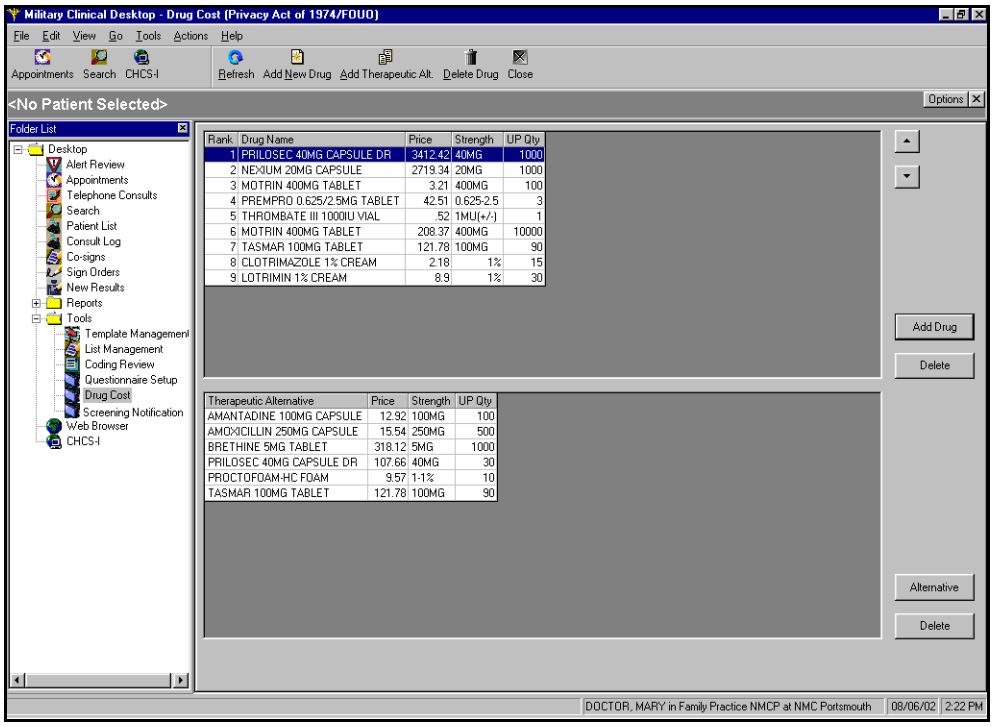

Figure 14-1: Military Clinical Desktop - Rx Alternatives Module

14.2 Action Bar Icons

	Refresh	Refreshes updated information in the Rx Alternatives window.
	Add New Drug	Allows you to add a new drug to the drug cost list.
	Add Therapeutic Alt.	Allows you to add a therapeutic alternative medication to the drug cost list.

	Delete Drug	Allows you to delete a medication from the drug cost list.
	Close	Closes the Rx Alternatives module and saves any information.

14.3 Setting Drug Display Options

The Drug Display Options window lets you establish the type of data that displays when primary and alternative medications are added to the Rx Alternatives module.

To set the drug display options:

1. On the Rx Alternatives window, click **Options** to open the Drug Display Options window (see Figure 14-2: Drug Display Options Window).

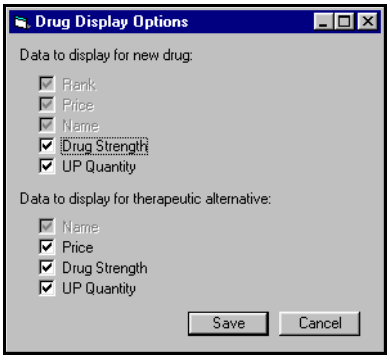

Figure 14-2: Drug Display Options Window

2. Select data options to display for the new drug:
   - Rank
   - Price
   - Name
   - Drug Strength
   - UP Quantity
3. Select data options to display for therapeutic alternative drugs:
   - Name
   - Price
   - Drug Strength
   - UP Quantity
4. Click **Save**.

14.4 Adding a New Drug

The Select Drugs window (see Figure 14-3: Select Drugs Window) allows you to add new drug cost information to the Rx Alternatives module. You can add drugs according to their name or description.

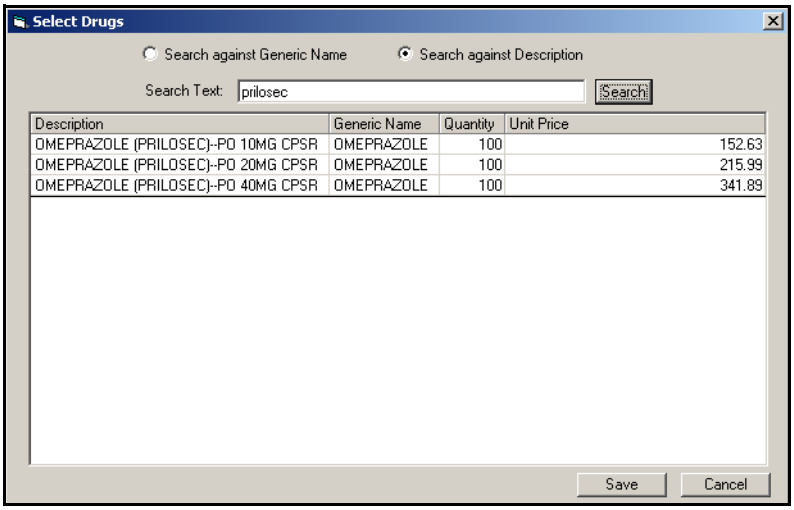

Figure 14-3: Select Drugs Window

To add a new drug:

1. On the Rx Alternatives window, click **Add New Drug** to open the Select Drugs window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the Search Text field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.

Note: To select more than one medication, press the **Ctrl** key on the keyboard while you are selecting each medication.

Tip:
*If you do not see the added medication(s), on the Rx Alternatives window, click **Refresh**.*

7. Click **Save**. You are returned to the Rx Alternatives window.

14.5 Adding Therapeutic Alternatives

The Select Therapeutic Alternative window (see Figure 14-4: Select Therapeutic Alternative Window) allows you to add therapeutic alternative drug cost information

to the Rx Alternatives module for selected primary drugs. You can add therapeutic alternatives according to their name or description.

Note: You must have a primary drug selected before you can add a therapeutic alternative.

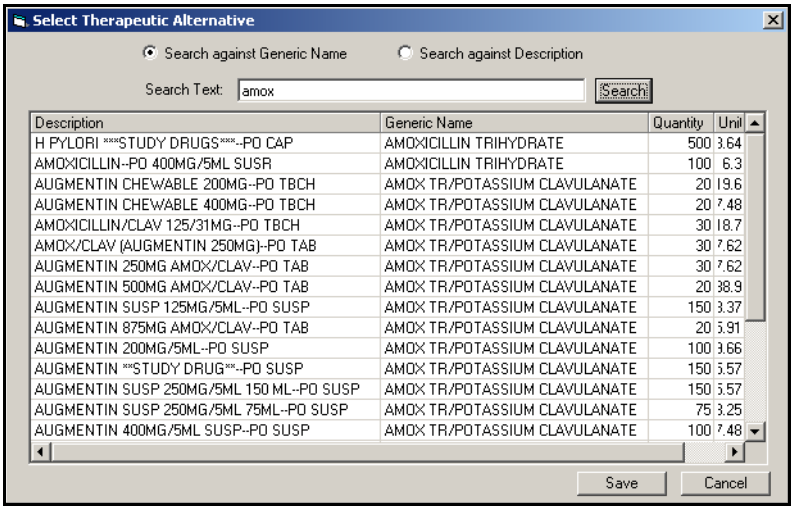

Figure 14-4: Select Therapeutic Alternative Window

To add therapeutic alternatives:

1. On the Rx Alternatives window, click **Add Therapeutic Alt** to open the Select Therapeutic Alternative window.
2. If you want to search for the drug by name, select **Search against Generic Name**.
3. If you want to search for the drug by description, select **Search against Description**.
4. In the Search Text field, enter the drug name or description.
5. Click **Search**.
6. Select the medication you want to add.
7. Click **Save**. You are returned to the Rx Alternatives window.

Tip:
*If you do not see the added medication(s), on the Rx Alternatives window, click **Refresh**.*

14.6 Deleting a Drug

To delete a drug from the Rx Alternatives window:

1. In the Rx Alternatives window select the primary or alternative drug you want to delete.
2. On the action bar, click **Delete Drug**.
3. At the Delete Drug Ranking confirmation prompt, click **Yes**.

Tip:
*If you want to delete the therapeutic alternative but keep the primary drug, in the Therapeutic Alternative area, select the alternative and click **Delete**.*

15.0 FLOWSHEETS

15.1 Overview of Flowsheets

The purpose of the Flowsheets module (see Figure 15-1: Military Clinical Desktop - Flowsheets Module) is to display multiple data items such as lab values, medication profile (drug, dosage, and frequency), and vital signs in a chronological descending format over a period of time without having to open an encounter. To access this module, you must select a patient.

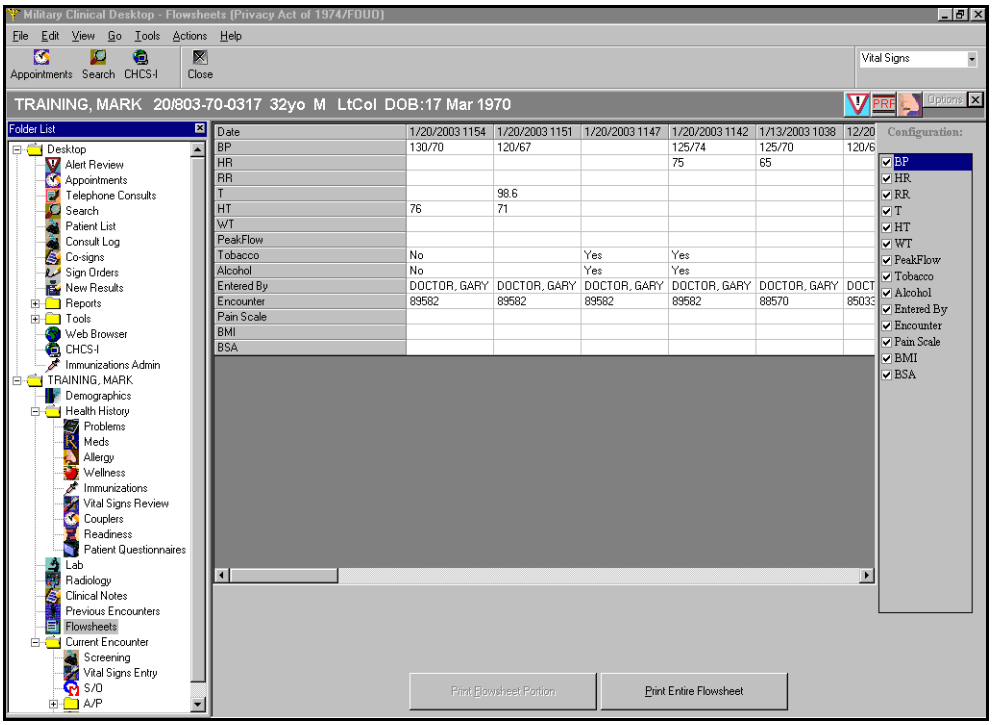

Figure 15-1: Military Clinical Desktop - Flowsheets Module

15.2 Action Bar Icons

	Close	Closes the Flowsheets module.

15.3 Viewing Flowsheets

When you access the Flowsheet module, the Vital Signs Flowsheet is displayed by default (see Figure 15-1: Military Clinical Desktop - Flowsheets Module).

- **Filter:** To view additional flowsheets, select **Lab Results** or **Medications** in the drop-down filter, in the upper, right corner. A flowsheet is created with all past data.
- **Configuration:** The Flowsheet can be configured to show desired information by clicking in the checkbox next to the desired information shown at the right of the Flowsheet window.

Note: Items in the Configuration Panel pertain only to the selected flowsheet.

15.4 Printing Flowsheets

To print flowsheets:

1. Select the flowsheet you want to print:
   - Vital Signs
   - Lab Results
   - Medications
2. Do one of the following:
   - If you want to print the entire flowsheet, click **Print Entire Flowsheet**. The worksheet is sent to your local printer.
   - If you want to print a portion of the flowsheet:
     a. Select the portion of the flowsheet you want to print.
     b. Click **Print Flowsheet Portion**.

Note: The Print Flowsheet Portion button is inactive until the columns are selected.

16.0 HEALTH HISTORY

16.1 Overview of Health History

The Health History window displays patient historical data from various modules in one window (see Figure 16-1: Military Clinical Desktop - Health History Module). The window can be customized to show different modules containing the patient's historical information.

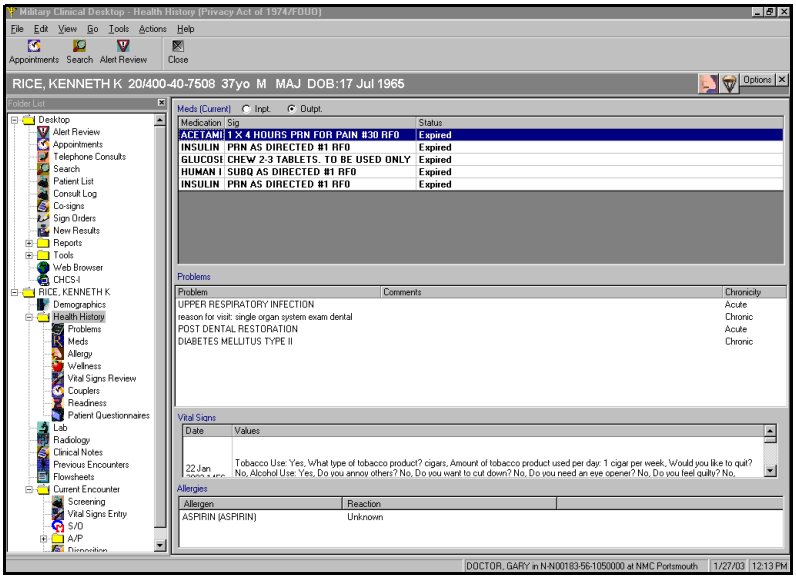

Figure 16-1: Military Clinical Desktop - Health History Module

16.2 Action Bar Icons

	Close	Closes the Health History window.

16.3 Customizing Health History

To customize Health History:

1. Click **Options** on the Health History window. The Design Summary window opens (see Figure 16-2: Design Summary Window).

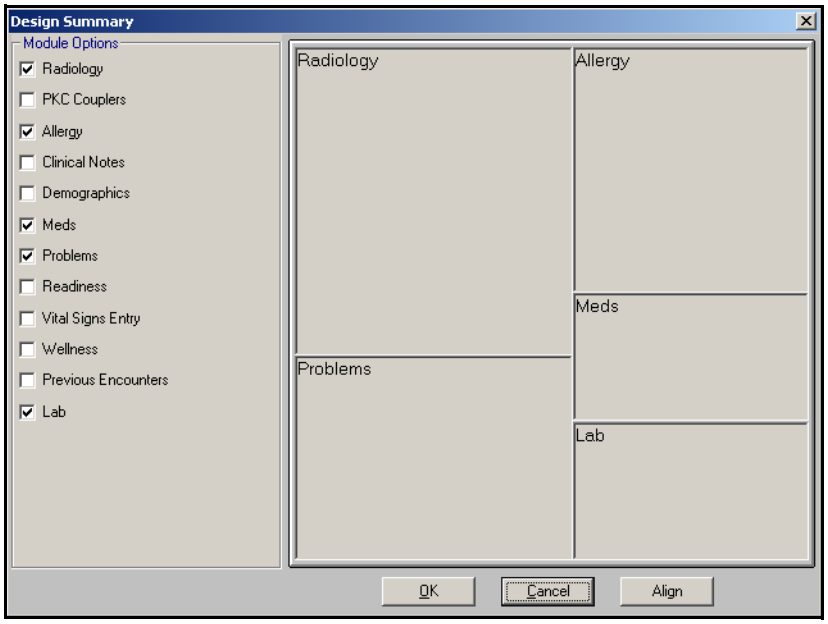

Figure 16-2: Design Summary Window

2. Select **Module Options** in which you want patient information to display in the Health History window.
3. Click **Align** to allow the system to place the selected modules.

Note: You can also position and size each selected module by clicking and dragging each one separately.

---

4. Click **OK**.

16.4 Viewing Historical Modules

Modules selected for display on the Health History window are easily accessible.

To view Historical modules, in the Health History window, double-click the desired module you want to open. The selected module opens.

17.0 IMMUNIZATIONS ADMIN

17.1 Overview of Immunizations Admin

The Immunization Admin module (see Figure 17-1: Military Clinical Desktop - Immunizations 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 contains two tabs: Admin and Multiple Entry. The Immunizations Admin module can be accessed without having a patient's record open.

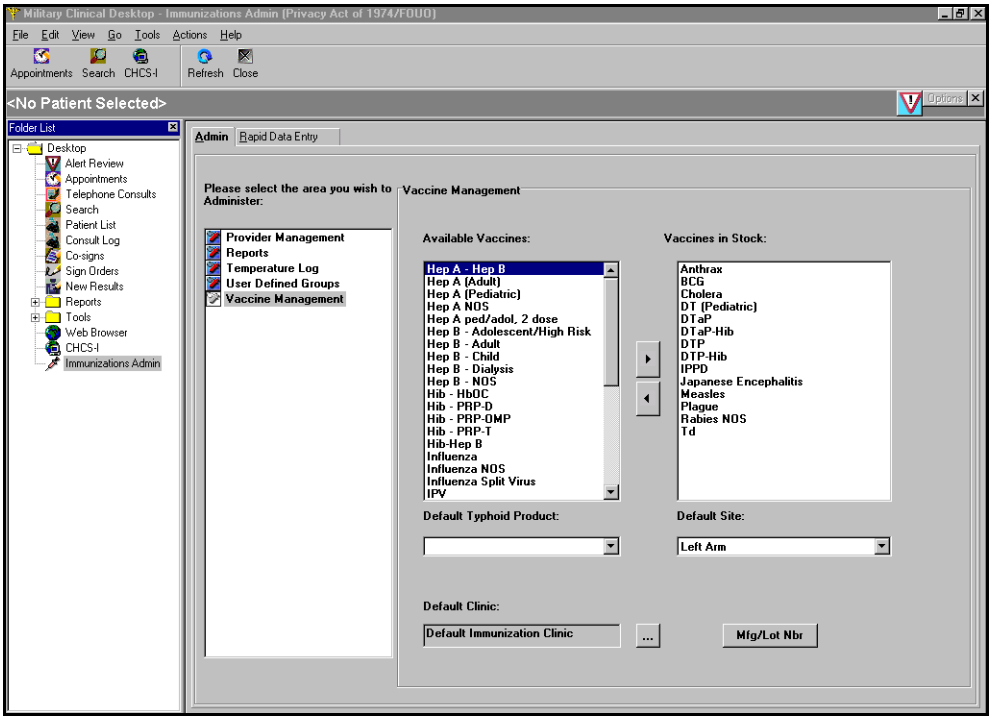

Figure 17-1: Military Clinical Desktop - Immunizations Admin Module

17.2 Action Bar Icons

	Refresh	Refreshes updated information documented in the Immunizations Administration and Management areas.
	Close	Closes the Immunization admin module.

17.3 Adding User Defined Groups

To add user defined groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays (see Figure 17-2: Immunizations Admin—User Defined Groups).

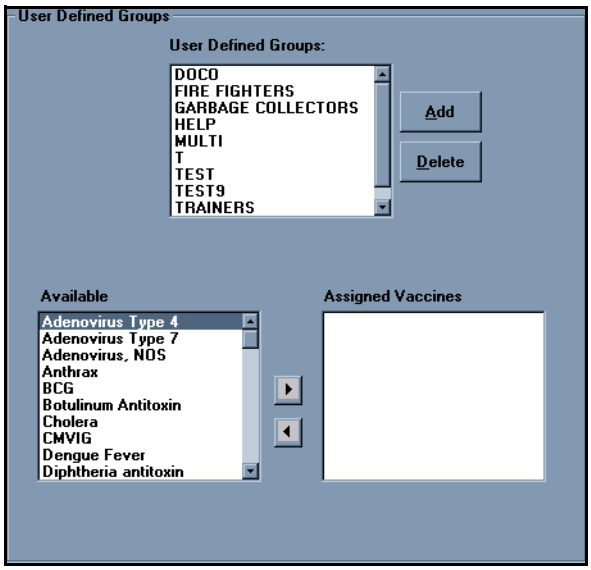

Figure 17-2: Immunizations Admin—User Defined Groups

2. Click **Add**. The Add User Defined Group window opens (see Figure 17-3: Add User Defined Group Window).

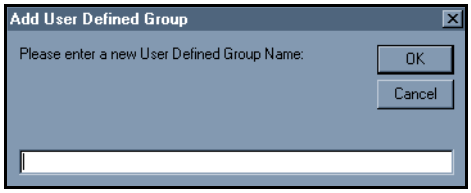

Figure 17-3: Add User Defined Group Window

3. Enter the name of the user group you want to add.
4. Click **OK**.

17.4 Adding a Refrigerator

To add a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays (see Figure 17-4: Immunizations Admin—Temperature Log).

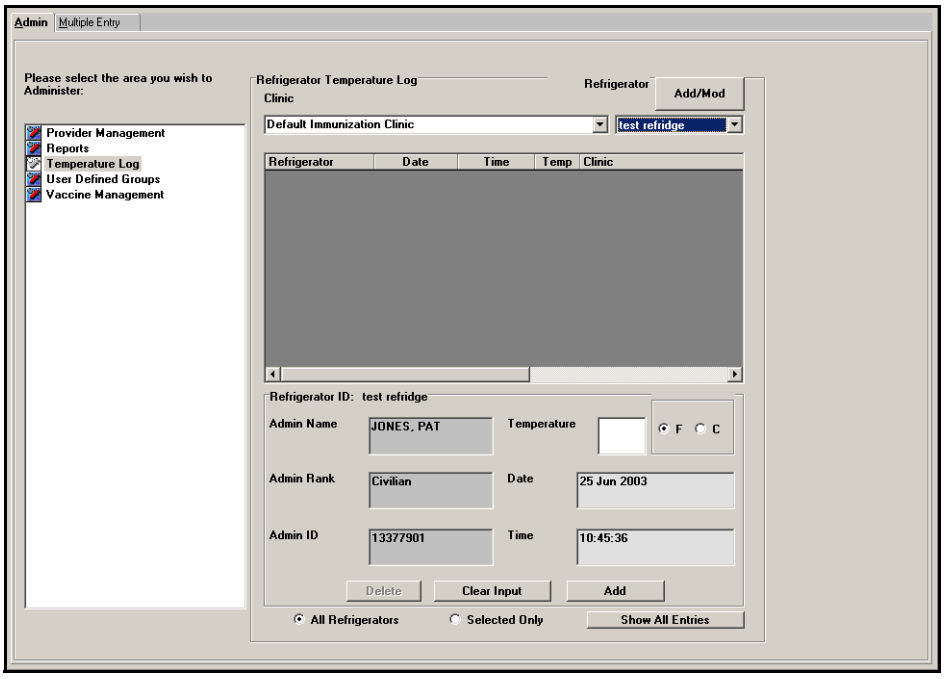

Figure 17-4: Immunizations Admin—Temperature Log

2. Select the clinic for which you are adding the refrigerator.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens (see Figure 17-5: Add/Modify a Refrigerator Window).

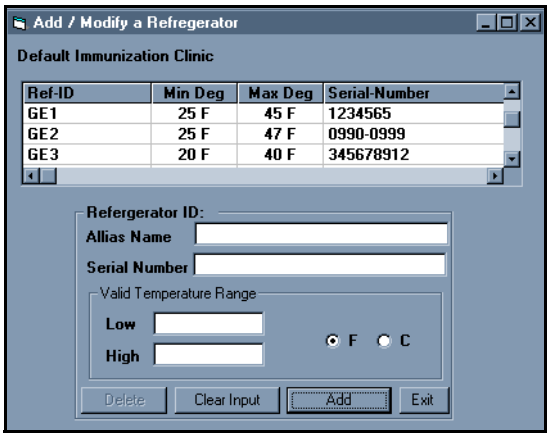

Figure 17-5: Add/Modify a Refrigerator Window

4. Complete the following fields:
   - **Alias Name:** Enter the name of the refrigerator (such as, Maytag, GE, Westinghouse)
   - **Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.
   - **Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature the refrigerator should ever operate.

- **High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature the refrigerator should ever operate.

5. Click **Add**.

17.5 Adding a Vaccine for Multiple Entry

To add a vaccine for multiple entry:

1. Click **Add** on the Multiple Entry tab. The Vaccines in Stock window opens (see Figure 17-6: Vaccines in Stock Window).

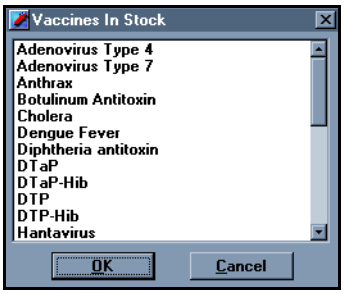

Figure 17-6: Vaccines in Stock Window

2. Select a vaccine from the list of available vaccines.
3. Click **OK**. The vaccine is added to the list of vaccines on the Multiple Entry tab (see Figure 17-7: Immunizations Admin—Multiple Entry Tab).

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

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

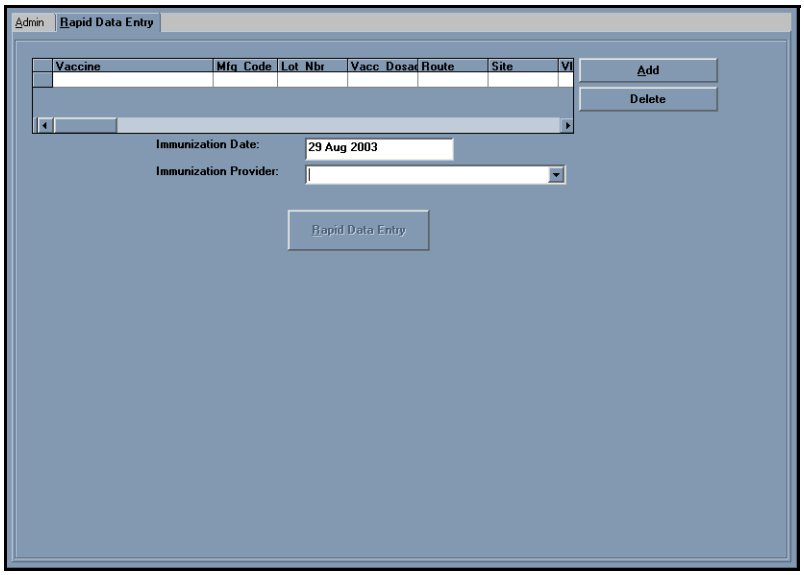

Figure 17-7: Immunizations Admin—Multiple Entry Tab

17.6 Assigning Vaccines to User Defined Groups

To assign vaccines to User Defined Groups:

1. Click **User Defined Groups** on the Admin tab. The User Defined Groups area displays (see Figure 17-8: Immunizations Admin—User Defined Groups).

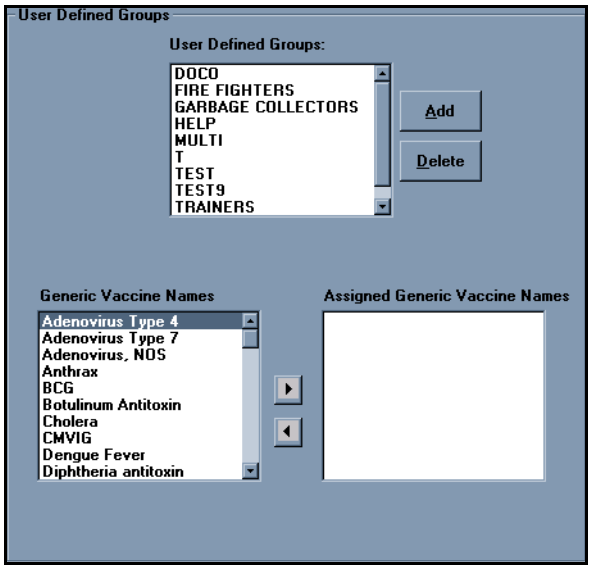

Figure 17-8: Immunizations Admin—User Defined Groups

2. Select a **User Defined Group**.
3. Select a vaccine from the Available vaccine list.

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

17.7 Deleting Providers from Administering Immunizations

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

To delete a provider from administering immunizations:

1. Click **Provider Management** on the Admin tab. The Provider Management area displays (see Figure 17-9: Immunizations Admin—Provider Management).

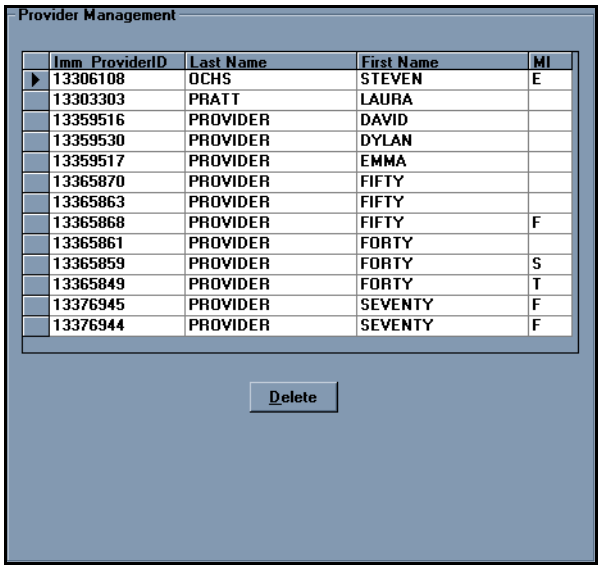

Figure 17-9: Immunizations Admin—Provider Management

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

17.8 Entering Multiple Vaccines for a Patient

To enter multiple vaccines for a patient (see Figure 17-10: Immunizations Admin—Multiple Entry Tab):

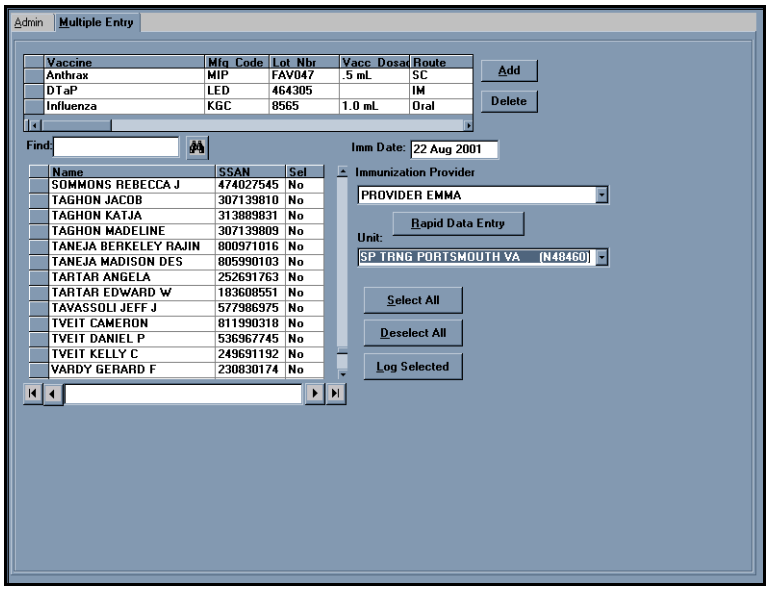

Figure 17-10: Immunizations Admin—Multiple Entry Tab

1. Select an **Immunization Provider** from the drop-down list on the Multiple Entry tab.

Note: The Immunization Date field defaults to the current date. Enter the applicable date in the field if the current date is not the correct date.

---

2. Select the **Unit** in which the patient is located from the drop-down list. A list of patients assigned to the unit is displayed.
3. Select the patient for which you want to enter multiple vaccines.
4. Click the **Select** field for the associated patient and click the down arrow to select the patient.

Note: Click **Select All** if you want to enter the same multiple vaccines for every patient in the list.

---

5. Click **Log Selected**.

17.9 Logging Refrigerator Temperatures

To log refrigerator temperatures:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays (see Figure 17-11: Immunizations Admin—Temperature Log).

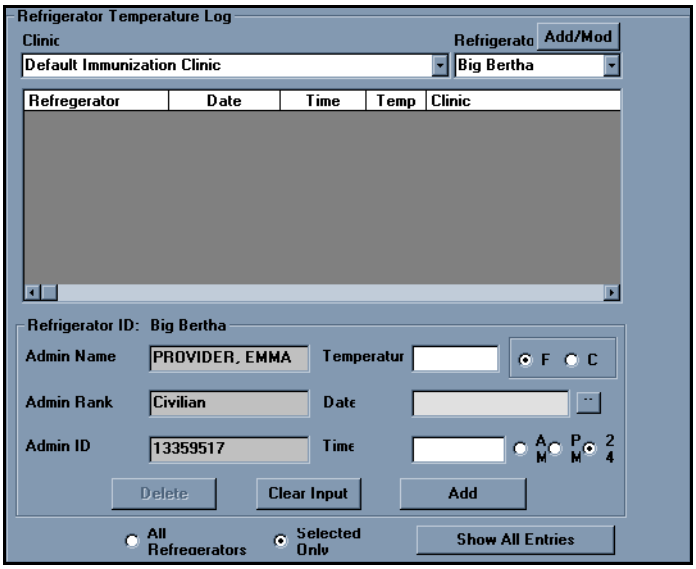

Figure 17-11: Immunizations Admin—Temperature Log

2. Select a clinic from the drop-down list.
3. Select a refrigerator from the drop-down list.
4. Complete the following fields:
   - **Temperature:** Enter the temperature of the refrigerator you are logging in the system. You can enter a temperature in degrees Fahrenheit or Celsius.
   - **Date:** Click the **Ellipsis** button to open the Date Builder window and select the date you are logging the temperature.
   - **Time:** Enter the time you are logging the temperature. You can enter the time in AM, PM, or Military.
5. Click **Add**.

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

17.10 Modifying Refrigerator Temperature Logs

To modify refrigerator temperature logs:

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

4. Click the **Selected Only** radio button.

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

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

17.11 Modifying a Refrigerator

To modify a refrigerator:

1. Click **Temperature Log** on the Admin tab. The Refrigerator Temperature Log area displays.
2. Select a clinic from the drop-down list.
3. Click **Add/Mod**. The Add/Modify a Refrigerator window opens (see Figure 17-12: Immunizations Admin—Add/Modify a Refrigerator).

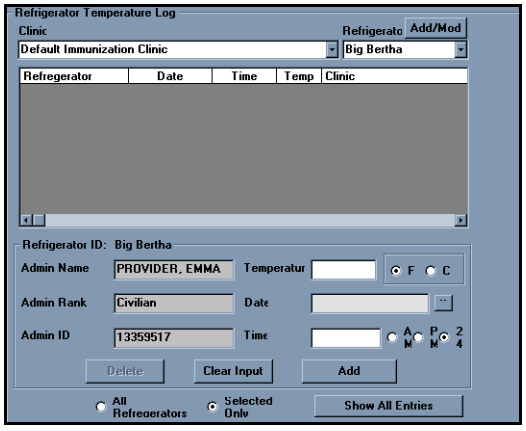

Figure 17-12: Immunizations Admin—Add/Modify a Refrigerator

4. Double-click the refrigerator you want to modify.
5. Update the following fields, as necessary.
   - **Alias Name:** Enter the name of the refrigerator (such as, Maytag, GE, Westinghouse)
   - **Serial Number:** Enter the refrigerator's serial number for identification and tracking purposes.

- **Low Temperature:** Enter the refrigerator's low temperature. This is the minimum temperature the refrigerator should ever operate.
- **High Temperature:** Enter the refrigerator's high temperature. This is the maximum temperature the refrigerator should ever operate.

6. Click **Modify**.

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

17.12 Printing Immunization Reports

To print immunization reports:

1. Click **Reports** on the Admin tab. The Reports area displays (see Figure 17-13: Immunizations Admin—Reports).

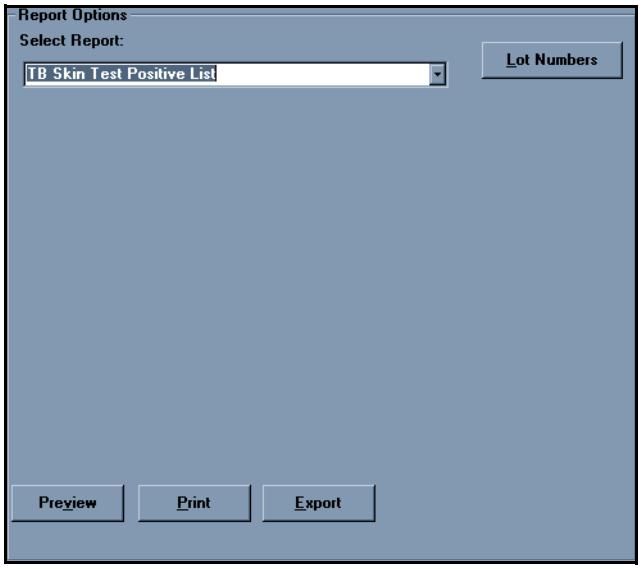

Figure 17-13: Immunizations Admin—Reports

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

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

3. Click **Print**.
4. Select a print range on the Print window.
5. Click **OK**.

17.13 Selecting a Default Vaccination Clinic

To select a default vaccination clinic:

1. Click **Vaccine Management** on the Admin tab. The Vaccine Management area displays (see Figure 17-14: Immunizations Admin—Vaccine Management).

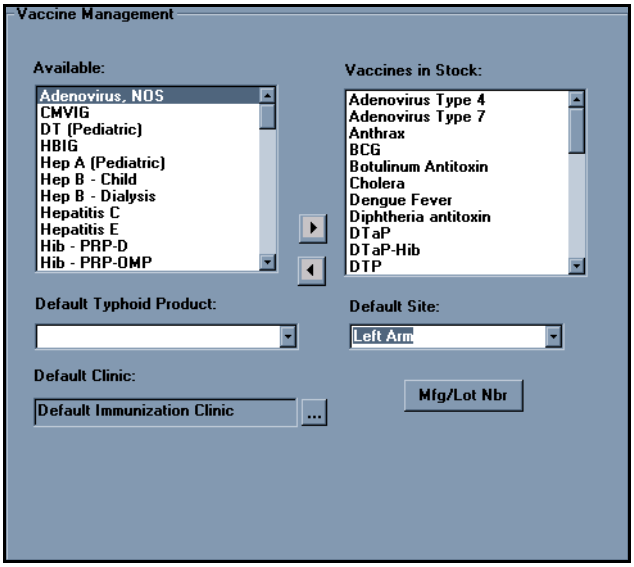

Figure 17-14: Immunizations Admin—Vaccine Management

2. Click the **Ellipsis** button ... next to the Default Clinic field. The Clinic List Edit window opens (see Figure 17-15: Clinic List Edit Window).

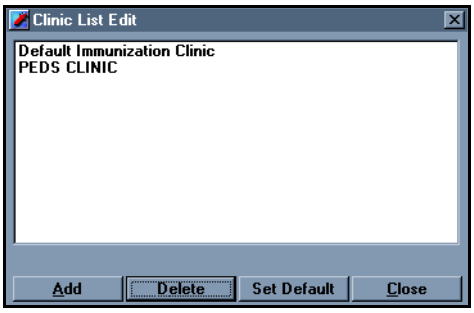

Figure 17-15: Clinic List Edit Window

3. Select the clinic from the list.

Note: If the clinic you want to select is not listed, click **Add**. In the text field, enter the clinic name and press **Enter** on your computer keyboard.

---

4. Click **Set Default**. You are returned to the Vaccine Management area.
5. Do one of the following:

- If you want to associate stocked vaccines to the default clinic:
  - — Select a vaccine from the list of available vaccines.
  - — Click the **Right Arrow** button. The vaccine is moved to the Vaccines in Stock list.
- If you want to set the default typhoid product, select the typhoid product from the drop-down list.
- If you want to set the default body area where the vaccine is given, select the site from the drop-down list.
- If you want to view the manufacturer and lot number information for the vaccines in stock:
  - — Click **Mfg/Lot Nbr**. The Vaccine in Stock Information window opens (see Figure 17-16: Vaccines In Stock Information Window).

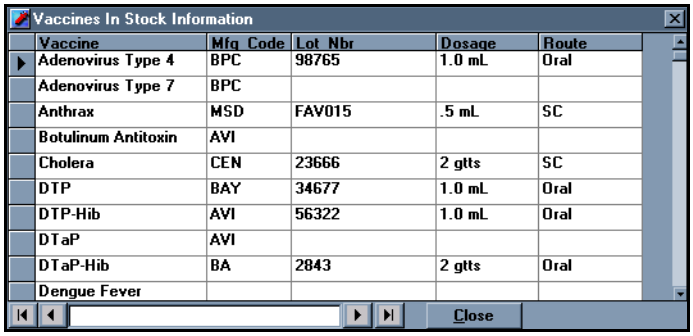

Figure 17-16: Vaccines In Stock Information Window

  - — Click **Close** to return to the Admin tab.

17.14 Viewing the Vaccine Lot Number List

To view the Vaccine Lot Number List:

1. Click **Reports** on the Admin tab. The Reports area displays (see Figure 17-17: Immunizations Admin—Reports).

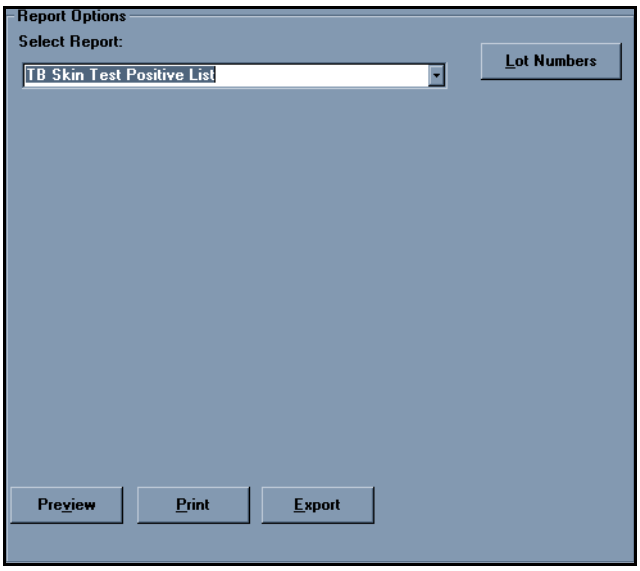

Figure 17-17: Immunizations Admin—Reports

2. Click **Lot Numbers**. The Vaccine Lot Number List window opens (see Figure 17-18: Vaccine Lot Number List Window).

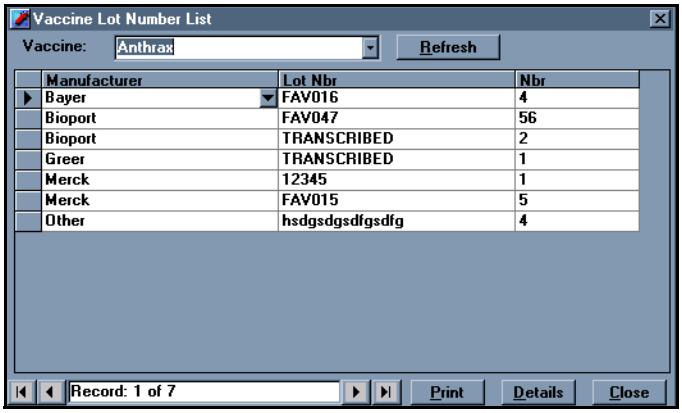

Figure 17-18: Vaccine Lot Number List Window

3. Select a vaccine from the drop-down list. Manufacturer information displays for each manufacturer associated with the selected vaccine.
4. Select a manufacturer.
5. Click **Details**. All patients associated with the vaccine distributed by the selected manufacturer display.

Note: 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.

18.0 LABORATORY

18.1 Overview of Laboratory

The Laboratory module (see Figure 18-1: Military Clinical Desktop - Laboratory 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.

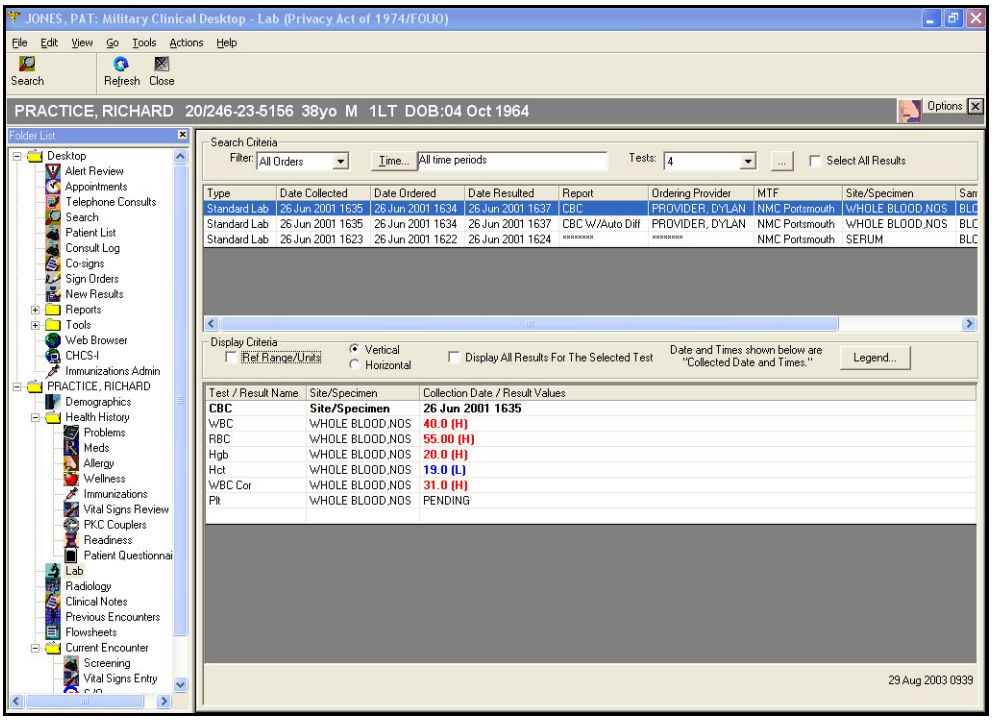

Figure 18-1: Military Clinical Desktop - Laboratory Module

18.2 Action Bar Icons

	Refresh	Refreshes the window with updated information.
	Close	Closes the Laboratory window.

18.3 Creating a Filter in the Lab Module

The results listed in the Lab Results window can be filtered and a specified number can be reviewed at a given time.

To create a filter for viewing lab results:

1. Click **Options** on the Lab Results window. The Lab Results—Properties window opens and the Filter tab appears by default (see Figure 18-2: Lab Results - Properties Window—Filter Tab).

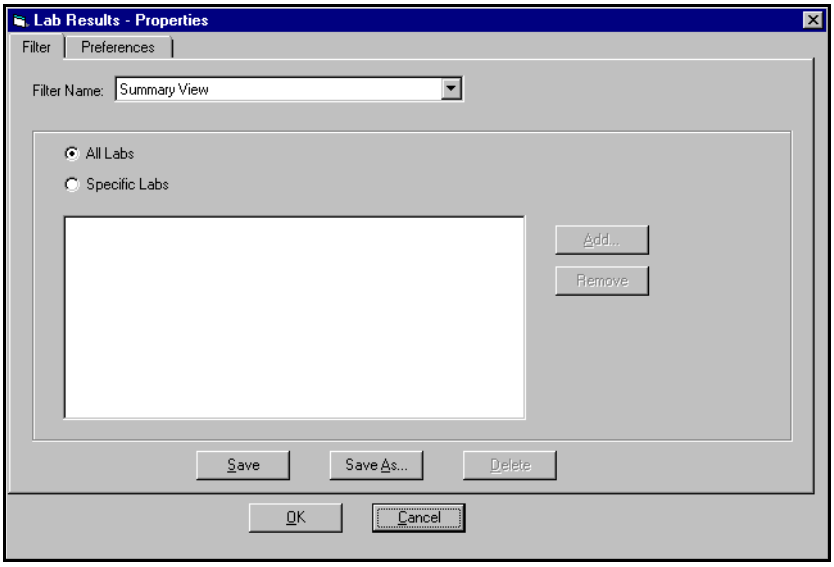

Figure 18-2: Lab Results - Properties Window—Filter Tab

2. Click the applicable radio button for the lab results you want to view.

Note: If **All Labs** is selected, all of the listed lab results are displayed.

If **Specific Labs** is selected, click **Add** to open the Add Lab Type window to add specific lab results.

---

3. Click **Save As** (see Figure 18-3: Save As Window).

Note: If this is a change to a pre-existing filter, click **Save**.

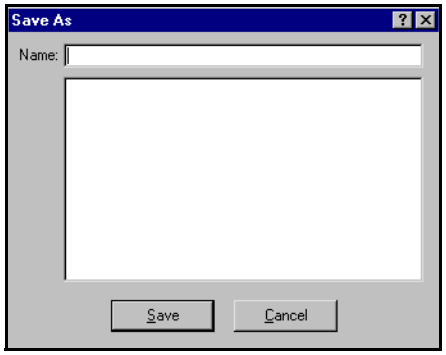

Figure 18-3: Save As Window

4. Enter the name for the filter.
5. Click **Save**.

Note: To delete a filter, select the filter from the drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.

6. Click **OK** on the Lab Results—Properties window.

18.4 Setting Laboratory Module Preferences

The Preferences tab allows you to set default times and viewing options (see Figure 18-4: Lab Results—Properties Window—Preferences Tab).

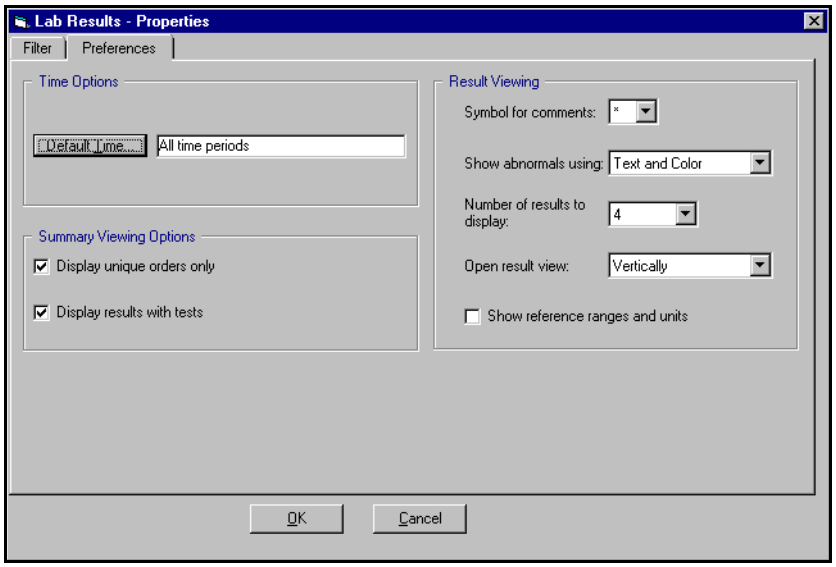

Figure 18-4: Lab Results—Properties Window—Preferences Tab

To set Laboratory module preferences:

1. Click the Preferences tab on the Lab Results—Properties window.
2. Click **Default Time**. The Time Search window opens (see Figure 18-5: Time Search Window).

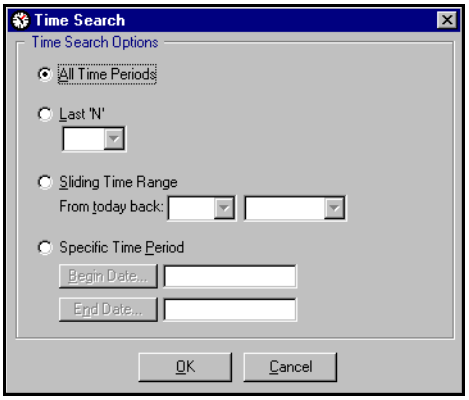

Figure 18-5: Time Search Window

3. Click the radio button for the applicable Time Search Option. You are returned to the Preferences tab on the Lab Results—Properties window.
4. Click the checkbox for the applicable Summary Viewing Option.

Note: Both options can be selected at the same time.

5. In the Result Viewing area, complete the following fields:
   - **Symbol for comments:** This field has no bearing on the Lab Results window.
   - **Show abnormals using:** This field has no bearing on the Lab Results window.
   - **Number of results to display:** Select the number of results to be displayed in the Lab Results window.
   - **Open result view:** Select the desired view for the results. Options include vertically and horizontally.
6. Click **Show Reference Ranges and Units** to display units upon opening the Lab Results module.
7. Click **OK**.

18.5 Viewing Lab Results

Once the search criteria have been defined, the lab test results are displayed (see Figure 18-6: Lab Test Results).

SEE RELATED TOPICS

- **5.4 ADDRESSING NEW AND PRIORITY RESULT ALERTS**
- **5.5 DELETING AN ALERT**
- **5.6 VIEWING DETAILS OF AN ALERT**

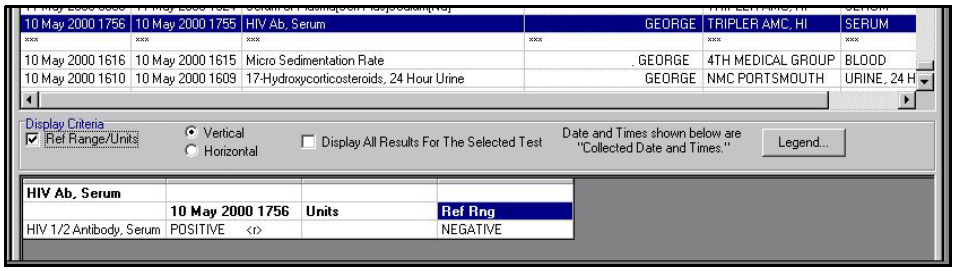

Figure 18-6: Lab Test Results

Select the desired test data to be viewed by selecting the test name. The data is displayed in the bottom of the Lab Results window. The Lab Result Profile area can be changed according to individual preference.

- **Display All Test Results:** To view all test result data in the test viewing area simultaneously, simply click **Select All Results**.
- **Ref Range/Units:** Click the check box to view the CHCS II normal range and unit for each test.
- **Change Viewing Format:** The layout of the results can either be seen vertically or horizontally. Click appropriate radio button.
- **Legend:** Click **Legend** to view the codes used in the test results.

Tip:
*To view any comments associated with the result, double-click on a cell with <**o**>, <**i**>, <**r**>, or <**a**> to view the order comments, interpretations, results comments, and amendments.*

Note: Sensitive lab results are displayed with asterisks. Remaining columns are viewed as normal. You must have "break the glass" privileges to view sensitive lab results.

18.6 Viewing Sensitive Results

To view sensitive results:

1. Double-click the result. A security message is displayed stating that all further actions are audited (see Figure 18-7: Security Warning). A separate message is displayed if you do not have sufficient security privileges.

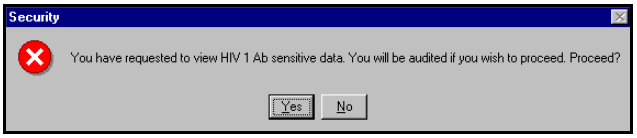

Figure 18-7: Security Warning

2. Click **Yes** to continue. The sensitive lab result are displayed in the bottom portion of the window.

Note: If you do not have access to sensitive labs, a security message is displayed and you cannot proceed.

Sensitive lab results are displayed with asterisks. Remaining columns are viewed as normal. You must have "break the glass" privileges to view sensitive lab results.

18.7 Copying Lab Results to a Note

Details of a lab result can be copied to the clipboard or copied and placed directly into the S/O portion of the patient encounter summary.

To copy lab results to a note:

1. Select the desired result so the details are in the bottom of the Lab Results window (see Figure 18-8: Lab Results Window (Copy Lab Results)).

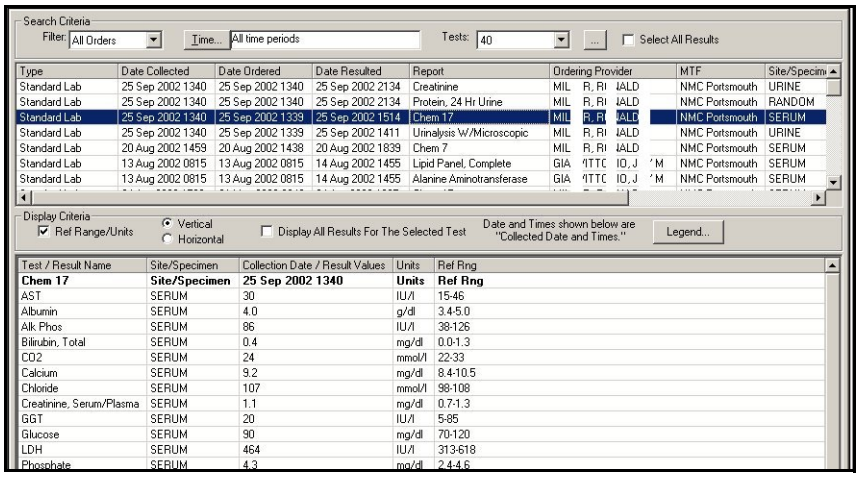

Figure 18-8: Lab Results Window (Copy Lab Results)

2. Select the result(s) you want to copy.
3. With the results selected, right click your mouse, then select either:
   - **Copy:** Copies the selection on the clipboard so it can be used in another location.
   - **Copy to Note:** Copies the details directly into the S/O portion of the current patient encounter summary.

Note: You must open an encounter to use the Copy to Note function. The result is pasted directly into the patient encounter.

19.0 LIST MANAGEMENT

19.1 Overview of List Management

The List Management module (See Figure 19-1: Military Clinical Desktop - List Management Module) allows you to create and manage various lists within the system. These lists include Diagnosis and Procedure lists. The customized lists are available within the Problems and the Assessment and Plan modules to streamline the selection process. The provider-specific lists are tied to the individual provider's profile.

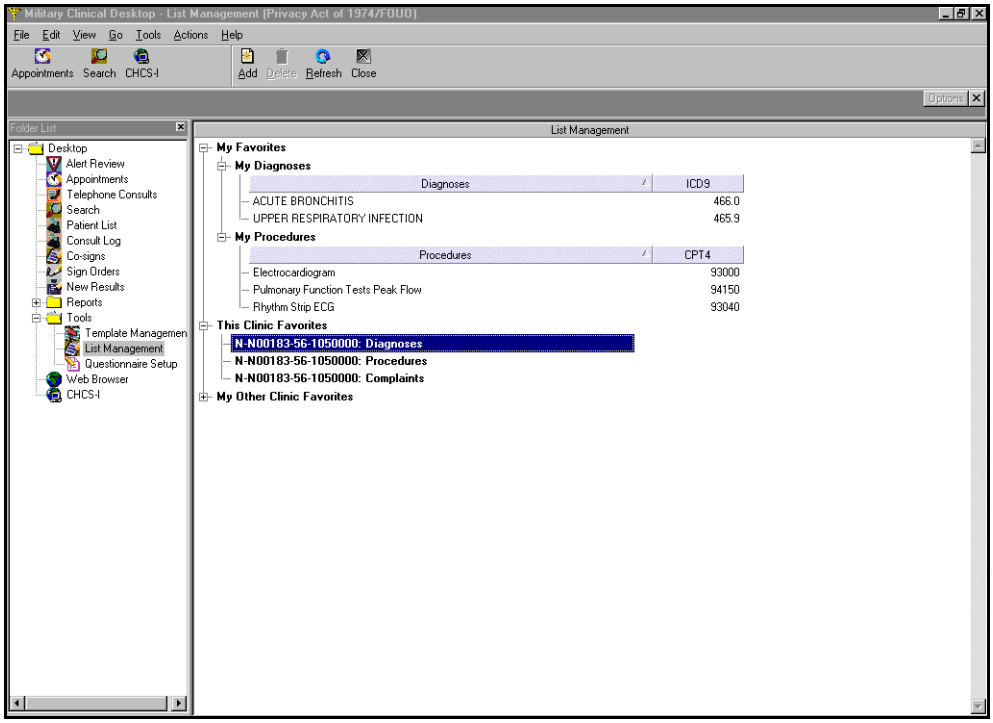

Figure 19-1: Military Clinical Desktop - List Management Module

19.2 Action Bar Icons

	Add	Allows a diagnosis or procedure to be added.
	Delete	Deletes the highlighted diagnosis or procedure.
	Cancel	Cancels the addition of any new items.
	Close	Closes the List Management module.

19.3 Adding an Item to a Favorites List

Tip:
When selecting a diagnosis or procedure in the Assessment and Plan or Problems modules, the saved list can be accessed to avoid searching for an item.

You can also create a Favorite List of diagnoses and procedures.

To add an item to a Favorites List:

1. Select the list to which you want to add an item.
2. Click **Add** on the Action bar. The Select Item to Add to List window opens (see Figure 19-2: Select Diagnosis to Add to Clinic List Window).

Note: The title of the window changes, depending on the type of list you have selected to add (such as diagnosis, procedure, clinic, user).

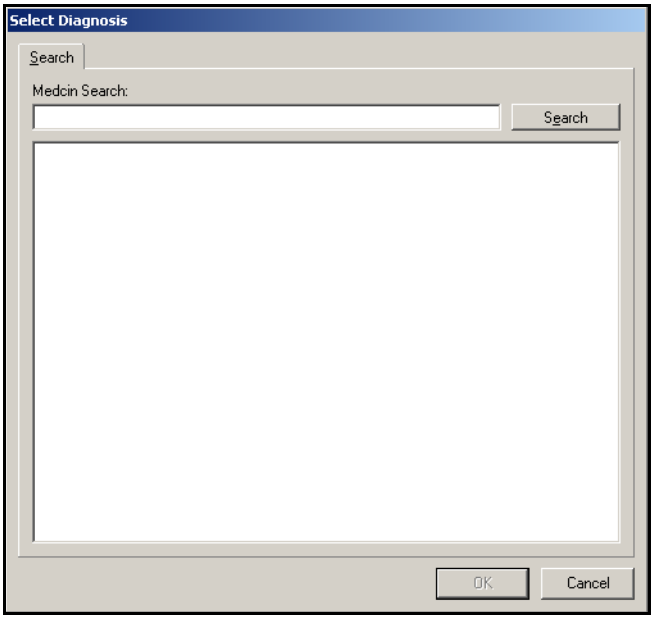

Figure 19-2: Select Diagnosis to Add to Clinic List Window

3. Enter search criteria.
4. Click **Search**. The bottom of the window populates with items matching the search criteria.
5. Select the item to be added.
6. Click **OK**. The new item is added on the List Management window.

19.4 Deleting an Item From a Favorites List

To delete an item from a Favorites List:

1. Select the item you want to delete from the Favorites List.
2. Click **Delete** on the Action bar.

20.0 MEDICATIONS

20.1 Overview of Medications

The Medications module lists the patient's past and present medications. 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 (see Figure 20-1: Military Clinical Desktop - Medication Module).

Active medications appear in bold text. Inactive medications appear in regular text. Medications are listed based on the search filter you selected.

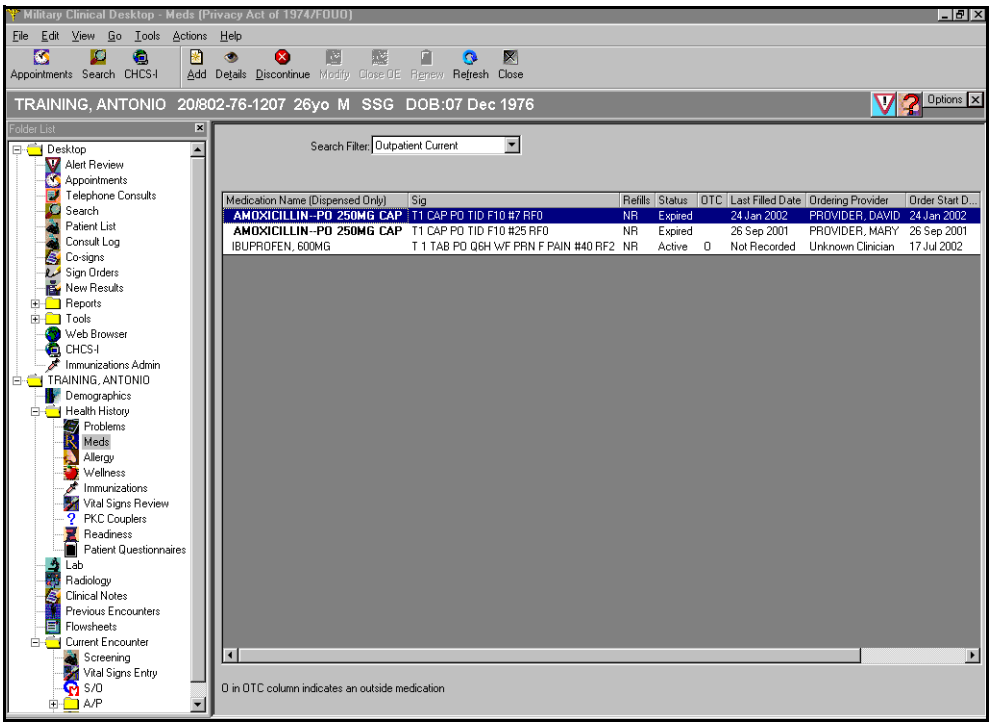

Figure 20-1: Military Clinical Desktop - Medication Module

20.2 Action Bar Icons

	Add	Allows a new over-the-counter or outside medication to be documented or a CHCS II medication to be ordered.
	Modify	Allows a current medication to be modified.
	Close OE	Closes the Order Entry window if ordering a CHCS II medication.

	Details	Displays read-only details of the highlighted medication.
	Discontinue	Discontinues the highlighted medication.
	Renew	Opens the Order Entry module to re-order the highlighted medication.
	Refresh	Refreshes the list of medications.
	Close	Closes the Medications module.

20.3 Setting the Properties of the Medications Module

Click **Options** to set the Properties of the Medication module Figure 20-2: Properties Window.

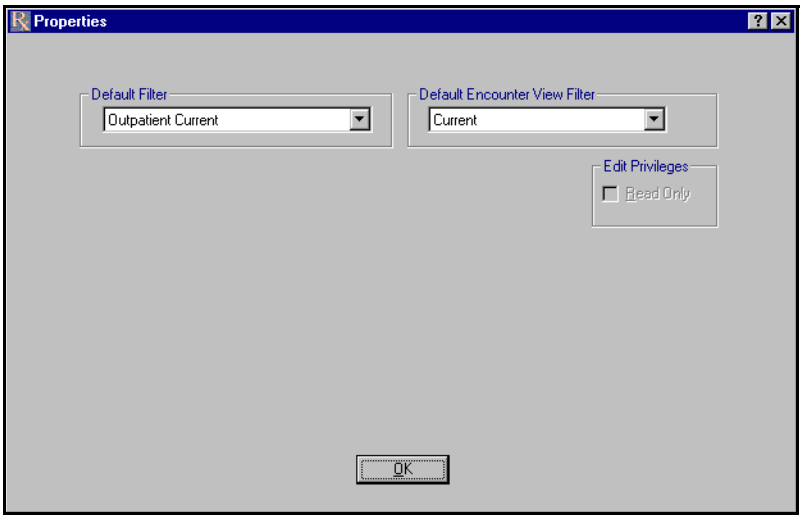

Figure 20-2: Properties Window

The Properties window in the Medications module contains two drop-down lists:

- **Default Filter:** Is used to set the default Search Filter in the Medications module.
- **Default Encounter View Filter:** Is used to set the View Filter to Current Medications or Discontinued Medications.

20.4 Adding a New Medication

To add a new medication:

1. Click **Add** on the Action bar. The Select Type of New Medication window opens (see Figure 20-3: Select Type of New Medication Window).

Note: To add a new medication, you must set the filter to Outpatient Current.

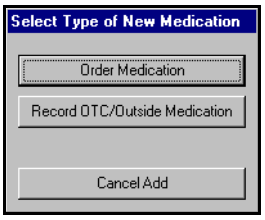

Figure 20-3: Select Type of New Medication Window

2. Do one of the following:
   - If you want to order the medication through a pharmacy using the Order Entry module:
     a. Click **Order Medication**. The Order Entry Medications window opens within the Medications module (see Figure 20-4: Order Entry Medications Window).

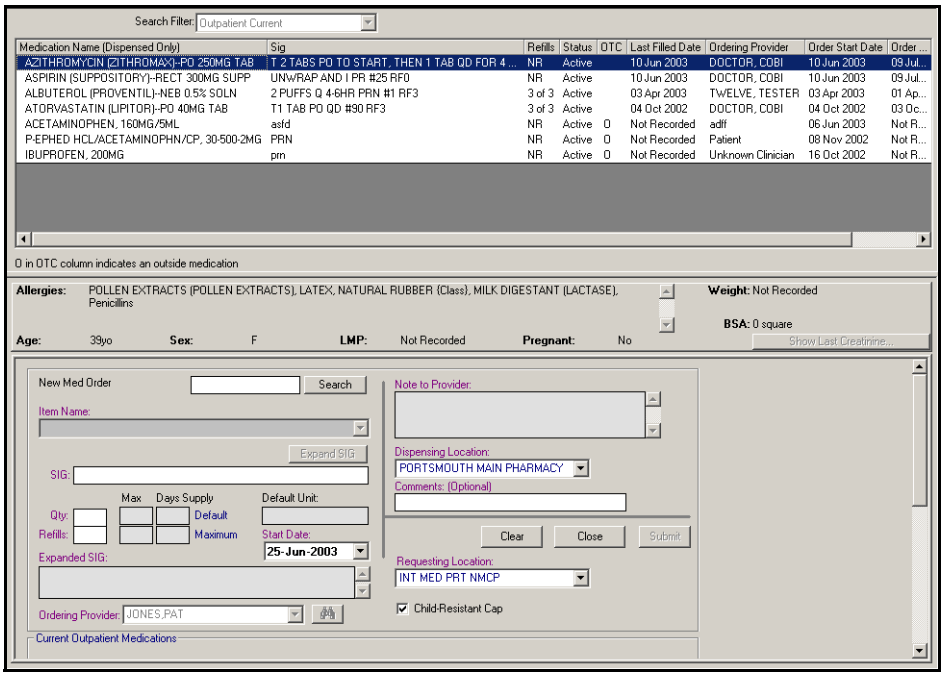

Figure 20-4: Order Entry Medications Window

b. Order the medication.

CHCS pre-verifies the order against patient and medications records and displays any resulting messages or warnings, as well as any SIG code(s) and standard order/refill quantities associated with the medication. In addition, CHCS II now provides connectivity to the Pharmacy Data Transaction System (PDTS), a central data repository containing patient medication profiles for all beneficiaries. PDTS will provide the CHCS II user with:

- Excessive and insufficient dose warnings
- Interaction, overlap and duplicate warnings, and warning override capabilities
- Warning overrides on renew and modify orders

If the pre-verify process identifies warnings regarding the order, the CHCS and PDTS warnings will display in the same window (See Figure 20-5: CHCS and PDTS Warning Window). To override the warning, type a reason for the override in the Warnings window and click the **Accept Override** button. To ignore the warning override, click the **Cancel Order** button.

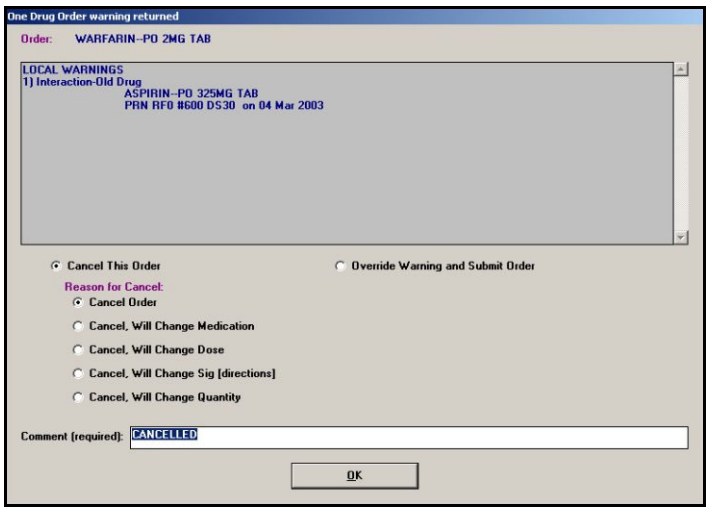

Figure 20-5: CHCS and PDTS Warning Window

- If you want to document an outside or OTC medication:

  a. Click **Record OTC/Outside Medication**. The Order Entry Outside Medication window opens within the Medications module (see Figure 20-6: Order Entry Outside Medications Window).

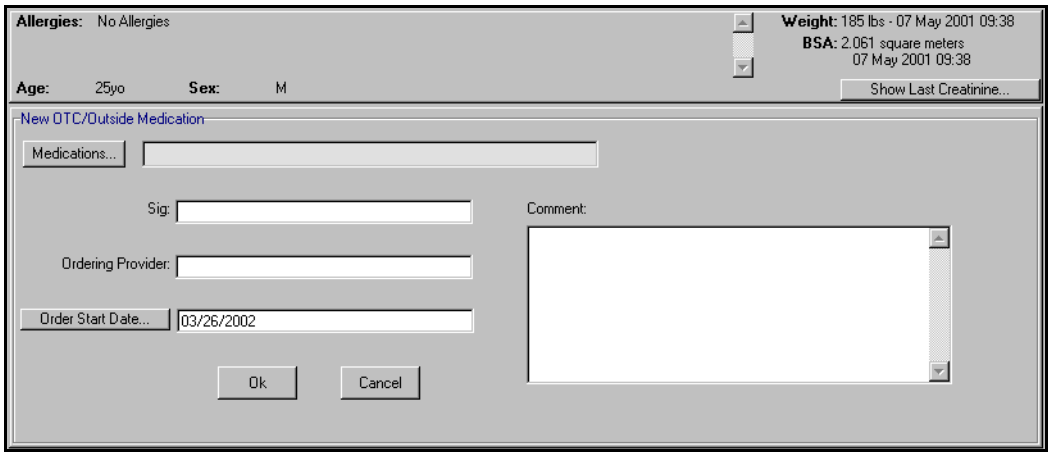

Figure 20-6: Order Entry Outside Medications Window

b. Complete the following fields:

- Medication
- Sig
- Ordering Provider
- Order Start Date
- Comment

c. Click **OK**.

20.5 Reviewing a Medication

To review a medication:

1. Select the medication you want to review.
2. Click **Details** on the Action bar. The Review Medication pane displays on the Medication Review window (see Figure 20-7: Review Medication Pane).

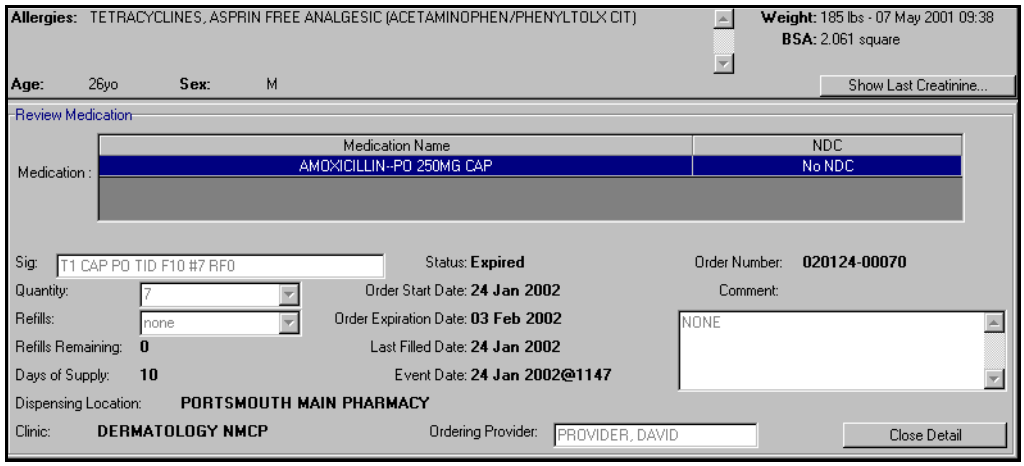

Figure 20-7: Review Medication Pane

3. The Review Medication pane is read-only. To return to the full Medication Review window, click **Close Detail**.

20.6 Discontinuing a Medication

To discontinue a medication:

1. Select the medication to be discontinued.
2. Click **Discontinue** on the Action bar.
3. At the Inactive Medications confirmation prompt, click **OK**.

Tip:
You can still view information for a discontinued medication by setting up a filter that displays discontinued medications.

20.7 Renewing a Medication

When the renew action is taken from the Medication window, the system automatically brings up the Order Entry Medication window. This function is only available for prescriptions that were originally ordered through the pharmacy.

To renew a medication:

1. Select the medication to be renewed.
2. Click **Renew** on the Action bar. The Order Entry Medication window opens (see Figure 20-8: Order Entry Medication Window).

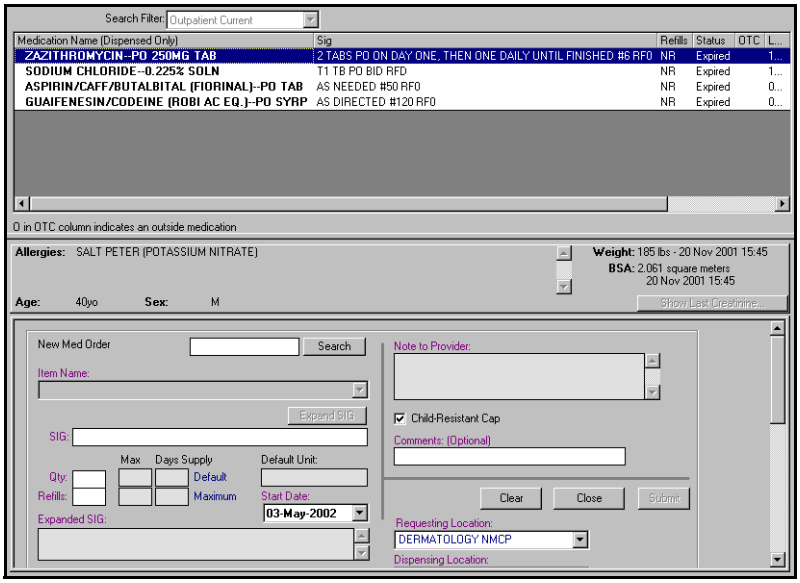

Figure 20-8: Order Entry Medication Window

3. Select the medication to be renewed.
4. Click **Renew**. The Enter a Reason for Action window opens.
5. Enter the reason for the renewal.
6. Click **OK** to renew the medication.

21.0 NEW RESULTS

21.1 Overview of New Results

The New Results module (see Figure 21-1: Military Clinical Desktop - New Results Module) provides an interface to manage your lists of new and saved test results. The module lets you view ordered laboratory and radiology results that have been resulted in CHCS. You can either view a high level summary or detailed result information for a specific order. Viewing detailed information automatically opens the Laboratory or Radiology module, depending on the selected order.

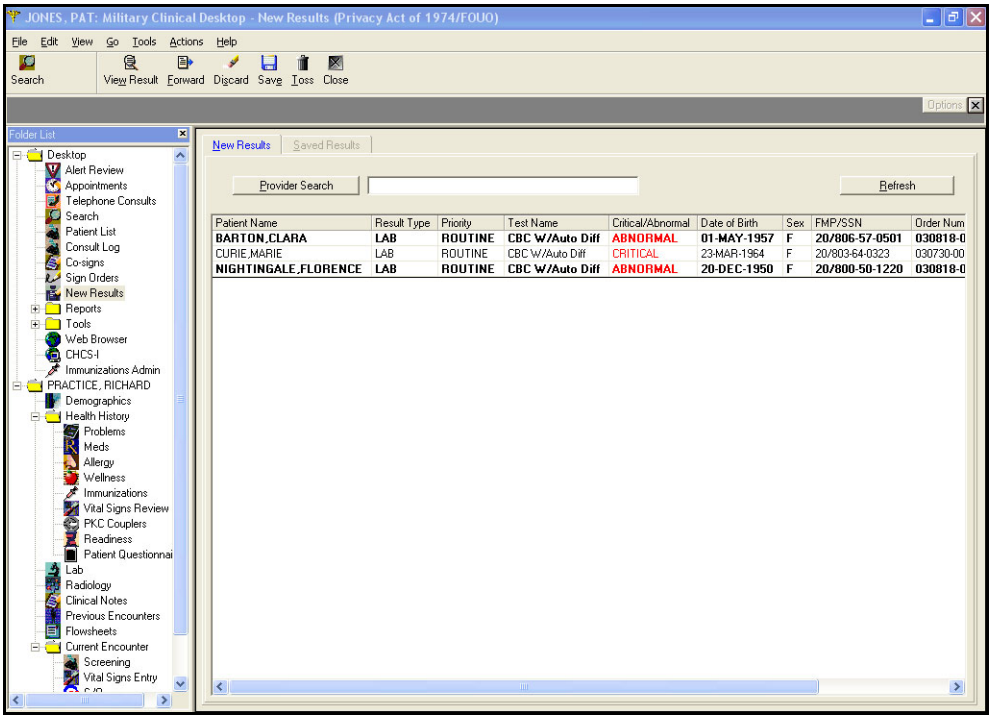

Figure 21-1: Military Clinical Desktop - New Results Module

21.2 Action Bar Icons

	**View Result**	Allows you to view detailed information for a selected result.
	**Forward**	Allows you to forward the result to a selected provider.
	**Discard**	Removes the result from your list without signing it.

	Save	Saves the selected result in the Saved Results tab.
	Toss	Removes the item from the list and attaches an electronic signature.
	Close	Closes the New Results module.

21.3 Viewing New Results

The New Results module lets you view detailed information for a selected result. The New Results module interfaces with the Labs and Rads module in viewing detailed result information depending on the selected result.

To view results:

1. On the New Results tab, select the result you want to view.
2. On the action bar, click **View Result**.
3. View the result in the Labs or Rads module.
4. When you are finished viewing the detailed result information, **close** the Labs or Rads module to return to the New Results module.

21.4 Discarding New Results

The New Results module lets you discard selected results. You can discard results without viewing the result (e.g., the result appears in your New Results list, but the result was forwarded to you for a patient from another provider). The discarded results are removed from your list without an electronic signature.

To discard results:

1. On the New Results tab, select the result you want to discard.
2. On the action bar, click **Discard**.
3. At the discard confirmation prompt, click **Yes** (see Figure 21-2: Discard Prompt Window).

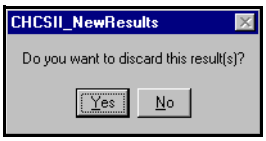

Figure 21-2: Discard Prompt Window

21.5 Saving New Results

The New Results module lets you save selected results. Saving a new result removes the result from the New Results tab and displays it in the Saved Results tab. You must first view the result before you can save it.

To save results:

1. On the New Results tab, select the result you want to save.
2. On the action bar, click **Save**.
3. At the save confirmation prompt, click **Yes** (see Figure 21-3: Save New Results Prompt).

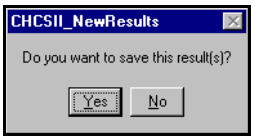

Figure 21-3: Save New Results Prompt

4. View the result on the Saved Results tab (see Figure 21-4: Saved Results Tab).

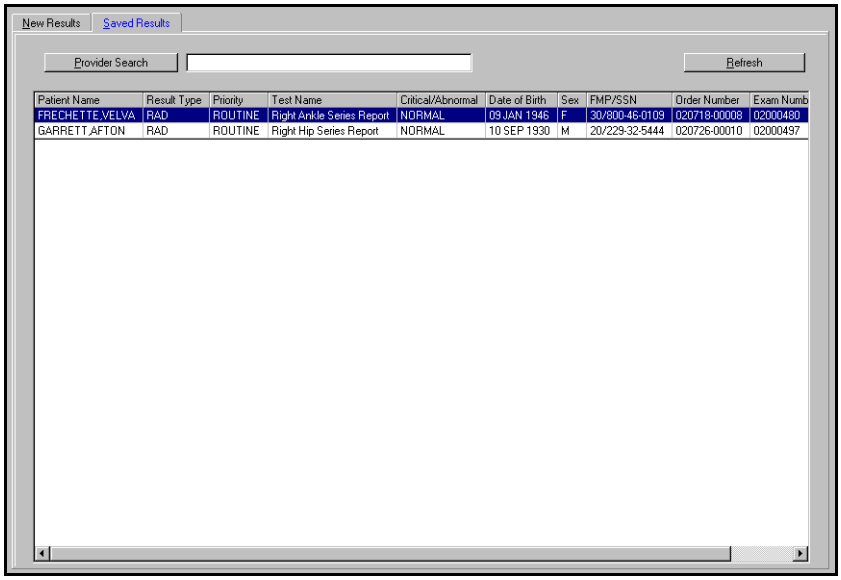

Figure 21-4: Saved Results Tab

Note: To move the result back to the New Results tab, on the action bar, click **New**. At the confirmation prompt, click **Yes**.

21.6 Forwarding New Results

The New Results module allows you to forward new results to other providers. When you forward a result to another provider, a copy of the result is made and added to the forwarding provider's New Results list. A provider can only have a single copy of the result. If you forward a saved result to a provider, the result displays in the forwarding provider's New Results list.

To forward a new result to a provider:

1. Search for the provider to whom you are forwarding the new result (see Figure 21-5: Clinician Search Window).

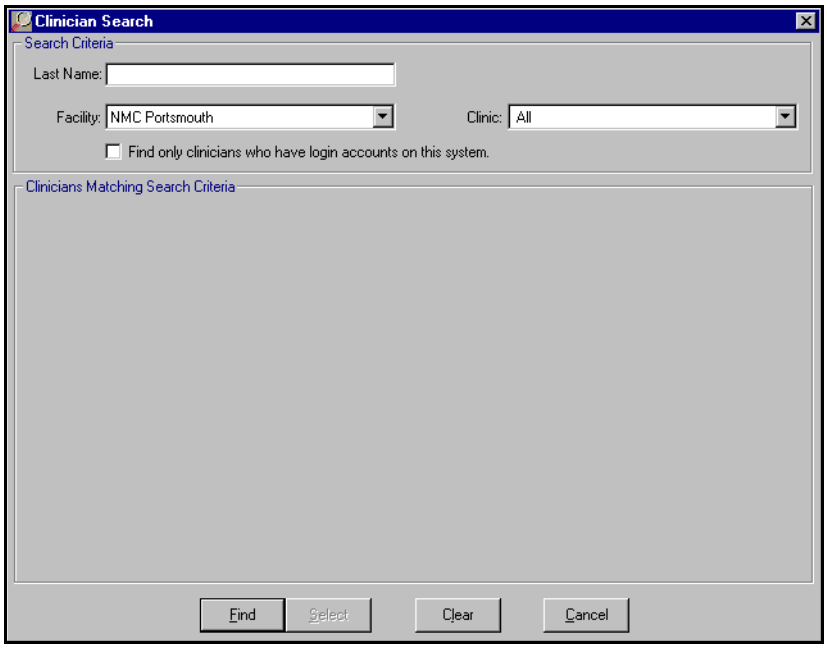

Figure 21-5: Clinician Search Window

2. When you have completed the provider search, you are returned to the New Results module. On the New Results tab, select the result you want to forward.
3. On the action bar, click **Forward**.
4. At the forward confirmation prompt, click **Yes** (see Figure 21-6: Forward Confirmation Prompt Window).

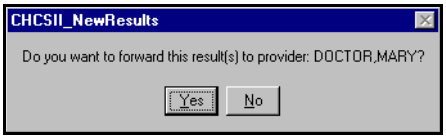

Figure 21-6: Forward Confirmation Prompt Window

21.7 Tossing New Results

The New Results module allows you to remove new results from the New Result list. A toss only results in a signature if the result is on the New Results list and it has not been previously signed. If the result is on the Saved Results list, a signature was cap-

tured at the time the result was originally saved; therefore, no signature is needed when a result is tossed from the Saved Results list.

Note: The system creates a signature to attest that a provider has viewed the new result information.

To toss results:

1. On the New Results tab or Saved Results tab, select the result you want to toss.
2. On the action bar, click **Toss**.
3. At the toss confirmation prompt, click **Yes** (see Figure 21-7: Toss New Results Prompt Window).

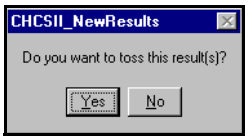

Figure 21-7: Toss New Results Prompt Window

22.0 ORDER SETS

22.1 Overview of Order Sets

Order sets are templates of laboratory, radiology, or medication orders that have been associated with a common diagnosis to assist the provider in streamlining the ordering process. Order sets are contained in Encounter Templates and can be managed from the Template Management module. Order sets are created from a current and previous encounters, or directly from the A/P module. The Encounter Template, which contains the order set, must be selected and loaded into an encounter to view and use the order set within the Assessment and Plan module.

22.2 Creating an Order Set from a Current or Previous Encounter

Order sets are created from documented encounters. Since an order set can be created from an existing encounter, which includes orders, you should begin on either the Patient Encounter window with a current documented encounter or the Previous Encounters window using a previous encounter containing orders.

1. Do one of the following:
    - If you are creating the order set from the Patient Encounter window, click **Save As Template** on the Actions menu. The Template Management window opens. The Template Details tab is displayed by default.
    - If you are creating the order set from the Previous Encounter window, click **New Template** on the Action bar. The Template Management window opens. The Template details tab is displayed by default (see Figure 22-1: Template Management Module—Template Details Tab).

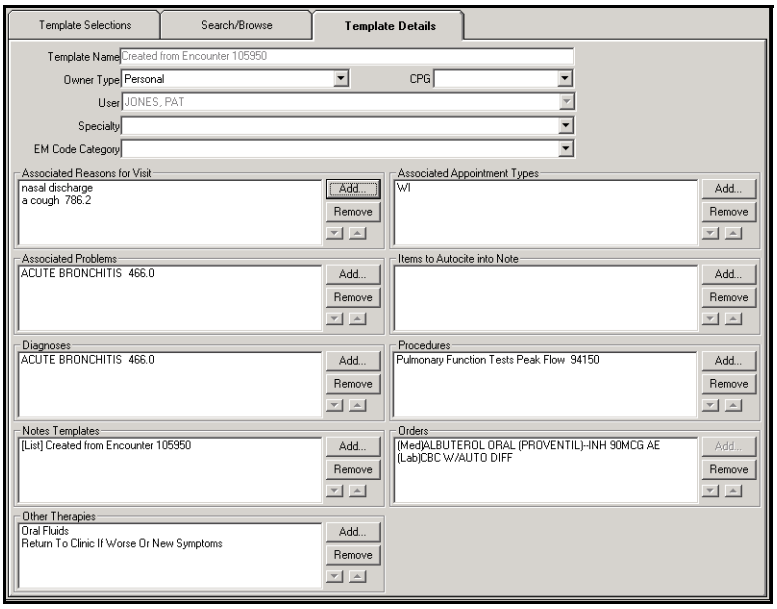

Figure 22-1: Template Management Module—Template Details Tab

2. Click **Add** to add any additional details within each area of the template.
3. Complete the top portion of the Template Details tab with the following information:
   - **Owner Type:** Select the desired owner type from the drop-down list. Options include Personal, Clinic, MTF, or Enterprise. The user's role determines whether the template can be saved as clinic, MTF, or enterprise.
   - **Shared:** Click this checkbox to allow other providers to copy the template.
   - **Specialty:** Select the specialty to which the template belongs from the drop-down list. This is a required field.
   - **E&M Code Category:** Access the drop-down list to select the desired codes for the template.

Note: The Template Name and User fields are not editable.

4. Click **Save As** on the Action bar. The Save Encounter Template window opens (see Figure 22-2: Save Encounter Template Window).

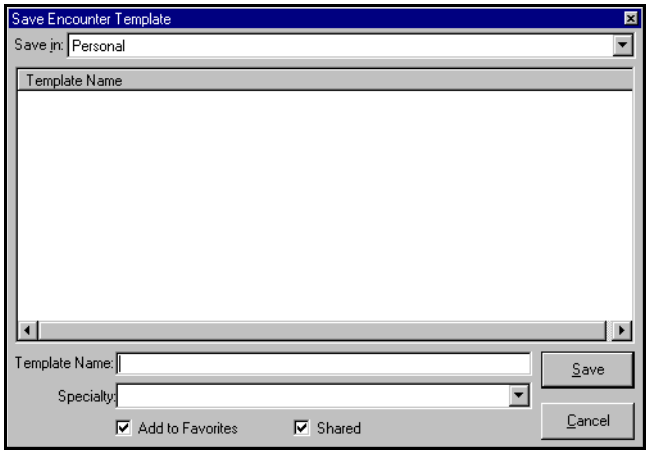

Figure 22-2: Save Encounter Template Window

5. Select a **template type** from the Save in drop-down list.
6. In the Template Name field, enter the template name.

Tip:
The order set is available any time the saved Encounter template is loaded into an encounter.

Note: The Specialty defaults to the Specialty you selected in the Template Details tab.

---

7. Click the **Add to Favorites** checkbox if you want the template to be added to your Favorites List on the Template Selections tab.

Note: Only providers within the same MTF can share order sets.

---

8. Click **Save**.

22.3 Creating an Order Set from A/P

An order set may also be created from within the Assessment and Plan module. This can be done during an encounter to capture the orders that are being placed for a particular patient because a patient encounter must be open.

To create an order set from A/P:

1. In the A/P module, document the lab(s), rad(s), and/or med(s) you want to include in the order set.
2. When you have documented the order, click **Save to Queue**. This saves the order without submitting it.
3. Once you have finished documenting the orders you want to include in your order set, click the Order Set tab to display the orders you have documented and saved to queue.

Tip:
Once an order has been submitted, it cannot be included in an order set. Orders must be located and then Saved to Queue.

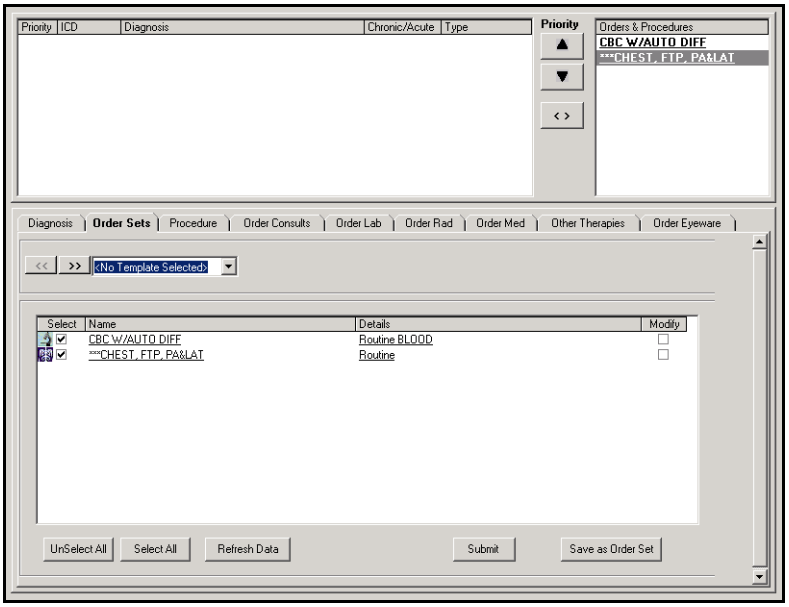

Figure 22-3: Order Sets Tab

4. Click **Save as Order Set**.
5. In the Save Encounter Template window Template Name field, enter the template name you want to use for the order set.
6. To save the order set, click **Save**. The order set encounter template can now be merged with other encounter templates and/or accessed in the Template Management and A/P modules.

Note: Remember to click **Submit All** from the Action bar if the orders need to be sent to the ancillary departments.

22.4 Using an Order Set in A/P

You must select and load the Encounter template into an encounter in order to view and use order sets within Assessment and Plan.

1. Click the **Order Sets** tab. The orders associated with the Encounter template are available (see Figure 22-4: A/P Order Sets Tab).

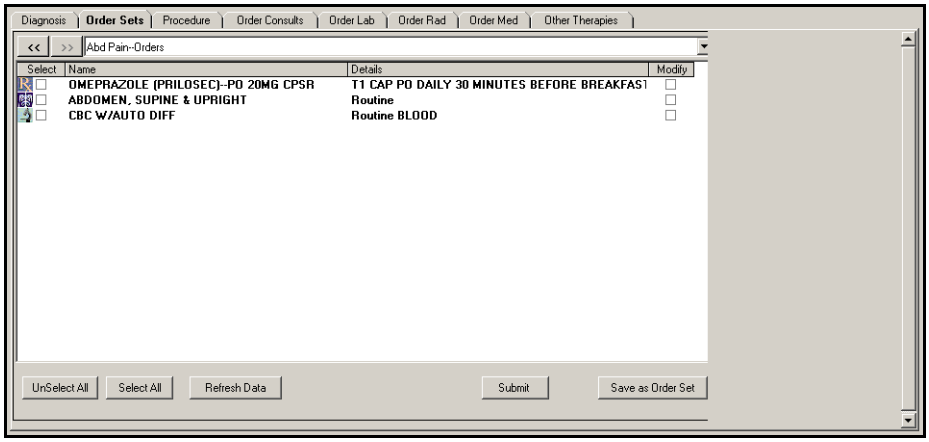

Figure 22-4: A/P Order Sets Tab

2. Do one of the following:
   - If you want to select and submit all orders with no modifications, click **Select All**.
   - If you want to select specific orders, click the checkbox in the Select column next to each applicable order.

Note: You can also click the checkbox in the Modify column next to each applicable order. Clicking a checkbox in the Modify column automatically put a check-mark in the checkbox in the Select column; however, clicking the checkbox in the Select column does not automatically put a checkmark in the checkbox in the Modify column.

3. Click **Submit**.

Note: Orders that were selected but not modified are sent out automatically. For orders needing modification, the appropriate order entry window opens. Make the desired modifications and click **Submit** on the order entry window.

Tip:
To associate an order with a diagnosis, select the desired diagnosis and double-click the order.

23.0 PATIENT ENCOUNTER SUMMARY

23.1 Overview of Patient Encounter

The Patient Encounter module is the main documentation area. The section buttons that are included represent the basic steps of an encounter. As each step is completed, gathered information is displayed. The information that is autocited can differ if a template is used. If an encounter template is selected, the Patient Encounter window reflects the selected template.

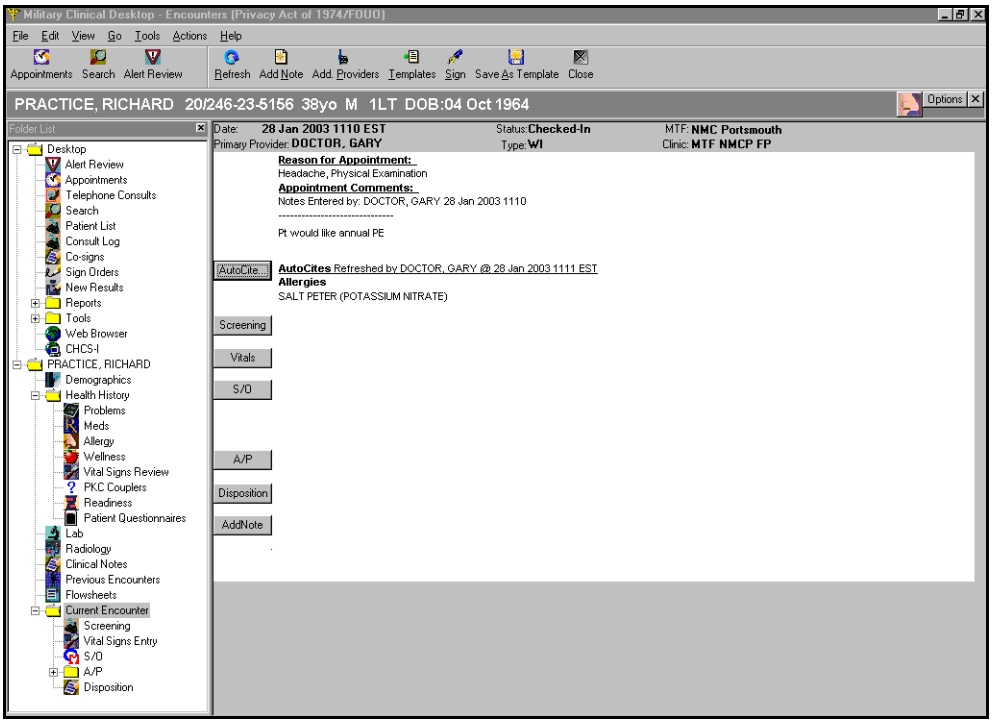

Figure 23-1: Military Clinical Desktop - Encounter Summary

23.2 Action Bar Icons

	Refresh	Refreshes the module with new data.
	Add Note	Displays the Encounter Note window.
	Add Providers	Displays the Add Provider window.
	Templates	Transfers you to the Template Management module.

	Sign	Allows a completed encounter to be signed.
	Save As Template	Allows you to save the current encounter information into a new template in the Template Management module.
	Close	Closes the Patient Encounter module.

23.3 Setting the Properties of the Patient Encounter Module

In the Patient Encounter module, the Signature Block and the items in AutoCite can be customized.

To set the properties of the Patient Encounter module:

1. Click **Options** in the top, right corner of the Patient Encounter window. The Encounter Summary Properties window opens (see Figure 23-2: Encounter Summary Properties Window).

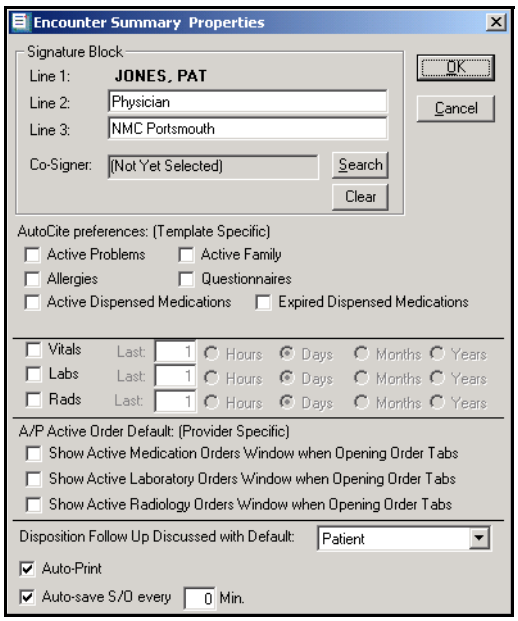

Figure 23-2: Encounter Summary Properties Window

2. In the Signature Block, enter the text you want for lines 2 and 3.

Note: Line 1 defaults to you and cannot be changed.

3. Click **Search** to assign a default co-signer. The Clinician Search window opens allowing you to search for a provider to select as a co-signer.

4. In the AutoCite Preferences area, click the check box next to the items you want to AutoCite. A check denotes the selected items.
   - **Active Problems, Allergies, Active Dispensed Medications, Active Family, Questionnaires, Expired Dispensed Medications:** Click the checkboxes to AutoCite the patient's information. The autocited information is pulled from the Problems, Medications, Allergy, and Patient Questionnaire modules.
   - **Vitals, Labs, Rads:** Click the checkboxes to AutoCite the patient's information. In the Last field, enter a numerical value and click the radio button to select the time setting.
   - **A/P Active Order Default:** Click the checkbox(es) if you want to display active medication, laboratory, or radiology orders when opening order entry tabs.
5. In the Disposition Follow Up Discussed with Default area, click the drop-down list and select who the disposition follow up will be discussed with.
6. Click the Auto-Print checkbox to auto-print.
7. Click the Auto-save S/O checkbox to have the encounter automatically save S/O at designated intervals. Click in the Min checkbox and enter the time.

Note: When vitals, labs, or rads are selected to AutoCite, additional fields become active. In the Number field, enter the desired number and then click inside the appropriate radio button. The system autocites vitals, labs, and rads according to these settings.

8. Click **OK**. The settings are saved.

23.4 Adding a Note

You can add a note to the Encounter Document. This narrative appears in the note section of the Patient Encounter window with the Time, Date, and Provider name next to the narration.

To add a note:

1. On the Patient Encounter window, click **Add Note** on the Action bar. The Select Note window opens (see Figure 23-3: Select Note Window).

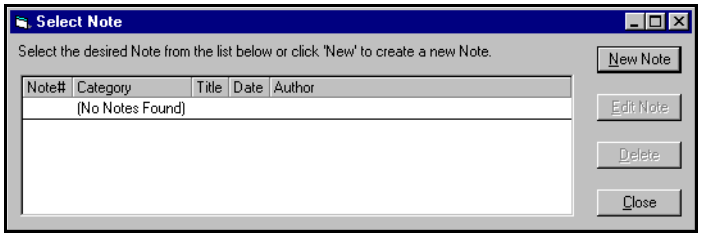

Figure 23-3: Select Note Window

2. Click **New Note** to begin a new note. The Encounter Note window opens, allowing you to add notes to any phase of the encounter (see Figure 23-4: Encounter Note Window).

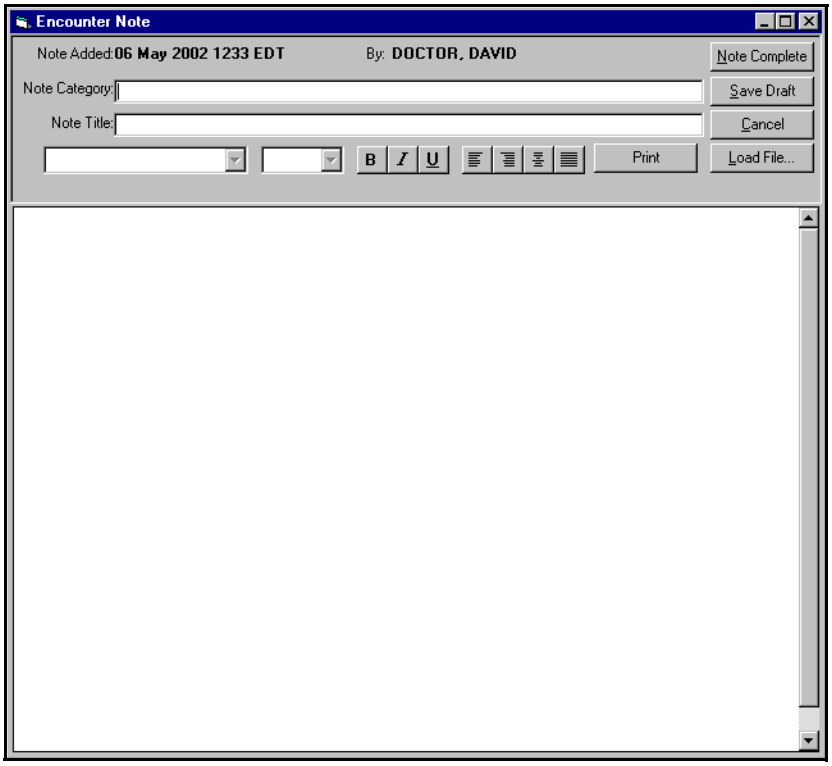

Figure 23-4: Encounter Note Window

3. Enter a Note Category, if necessary.
4. Enter a Note Title, if necessary.
5. Enter a note in the text box.
6. Do one of the following:
   - If you want to insert a file into the note:
     a. Click **Load File**.
     b. Select the desired file to be added.
     c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

   - If you want to print the note for your hardcopy records, click **Print**.

7. Click **Note Complete**. The note appears in the encounter document.

Note: Click **Save Draft** to save the note as a draft. The note is displayed on the Patient Encounter window in the Note section as a draft.

23.5 Adding an Additional Provider

An additional provider can be added to an encounter to receive credit for work done for a patient.

To add an additional provider:

1. On the Patient Encounter window, click **Add Providers** on the Action bar. The Providers window opens (see Figure 23-5: Providers Window).

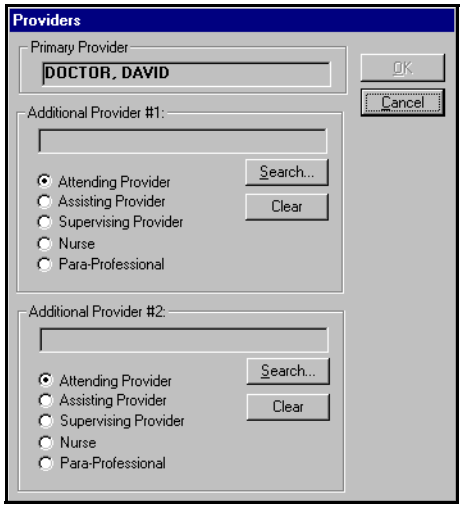

Figure 23-5: Providers Window

2. Click the applicable radio button for the type of clinician you want to add.
3. Click **Search** in the Additional Provider #1 area. The Clinician Search window opens (see Figure 23-6: Clinician Search Window).

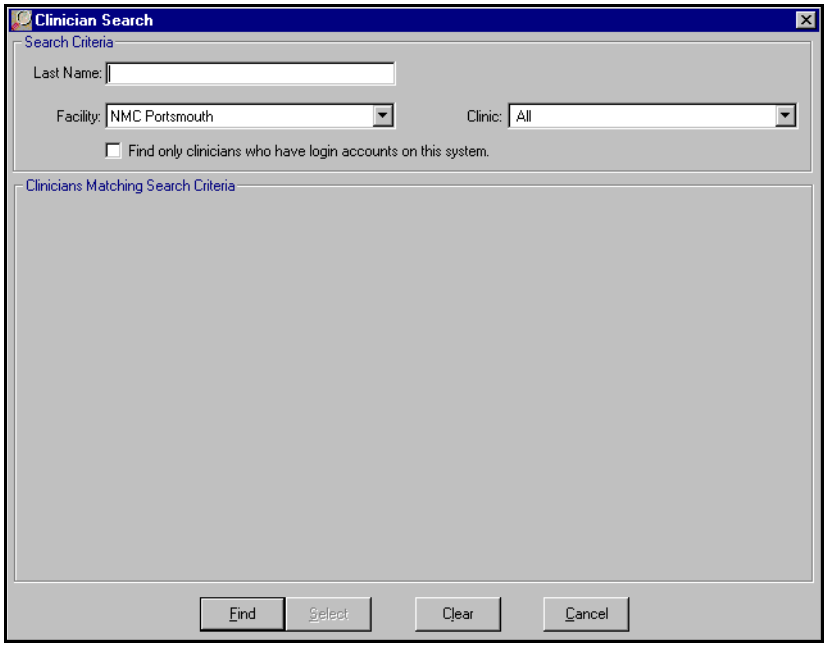

Figure 23-6: Clinician Search Window

4. In the Last Name field, enter the last name of the desired clinician.
5. Select a **Facility** from the drop-down list.
6. Select a **Clinic** from the drop-down list.
7. Click the checkbox to view only providers associated with CHCS II, if necessary.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates the Additional Provider field on the Providers window.

Note: Repeat steps 2–10 if you want to add a second clinician.

11. Click **OK**. The clinician(s) is added to the patient encounter.

23.6 Deleting a Note

To delete a patient encounter note:

1. On the Patient Encounter window, click **Add Note** on the Action bar. The Select Note window opens (see Figure 23-7: Select Note Window (With Data)).

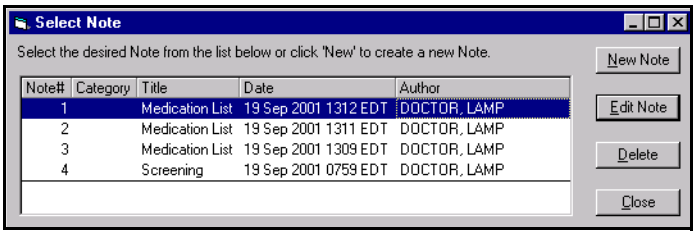

Figure 23-7: Select Note Window (With Data)

2. Select the note you want to delete.
3. Click **Delete**.
4. Click **Yes**. The Confirm Deletion of Note message appears.

23.7 Editing a Note

To edit a note:

1. On the Patient Encounter window, click **Add Note** on the Action bar. The Select Note window opens.
2. Select the note you want to edit.
3. Click **Edit Note**. The Encounter Note window opens (see Figure 23-8: Encounter Note Window (Edit Mode)).

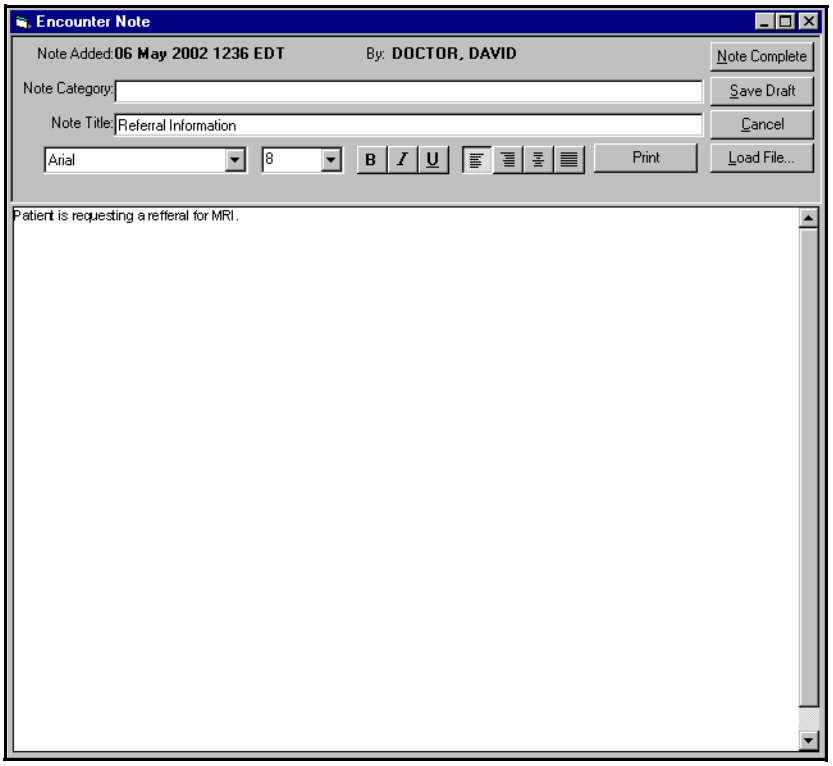

Figure 23-8: Encounter Note Window (Edit Mode)

4. Make the applicable edits to the note.
5. Click **Note Complete**.

Note: If the note you are editing has been created by another person, a message prompt appears asking if you want to create a note starting with the contents of the note you selected—click **Yes** to used the contents of the selected note, or **No** to create a note with no previous contents.

23.8 Selecting an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter Template contains AutoCite, diagnoses, procedures, S/O templates, orders, and patient instructions. The system provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, you select an encounter template from the Patient Encounter window before documenting the exam.

To select an encounter template:

1. On the Patient Encounter window, click **Templates** on the Action bar. The Template Selections tab opens within the Template Management module (see Figure 23-9: Template Management Window—Template Selections Tab).

Note: The top portion of the tab displays the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. To remove them, click the applicable checkboxes. If changes are made to the criteria, the system displays an updates list.

The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are also displayed in the associated folder.

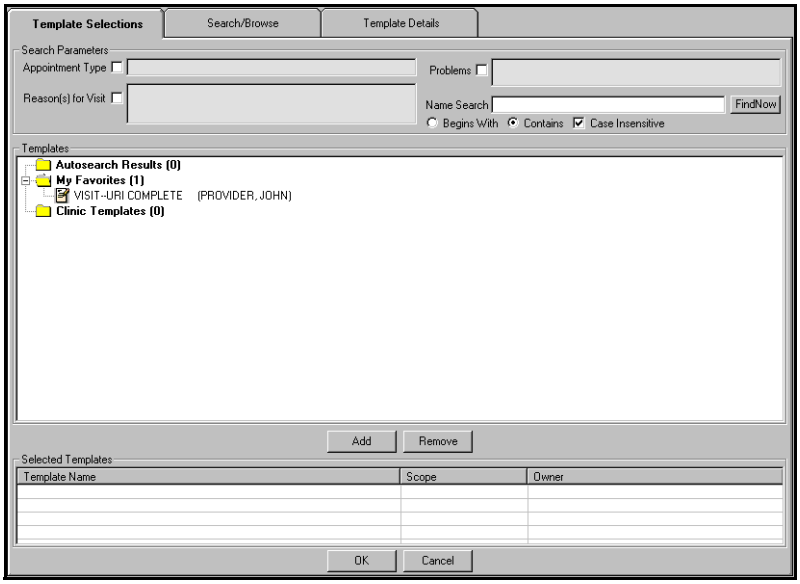

Figure 23-9: Template Management Window—Template Selections Tab

2. Select the template you want to use in the encounter.
3. Click **Add**. The template is moved to the Selected Templates List.

Note: More than one template can be added to the encounter.

4. Click **OK** to load the template(s) in the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the Patient Encounter (AutoCite), S/O (Notes template), and A/P (Diagnoses, Procedures, Orders, and Patient Instructions) modules.

Tip:
*If the desired template is not listed in any of the folders, enter the name of the template in the Name Search field and click **Find Now**. The search results display in the Name Search Results folder.*

24.0 PATIENT IMMUNIZATIONS MODULE

24.1 Overview of Patient Immunizations

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

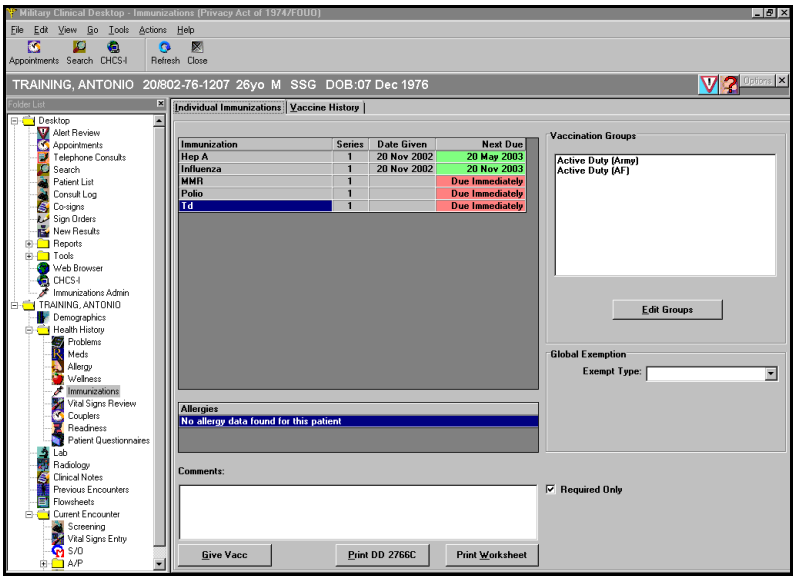

Figure 24-1: Military Clinical Desktop - Patient Immunizations Module

24.2 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 displays (see Figure 24-2: Immunizations Window—Vaccine History Tab).

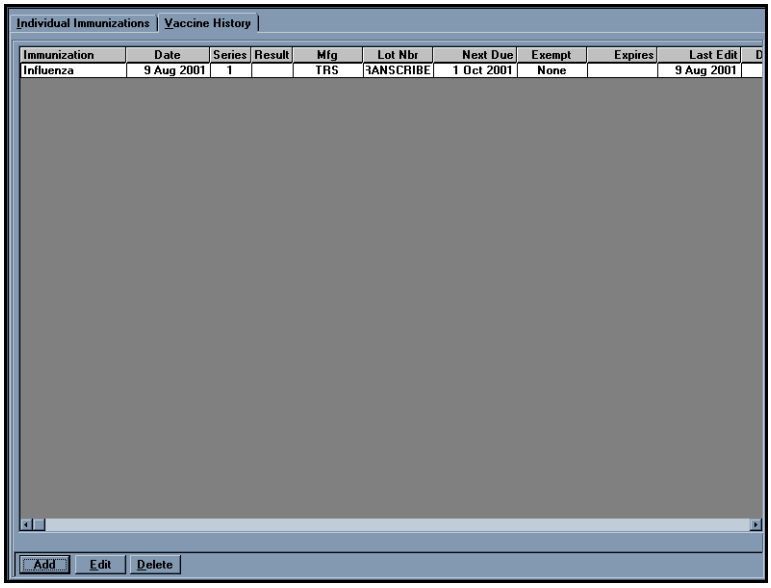

Figure 24-2: Immunizations Window—Vaccine History Tab

2. Click **Add**. The Vaccines window opens (see Figure 24-3: Vaccines Window).

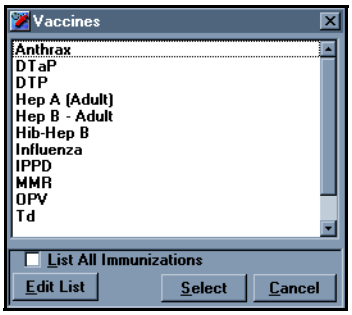

Figure 24-3: Vaccines Window

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**.

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4. Click **Select**. The Add Vaccine window opens(see Figure 24-4: Add Vaccine Window).

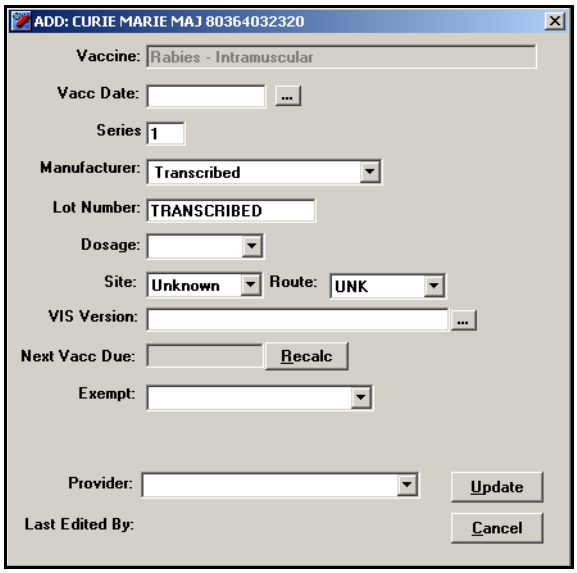

Figure 24-4: Add Vaccine Window

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 drop-down list, if necessary.
   - **VIS Version:** Click the ellipses button to open the Vaccine Information Statement (VIS) Version Info window.
   - **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.

24.2.1 Vaccine Information Statements

The Vaccine Information Statements (VIS) are information sheets produced by the Center for Disease Control and Prevention (CDC) that explain to vaccine recipients, their parents, or their legal representatives both the benefits and risks of a vaccine.

Federal law requires that VISs be handed out whenever (before each dose) certain vaccinations are given.

To document that a VIS has been given to a patient:

1. One the Vaccine History tab, click **Add**. The Vaccines window opens.
2. On the Vaccines window, select the vaccine and click **Select**. The Add Vaccine window opens.
3. Click the ellipses button next to the VIS Version field. The VIS Version window opens.
4. You will be able to select a checkbox if the VIS was given. Once the checkbox is selected, the version date is enabled.

Note: The version date will default to latest one available.

5. You can overwrite the default version by clicking the Free-text VIS Version Information checkbox. Once the checkbox is selected, you can enter text in the version date box.
6. Click **OK**.
7. Click **Update**.

24.2.2 Deleting Immunization History

To delete an immunization History:

1. Select the immunization you want to delete.
2. Click **Delete**.

Note: You are not deleting the immunization from the patient's records, you are deleting vaccination history associated with the selected immunization.

24.2.3 Editing Immunization History

To edit an immunization history:

1. Select the immunization you want to edit.
2. Click **Edit**. The Immunization History Edit window opens (see Figure 24-5: Immunization History Edit Window).

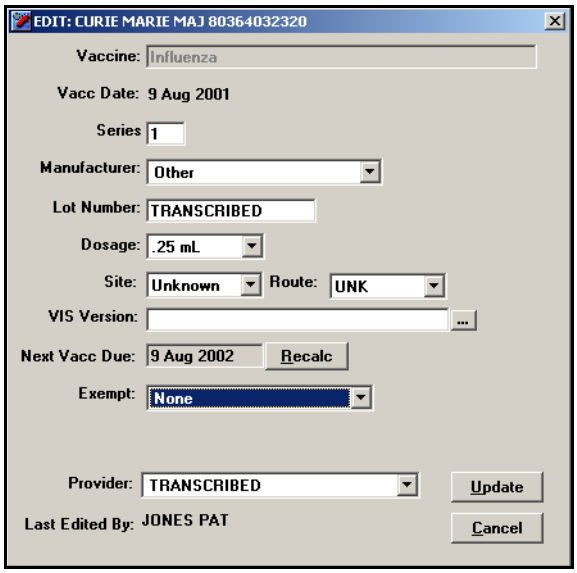

Figure 24-5: Immunization History Edit Window

3. Complete the following fields:
   - Series
   - Manufacturer
   - Lot Number
   - Dosage
   - Site
   - VIS Version
   - Route
   - Next Vacc Due
   - Exempt
   - Provider
4. Click **Update** to save the data and return to the Vaccine History tab.

24.2.4 Editing Vaccination Groups

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

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

To edit the Vaccination Groups:

1. Click **Edit Groups** in the Individual Immunization tab. The Immunization Groups window opens (see Figure 24-6: Immunization Groups Window).

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.

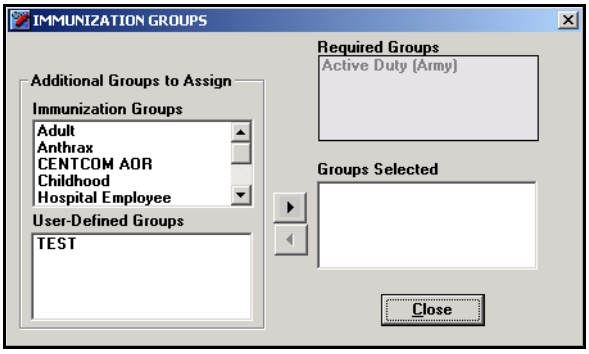

Figure 24-6: Immunization Groups Window

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.

24.2.5 Printing Immunization Records

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

To print immunization records:

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

24.2.6 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

24.2.7 Selecting an Immunization

To select an immunization:

1. Click **Give Vacc** on the Individual Immunizations tab. The Select Immunization window opens (see Figure 24-7: Select Immunization Window).

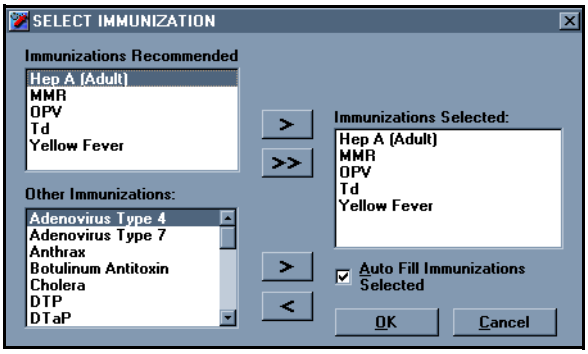

Figure 24-7: Select Immunization Window

2. Select an Immunization.

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

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

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

Click the left arrow to remove the selected immunization from the Immunizations Selected list back to the Immunizations Recommended or Other Immunizations list.

4. Click **OK**. The Vaccine Select window opens displaying the selected vaccines (see Figure 24-8: Vaccine Select Window).

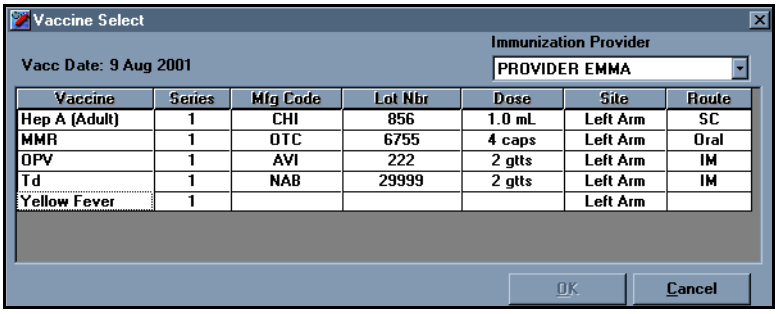

Figure 24-8: Vaccine Select Window

5. Select the vaccine(s).
6. Click **OK**.

24.2.8 Selecting the Immunization Exempt Type

To select the immunization exempt type:

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

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

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

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

2. Click, **Click to Save Exemption**.

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

1. Select the vaccination to be exempted.

2. Click **Edit**. The Immunization History Edit window opens (see Figure 24-9: Immunization History Edit Window).

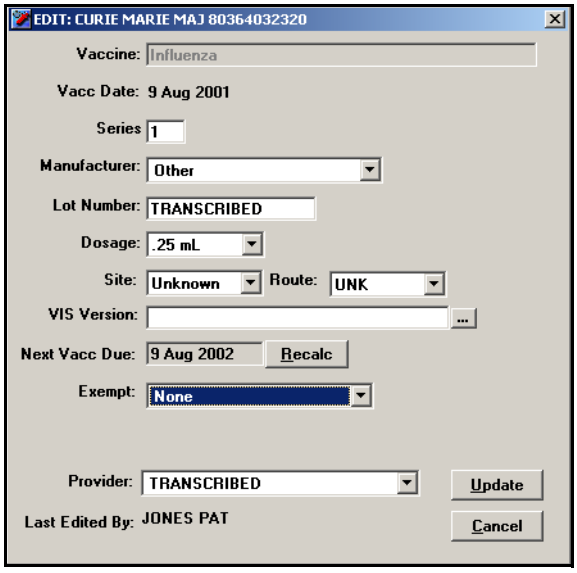

Figure 24-9: Immunization History Edit Window

3. Select the exempt type from the Exempt drop-down list.

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

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

25.0 PATIENT LIST

25.1 Overview of Patient List

The Patient List window displays your customized list of patients (see Figure 25-1: Military Clinical Desktop - Patient List Module). You can set up the patient list to contain patients specific to your caseload. Typically, this module is used to manage patients frequently seen or patients with common problems. Patient records can also be accessed from this window.

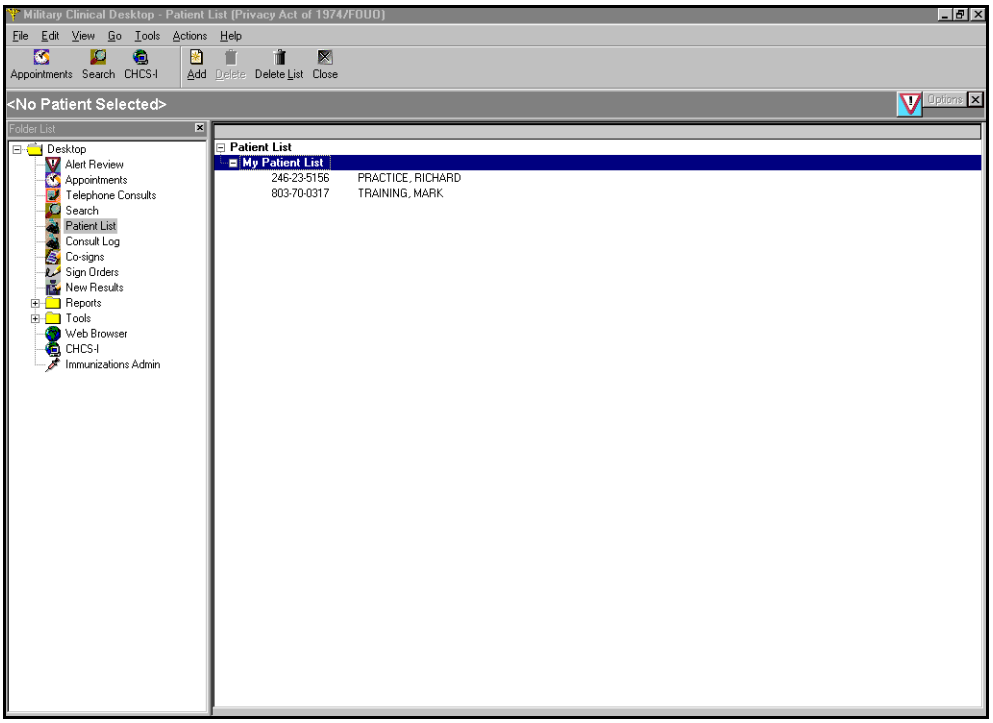

Figure 25-1: Military Clinical Desktop - Patient List Module

25.2 Action Bar Icons

	Add	Displays the Patient Search module so you can search for a new patient.
	Delete	Clears the highlighted patient from the list.
	Delete List	Allows you to delete the entire list of patients.
	Close	Closes the Patient List module.

25.3 Adding a Patient Name

If the Patient List window is blank upon opening, no patients have been added.

To add a patient name:

1. Click **My Patient List** on the Patient List window.
2. Click **Add** on the Action bar. The Patient Search window opens (see Figure 25-2: Patient Search Window).

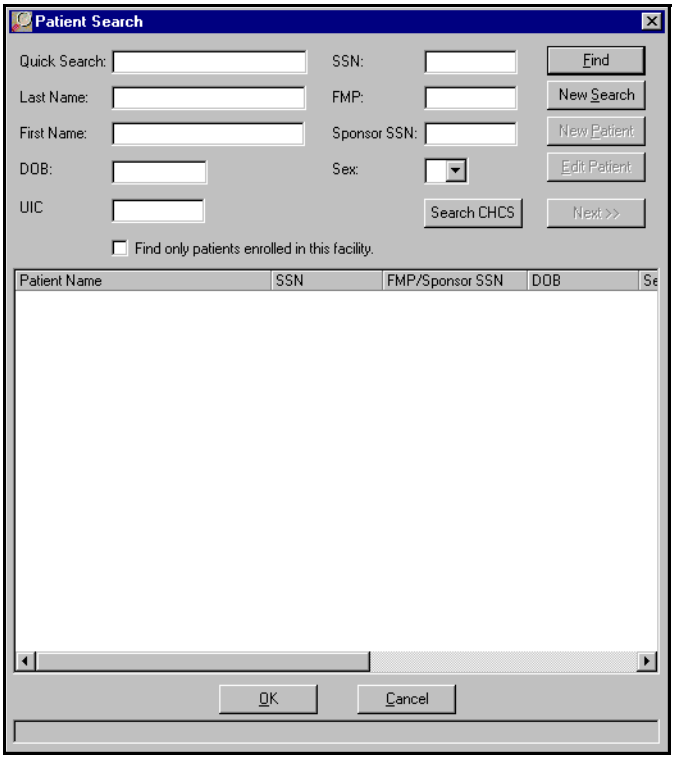

Figure 25-2: Patient Search Window

3. Conduct a patient search. The selected patient is displayed in the list.
4. Repeat the process until all desired patient names have been added.

Note: Select a patient from the Patient List to open the record for the selected patient.

25.4 Deleting a Patient Name

To delete a patient name:

1. Select the patient name to be deleted from the Patient List window.
2. Click **Delete** on the Action bar. The patient name is deleted from the list.
3. Click **Save**.

Tip:
*To delete the entire list of patients, click **Delete List** on the Action bar.*

26.0 PATIENT QUESTIONNAIRES

26.1 Overview of Patient Questionnaires

The Questionnaire Setup module (see Figure 26-1: Military Clinical Desktop — Questionnaire Setup Module) allows you to create and modify questionnaires.

Once created, you can modify, copy, delete, and mark obsolete these questionnaires. An open encounter is not required for questionnaires to be created or modified. To access the Questionnaire Setup module, from the Folder List, expand Tools, and select Questionnaire Setup.

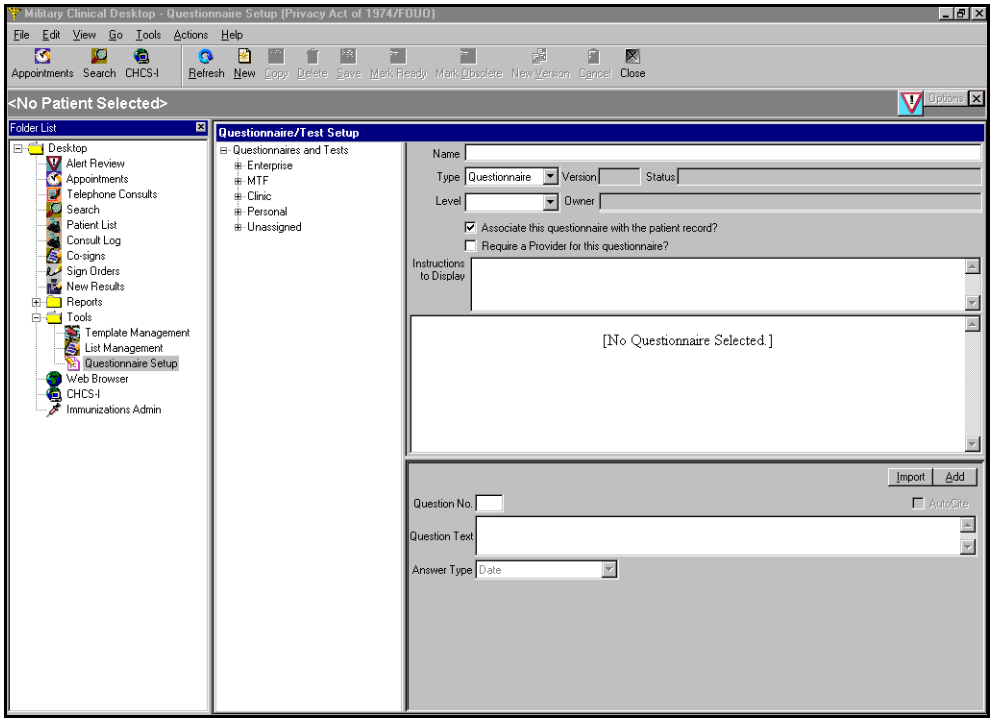

Figure 26-1: Military Clinical Desktop — Questionnaire Setup Module

26.2 Action Bar Icons

	Refresh	Updates the window with the latest questionnaire information.
	New	Enables you to create a new questionnaire.
	Copy	Enables you to create a new questionnaire by copying an existing questionnaire.
	Delete	Allows a questionnaire to be deleted if it has never been used.
	Save	Saves the created questionnaire.
	Mark Ready	Marks the questionnaire as ready for use. A questionnaire cannot be used until this button has been clicked.
	Mark Obsolete	Marks the questionnaire as obsolete.
	New Version	Allows you to create a new version of an existing questionnaire.
	Cancel	Cancels changes made to a questionnaire.
	Close	Closes the Patient Questionnaire module.

Note: If the action cannot be taken, the icon does not appear on the Action bar.

26.3 Creating a New Questionnaire

To view a questionnaire in an Encounter document, in a Patient encounter, in options, select AutoCite.

Note: In the patient encounter, under Options, the questionnaire must be autocited to be viewed in the Encounter Document.

To create a new questionnaire:

1. Click **New** on the Action bar. The New Questionnaire window opens (see Figure 26-2: Questionnaire Setup—New Questionnaire).

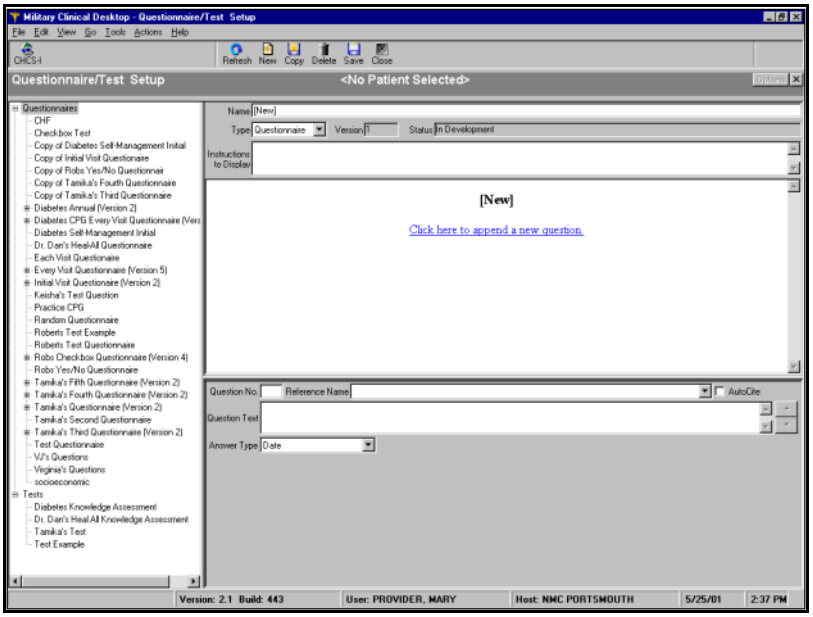

Figure 26-2: Questionnaire Setup—New Questionnaire

2. In the Name field, enter the name for the new questionnaire.
3. Select **Questionnaire** or **Test** from the Type drop-down list.

Note: The Status is *In Development* until you save the questionnaire.

---

4. In the Instructions to Display field, enter any instructions related to the questionnaire for the patient.
5. Click **Add** to create a new question.

Note: The Question No. field is pre-populated in numerical order.

---

6. In the Question Text field, enter the question.
7. Select an answer type from the drop-down list. The Answer Type field allows different answer format styles to be assigned to the question (see Figure 26-3: Questionnaire Answer Format Styles).
   - **Date:** Used for questions requiring a specified date to be entered as the answer.
   - **Multiple Choice:** Used for questions where a single choice is available for selection.
   - **Multi-Select:** Used for questions where more than one answer can be selected.
   - **Number:** Used for questions requiring a number to be entered. A minimum or maximum amount can be specified.

- **Yes/No:** Used for questions requiring a yes or no response.

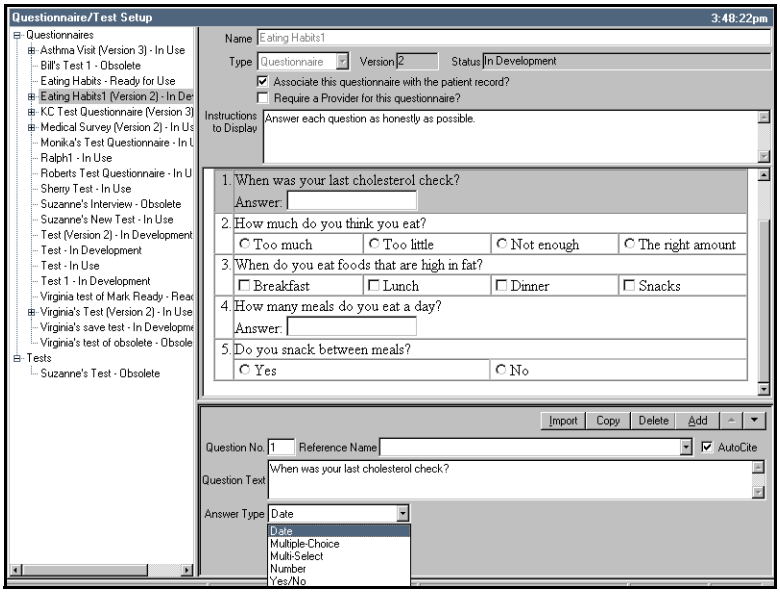

Figure 26-3: Questionnaire Answer Format Styles

8. Click **Save** on the Action bar to save the questionnaire as completed.
9. Click **Mark Ready** on the Action bar.

Note: The status changes from In Development to Ready for Use. The questionnaire must be marked Ready for Use before it can be used in the Patient Questionnaires module.

26.4 Copying a Questionnaire

A questionnaire can be copied and saved as another questionnaire so that questions can be reused.

To copy a questionnaire:

1. Select the questionnaire you want to copy from the Questionnaire list.
2. Click **Copy** on the Action bar. The Copied Questionnaire displays.
3. In the Name field, enter the name of the questionnaire.
4. Select the question you want to modify, if necessary.
5. Click **Save** on the Action bar.
6. Click **Mark Ready** to mark the test as ready for use.

26.5 Deleting a Questionnaire

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup.

To delete a questionnaire:

1. Select the questionnaire you want to delete from the Questionnaire list.
2. Click **Delete** on the Action bar.
3. Click **Yes** at the delete confirmation prompt.

26.6 Importing a Questionnaire or Question into a Questionnaire

Entire questionnaires or selected questions can be imported into questionnaires.

To import a questionnaire or question into a questionnaire:

1. Select the questionnaire into which you want to import.
2. Click **Import**.
3. Click **OK** at the import questionnaire prompt (see Figure 26-4: Import Questionnaire Prompt).

Figure 26-4: Import Questionnaire Prompt

4. Select the questionnaire you want to import from the Questionnaire list. The Import Questionnaire window opens (see Figure 26-5: Import Question Window).

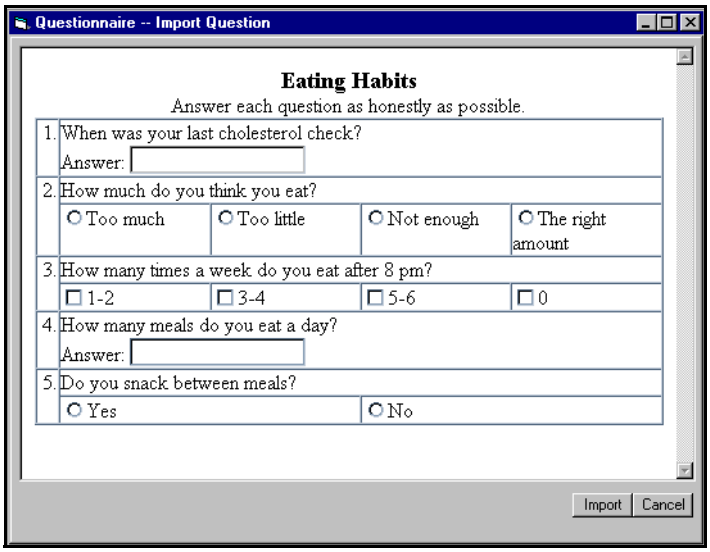

Figure 26-5: Import Question Window

5. Click the question(s) you want to import.
6. Click **Import**. The questions are imported after the last question in the questionnaire.
7. Click **Save**.

26.7 Maintaining Questionnaires

The Status section of each questionnaire denotes the level of development or use of a questionnaire. A new questionnaire always starts out as In Development.

- **Mark Ready:** Marks questionnaire as ready for use.
- **Mark Obsolete:** Allows a questionnaire to be removed from circulation.
- **New Version:** A questionnaire can be modified into another version of a specific questionnaire.

To mark a questionnaire Ready:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked Ready for Use.
2. From the Questionnaire Set Up window, access the Actions pull-down menu and select **Mark Ready** to mark the questionnaire as ready. Once marked as ready, the questionnaire is available for use. The Status bar reflects the questionnaire as Ready for Use.

To mark a questionnaire Obsolete:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked obsolete.
2. From the Questionnaire Set Up window, access the Actions pull-down menu and select **Mark Obsolete** to mark the questionnaire as Obsolete. Once marked Obso-

lete the questionnaire is not available for use. The Status bar reflects the questionnaire as Obsolete.

Note: A questionnaire that is marked obsolete can be made active again by selecting **Ready For Use**.

To mark a questionnaire as New Version:

1. From the Questionnaires listed in the side bar, select the questionnaire to be marked New Version.
2. From the Questionnaire Set Up window, access the Actions pull-down menu and select **New Version** to mark the questionnaire as a New Version. Once marked New Version, the questionnaire is available for use. The Status bar reflects the questionnaire as New Version.

To delete a questionnaire:

Only questionnaires that have never been used can be deleted. If a questionnaire is not used, it can be deleted so it does not appear in the Questionnaire list available in either the Questionnaire Setup or Patient Questionnaire Setup. A questionnaire cannot be deleted if it has been used.

26.8 Patient Questionnaire Delivery

Patients that have been added to the Patient Registry already have a questionnaire assigned to their encounter. The front desk supplies the patient with instructions on how to complete the questionnaire. The provider can then view the questionnaire, modify the answers, and link it to an encounter.

The actions associated with the Patient Questionnaire Setup module are:

- Refresh
- Setup
- Interview
- Edit
- Encounter
- Append
- Save
- Done
- Cancel
- Print
- Close

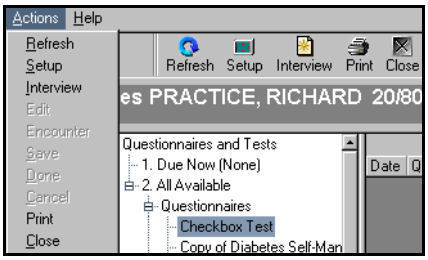

Figure 26-6: Questionnaire Delivery—Actions Menu and Action Bar

Note: If the action cannot be taken, it does not appear on the Action bar.

26.9 Assigning a Questionnaire to a Patient

To assign a questionnaire to a patient:

1. Within an open encounter, expand the Health History folder, and select the Patient Questionnaires option (see Figure 26-7: Questionnaire Module).

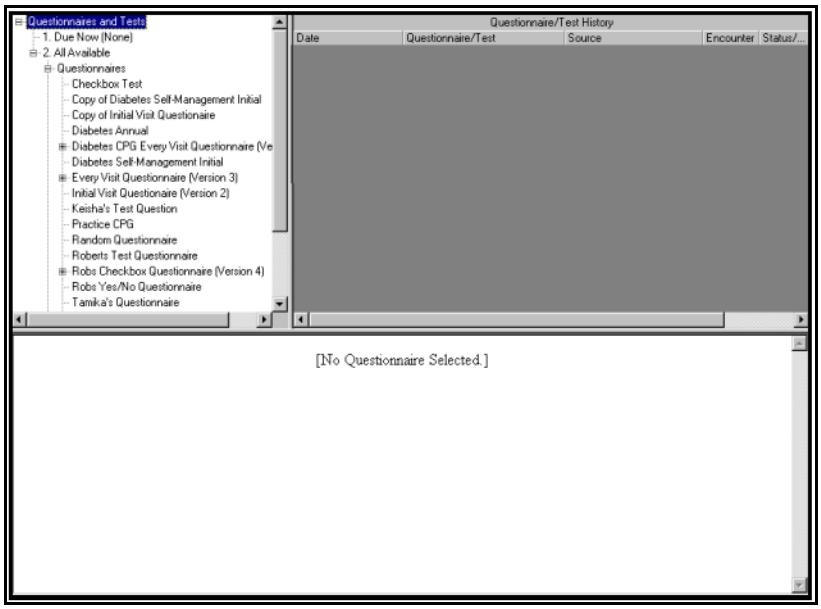

Figure 26-7: Questionnaire Module

2. When the Patient Questionnaires module opens, select the questionnaire that you want to assign to the encounter and click **Setup** from the Action bar. The Assign PIN for Patient Questionnaire/Test window opens (see Figure 26-8: Assign PIN for Patient Questionnaire/Test).

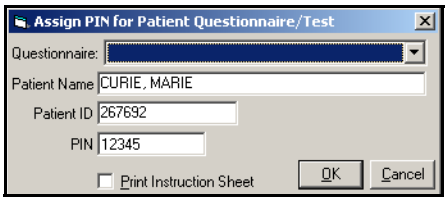

Figure 26-8: Assign PIN for Patient Questionnaire/Test

3. The patients are then supplied with the login credentials that they use at the kiosk to answer the questionnaire (see Figure 26-9: Kiosk and Login).

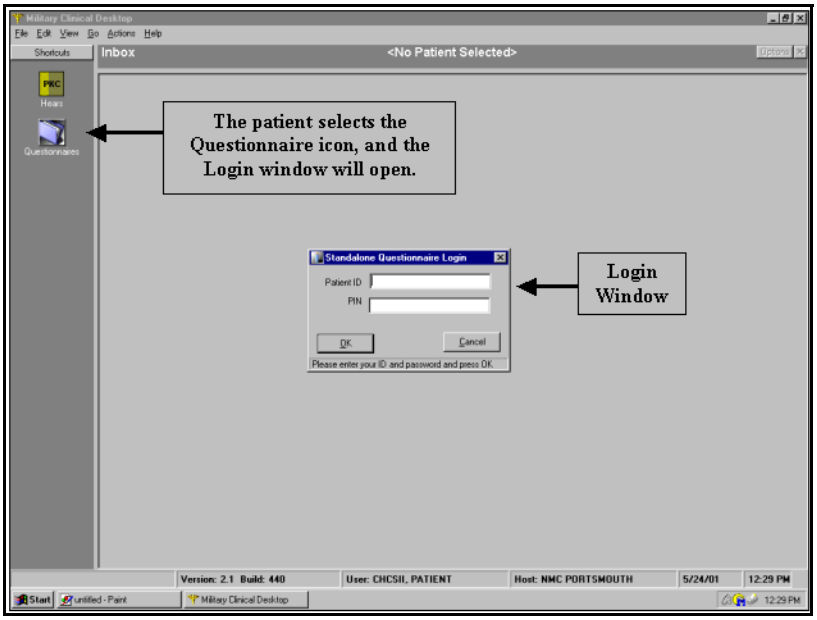

Figure 26-9: Kiosk and Login

4. The patients then proceed to the kiosk to answer the questionnaire. Patients select **Questionnaire** from the folder list and the login window opens, prompting them to enter their Patient ID and PIN.
5. Patients enter the requested information and click **OK**.
6. Patients then answer the questions that appear on screen (see Figure 26-10: Questions).

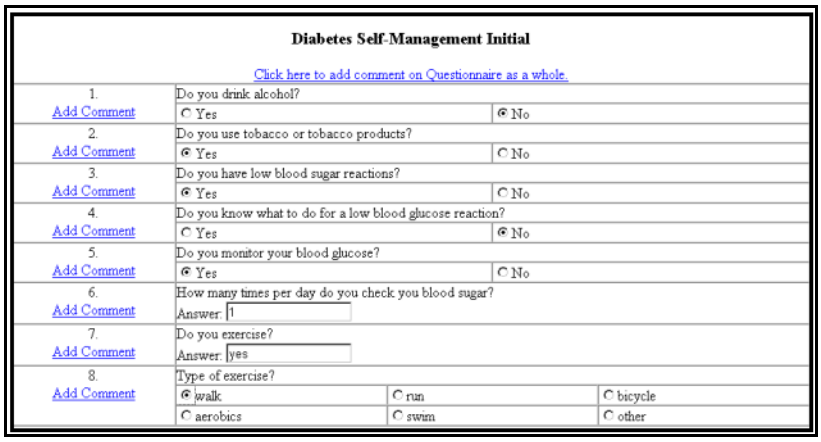

Figure 26-10: Questions

7. When the questions have been answered, the patients click **Save** and then **Done** from the Action bar.

26.10 Reviewing a Completed Questionnaire

You and your patients can review and modify completed questionnaire, as necessary, and assign it to an encounter.

1. Under the Health History, Questionnaire Folder the provider would then see a completed Questionnaire screen. The Status now shows Complete (see Figure 26-11: Completed Questionnaire).

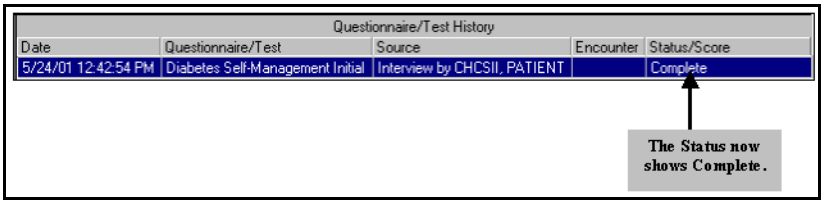

Figure 26-11: Completed Questionnaire

2. The questionnaire can be reviewed with the patient and you can make changes to the patient's answers, as needed. A correction notation appears on any answers that have been changed (see Figure 26-12: Correction Notation).

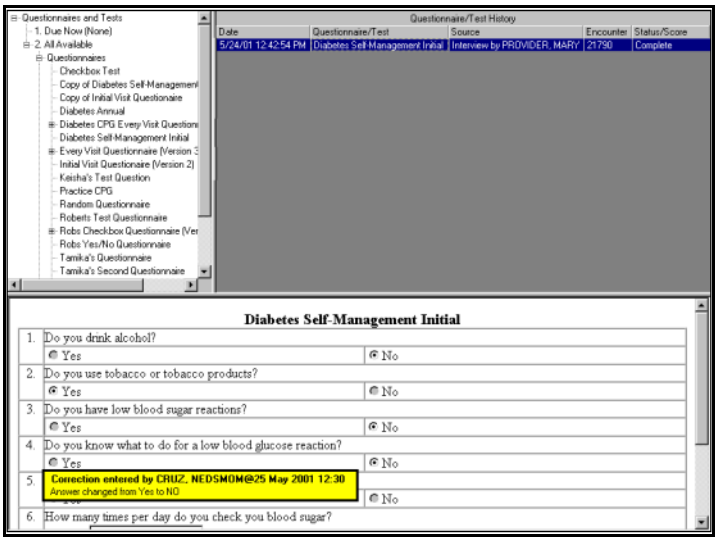

Figure 26-12: Correction Notation

3. You can link the questionnaire to an open encounter by clicking **Encounter** from the Action bar. All open encounters for that particular patient appear.
4. Select the desired encounter and click **OK**. Click **Cancel** to return to the current encounter.
5. Before you can view questionnaire data in the Encounter document you must set the encounter summary properties, by selecting the Properties—Encounter option from the Tools pull-down menu.
6. In the Encounter Summary Properties window, select **Questionnaires**.
7. Click **AutoCite** to refresh the current encounter. In the S/O section the Questionnaire information is displayed (see Figure 26-13: Questionnaire in Encounter).

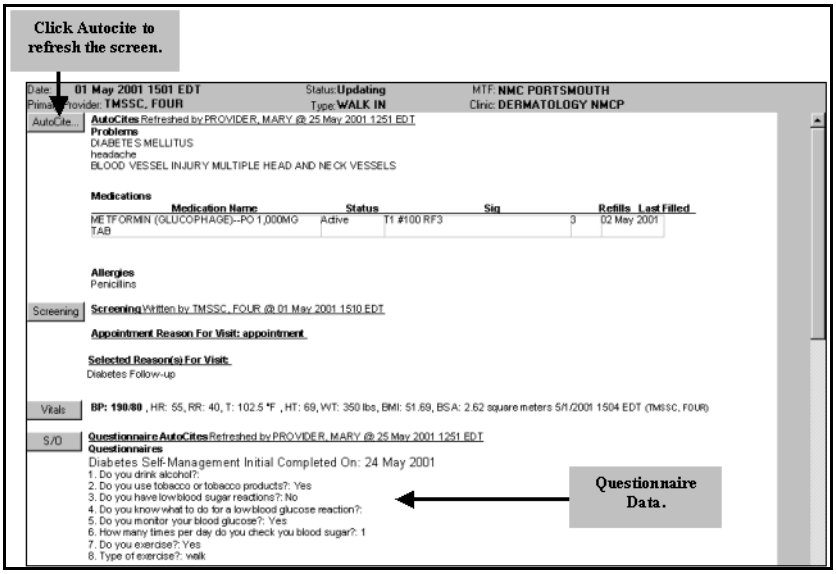

Figure 26-13: Questionnaire in Encounter

27.0 PATIENT SEARCH

27.1 Overview of Patient Search

The Patient Search module allows a specific patient record to be selected. Once a patient name is selected, patient-specific functions are available. These modules are visible in the Go Pull-down menu, the Shortcuts, the Folder List, and the Tool bar.

27.2 Conducting a Search

In order to do any work with a specific patient's record, a patient search must be conducted.

To conduct a search:

1. On the Folder List, click **Search**. The Patient Search window opens (see Figure 4-1: Patient Search Window).

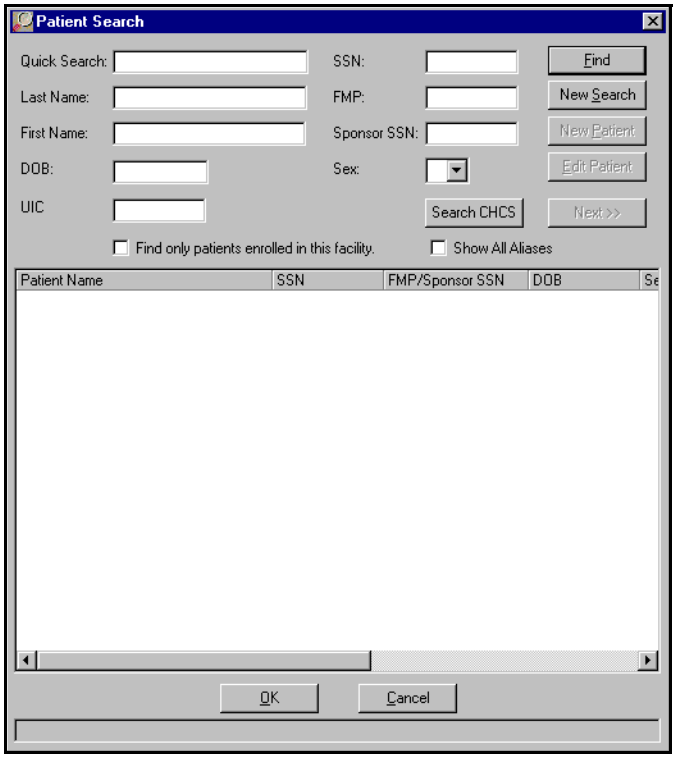

Figure 4-1: Patient Search Window

2. Enter search criteria into the appropriate field(s).
   - **Quick Search:** The Quick Search function allows a patient to be selected using the following criteria:
     — L1234: First letter of the last name and last 4 digits of the sponsor's SSN

SEE RELATED TOPICS

- **6.5 SCHEDULING A NEW APPOINTMENT**

— L/1234: First letter of the last name and last 4 digits of the patient's SSN

— 20/123456789: FMP/Sponsor SSN

- **Last Name:** The patient's last name (use any combination of upper and lower-case).
- **First Name:** The patient's first name (use any combination of upper and lower-case).
- **DOB:** The patient's date of birth (use the format mm/dd/yyyy). The search program returns all patients that were born in a four-year range-from two years before the date to two years after the date.
- **UIC:** The location of the patient's/sponsor's unit command.
- **SSN:** The patient's Social Security Number.
- **FMP:** The Family Member Prefix.
- **Sponsor SSN:** The sponsor's Social Security Number.
- **Sex:** The patient's gender (choose a value from the list).

Note: The value B (for Both) doesn't make the program search regardless of gender. Rather, it indicates a search for the patients with a gender value of "B", indicating that they are both male and female. 'U' is for unknown (identifying remains).

- **Find only patients enrolled in this facility:** Searches for only those patients enrolled in your selected facility.

Tip:
*When searching CHCS II, if the number of patients meeting the criteria exceeds 50, a prompt is shown, asking to continue the search. Click **Yes** to continue or **No** to end the search and display the first 50 matches.*

3. To view all patients that meet the selected criteria, click **Find**.
4. Select the patient from the list of results.
5. Click **OK**. The record opens in the Folder List with all available options (see Figure 27-2: Selected Patient's Record in the Folder List).

Note: Click **Search CHCS** when creating unscheduled appointments for CHCS patients that need to be seen. In some cases, these patients are not found through a generic search in CHCS II so they need to be located through an advanced search of CHCS.

Figure 27-2: Selected Patient's Record in the Folder List

27.3 Selecting a Patient Without a Search

The system allows the last 20 patient records to be accessible without a search. The system lists the last 20 patient records so they can be retrieved without having to perform a search.

To select a patient without a search:

1. On the Go menu, point to Patient (see Figure 27-3: Select Patient Using the Go Drop-down Menu).
2. Select the desired patient from the list of recently viewed patient records.

SEE RELATED TOPICS

- **27.2 CONDUCTING A SEARCH**

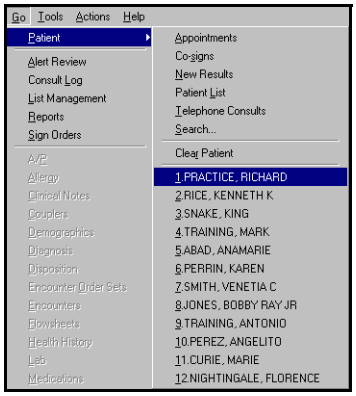

Figure 27-3: Select Patient Using the Go Drop-down Menu

28.0 PREVIOUS ENCOUNTERS

28.1 Overview of Previous Encounters

The Previous Encounter module displays a list of a patient's completed encounters. Select a previous encounter to view the details in the bottom of the window (see Figure 28-1: Military Clinical Desktop - Previous Encounters Module). You must select a patient record to view previous encounters.

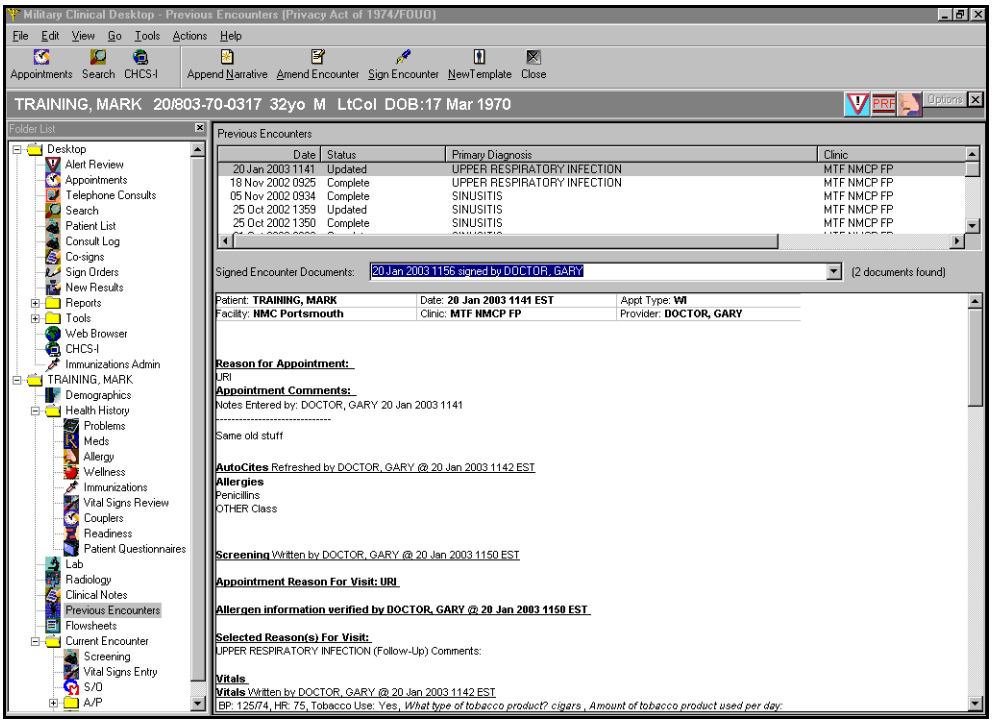

Figure 28-1: Military Clinical Desktop - Previous Encounters Module

28.2 Action Bar Icons

	**Append Narrative**	Opens the Encounter Note window allowing for a note to be added to the highlighted encounter.
	**Amend Encounter**	Opens the Patient Encounter window with the details of the highlighted encounter.
	**Sign Encounter**	Opens the Sign Encounter window.

	New Template	Creates a new encounter from the highlighted encounter by opening the Template Details window with the structure in place.
	Close	Closes the Previous Encounter window.

28.3 Adding a Narrative to a Previous Encounter

SEE RELATED TOPICS

- **23.4 ADDING A NOTE**
- **35.0 SIGNING THE ENCOUNTER**

Information from this window cannot be modified. However, a narrative can be appended to an encounter document.

To append a narrative to the previous encounter:

1. Select the previous encounter you want to append.
2. Click **Append Narrative** on the Action bar. The Encounter Note window opens (see Figure 28-2: Previous Encounter Note Window).

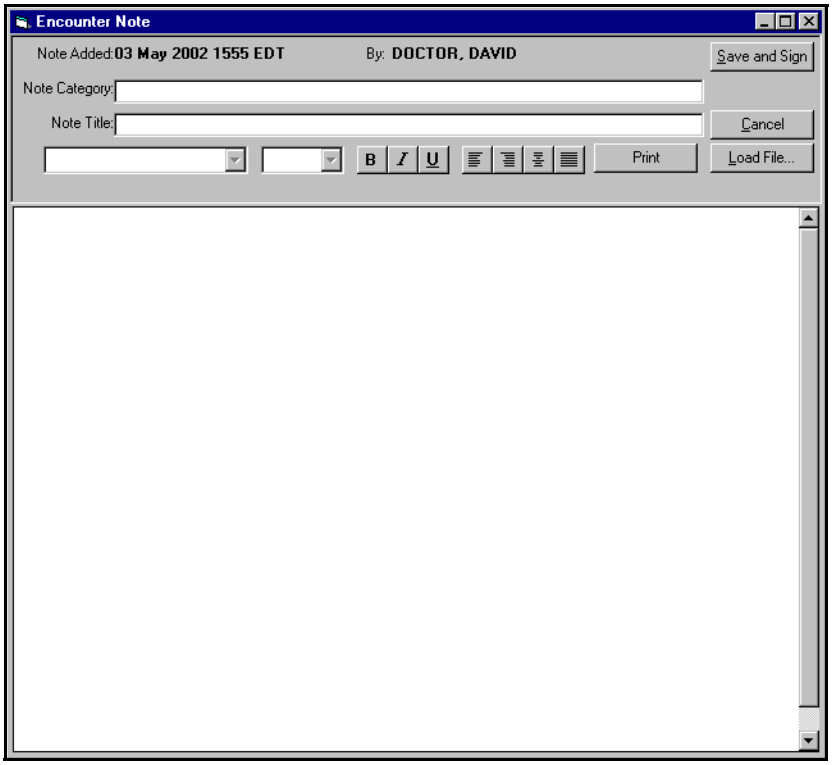

Figure 28-2: Previous Encounter Note Window

3. Enter a note category, if applicable.
4. Enter a note title, if applicable.
5. Enter the note in the text box.
6. Do one of the following:
   - If you want to insert a file into the note:

a. Click **Load File**.

b. Select the file you want to add.

c. On the Select Destination File window, click **Open**.

Note: Graphics that are imported must be 500K or less.

- If you want to print the note for your hardcopy records, click **Print**.

7. Click **Save and Sign**. The Sign Appended Note window opens, allowing for the review of the note before signing (see Figure 28-3: Sign Appended Note Window).

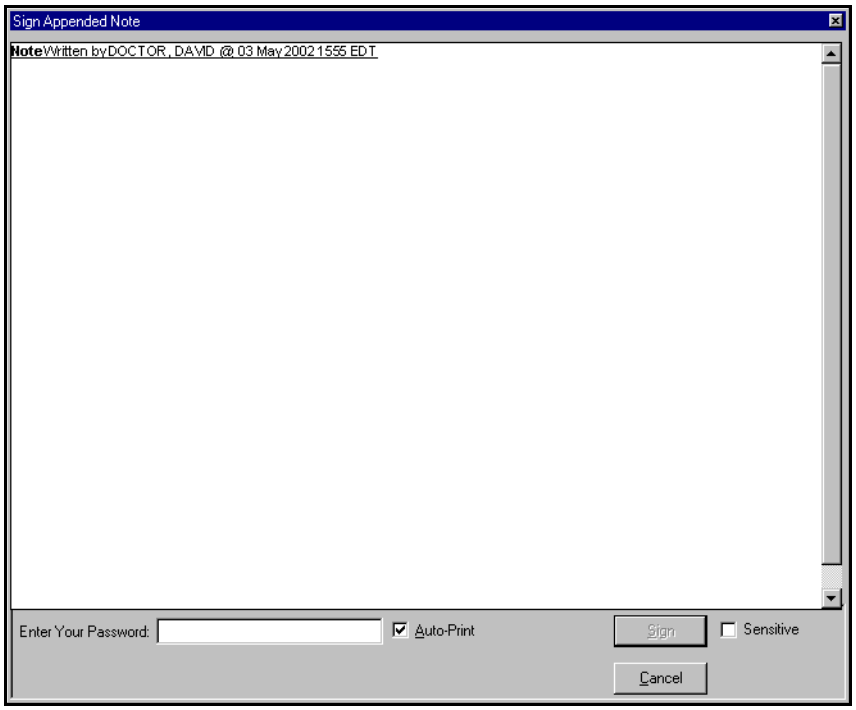

Figure 28-3: Sign Appended Note Window

8. In the Enter Your Password field, enter your password.
9. Click **Sign**.
10. The appended narrative note is added to the encounter document.

28.4 Amending a Previous Encounter

Amending an encounter allows original information to be changed by the original provider or the provider's supervisor. The amended encounter document must be signed.

To amend an encounter:

1. Select the previous encounter you want to amend.

See Related Topics

- 35.0 Signing the Encounter
- 33.0 Screening (Reason for Visit)
- 39.0 Vital Signs
- 36.0 Subjective/ Objective (S/O)
- 7.0 Assessment and Plan (A/P)
- 13.0 Disposition
- 23.4 Adding a Note
- 23.7 Editing a Note

2. Click **Amend Encounter** on the Action bar. The Patient Encounters window opens for the selected encounter (see Figure 28-4: Encounter Summary).

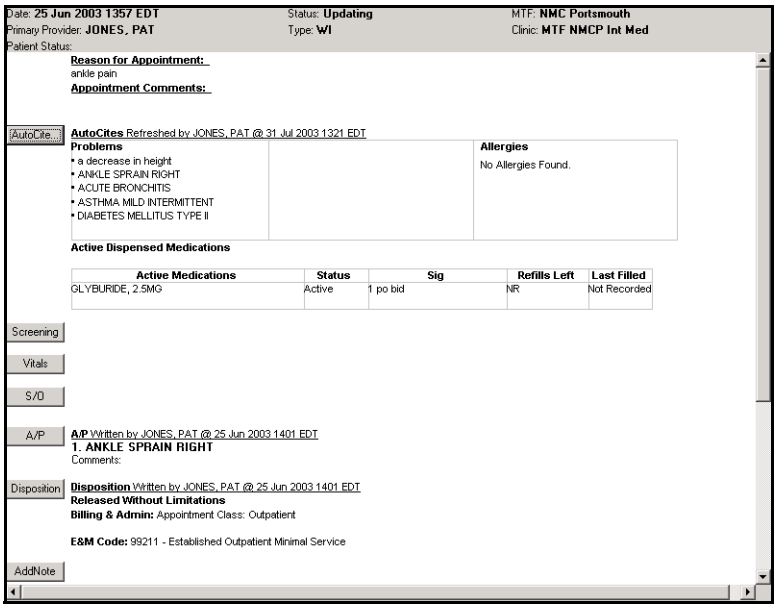

Figure 28-4: Encounter Summary

3. Update applicable sections of the encounter.
4. Once the changes have been made, the amended encounter document must be signed. Click **Sign** on the Action bar. The Sign Encounter window opens (see Figure 28-5: Sign Encounter Window).

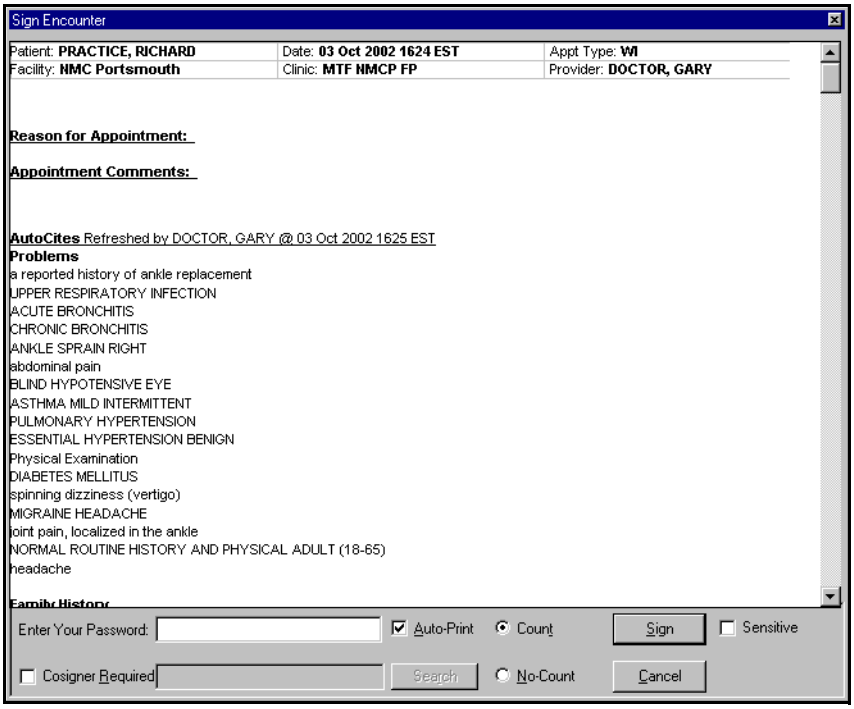

Figure 28-5: Sign Encounter Window

5. In the Enter Your Password field, enter your password.
   - If you do not want to Auto-Print the signed encounter, click the **Auto-Print** checkbox to deselect this option.
   - If a co-signer is required, click the **Cosigner Required** checkbox.
   - If the encounter is not being billed, click the **No-Count** radio button.
   - If you want to mark the amended encounter as sensitive, click the **Sensitive** checkbox. Sensitive data is displayed with asterisks. Providers other than the primary and co-signing must have "break the glass" privileges to view the sensitive data.
6. Click **Sign** to sign the encounter. The Change History section of the encounter is documented with the amendments (see Figure 28-6: Change History Section of an Encounter).

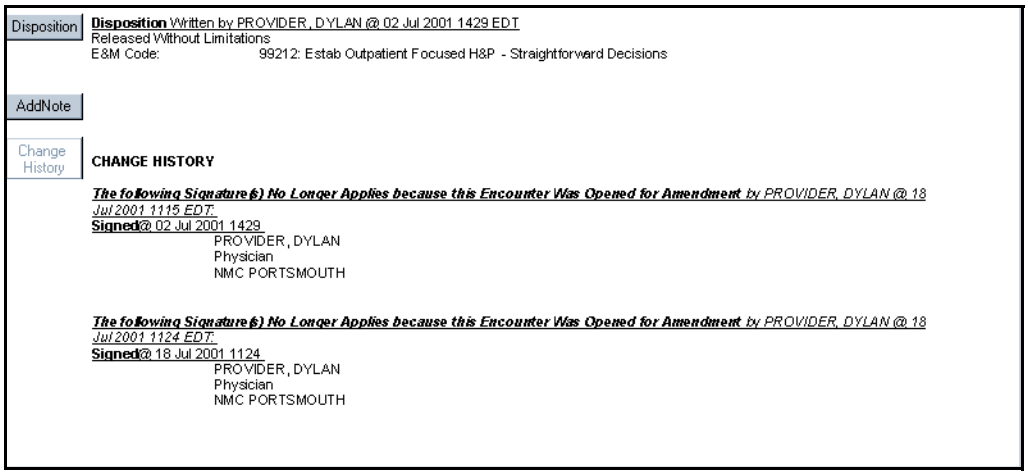

Figure 28-6: Change History Section of an Encounter

28.5 Creating a New Encounter Template

After you document an encounter, you can use the structure of the current encounter to create a new encounter template. No patient specific information is saved in the encounter template.

To create a new encounter template:

1. Click **New Template** on the Action bar. The Template Management window opens with details populated in the Template Details tab (see Figure 28-7: Template Management Window—Template Details Tab).

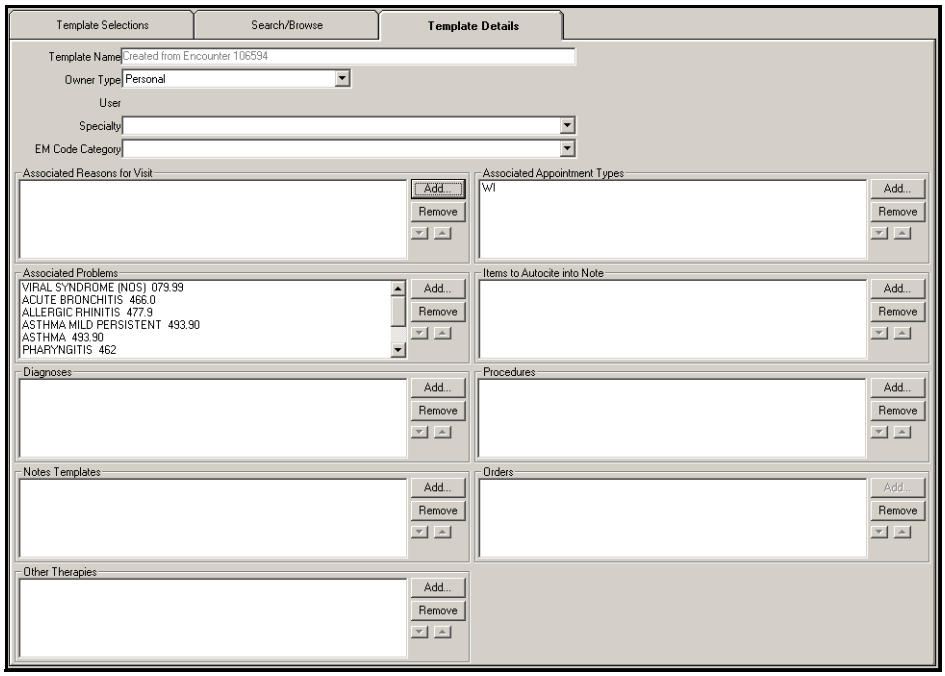

Figure 28-7: Template Management Window—Template Details Tab

2. Select an **Owner Type** from the drop-down list, if necessary.
3. Select a **Specialty** from the drop-down list, if necessary.
4. Select an **E&M Code Category** from the drop-down list, if necessary.
5. Add or remove information from the following areas:
   - **Associated Reasons for Visit:** In the Search Term field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Associated Problems:** In the Search Term field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Diagnoses:** In the Search Term field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Item**s. Click **Done** to return to the Template Details tab.
   - **Notes Templates:** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note template and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Other Therapies:** In the Search Term field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Associated Appointment Types:** In the Search Term field, enter the first few letters of the appointment type and click **Search**. Select the appointment type

from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

- **Items to AutoCite into Note:** Select an Auto Cite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Procedures:** In the Search Term field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

Note: Orders cannot be created or added in the Template Details tab. They can only be created in the A/P module. Once created, Orders can only be removed in the Template Details tab.

6. Click **Save As** on the Action bar. The Save Encounter Template window opens.
7. Select the template type from the Save in drop-down list.
8. In the Template Name field, enter the name of the template.
9. Select a specialty from the drop-down list.
10. Click the checkboxes to denote whether the template should be added to the favorites list or shared with other clinical team members.
11. Click **Save**.

28.6 Copy Forward

Users can "Copy Forward" a previous encounter document for use in the current encounter. This enables users to quickly and efficiently copy work from previous encounter(s) to the current encounter. This feature saves charting steps when seeing a follow-up visit or the patient has many complicated problems and the user does not have the templates to recreate this visit/physical exam findings. The S/O and A/P sections of the previous encounter will copy forward as if it were an Encounter Template.

To Copy Forward a previous encounter:

1. With a current encounter summary open, click **Previous Encounters** in the patient's Folder List. The Previous Encounter module displays (see Figure 28-8: Previous Encounter Module).

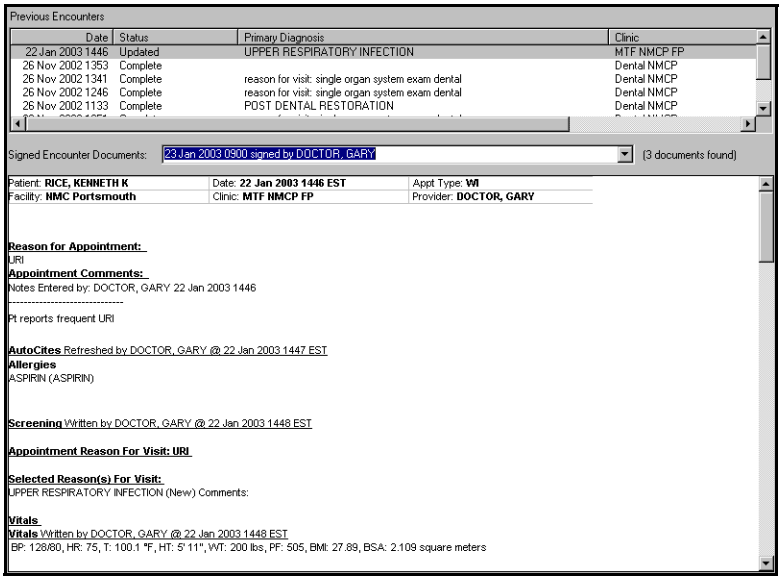

Figure 28-8: Previous Encounter Module

2. Right click on the previous encounter to be copied forward, and select **Copy Forward** (see Figure 28-9: Copy Forward Selected). You are returned to the Current Encounter Summary (see Figure 28-10: Current Encounter Summary).

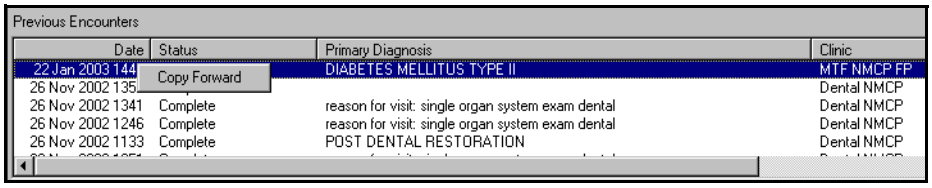

Figure 28-9: Copy Forward Selected

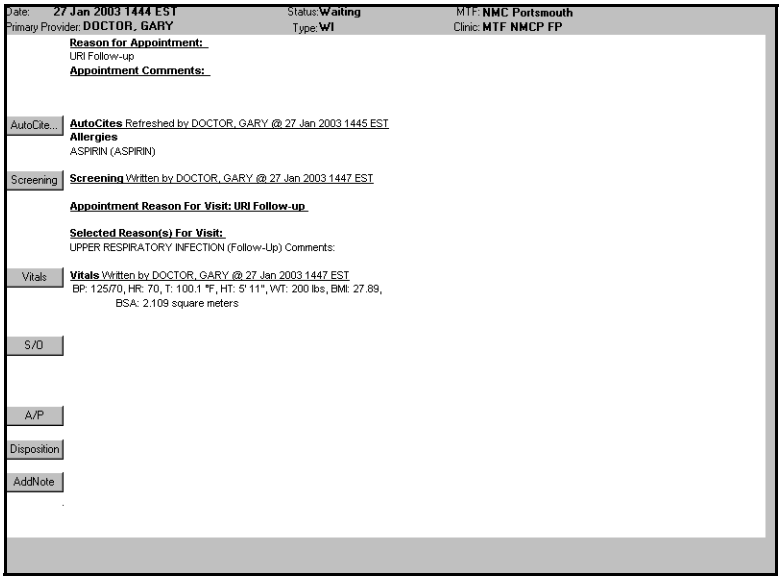

Figure 28-10: Current Encounter Summary

3. Click **S/O**. The S/O module opens (see Figure 28-11: Copy Forward Items Highlighted).

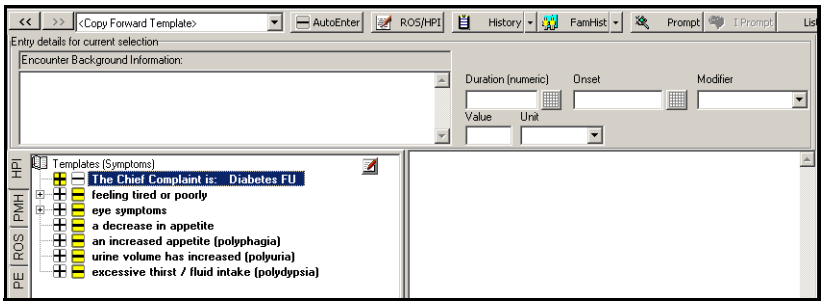

Figure 28-11: Copy Forward Items Highlighted

Note: Items copied forward are marked in yellow. To insert items copied forward into the current encounter note, click on them. To insert all items copied forward, click AutoEnter on the S/O dashboard.

28.7 Printing Previous Encounter Documents

To print selected previous encounters:

1. Select the previous encounter you want to print.
2. On the File menu bar, point to Print (see Figure 28-12: Print Previous Encounter).
3. Do one of the following:
   - If you want to print the previous encounter in a Form DD2766, click **DD2766**.
   - If you want to print the previous encounter in a Form SF600, click **SF600**.

Tip:
To print multiple encounters, press the Ctrl key on your keyboard and select each encounter.

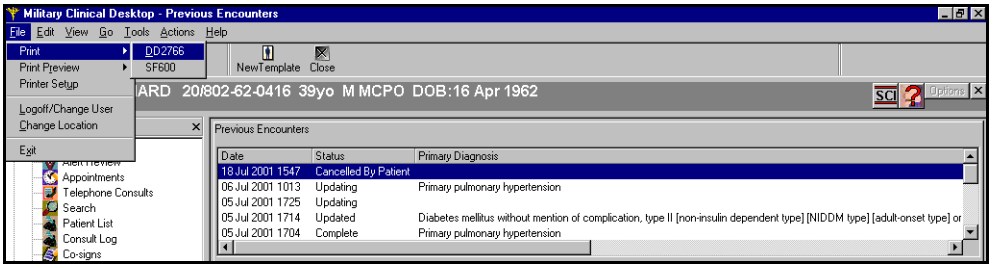

Figure 28-12: Print Previous Encounter

29.0 PROBLEMS

29.1 Overview of Problems

The Problems module displays a problem list, healthcare maintenance, Dental Readiness Classification, Historical Procedures, and Family History information for the selected patient in the top portion (see Figure 29-1: Military Clinical Desktop - Problems Module). Dental Readiness Classification information is populated by the Dental module and is read only.

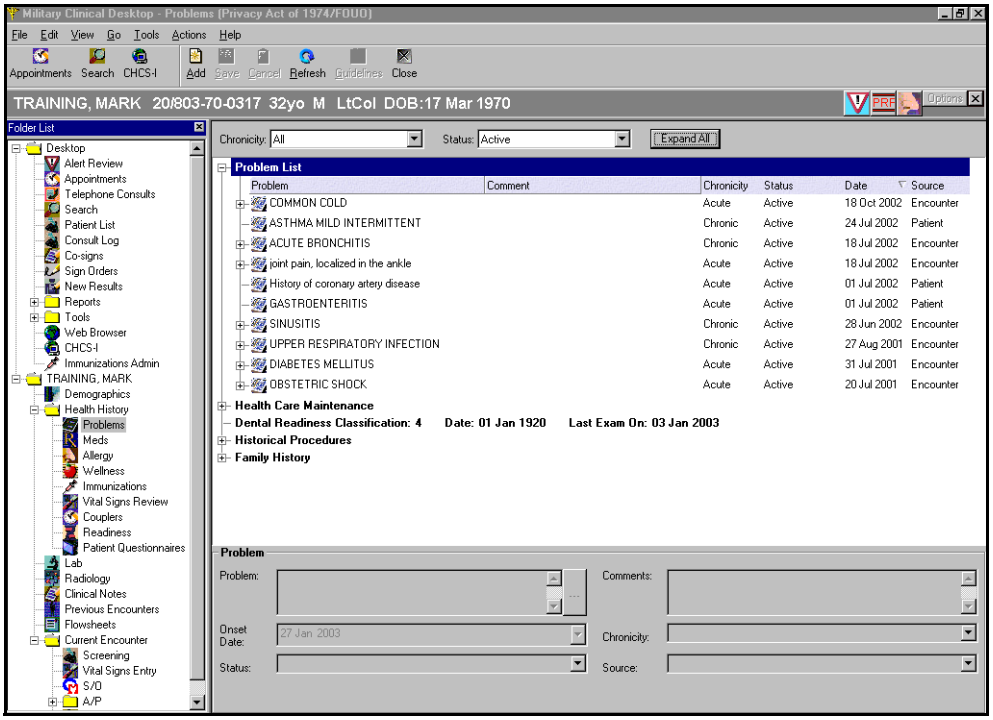

Figure 29-1: Military Clinical Desktop - Problems Module

29.2 Action Bar Icons

	Add	Allows a new problem to be added.
	Save	Saves the new information.
	Cancel	Cancels the current action.
	Refresh	Refreshes information in the module.

	Guidelines	Provides a description of the Healthcare Maintenance item.
	Close	Closes the Problems module.

29.3 Viewing the Problem List

Use the two filter options to view selected problems on the list. The two filter criteria are Chronicity and Status.

Tip:
Click the Expand All checkbox to view the associated encounters and orders for all problems.

To view the problem list:

1. Select a **Chronicity** filter from the drop-down list. The default is Chronic.
2. Select a **Status** filter from the drop-down list. The default is Active.

Note: Details about any associated encounters, procedures, medications, labs, and radiology procedures associated with the selected problem can be displayed by clicking the plus sign to the left of the item. Double-click the associated encounter to view the encounter details in the Previous Encounter module. Double-click the radiology or lab results to view the details in the respective modules.

29.4 Adding a Problem

New problems are automatically added to the problem list every time an encounter is signed. The diagnosis from each encounter becomes a problem. Use the following procedure to add a problem that was not documented through an encounter.

Too add a problem:

1. Select the **Problem List** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens (see Figure 29-2: Problems—Select Diagnosis Window).

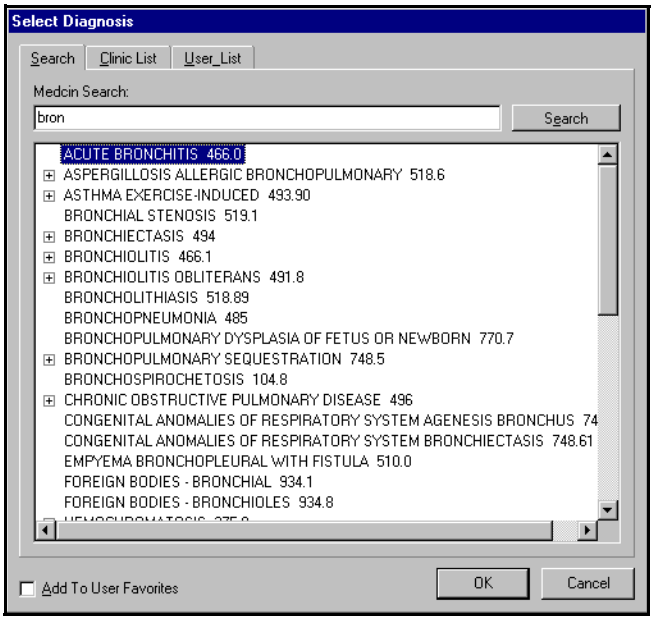

Figure 29-2: Problems—Select Diagnosis Window

3. Select the diagnosis you want to add. The selected problem appears in the New Problem pane on the Problems window (see Figure 29-3: New Problem Pane).

Note: The Select Diagnosis window contains three tabs:

- **Search:** To select a diagnosis using the Search tab, type the first few letters of the diagnosis in the Medcin Search field and click **Search**. Select the diagnosis from the search results and click **OK**.
- **Clinic List:** To select a diagnosis using the Clinic List tab, type the first few letters of the diagnosis in the Find field and select the diagnosis from the clinic list results. Click **OK**.
- **User List:** To select a diagnosis using the User List tab, type the first few letters of the diagnosis in the Find field and select the diagnosis from the user list results. Click **OK**.

If the Add to Favorites checkbox is checked, the selected diagnosis and ICD-9 code are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the Problems module, in the User List tab. You cannot change the items in the Clinic List tab.

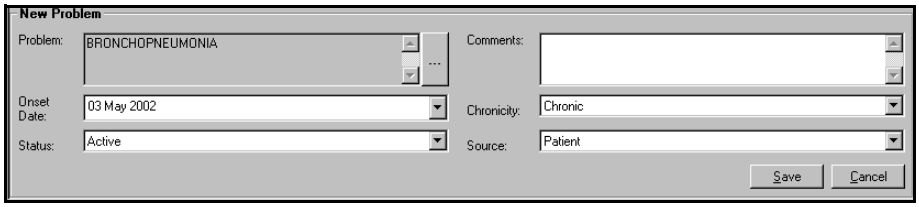

Figure 29-3: New Problem Pane

4. Complete the appropriate fields.
   - **Onset Date:** Click the drop-down arrow to select the correct date the problem began.
   - **Chronicity:** Select **Acute** or **Chronic** from the drop-down list.
   - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
   - **Comments:** Add a note for a selected problem or procedure.
   - **Source:** The manner in which you received the problem information:
     — Patient
     — Encounter
     — HEAR
5. Click **Save** on the Action bar.

29.5 Adding an Historical Procedure

Historical procedures can be followed as problems. These procedures are not automatically populated from the Assessment and Plan module when an encounter is signed, in the way diagnoses are. The procedures are added directly from the Problems module.

To add an historical procedure:

1. Click the **Historical Procedures** header.
2. Click **Add** on the Action bar. The Select Procedure window opens (see Figure 29-4: Problems—Select Procedure Window).

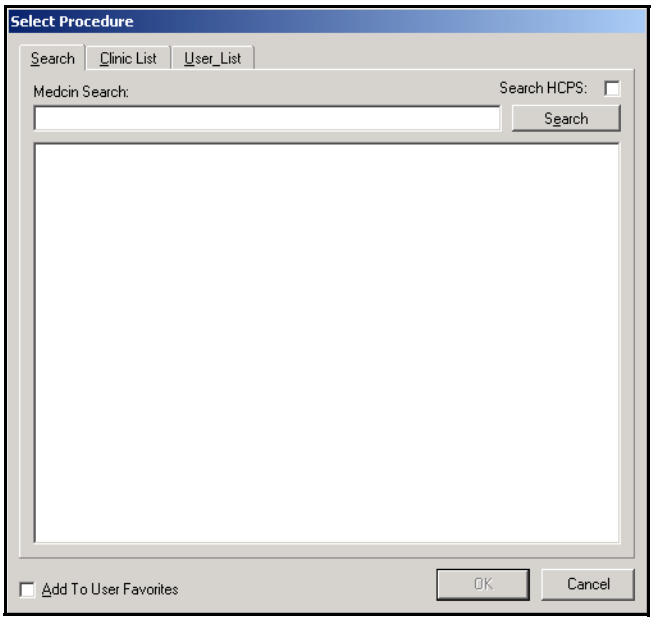

Figure 29-4: Problems—Select Procedure Window

3. Select the procedure you want to add. The selected procedure displays in the New Procedure pane on the Problems window (see Figure 29-5: New Procedure Pane).

Note: The Select Procedure window contains three tabs:

- **Search:** To select a procedure using the Search tab, type the first few letters of the procedure in the Medcin Search field and click **Search**. Select the procedure from the search results and click **OK**.
- **Clinic List:** To select a procedure using the Clinic List tab, type the first few letters of the procedure in the Find field and select the procedure from the clinic list results. Click **OK**.
- **User List:** To select a procedure using the User List tab, type the first few letters of the procedure in the Find field and select the procedure from the user list results. Click **OK**.

If the Add to Favorites checkbox is checked, the selected Procedure and CPT-4 codes are added to your list of favorite diagnoses in the List Management module. All diagnoses in that list are available in the Problems module, in the User List tab. The items in the clinic list cannot be changed by the user.

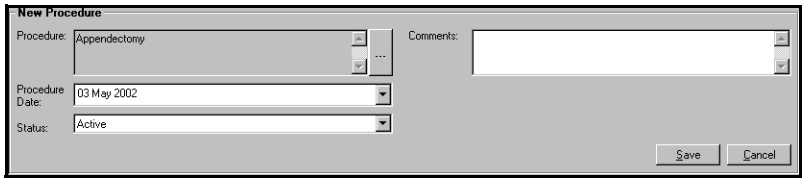

Figure 29-5: New Procedure Pane

4. Complete the appropriate fields:
   - **Procedure Date:** Click the drop-down arrow to select the date the procedure was performed.
   - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
   - **Comments:** Add a note for a selected problem or procedure.
5. Click **Save** on the Action bar.

29.6 Adding Family History Problems

The Problems module allows you to document specific problems in a patient's family history. Positive and negative family history documentation from the S/O module is displayed in the Family History area in the Problems module.

To add family history problems:

1. Select the **Family History** header.
2. Click **Add** on the Action bar. The Select Diagnosis window opens.

3. Select the diagnosis you want to add. The selected problem appears in the New Family History pane on the Problems window (see Figure 29-6: New Family History Pane).

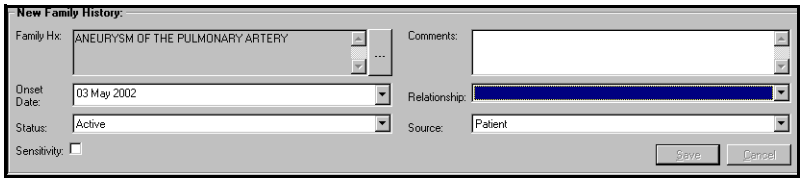

Figure 29-6: New Family History Pane

4. Complete the appropriate fields:
   - **Onset Date:** Click the drop-down arrow to select date of the onset of the problem.
   - **Status:** Select **Active**, **Deleted (Error)**, or **Inactive** from the drop-down list.
   - **Sensitivity:** Click the checkbox to mark the family history problem as sensitive.
   - **Comments:** Add a note for the family history problem.
   - **Relationship:** Select the family member from the drop-down list.
   - **Source:** The manner in which you received the family past medical history problem.
5. Click **Save** on the Action bar.

29.7 Updating a Problem or Procedure

Problems and procedures can be updated from the Problem List, Historical Procedures, and Family History areas.

To update a problem or procedure:

1. Select a problem or procedure. The Update Problem or Procedure pane displays on the Problems window (see Figure 29-7: Update Problem Pane and Figure 29-8: Update Procedure Pane).

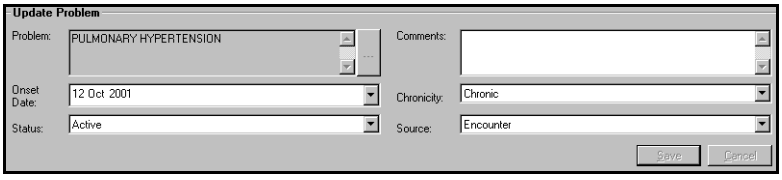

Figure 29-7: Update Problem Pane

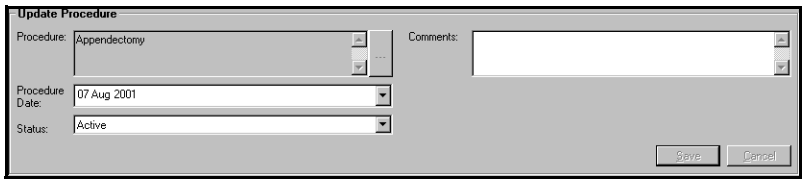

Figure 29-8: Update Procedure Pane

2. Do one of the following:
   - If you are updating a problem:
     — Update the following fields, as necessary:
       - Onset Date
       - Status
       - Comments
       - Chronicity
       - Source
   - If you are updating a procedure:
     — Update the following fields, as necessary:
       - Procedure Date
       - Status
       - Comments
   - If you are updating a patient's family history:
     — Update the following fields, as necessary:
       - Onset Date
       - Status
       - Comments
       - Relationship
3. Click **Save**.

Note: Active Problems added to the patient's problem list will auto-age to Acute-Inactive after 180 days.

29.8 Accessing Healthcare Maintenance

Healthcare Maintenance items are the same wellness reminders found in the Wellness module. Any expired medications for the patient also display as Healthcare Maintenance items.

To access Healthcare Maintenance:

Click the plus sign next to **Healthcare Maintenance** to view a list of the wellness reminders (see Figure 29-9: Healthcare Maintenance).

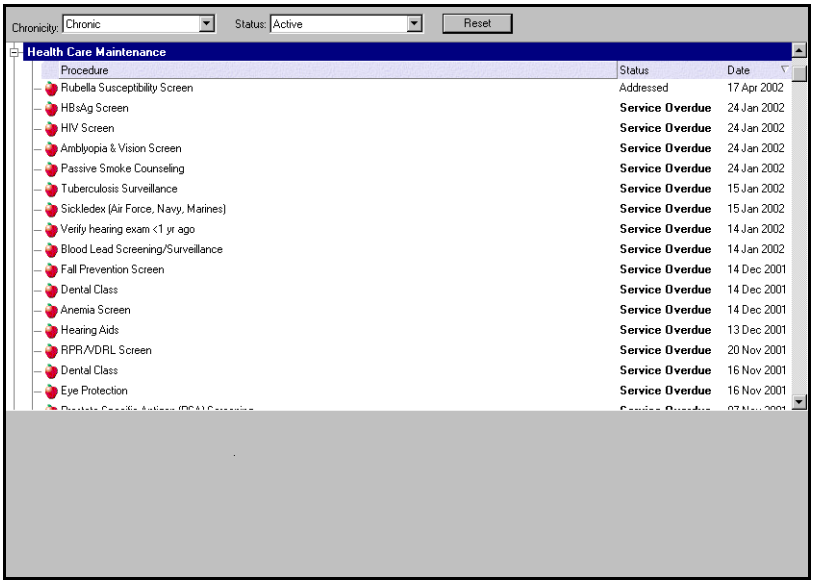

Figure 29-9: Healthcare Maintenance

Tip:
Select a Healthcare Maintenance Item and press F1 to view the clinical guidelines associated with the item.

Note: Click **Guidelines** to view a description of the Healthcare Maintenance item.

30.0 RADIOLOGY

30.1 Overview of Radiology

The Radiology module is designed to display radiology test result data for desired patients (see Figure 30-1: Military Clinical Desktop - Radiology Module). Results are viewed, not ordered, from this module. Radiology results are pulled from CHCS. An alert is triggered when new results are received.

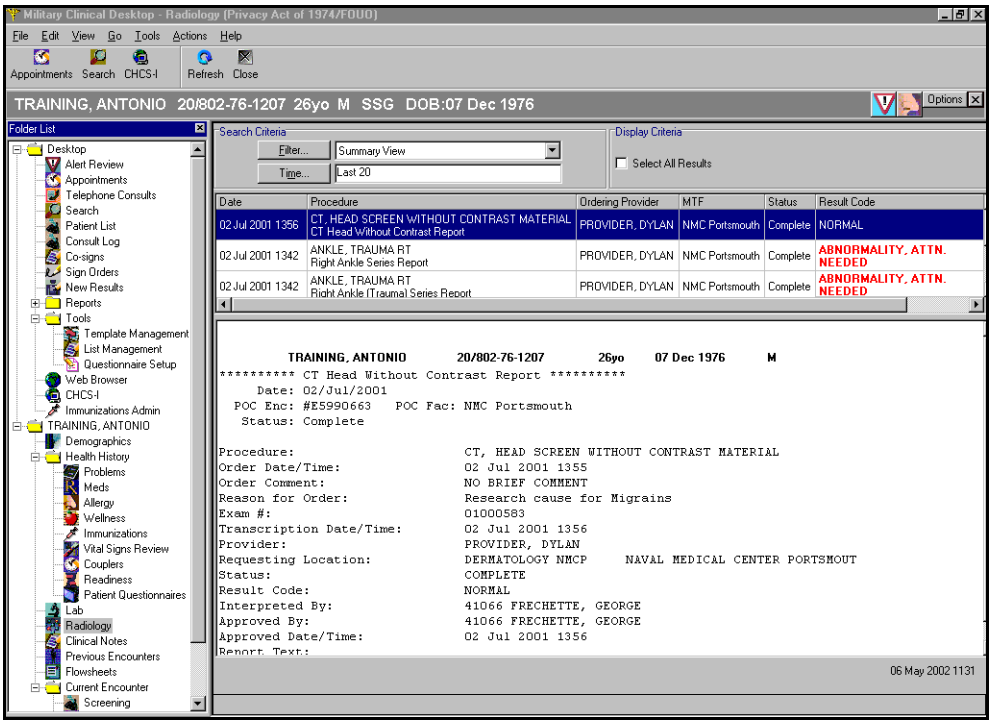

Figure 30-1: Military Clinical Desktop - Radiology Module

30.2 Action Bar Icons

	Refresh	Refreshes the window with updated information.
	Close	Closes the Radiology window.

30.3 Creating a Filter in the Radiology Module

The Filter tab on the Properties window enables you to view radiology results by selecting a previously saved filter from the drop-down list or creating a new filter (see Figure 30-2: Radiology Properties Window—Filter Tab).

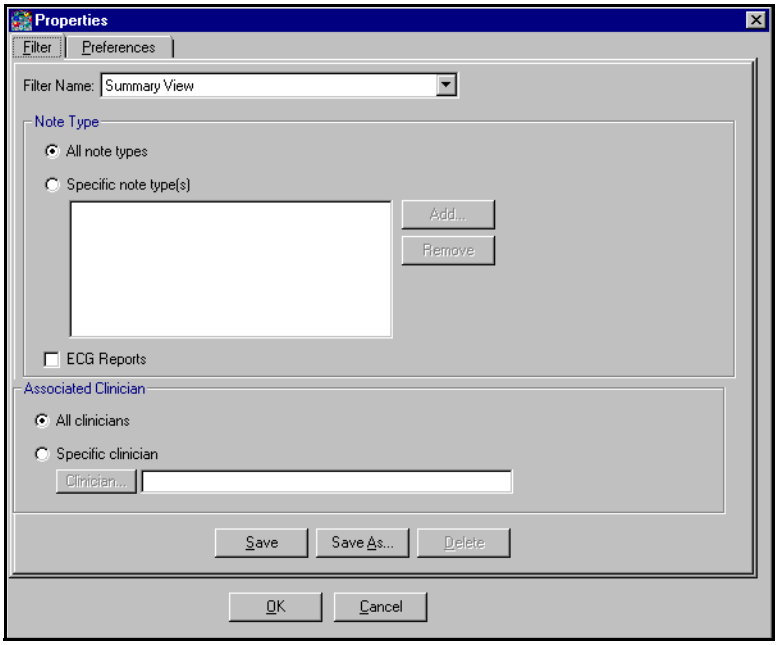

Figure 30-2: Radiology Properties Window—Filter Tab

To create a new filter:

1. Click the applicable radio button for the Note Type.

Note: If **All Note Types** is selected, all of the listed note types are displayed.

If **Specific Note Type(s)** is selected, click **Add** to open the Healthcare Data Dictionary Search window to search and add specific clinical note(s).

---

2. Click the applicable radio button for the Associated Clinician.

Note: If **All Clinicians** is selected, all of the listed clinicians are displayed.

If **Specific Clinician** is selected, click **Clinician** to locate and select the specific clinician(s).

Tip:
*To delete a filter, select the filter from the drop-down list and click **Delete**. At the confirm deletion prompt, click **Yes**.*

3. Click **Save As**.

Note: If this is a change to a pre-existing filter, click **Save**.

---

4. Enter the name for the filter.
5. Click **Save**.
6. Click **OK** on the Properties window.

30.4 Setting Time Preferences in the Radiology Module

The Preferences tab on the Properties window allows you to customize the default times within the Radiology module (see Figure 30-3: Radiology Properties Window—Preferences Tab).

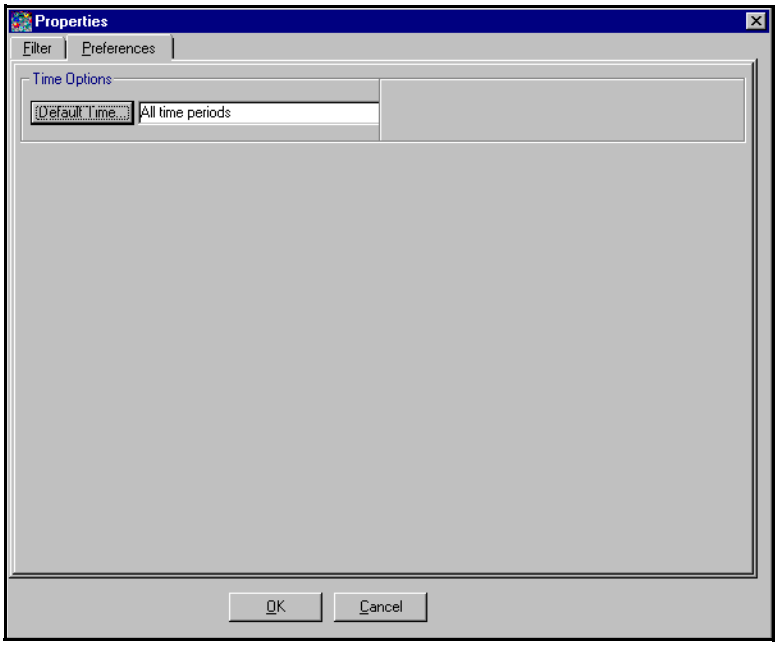

Figure 30-3: Radiology Properties Window—Preferences Tab

To set time preferences:

1. Click **Default Time**. The Time Search window opens (see Figure 30-4: Time Search Window).

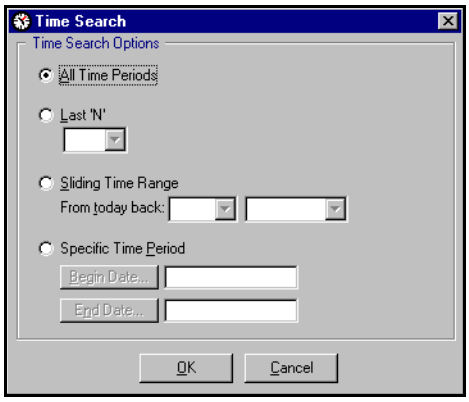

Figure 30-4: Time Search Window

2. Click the radio button for the applicable Time Search Option.
3. Click **OK** on the Properties window.

30.5 Viewing Radiology Results

Once the search criteria have been defined, the lab test results are displayed.

Select the desired test data to be viewed by selecting the test name (i.e., mammogram). The data is displayed in the bottom of the Radiology Results window.

Note: When mammogram results are ready, a letter is sent to the patient notifying her that her results are ready. A copy of this letter can be found in the Clinical Notes module.

30.6 Printing Radiology Results

SEE RELATED TOPICS

- **5.4 ADDRESSING NEW AND PRIORITY RESULT ALERTS**
- **5.5 DELETING AN ALERT**
- **5.6 VIEWING DETAILS OF AN ALERT**

To print the radiology results:

1. Select the test(s) you want to print.
2. On the File menu, point to Print and click **DD2766**.

30.7 Copying Radiology Results to a Note

Once the radiology result is displayed, the result can be copied for use in other modules or can be copied directly into the Note area of the Patient Encounter module.

To copy the details of a radiology result:

1. Select the desired result so the details display in the bottom of the Radiology window (see Figure 30-5: Radiology Results Window (Copy Radiology Results)).

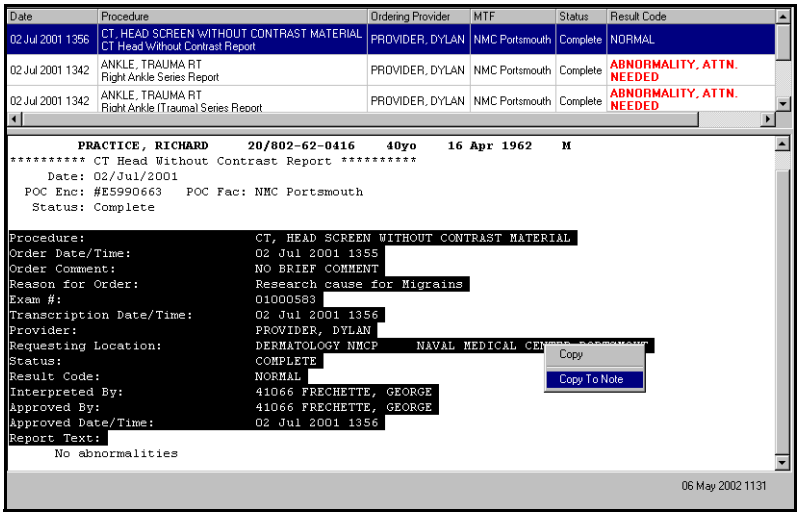

Figure 30-5: Radiology Results Window (Copy Radiology Results)

2. Select the portion of the result to be copied.
3. Right click your mouse, then select either:

- **Copy:** Copies the selection on the clipboard so it can be used in another location.
- **Copy to Note:** Copies the details directly into the S/O area of the current patient encounter summary.

Note: An encounter must be open to utilize the **Copy to Note** function. The result is pasted directly into the patient encounter.

31.0 READINESS

31.1 Overview of Readiness

The Readiness module displays information to determine whether the patient is ready for deployment. An encounter must be open to access the Readiness module. Most of the data displayed on the Readiness window is received from other sources. Data edited in the Readiness window does not update data in its original source (see Figure 31-1: Military Clinical Desktop - Readiness Module).

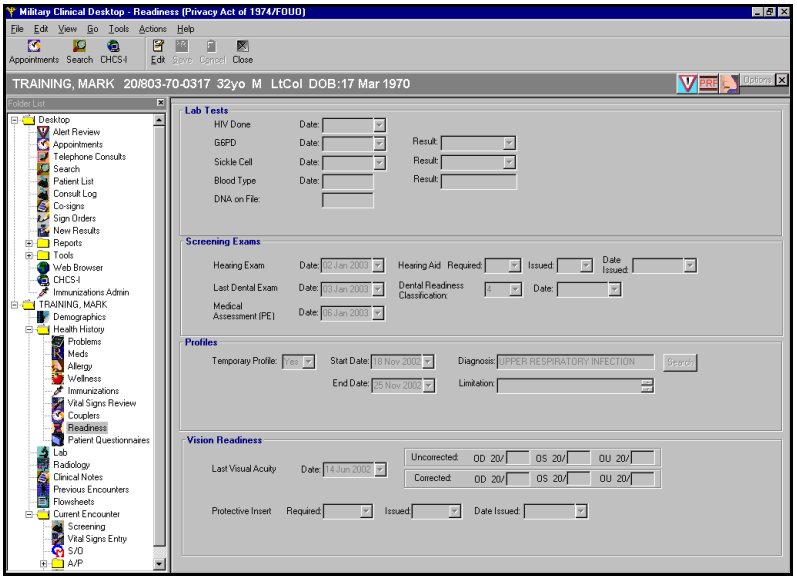

Figure 31-1: Military Clinical Desktop - Readiness Module

31.2 Action Bar Icons

	Edit	Allows Readiness information to be updated.
	Save	Saves new information.
	Cancel	Cancels any changes made to the Readiness module.
	Close	Closes the Readiness window.

31.3 Modifying Readiness Information

Most of the data displayed in the Readiness window is downloaded from other sources. Data edited in the Readiness window does not update data in its original source.

Tip:
*The fields in the window are not active until you click **Edit**.*

To modify readiness information:

1. Click **Edit** on the Action bar.
2. Complete the following areas, as necessary:
   - Lab Tests
   - Screening Exams
   - Profiles
   - Vision Readiness
3. Click **Save**.

Note: If changes were made, the Save option must be completed before closing the window. If not, changes are not saved.

32.0 REPORTS

32.1 Overview of Reports

The Reports module consists of three different types of predefined reports used to collect statistical data to determine the needs of MTFs, Clinics, or Providers (see Figure 32-1: Military Clinical Desktop - Reports Module).

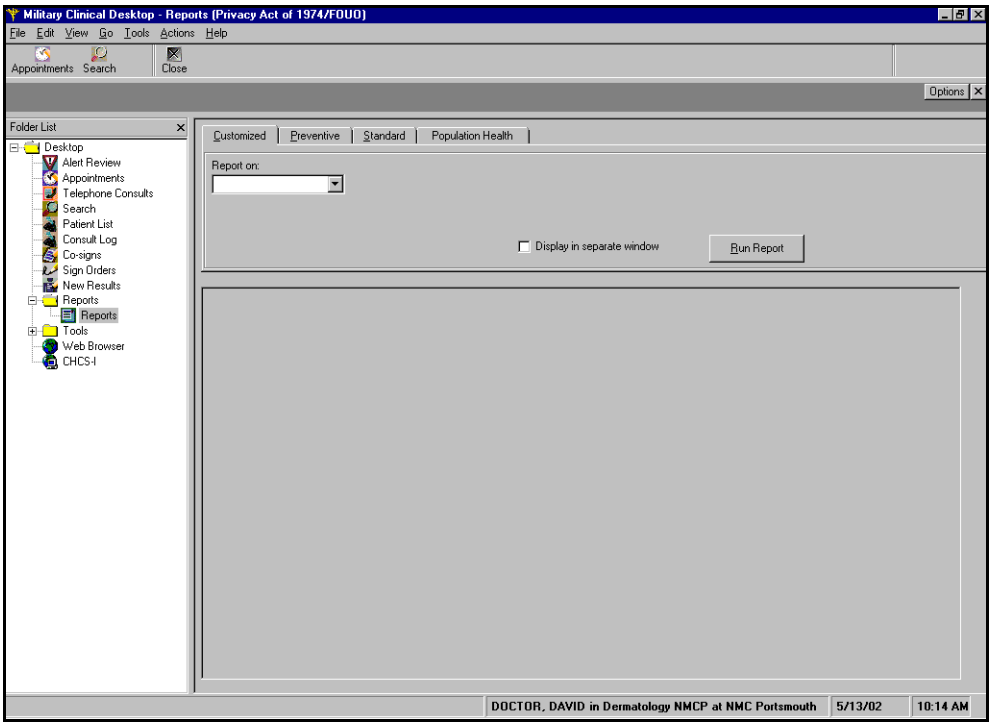

Figure 32-1: Military Clinical Desktop - Reports Module

32.2 Action Bar Icons

	Close	Closes the Reports module.

32.3 Running Customized Reports

Customized Reports enable you to run different types of reports for a desired patient.

Current pre-defined customized reports include:

- Allergy Verified (Audit)
- Appointments

- Consults
- Diagnosis
- Disposition
- E&M
- Lab Tests Ordered
- Medication Ordered
- Primary Diagnosis
- Procedure
- Radiology Tests

Tip:
*If you select Clinic/ Lab or Provider from the drop-down list, click the **Lookup** icon to search for the desired clinic or provider.*

To run customized reports:

1. Select the report from the Report on drop-down list on the Customized tab.
2. Select a scope from the With Scope of drop-down list. Depending on the selection, a default MTF, clinic/lab, or provider displays.

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the From and To fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays (see Figure 32-2: Customized Report).

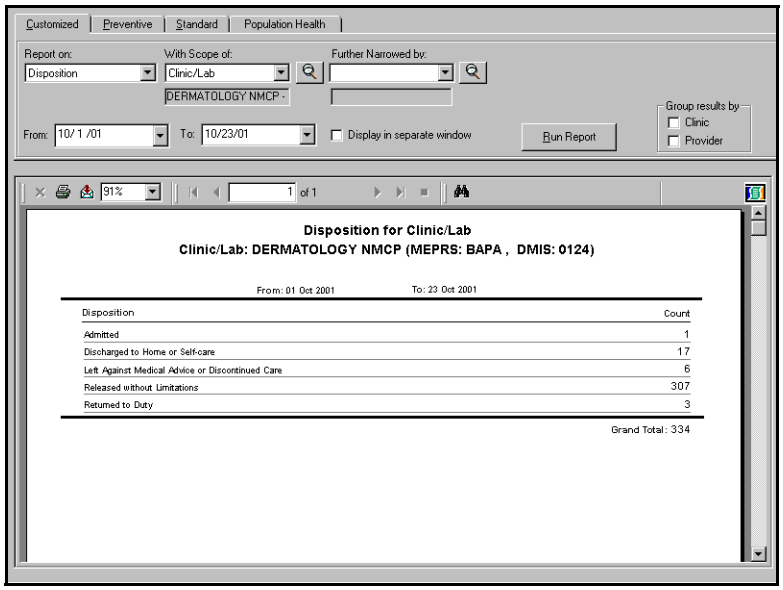

Figure 32-2: Customized Report

7. Click **Print Reports** to send the report to your local printer.

32.4 Running Preventive Reports

There are 21 different Preventive Reports that can be run for a desired patient.

Available reports include:

- 2 Year Olds, DTP/OPV/MMR Immunizations
- 2 Year Olds, Hepatitis B Immunizations
- 2 Year Olds, Varicella Immunization
- Cholesterol Screening Aggregate
- CPS Services Due
- CPS Summary
- Discontinued Services Risk
- High Cholesterol Follow-Up Counseling
- High Cholesterol Follow-Up Repeat
- High Cholesterol HDL/LDL Follow-Up
- Immunizations Active Duty Hepatitis A-1 Dose
- Immunizations Active Duty Hepatitis A-2 Dose
- Mammography, Have Not
- Mammography, Query for
- MMR #2, HBV #3, Varicella and TD Immunizations for 13 year old

- PAP Smear, Have Not
- Prevention Report Card
- Query for Potential Heavy Alcohol Use
- Safe Sex Counseling
- Tobacco Use Screening
- Tobacco, Advising Users to Quit

Tip:
*If you select **PCM**, the default PCM displays. If you select **Patient**, click the **Lookup** icon to search for the desired patient. You can also search for a different PCM.*

To run preventive reports:

1. Select the report from the Report on drop-down list on the Preventive tab.
2. Select a scope from the With Scope of drop-down list.

Note: Additional filters are available depending on the selected report. Use the drop-down lists to select the desired options.

3. Select a date range in the From and To fields.

Note: The date range defaults to the current date.

4. Click the checkbox if you want the report to Display in a separate window.
5. Click **Run Report**. The customized report displays (see Figure 32-3: Preventive Report).

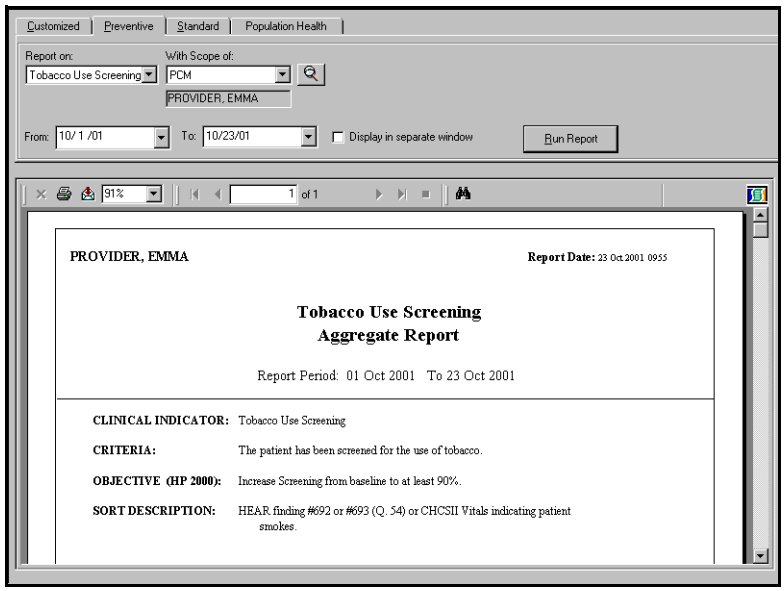

Figure 32-3: Preventive Report

6. Click **Print Reports** to send the report to your local printer.

32.5 Running Standard Reports

There are 13 different predefined Standard Reports that can be run.

Available reports include:

- Alphabetic Patient List for Encounters
- Appointment by Status for Encounters
- Diagnosis
- Inpatient Workload
- Insurance Change
- Insurance Indicator
- Insurance Indicator Not Marked
- Outpatient Workload, for Clinic/Lab
- Patient Categories by Disposition
- Patient Categories by Provider
- Patient Encounter
- Procedures
- Readiness

To run standard reports:

1. Select the report from the Report on drop-down list on the Standard tab.
2. Select a scope from the With Scope of drop-down list.
3. Select a date range in the From and To fields.

Note: The date range defaults to the current date.

Tip:
*Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the **Lookup** icon to search for the desired scope option. Additional scopes are available depending on the selected scopes.*

4. Click the checkbox if you want the report to display in a separate window.
5. Click the checkbox(es) if you want to group the results by clinic or provider.
6. Click **Run Report**. The customized report displays (see Figure 32-4: Standard Report).

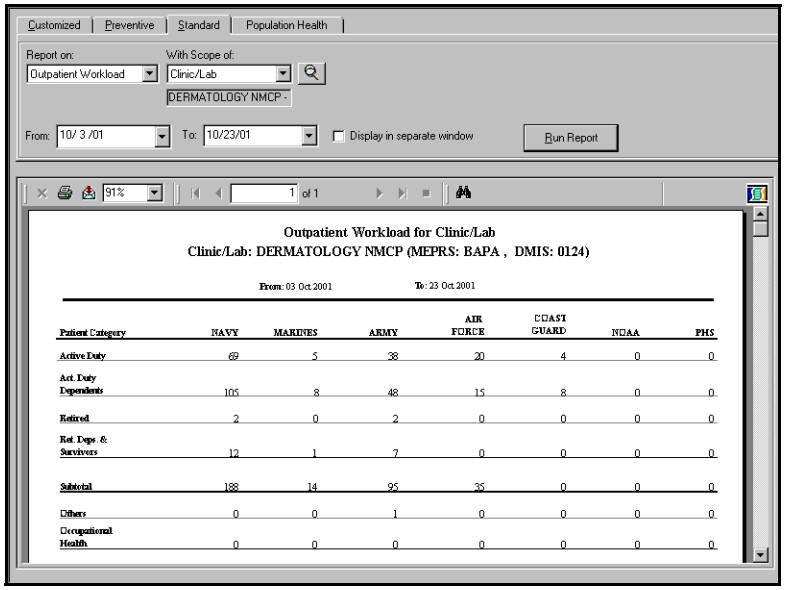

Figure 32-4: Standard Report

7. Click **Print** to send the report to your local printer.

32.6 Running Population Health Reports

There are different predefined Population Health reports that can be run.

Note: In order to run Population Health Reports, special user privileges are required. If you do not have these privileges and wish to run these reports, please contact your system administrator.

To run a Population Health report:

1. Select the report from the Report on drop-down list on the Population Health tab.
2. Select a scope from the With Scope of drop-down list.

Note: Depending on the selected report, you can select a scope of MTF, Clinic/Lab, Provider, PCM, or Patient. Click the Look up icon to search for the desired scope option. Additional scopes are available depending on selected scopes.

---

3. Select a date range in the From and To fields.

Note: The date range defaults to the current date.

---

4. Click the checkbox if you want the report to Display in a separate window.

5. Click **Run Report** to run the customized report.
6. Click **Print** to send the report to your local printer.

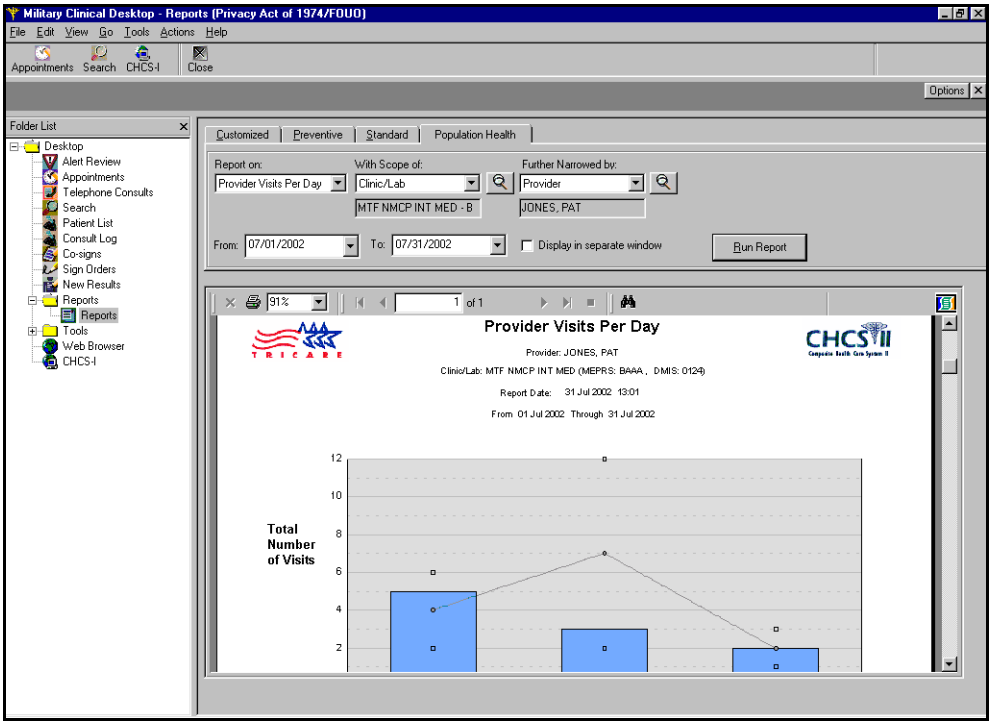

Figure 32-5: Population Health Tab

33.0 SCREENING (REASON FOR VISIT)

33.1 Overview of Screening

The Screening module is made up of two tabs (see Figure 33-1: Military Clinical Desktop - Screening Module—Reason for Visit Tab):

- **Reason for Visit:** Allows you to document why the patient has an appointment.
- **Due Reminders:** Displays due reminders from the Wellness module as health maintenance items for the patient.

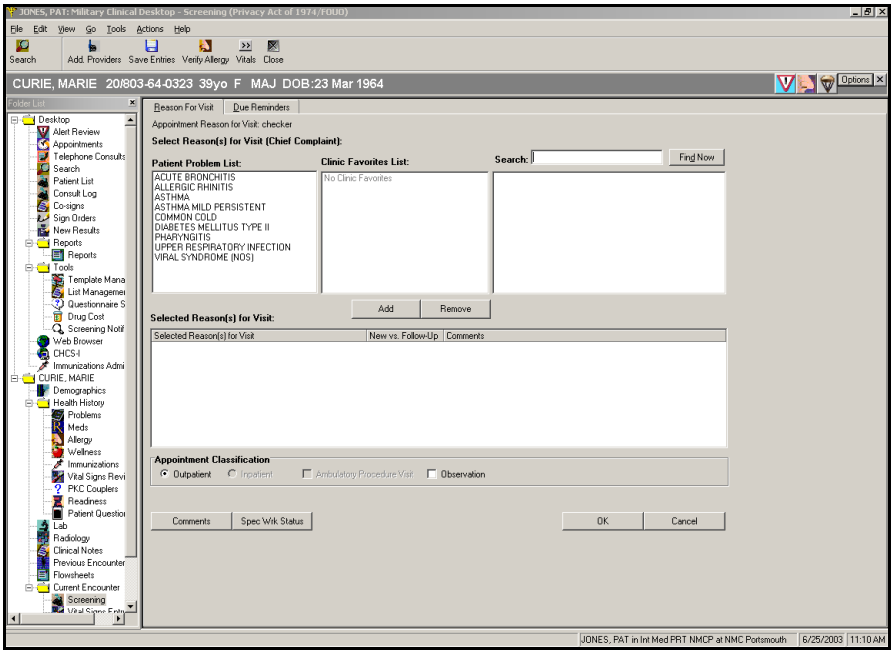

Figure 33-1: Military Clinical Desktop - Screening Module—Reason for Visit Tab

33.2 Action Bar Icons

	Add Providers	Opens the Add Provider window, so you can select an additional provider.
	Save Entries	Saves the selected reason for visit.
	Verify Allergy	Opens the Allergy module for quick verification of current allergies.
	Vitals	Navigates to the Vital Signs module.
	Close	Closes the Screening module.

33.3 Adding a Provider in Screening

An additional provider can be added to an encounter to receive credit for work performed on a patient.

To add a provider in screening:

1. On the Patient Encounter window, click **Add Providers** on the Action bar. The Providers window opens (see Figure 33-2: Providers Window).

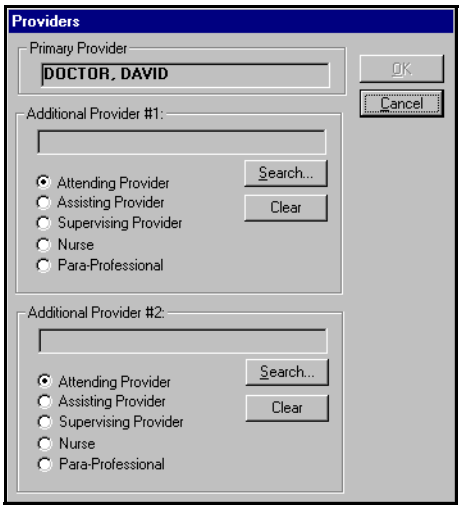

Figure 33-2: Providers Window

2. Click the applicable radio button for the type of clinician you want to add.
3. Click **Search** in the Additional Provider #1 area. The Clinician Search window opens (see Figure 33-3: Clinician Search Window).

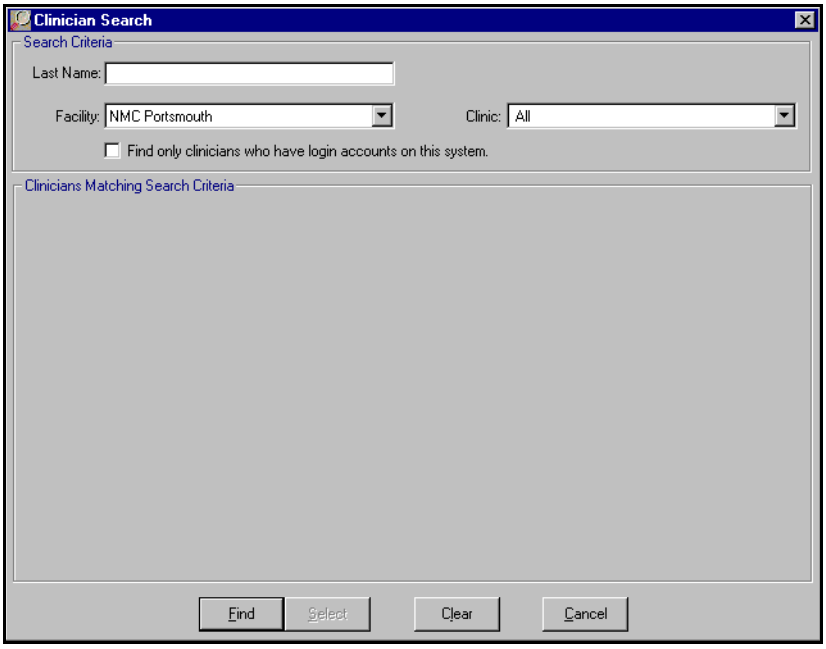

Figure 33-3: Clinician Search Window

4. In the Last Name field, enter the last name of the desired clinician.
5. Select a facility from the drop-down list.
6. Select a clinic from the drop-down list.
7. Click the checkbox to view only providers associated with CHCS II, if necessary.
8. Click **Find**. The results are displayed in the bottom half of the Clinician Search window.
9. Select the desired clinician.
10. Click **Select**. The name populates in the Additional Provider field on the Providers window.

Note: Repeat steps 2–10 if you want to add a second clinician.

11. Click **OK**. The clinician(s) is added to the patient encounter.

33.4 Documenting Reason for Visit

To document the reason for visit:

1. On the Reason For Visit tab, select a reason for the visit from one of the following areas (see Figure 33-4: Reason for Visit Tab):
   - **Patient Problem List:** Displays entire history of the patient's past problems.
   - **Clinic Favorites List:** Displays a list of reasons specific to the clinic.

- **Search:** Allows you to select a reason not listed in the Patient Problem List or the Clinic Favorites List. To conduct a search, type in the desired reason (a minimum of two letters must be typed) and click **Find Now**. The search results appear in the third column.

2. Click **Add**. The selected reason displays in the Selected Reason(s) for Visit area.

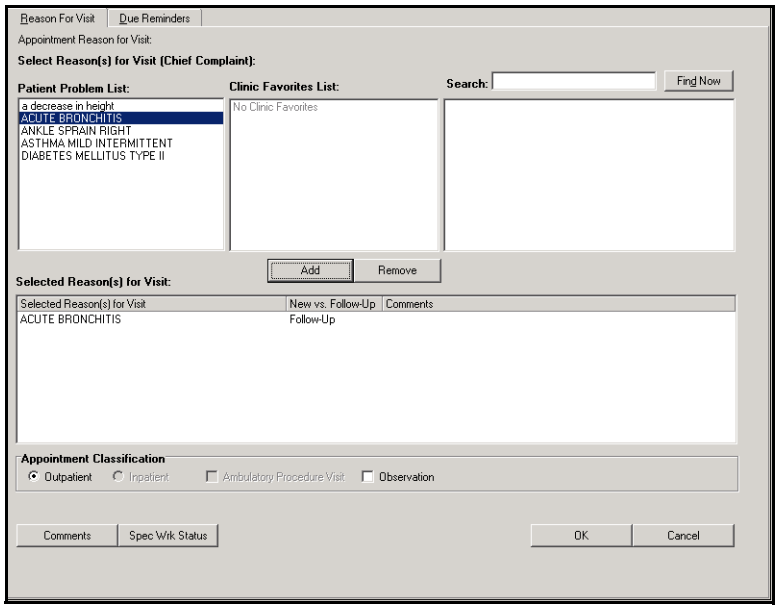

Figure 33-4: Reason for Visit Tab

Note: Reasons from the patient's problem list are marked as Follow-Up and reasons from the other lists are marked as New. To change the status, select the reason for visit and click in the **New vs. Follow-up** column. A drop-down list displays allowing a new selection.

If you want to enter additional comments for the selected reason for visit, select the reason. In comments, enter comments for the associated reason for visit.

You can also add comments by clicking **Comments** on the Reason For Visit tab.

3. Complete the following:

- **Appointment Classification:** Click the radio button next to the specific type of appointment for the patient. The system defaults to Outpatient.

See Related Topics

- 4.4 Adding an Allergy
- 4.6 Deleting an Allergy
- 39.7 Deleting Vital Signs
- 4.5 Editing an Allergy
- 39.6 Editing Vital Signs
- 39.5 Entering New Vital Signs
- 39.8 Graphing Vital Signs
- 39.9 Reviewing Vital Signs
- 39.10 Vital Sign Ranges

- **Special Work Status:** Click **Spec Wrk Status** to view the Special Work Status window. Click the checkbox next to the applicable work status and click **Save**.

Note: Once a reason for visit has been selected, it appears in the Selected Chief Complaint(s) window. The reason for visit is one of two items used for selecting suggested templates to document the encounter.

4. Click **OK**.

33.5 Verifying Allergies

To verify a patient's allergies during the screening process:

1. Click **Verify Allergy** on the Action bar. You are transferred to the Allergies module.
2. Verify the patient's allergies in the Allergy window.

Note: You must have a patient encounter open to verify a patient's allergies during screening.

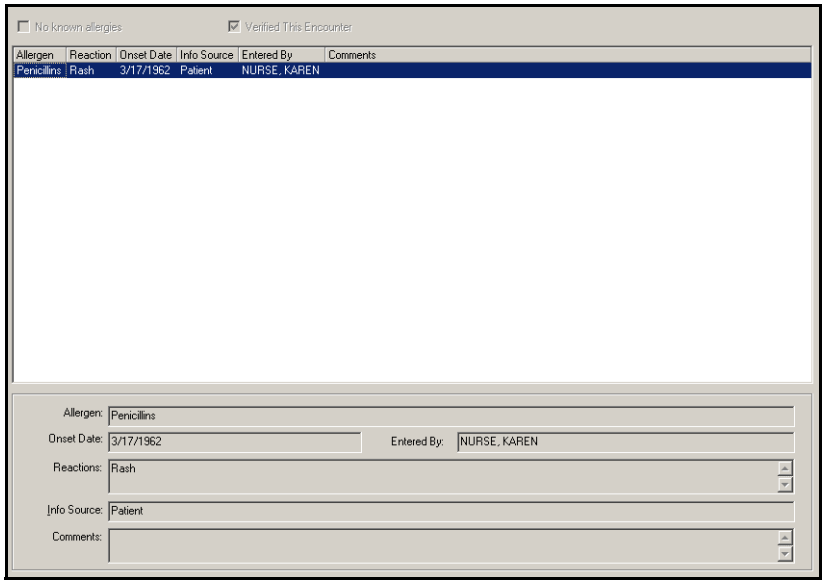

Figure 33-5: Verifying Allergies

Tip:
These are the same reminders found under Healthcare Maintenance in the Problem List module and on the Due Reminders tab in the Wellness module.

33.6 Managing the Wellness Reminders

To manage the wellness reminders:

1. Click the Due Reminders tab in the Screening module. A list of Healthcare Maintenance items display in the tab (see Figure 33-6: Due Reminders Tab (Screening Module)).

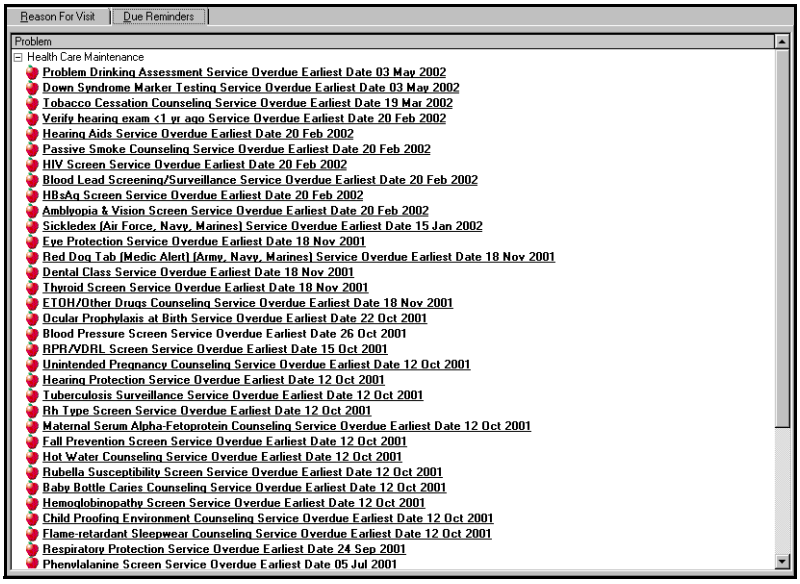

Figure 33-6: Due Reminders Tab (Screening Module)

2. To manage a specific reminder, double-click on the reminder. The Due Reminders tab in the Wellness module opens (see Figure 33-7: Due Reminders Tab (Wellness Module)).

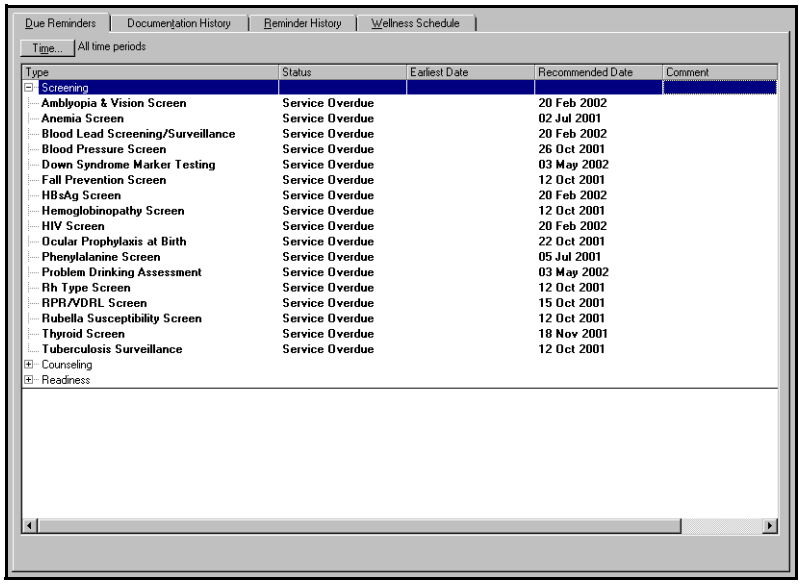

Figure 33-7: Due Reminders Tab (Wellness Module)

SEE RELATED TOPICS

- 4.4 ADDING AN ALLERGY
- 4.6 DELETING AN ALLERGY
- 39.7 DELETING VITAL SIGNS
- 4.5 EDITING AN ALLERGY
- 39.6 EDITING VITAL SIGNS
- 39.5 ENTERING NEW VITAL SIGNS
- 39.8 GRAPHING VITAL SIGNS
- 39.9 REVIEWING VITAL SIGNS
- 39.10 VITAL SIGN RANGES

3. Document the selected due reminder.
4. When you have completed documenting the due reminder in the Wellness module, close the Wellness module to return to the Due Reminders tab in the Screening module.

34.0 SCREENING NOTIFICATION

34.1 Overview of Screening Notification

The Screening Notification window (see Figure 34-1: Military Clinical Desktop - Screening Notification Module) allows you to notify patients via e-mail or letter when a wellness reminder is scheduled. The Screening Notification module interfaces with the Wellness module in tracking wellness reminders.

The Screening Notification window allows you to search for patients by MTF or PCM.

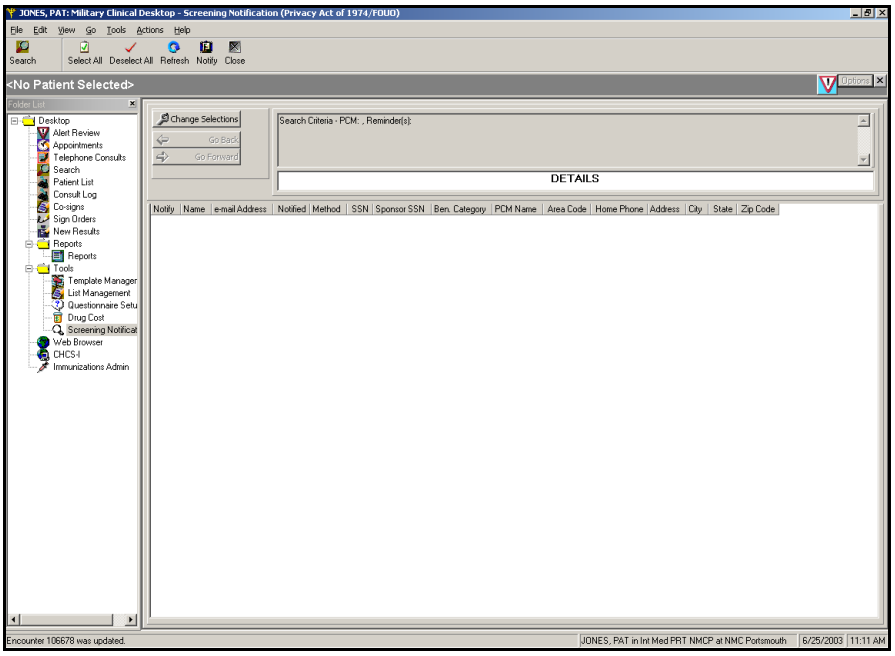

Figure 34-1: Military Clinical Desktop - Screening Notification Module

34.2 Action Bar Icons

	**Select All**	Allows you to select all patients requiring notification in the Screening Notification window.
	**Deselect All**	Allows you to deselect all patients who do not require notification in the Screening Notification window.
	**Refresh**	Allows you to refresh data in the Screening Notification window.

	Notify	Allows you to notify selected patients about wellness reminders.
	Close	Allows you to close the Screening Notification window.

34.3 Setting the Properties for the Screening Notification Module

You can notify patients by e-mail or letter. The Properties window lets you establish how you are going to notify patients. The properties you select are your default properties each time you access the Screening Notification module.

Tip:
*You can also access the Properties window for the Screening Notification module by clicking **Properties - Screening Notification** on the Tools menu. The Screening Notification window must be open to access the Properties window in this manner.*

To set the properties for the Screening Notification module:

1. On the Screening Notification window, click **Options** to open the Properties window (see Figure 34-2: Screening Notification Properties Window).

Figure 34-2: Screening Notification Properties Window

2. Select a **Notification** option.

Note: If you select E-mail, the Envelope option remains selected but does not affect e-mails. All other options require you to select the Envelope or Label option for mailing letters.

3. Click **OK**.

34.4 Selecting Screening Notification Reminder Search Options

Screening service results depend on the selected wellness reminder and the number of patient(s) scheduled to be notified for the reminder. Viewing results for an entire MTF may produce extensive feedback and take an extended amount of time; therefore, it may be more beneficial to view results for a specific Primary Care Manager (PCM).

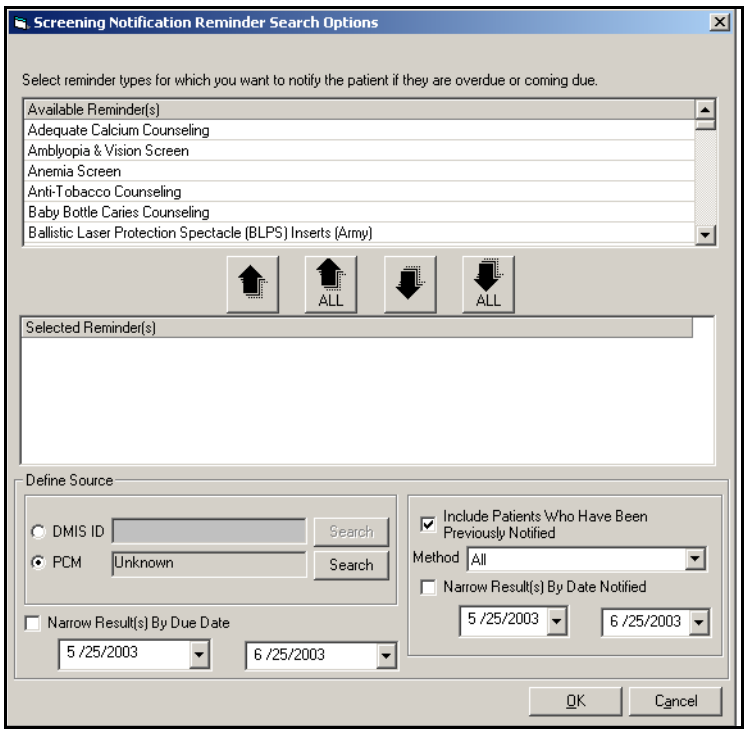

Figure 34-3: Screening Notification Reminder Search Window

To select Screening Notification reminder search options (see Figure 34-3: Screening Notification Reminder Search Window):

1. In the **Available Reminder(s)** list, select the reminder.
2. To move the reminder to the **Selected Reminder(s)** list, click the Associate icon.

Note: To select multiple reminders, select the reminders while pressing the **Ctrl** key on your keyboard and click the Associate icon.

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3. Do one of the following:
   - If you want to search for patients associated with a DMIS ID, select **DMIS ID** and click **Search**.
   - If you want to search for patients associated with a primary care manager, select **PCM** and search for the provider.

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

---

4. If you want to filter reminders by reminder date, select the applicable date range.
5. If you want to include patients who have already been notified, select **Include Patients Who Have Been Previously Notified**.

6. Select a **Method** of notification from the drop-down list.
7. If you want to filter reminders by notification date, select the applicable date range.
8. Click **OK**.

34.5 Notifying Patients About Screening Services

Patients listed in the Screening Notification 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 Notification:

1. Search for the patient(s) you want to notify.

Note: As a default, the patients displayed are all selected to be notified. Double-click on a patient if you do not want him/her to be notified.

2. Click **Notify**.
   - If you are notifying the patient by letter, the Print Preview window opens displaying a form letter for the patient you are notifying (see Figure 34-4: Print Preview WIndow).

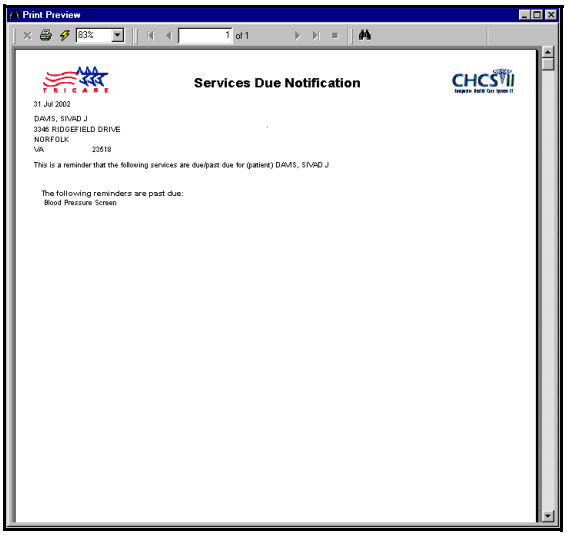


Figure 34-4: Print Preview WIndow

   — Click the **Print** icon.

   — On the Print window, click **OK**. The letter(s) is sent to your designated printer.

— If you are printing labels, a Notification Reminders window opens. Click **Yes** when you have manually loaded the printer with label-specific paper. Click **No** if you are not printing envelope labels (see Figure 34-5: Notification Reminders Window).

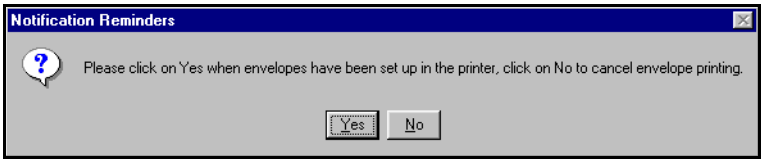


Figure 34-5: Notification Reminders Window

- If you are notifying the patient by e-mail, the E-Mail Notifications window opens. Click **Yes** to send the patient a form e-mail notifying him/her of the due screening service(s).

Note: The letter and e-mail notifications contain the same information, they are just sent using different methods.

Tip:
The patient's postal and e-mail addresses are maintained in the Demographics module and can be modified, if necessary.

35.0 SIGNING THE ENCOUNTER

When the provider is satisfied that the encounter is complete, the final step in the encounter process is to sign the encounter. The primary provider performing the encounter documentation must sign the encounter.

To sign the encounter:

1. Click **Sign** on the Action bar. The Sign Encounter window opens (see Figure 35-1: Sign Encounter Window).

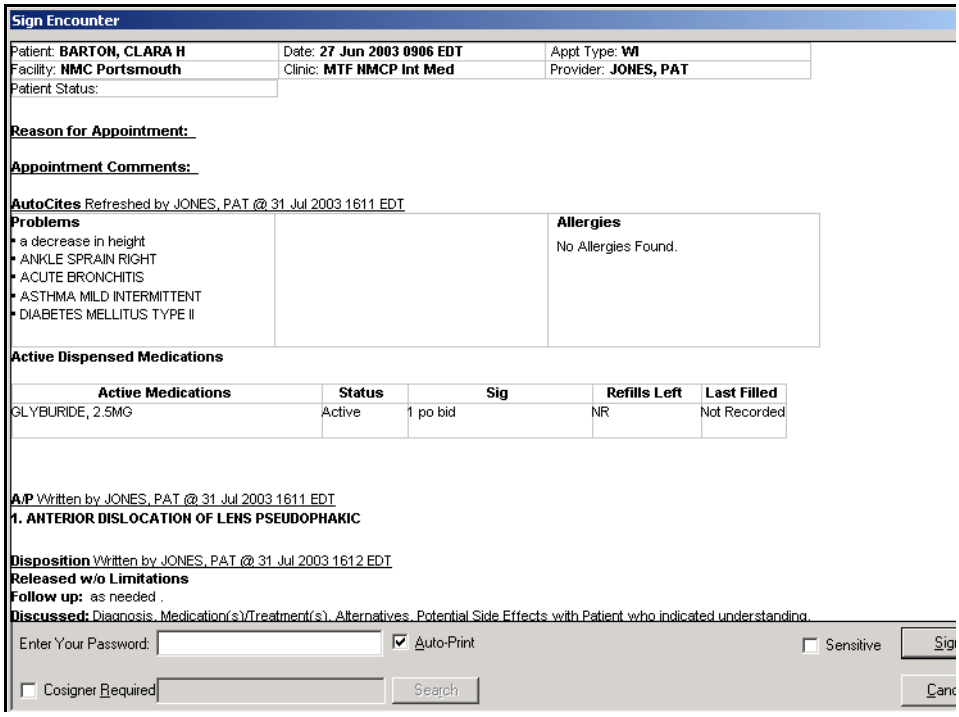


Figure 35-1: Sign Encounter Window

Note: If an encounter is incomplete, the Encounter is Not Complete window opens explaining which sections are incomplete (see Figure 35-2: Encounter is not Complete Window). The primary provider has the option to:

- Designate the incomplete sections of the encounter as complete and sign the encounter
- Designate the encounter as No Count and continue the signing process
- Return to the current encounter to complete it

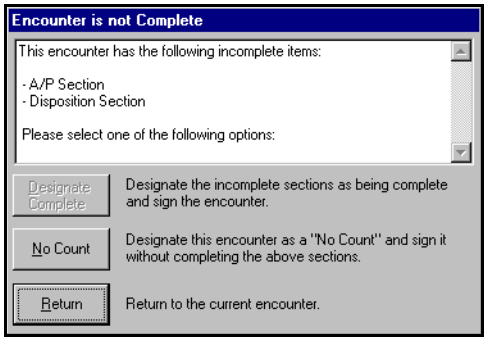


Figure 35-2: Encounter is not Complete Window

2. In the Enter Your Password field, enter your password.
3. Do one of the following:
   - If you do not want to auto-print the signed encounter, deselect the **Auto-Print** checkbox. The system defaults to print the encounter summary.
   - If you are not billing for the encounter, click the **No-Count** radio button. The system default is set to **Count**.
   - If a co-signer is required:
     a. Click the **Co-Signer Required** checkbox.
     b. Click **Search**. The Clinician Search window opens.
     c. Search for the clinician you want to designate as a co-signer.
   - If you want to mark the encounter as sensitive, click the **Sensitive** checkbox. The system marks the encounter as sensitive.

Note: If a provider accesses the encounter from the Previous Encounters module, asterisks display in place of the sensitive data. The provider must have "break the glass" privileges to view the data.

4. Click **Sign** to sign the encounter.

Note: Only the provider who was assigned the appointment can sign the encounter. Other Clinical Team members can add to the encounter but cannot sign it. Click the Sensitive checkbox if you want only those providers with "Break the Glass" privileges to have access to the encounter.

35.1 Saving an Encounter as a Template

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information can be saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

To save an encounter as a template:

1. Document the encounter.
2. On the Actions menu, click **Save As Template**. The Template Details tab on the Template Management module opens (see Figure 35-3: Template Management Window—Template Details Tab).

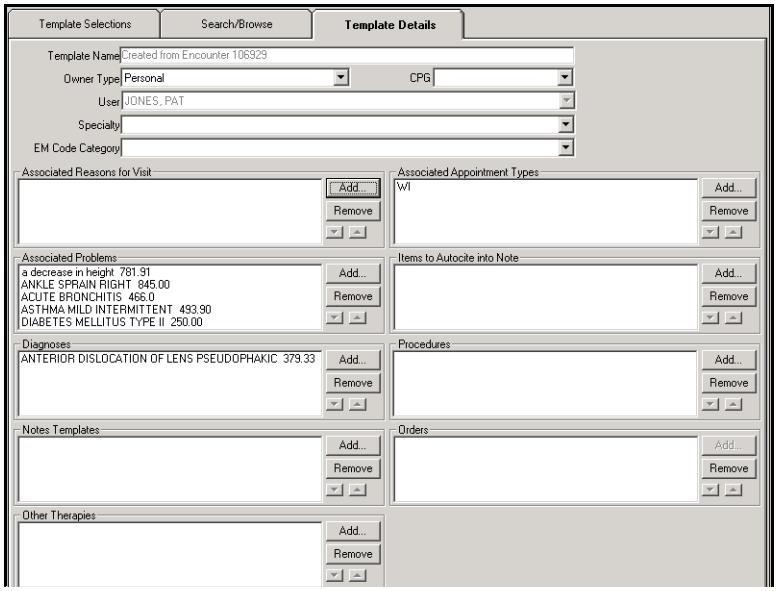


Figure 35-3: Template Management Window—Template Details Tab

3. Select an **owner type** from the drop-down list, if necessary.
4. Select a **specialty** from the drop-down list, if necessary.
5. Select an **E&M code category** from the drop-down list, if necessary.
6. Add or remove information from the following areas:
   - **Associated Reasons for Visit:** In the Search Term field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Associated Problems:** In the Search Term field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Diagnoses:** In the Search Term field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Notes Templates:** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note template and click **Add Items**. Click **Done** to return to the Template Details tab.

- **Other Therapies:** In the Search Term field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Associated Appointment Types:** In the Search Term field, enter the first few letters of the appointment type and click **Search**. Select the appointment type from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Items to AutoCite into Note:** Select an AutoCite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Procedures:** In the Search Term field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

7. Click **Save As** on the Action bar. The Save Encounter Template window opens (see Figure 35-4: Save Encounter Template Window).

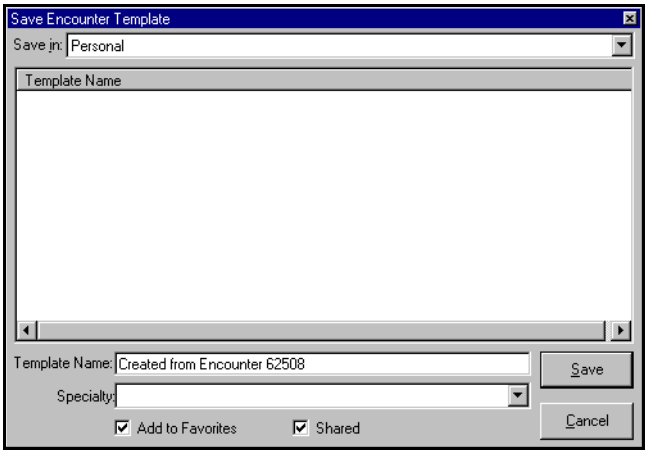


Figure 35-4: Save Encounter Template Window

8. Select the **template type** from the Save-in drop-down list.
9. In the Template Name field, enter the template name.
10. Select the **Specialty** from the drop-down list.
11. Click the checkboxes to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
12. Click **Save**.

35.2 Unlocking an Encounter

More than one clinical team member can view and document a patient's record at the same time. The S/O Note is the only module of the current encounter that can be documented concurrently. If this is the case, both S/O notes are saved to the patient encounter. Only the primary provider can sign the encounter. The primary provider is the provider who owns the appointment.

35.2.1 Two Providers Accessing the Same Module

Two providers cannot document the A/P or the Disposition at the same time. If this occurs, a provider can take the section from the original provider. For example, if one provider is documenting A/P and a second provider accesses the A/P module, a message window appears, stating that A/P is being used and asks whether to break the lock. If the lock is broken, the second provider can document A/P. The original provider is informed upon saving A/P that this section was taken and no information from that section can be saved (see Figure 35-5: Encounter Section Ownership Window).

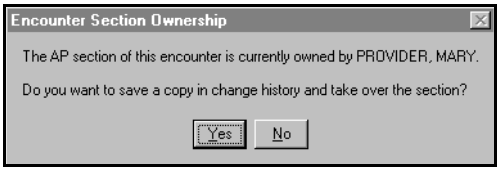


Figure 35-5: Encounter Section Ownership Window

35.2.2 Second Provider Changing First Provider's Information

A second provider can go behind the original provider and change any section of the encounter. When this occurs, the documentation done by the original provider is saved in the Notes section of the encounter under the heading of Change History.

36.0 SUBJECTIVE/OBJECTIVE (S/O)

36.1 Overview of S/O

The Subjective/Objective module is used to document the exam (see Figure 36-1: Military Clinical Desktop - Subjective/Objective Module). Terms to describe the exam findings are available to select into the note. Each term is coded and those codes are one of the elements used to determine the E&M code in the Disposition module. Templates are used to rapidly document the patient visit. Once the exam is documented and saved, the notes appear in the Encounter window.

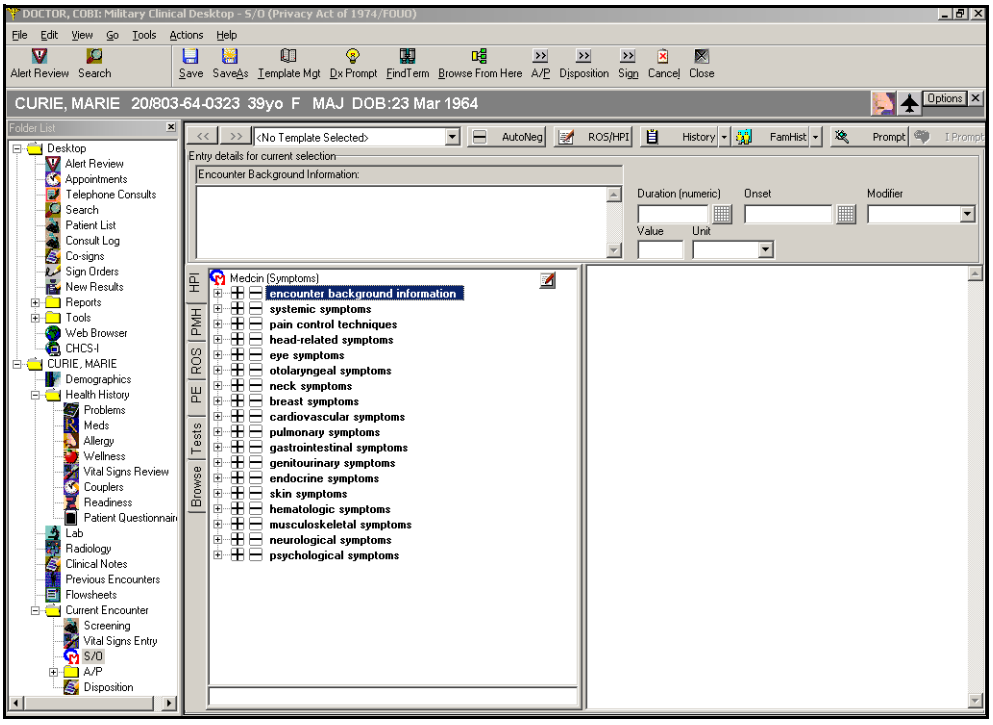


Figure 36-1: Military Clinical Desktop - Subjective/Objective Module

Note: The use of this software is not intended to suggest or replace any professional medical judgment, decisions, or actions with respect to a patient's medical care. The user of this software must monitor and verify the input to the software and determine the accuracy, completeness, or appropriateness of any diagnostic, clinical, or medical information, or other output provided by the software.

36.2 Action Bar Icons

Save	Saves the current Medcin note as an S/O template.
Save As	Saves the opened S/O template as a different name.
Templates	Allows you to access the list of saved S/O templates.
Dx Prompt	Creates a list of findings based on one or more selected diagnoses.
Find Term	Searches for a term in the Medcin terminology.
Browse From Here	Displays the highlighted finding as it appears within the Medcin terminology.
A/P	Transfers you to the Assessment and Plan module.
Disposition	Transfers you to the Disposition module.
Sign	Opens the Sign Encounter window, which allows you to sign the encounter.
Cancel	Cancels S/O documentation.
Close	Closes the S/O module.

36.3 Overview of S/O Templates

A template pre-positions clinical terms for rapid entry and reflects how providers typically document encounters. If a template is created correctly, a provider should be able to, with minimal clicks, document a normal exam. To use the S/O module efficiently, personal templates should be built and utilized.

Each provider should develop a set of templates to document routine appointments. A set of templates should include five types: Physical Exam, Review of Systems, Past Medical History, Procedure, and Visit templates. Multiple templates can be created for each type.

- **Physical Exam (PE) Templates:** A good PE template includes items that are typically reviewed for each physical exam.
- **Review of Systems (ROS) Templates:** Each provider has a list of questions that is asked of every patient in regards to the ROS. Therefore, the template should reflect those questions. One comprehensive ROS template can be built with every possible finding included or several focused ROS templates can be built to deal with “oh, by the way” situations.

- **Past Medical History (PMH) Templates:** The PMH templates deal with common questions concerning previous hospitalizations and family and social history. Again, findings should be selected that reflect what you normally ask the patient. A good set of PMH templates should include generic adult, generic pediatric, generic adult male, and generic adult female.
- **Procedure (PROC) Templates:** Procedure templates are blocks of free-text that cover routine procedure, education, and informed consent notes. These can be added using the free-text icon from the PE tab or by typing the free-text to an actual term (e.g., attaching a procedure note to the term skin biopsy).
- **Visit Templates:** These templates are built for the most common types of diagnoses of the clinic. They are the most comprehensive of the five types and are made up of a PE, ROS, PMH, and PROC template. Also included is the history of present illness (HPI) and chief complaint.

36.3.1 Putting it into Practice

When a patient has a common reason for appointment; for example, asthma follow-up, the provider simply loads the Asthma Visit Template that contains the appropriate component templates (PE, ROS, PHM, PROC). If in the process of the exam, the patient complains of a sore throat, the provider can load just the Sore Throat, ROS-focused template to document the “oh, by the way” symptom.

36.3.2 Selecting an S/O Template

The most efficient way to document the S/O note is to use an S/O visit template that has been created by the individual provider. Once a template is loaded, there are various approaches to document findings from certain tabs. Generally, positive or abnormal findings are documented first in order to capitalize on the AutoNeg function. This can be done on the HPI, ROS, and PE tabs. Care needs to be taken when documenting from the ROS tab if using a comprehensive ROS. You should not use AutoNeg because of the large size and improbability of asking about all the terms.

To select an S/O template:

1. Use the Template drop-down list to select an S/O template from your favorites list. If the template you need cannot be found, use the following steps to locate and load the appropriate template (see Figure 36-2: S/O Template Drop-Down List).

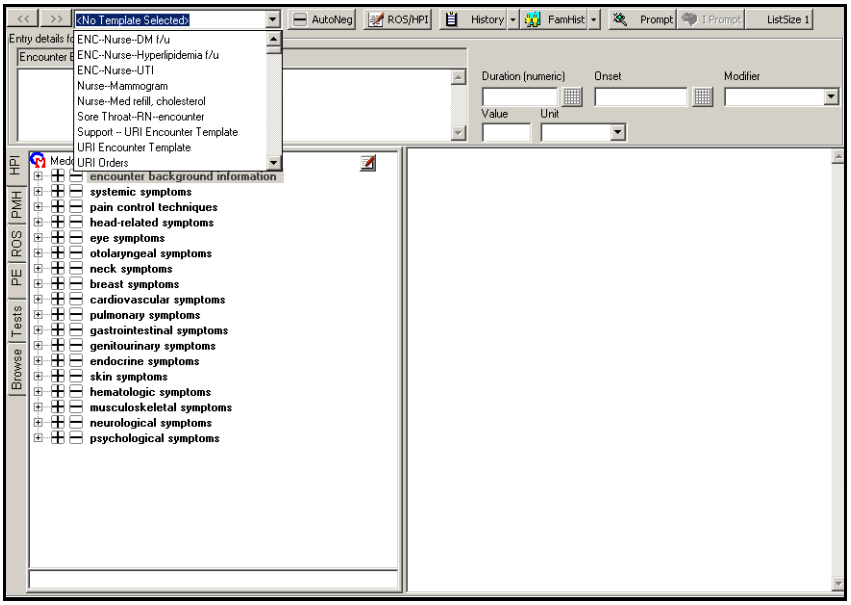


Figure 36-2: S/O Template Drop-Down List

OR

1. Click **Template Management** from the Action bar to view the S/O Template Management window (see Figure 36-3: S/O Template Management Window).

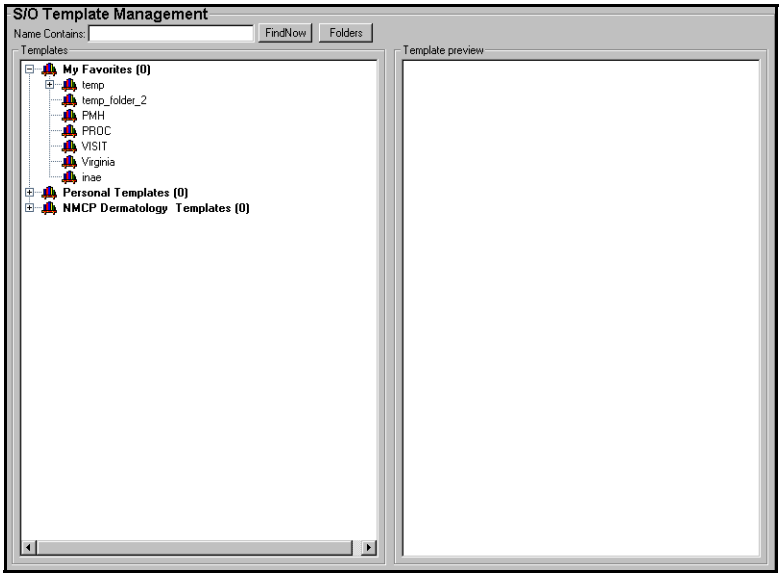


Figure 36-3: S/O Template Management Window

2. Search for the desired templates by entering in the name or the type of template (URI, visit) in the Name Contains field.
3. Click **Find Now** to view the templates that meet the search criteria.
4. Double-click the desired template to load it into the encounter (see Figure 36-4: Loaded Template).

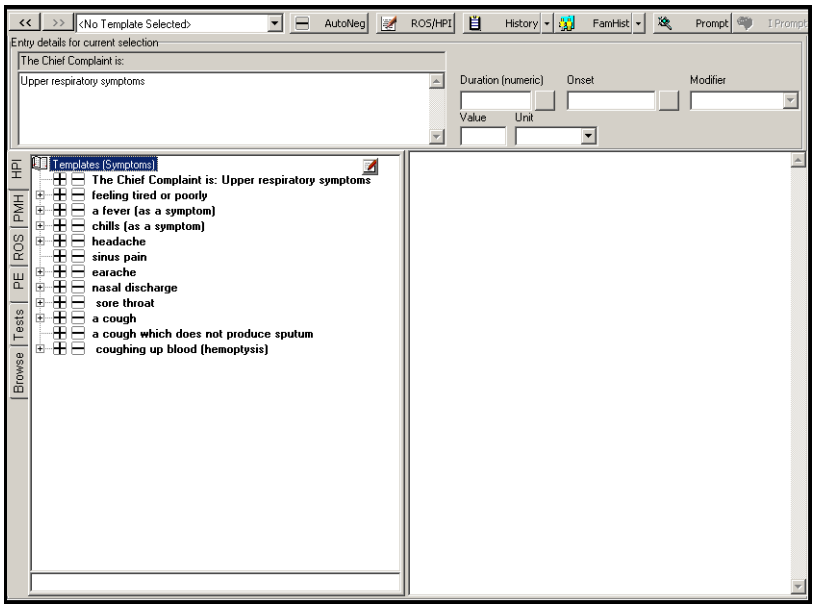


Figure 36-4: Loaded Template

5. After a template is loaded, terms from the template are displayed on the appropriate tabs. If there is a small plus sign next to a parent term, click it to expand the list and view the associated children terms. A small minus sign indicates the term has been expanded completely (see Figure 36-5: Parent/Child Relationship).

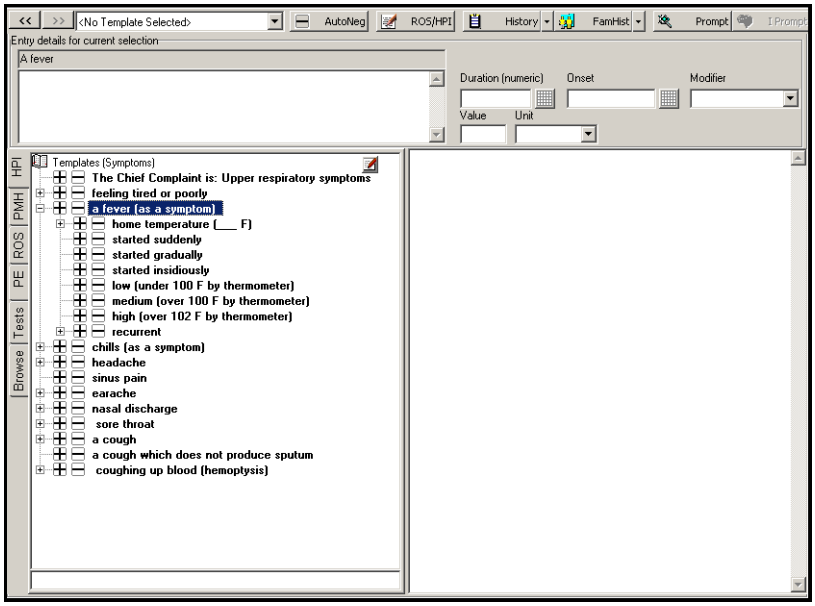


Figure 36-5: Parent/Child Relationship

36.3.3 Documenting from the HPI Tab

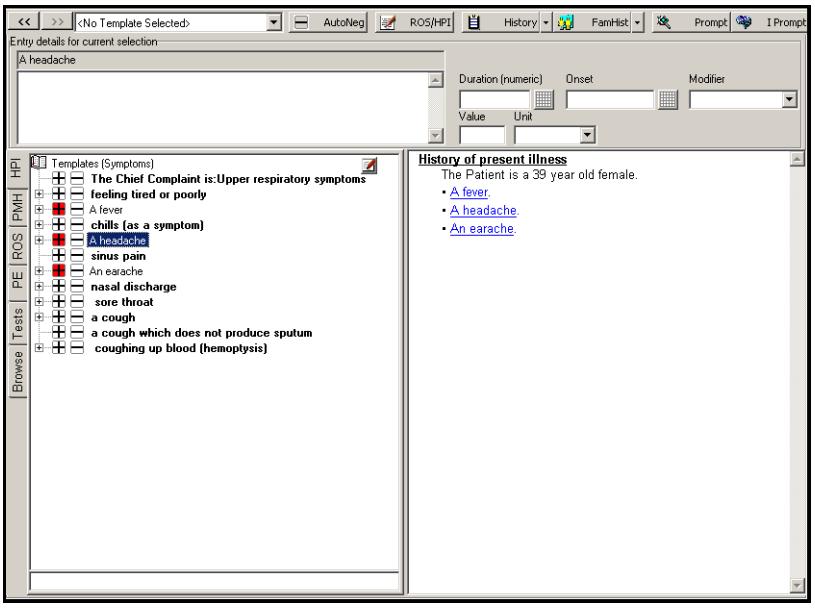


Figure 36-6: HPI Tab

To document from the HPI tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term. The selected terms are added to the Narrative window under the History of Present Illness (HPI) heading.

Note: If a Chief Complaint is added, it will fall under a Chief Complaint heading in the Narrative window.

---

2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal findings.

Note: One can document rapidly and accurately using the AutoNeg function. This is active only for the History of Present Illness, Review of Systems, and Physical Exam tabs. Clicking **AutoNeg** enters all the top-level, parent findings in the list as negative or normal. This is extremely helpful for physical exams and review of systems.

---

3. To change a finding, simply click the opposite sign. To delete, click the sign that has been selected.
4. If desired terms are not present on the template or the HPI needs to be characterized, a subjective free-text note can be added. Click the **Notepad** icon in the top right corner of the findings list.

5. Enter the note (see Figure 36-7: S/O Notepad).

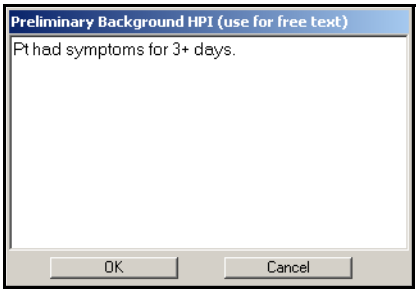


Figure 36-7: S/O Notepad

6. Click **Save** to save the note, or **Cancel** to exit the note without saving.

Note: When a free text note is accessed, modified, and closed by clicking **Cancel**, a pop-up warning box displays, warning that changes will be lost.

36.3.4 Documenting from the PMH Tab

To document from the Past Medical History (PMH) tab, simply add positive or negative responses to the terms by clicking the large plus or minus sign (see Figure 36-8: PMH Tab).

Note: The AutoNeg function cannot be used on the PMH tab.

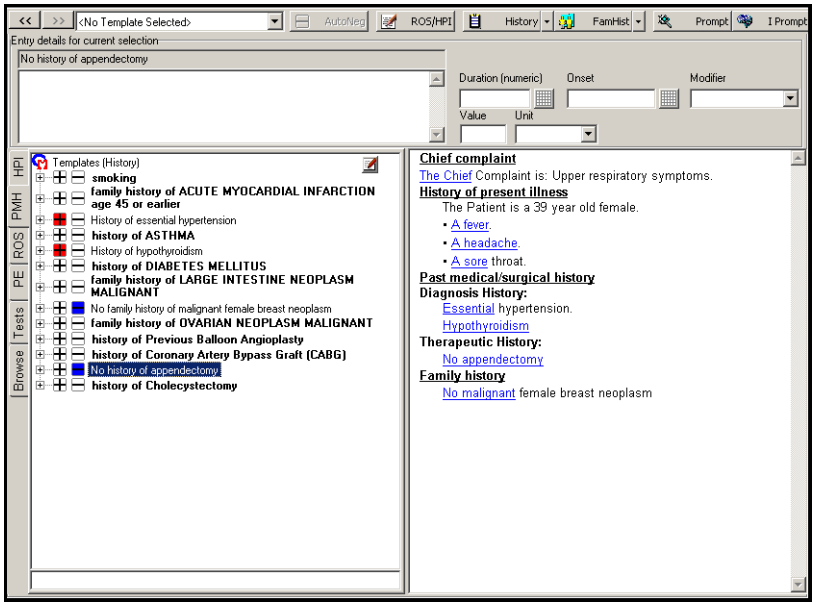


Figure 36-8: PMH Tab

36.3.5 Documenting from the ROS Tab

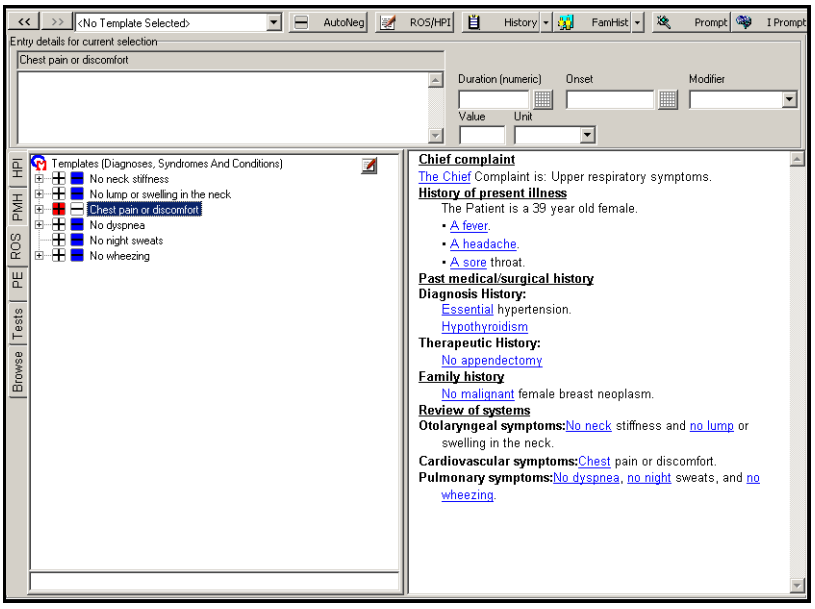


Figure 36-9: ROS Tab

Tip:
Flipping can be used with either the focused or comprehensive ROS. Highlight a term and then click ***ROS/HPI*** *from the Dashboard. This moves the term from the Review of Systems heading to the History of Present Illness heading and back again.*

To document from the ROS tab:

1. If using a focused ROS template, document the positive or abnormal findings first by clicking the large plus sign next to the term. Click **AutoNeg** to document the rest of the findings as normal.
2. If using a comprehensive ROS template, document both the positive and normal findings. Never use AutoNeg with a comprehensive ROS because all of the terms are not addressed in the course of an encounter.

36.3.6 Documenting from the PE Tab

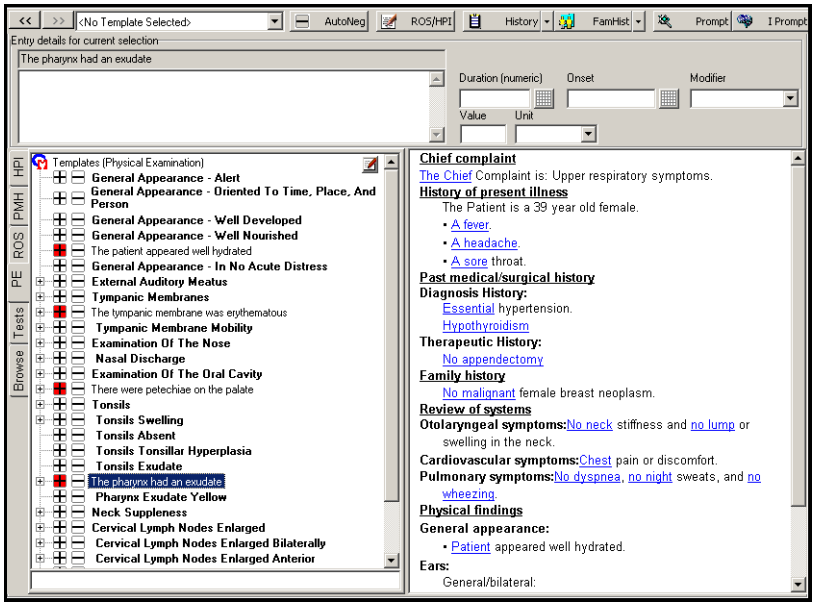


Figure 36-10: PE Tab

To document from the PE tab:

1. Document all the positive or abnormal findings first by clicking the large plus sign next to the term.
2. Once all the positive or abnormal terms have been selected, click **AutoNeg** to document the rest of the terms as normal.

Note: The use of the AutoNeg function assumes the template has been customized to fit your workflow. If you own the template, the narration for normal findings is already known and can be added with confidence.

---

3. Once all findings are documented, click **Close** to save the note and return to the Encounter.

36.3.7 Adding Details to a Finding

Once a term has been selected from the findings list, it is displayed in the Entry details for Current Selection field and in the Narrative window. To further explain the finding, use the S/O Tool bar or the Dashboard (see Figure 36-11: Toolbar and Dashboard).

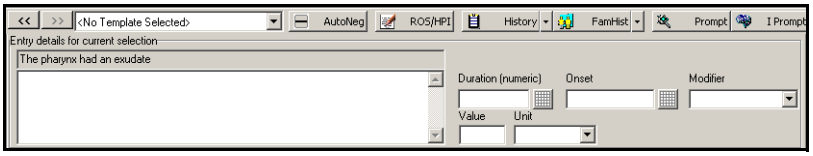


Figure 36-11: Toolbar and Dashboard

Tip:
If the button is not appropriate for the selected finding, it is grayed out.

To add details to a finding:

1. Select the term in the Findings List.
2. Select the desired detail or modifier:
   - **ROS/HPI:** Flips the highlighted finding between the Review of Systems and History of Present Illness headings.
   - **History:** Sets the prefix to History of, then adds the current finding to the documentation.
   - **Family History:** Sets the prefix to 'Family History of' then adds the current finding to the documentation.
   - **Entry Details for Current Selection Free-Text Field:** Enter in any additional information in the free-text field next to the Entry Details For Current Selection field and press **Enter**.
   - **Duration:** Click the **grid** to enter the associated value.
   - **Onset:** Click the grid to enter the associated value.
   - **Modifier:** Access the pull-down menu to add an adjective to the finding.
   - **Value:** Enter in the appropriate value.
   - **Unit:** Enter in the appropriate value.

36.3.8 Using the Search Capabilities

Use one of the following tools to search for specific terms or to dynamically build a Visit template. Each tool is found in the Action bar or the dashboard.

Find Term: Searches for a term in the Medcin terminology. This conceptual search returns terms relevant to the search text regardless of spelling. Abbreviations such as HTN (hypertension) or CHF (congestive heart failure) are recognized.

1. Click **Find Term** from the Action bar to view the Search String window (see Figure 36-12: Find Term Search String).

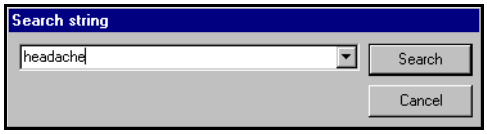


Figure 36-12: Find Term Search String

2. Enter the desired term and click **Search**.

Dx Prompt: Creates a list of findings based on one or more selected diagnoses. This is helpful when adding the history of present illness to a visit template.

1. Click **Dx Prompt** from the Action bar to view the Search String window (see Figure 36-13: Dx Prompt Search String).

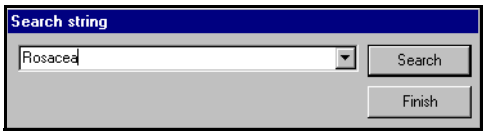


Figure 36-13: Dx Prompt Search String

2. In the Search String window, enter in the suspected diagnosis and click **Search**.
3. In the Select Diseases for Consideration window, select the appropriate disease and click **OK** (see Figure 36-14: Select Diseases for Consideration). If desired, repeat the process to add additional diseases. The resulting findings list merges all of the terms associated with the selected diseases.

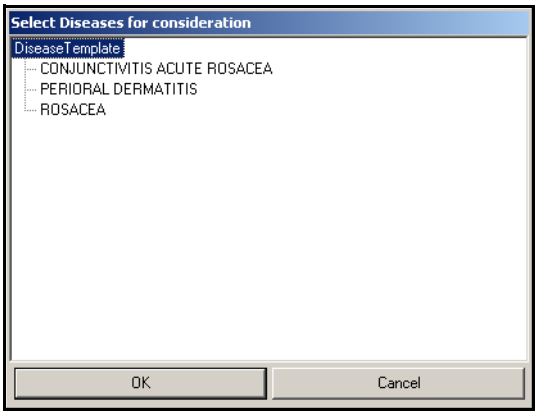


Figure 36-14: Select Diseases for Consideration

4. Click **Finish** from the Search String window. A template relevant to the term selected is displayed. Use the **List Size** button to control the number of terms on each tab.

Prompt: Builds a finding list based on a single highlighted term.

1. Highlight a term from the Findings list.
2. Click the **Prompt** icon from the Action bar.

I-Prompt (Intelligence Prompt): Builds a list of terms based on the documentation in the Narrative window. Once terms have been documented, click the **Intelligent Prompt** icon from the Action bar to view a list of additional terms that might also be considered.

List Size: Creates a broader or narrower list of findings. Three levels exist, short (List Size 1), medium (List Size 2), and long (List Size 3).

Browse from Here: Displays the highlighted finding as it appears within the Medcin terminology. Related Findings can be seen and selected.

1. From the Findings list, select the term to be located.
2. Click **Browse from Here** from the Action bar.

Tip:
This tool is helpful for multi-symptom patients. You may want to see a list of relevant terms for consideration to help document the note.

Tip:
The Browse from Here function is helpful when building PE templates.

36.3.9 Importing/Exporting an S/O Template

An S/O template can be imported or exported from other facilities using CHCS II.

To export an S/O template:

1. From the S/O Template Management window, select the template to export.
2. Click **Export** from the Action bar to view the Export S/O List Template window (see Figure 36-15: Export S/O List Template Window).

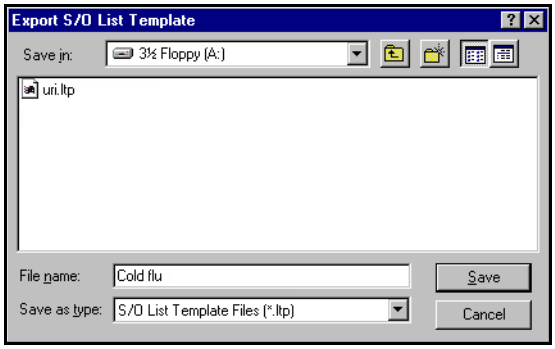


Figure 36-15: Export S/O List Template Window

3. Select the desired location for the template, type in the name of the template, and click **Save**.

To export multiple templates:

1. Select the templates to export by holding down the **Ctrl** key.
2. Click **Export** from the Action bar to view the Select Export Path window (see Figure 36-16: Select Export Path Window).

Figure 36-16: Select Export Path Window

3. Select the location for the exported templates and click **OK**.

To import a template:

1. From the S/O Template Management window, click **Import** from the Action bar to view the Import Medcin Template window (see Figure 36-17: Import Medcin Template Window).

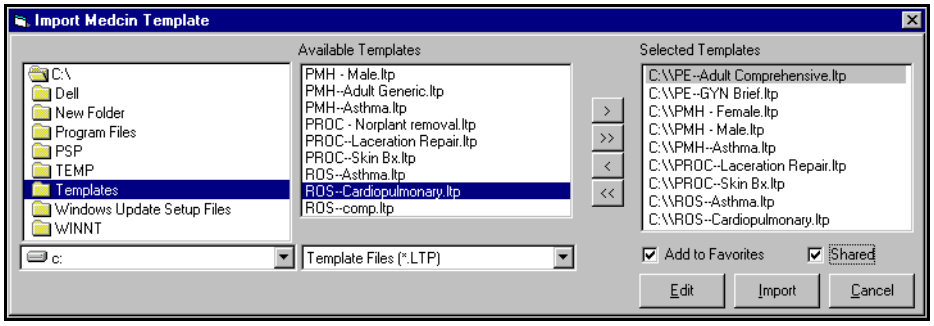


Figure 36-17: Import Medcin Template Window

2. In the far left pane, navigate to the location of the template (s). Once the location is determined, the available templates are displayed.
3. Select the template(s) to be imported and use the arrow keys to move the templates to the Selected Templates column.
4. Click **Import** to save the templates as is. Click **Edit** to open the template in Template Edit mode to add or remove terms prior to saving.

Note: If a template currently exists with the same name as a template being imported, a message is displayed asking whether or not to override the existing template.

36.4 Overview of S/O Template Creation

CHCS II contains a list of common templates as a starting point. Though these are helpful, clinicians need to build their own templates to optimize the use of the application in clinical practice. Templates are the key to rapid documentation and accurate coding.

The first step to creating a useful set of templates is to create a template for the physical exams that are commonly used. One can build any type of physical exam template. The most important factor in template creation is to build exams that reflect what you do.

Once you build your Common Physical Exam templates, you can move on to Visit templates. These contain all the findings used for history, physical, and tests. These are created for common visit types and chronic diseases seen in the clinic. They typically use the physical exam templates previously created as building blocks. It is important also to create ROS templates.

36.4.1 Creating a Physical Exam Template

When building a PE template, keep in mind the AutoNeg function. If a template is built correctly, documentation of a normal PE can be done by clicking **AutoNeg**.

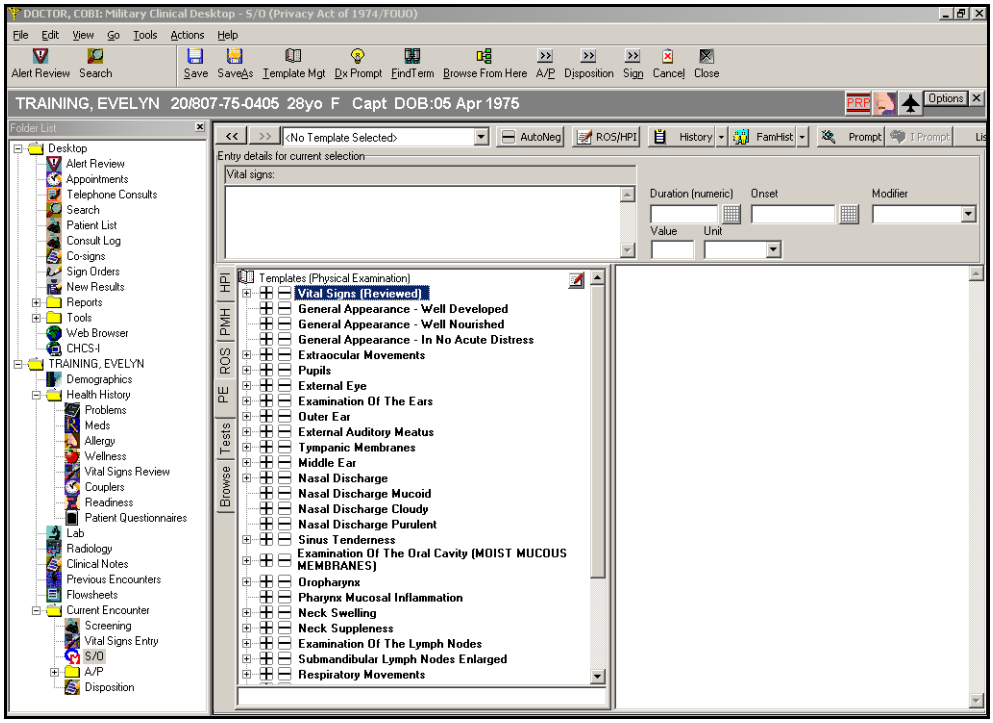


Figure 36-18: Physical Exam Template

Tip:
*To load a template, click **Templates** from the Action bar. Search for the desired template by typing in the type of the template (PE). Click **Find Now** and then double-click the desired template to load it.*

To build a Physical Exam template:

1. Load an appropriate PE template from the Starter Kit.
2. Click the PE tab to view the list of physical exam findings.
3. Add terms from the Starter Template that match your documentation style. Only the terms in the Narrative window are saved as the template. It does not matter which sign (+ or -) is selected. Both options are available when using the template (see Figure 36-19: Starter Template Terms).

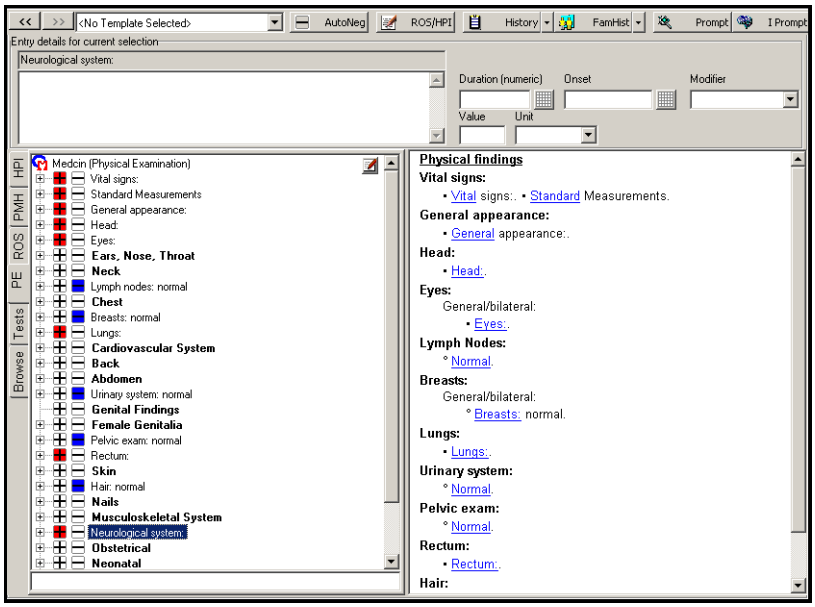


Figure 36-19: Starter Template Terms

4. When adding findings to a template, keep in mind the following hints:

   - **Browse from Here:** Use the **Browse from Here** icon from the Action bar to quickly locate terms for the PE. Highlight a term from the Starter Template and click **Browse from Here**. The highlighted term is displayed as it appears in the Medcin hierarchy. This enables access to other terms related to the highlighted term.
   - **Bilateral Structures:** When adding terms to document bilateral structures, drill down to the right-left level of the hierarchy (see Figure 36-20: Bilateral Structures). This enables you to document on either the right or left side.

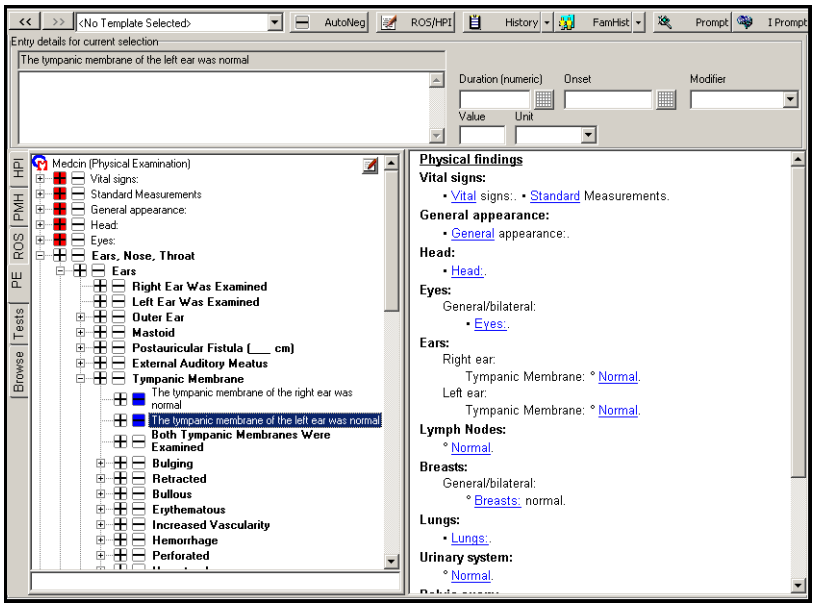


Figure 36-20: Bilateral Structures

- **Common Positives:** Common positives are findings that are frequently abnormal in a provider's exam. To add these terms to a template to allow for easy selection, add the parent findings as normal (click the large plus sign) and select the children findings as abnormal (click the large minus sign). In the template, the children findings are the common positives.
- **Free-text added to a Term:** Free-text can be added to an individual finding for clarification. For example, if the finding 'Lymph Node: Normal' needs to be clarified to state there are no nodules present, highlight the finding Lymph Nodes: Normal and enter the desired text in the free-text field in the dashboard. Press **enter** to add the note to the Narrative window

5. For hard to find terms, use the Find Term function from the Action bar. Click **Find Term**, enter the desired term, and click **Search**.
6. When all findings used for a typical physical exam are selected, click **Save As** from the Action bar to view the Save List Note Template window (see Figure 36-21: Save List Note Template Window).

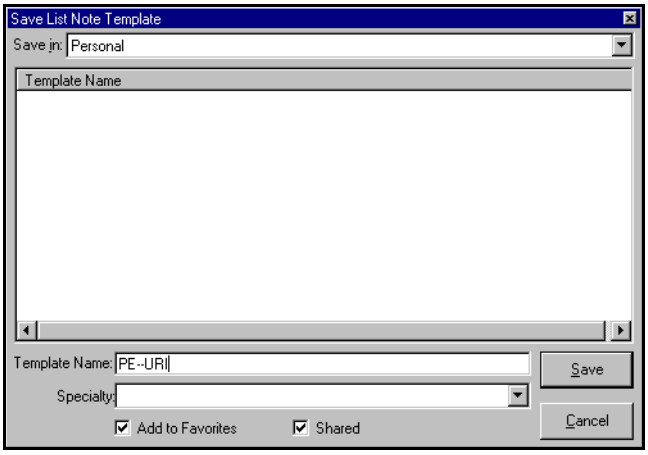


Figure 36-21: Save List Note Template Window

7. On the Save List Note Template window, enter the name of the template using the convention 'PE--[name].' This groups the component templates together so they can be easily found.
8. The template is automatically added to your Favorites List (unless the checkbox is deselected). Select the Shared checkbox to make your template available to other clinical team members.
9. Click **Save** to save the template. **Cancel** closes the window without saving the template.
10. To test the template, load it into the encounter, click the PE tab, and click **AutoNeg** (see Figure 36-22: PE Note). The resulting note should display an accurate narrative for a normal exam. Those findings that are not selected should be the findings that are used to document any abnormalities. When using this template to see patients, document the abnormals first and the click **AutoNeg** to denote all other findings as normal.

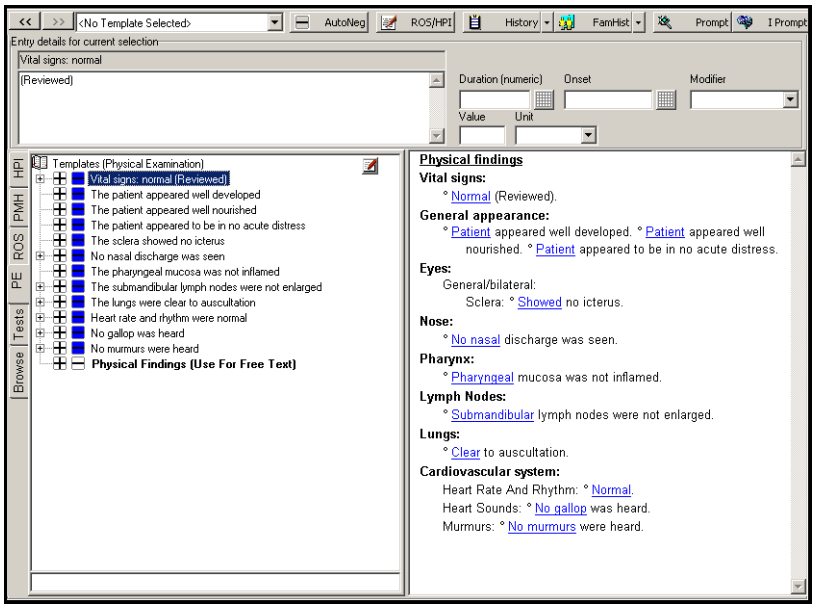


Figure 36-22: PE Note

36.4.2 Creating a Focused ROS Template

Focused ROS templates are used for specific visits, complaints, or organ systems, including depression, headache, cardiopulmonary (see Figure 36-23: Focused ROS Template). Due to the short, focused nature of these templates, the AutoNeg function is especially useful.

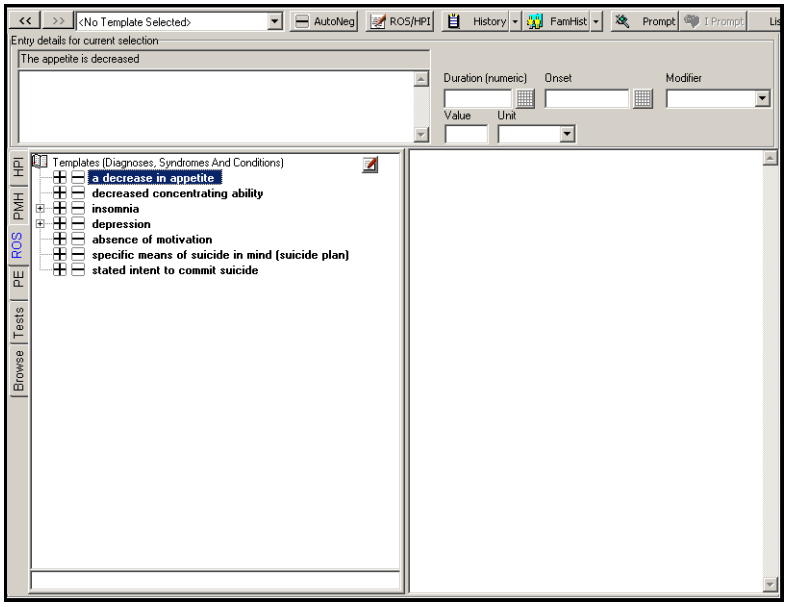


Figure 36-23: Focused ROS Template

To build a focused ROS template:

1. Load an ROS template from the Starter Kit or start from scratch.
2. Use one of the following techniques to add terms to the template:
   - If building the template around an organ system, select terms from the ROS tab (e.g., Pulmonary)
   - If building the template around a complaint or a disease, use the **Find Term** function and the **Single Prompt**.
     - — **Find Term:** Click **Find Term**, enter the desired term, and click **Search**.
     - — **Single Prompt:** Builds a finding list based on a single highlighted term (e.g., dizziness). Highlight the term and click **Prompt** from the Dashboard.
3. Be sure the terms emit into the Narrative window under the Review of Systems heading. Each time a Find Term or Single Prompt is completed, the HPI tab becomes the default. Click the ROS tab prior to making the selection of a term to ensure the correct heading. If a term does fall under the HPI heading, highlight the term in the Narrative window and click **ROS/HPI** from the dashboard to flip the term down into the ROS.
4. To save the template, click **Save As** from the Action bar. Name the template 'ROS--[name].'
5. Test the template by loading it into a clean note and clicking **AutoNeg**. The result should be a normal ROS.

36.4.3 Creating a Comprehensive ROS Template

Comprehensive ROS templates are a large repository of symptoms that can be used in the HPI or ROS. AutoNeg should not be used with the Comprehensive ROS due to the size of the list. The ROS—Comprehensive component is used in the Generic Visit template to act as a starting point for both the HPI and ROS.

To build a comprehensive ROS template (see Figure 36-24: Comprehensive ROS Template):

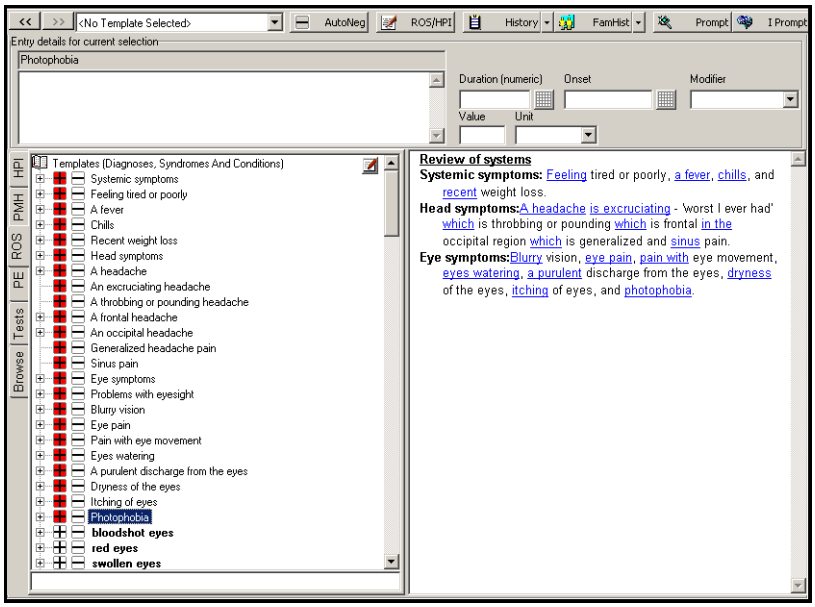


Figure 36-24: Comprehensive ROS Template

1. Load the **ROS--Comprehensive** template from the Starter Kit.
2. Starting at the top of the ROS tab, review each term and either add it to the template or ignore it. Remember, this is a repository of symptoms that are used to document “oh, by the way” complaints.
3. Load any focused ROS templates that have been built and add all the terms to the current template. The terms on the focused templates have already been selected and should also appear on the comprehensive ROS. Duplicate terms are not allowed in one template so terms are not added twice if found on both the comprehensive and focused template.
4. Use **Find Term** to locate any additional terms for the template.
5. Click **Save As** from the Action bar and name the template 'ROS--[comprehensive or complete].'
6. Test the use of the template by loading it into an encounter. Once loaded, practice adding terms to the Narrative window and flipping terms up into the HPI.

Tip:
*To load an additional template, click **Templates** from the Action bar, enter ROS in the search field and click **Find Now**. Multi-select any focused ROS templates by holding down the **Ctrl** key while clicking on individual templates. Click **Load** from the Action bar.*

Tip:
*To flip a term from the ROS heading to the HPI, select the term and click **ROS/HPI** from the Dashboard.*

36.4.4 Creating a PMH Template

PMH templates include the patient's past history, social history, and family history. Typical PMH templates are adult generic, adult female, adult male, and pediatric.

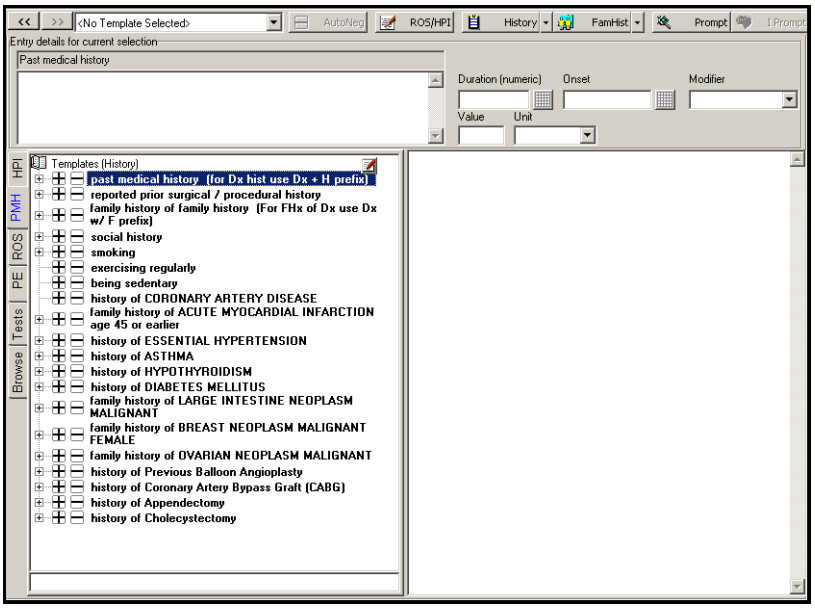


Figure 36-25: PMH Template

Tip:
Remember to click the PMH tab after completing a Find Term. Look under the History of Diagnoses, Syndromes, and Conditions and History of Therapy nodes for the desired terms.

To build a PMH template:

1. Load an appropriate PMH template from the Starter Kit.
2. Add terms to the template by using the Find Term functionality.

Note: Sometimes the search returns a message stating that "no items have been found." Click **OK**, click the PMH tab, and expand either the History of Diagnoses, Syndromes, and Conditions or the History of Therapy node to locate the term.

3. Add the Family History prefix when needed. Highlight the term and click **Family History** from the Dashboard.
4. Click **Save As** from the Action bar and name the template 'PMH--[name].'
5. Test the use of the template by loading it into an encounter. Once loaded, you cannot AutoNeg when documenting from the PMH tab.

36.4.5 Creating a Procedure Template

A procedure template can be used for routine procedure, education, and informed consent notes.

To build a Procedure template:

1. Click the PE tab and click **Notepad** to open the free-text window (see Figure 36-26: Free-Text Window).

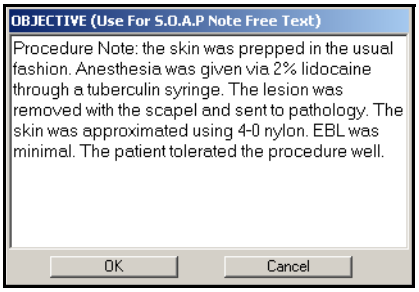


Figure 36-26: Free-Text Window

2. Enter the first words of the note the category of the template (e.g., "Procedure Note:" or "Education Note:")
3. Enter the rest of the free-text.
4. Click **Save and Close**. The note is added to the Narrative window.
5. Click **Save As** from the Action bar and name the template "PROC--[name]" or "EDU--[name]" as appropriate.

Note: A procedure note can also be attached to a structured test term. Highlight the desired term (e.g., Skin biopsy) and add the procedure in the free-text field in the Dashboard. Press **Enter**, then save the template.

---

6. Test the use of this template by loading it into an encounter. Remember to look on the PE tab for the procedure note (see Figure 36-27: Procedure Note).

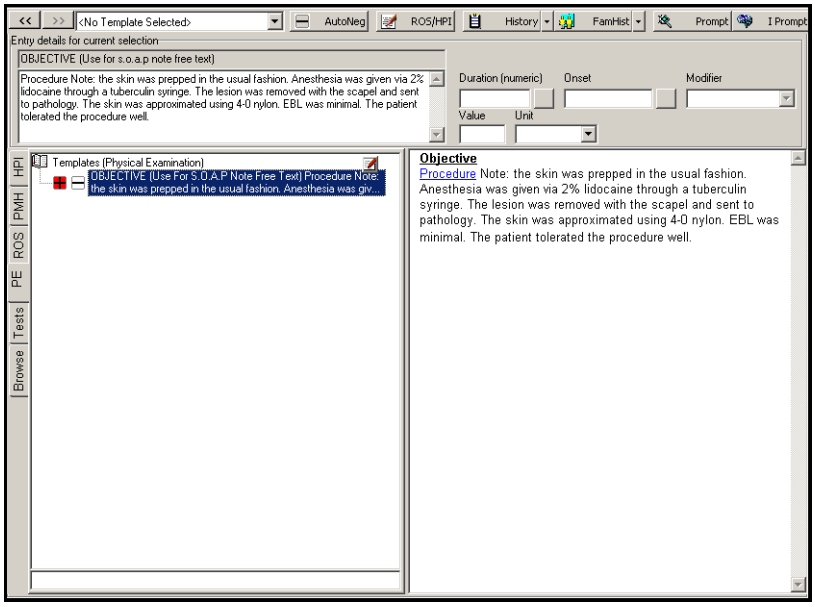


Figure 36-27: Procedure Note

36.4.6 Visit Templates

Building Visit templates is the final step in building templates. It is the Visit template that is used when seeing patients. Visit templates are built by combining the appropriate component templates into one template, thus allowing an entire encounter to be documented with one template. The Chief Compliant is added to every Visit template to characterize the note. Without the Chief Complaint, the purpose of the visit is lost in the note.

When building either Visit template (Generic or Standard), the Template Edit mode is used instead of the Documentation mode. The Template Edit mode allows for easy merging and editing of component templates. When in this mode, terms are selected using a single large plus and the template is shown in outline form in the Narrative window.

36.4.7 Creating a Generic Visit Template

A Generic Visit template consists of a chief complaint, PMH, comprehensive ROS, PE, and PROC templates. It is used when no Standard Visit template exists for that type of patient encounter. The comprehensive ROS is key because this is where terms are selected and then flipped up into the HPI. This template is heavily used initially until an adequate repository of templates is built.

To build a Generic Visit template (see Figure 36-28: Generic Visit Template):

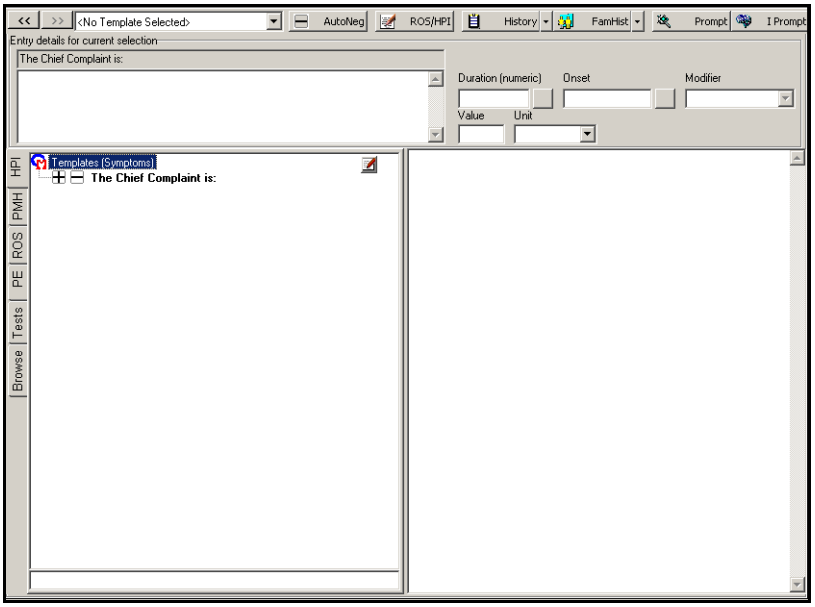


Figure 36-28: Generic Visit Template

1. Click **Templates** from the Action bar to enter S/O Template Management.
2. Click **New** from the Action bar to enter Template Edit mode (see Figure 36-29: Template Edit Mode).

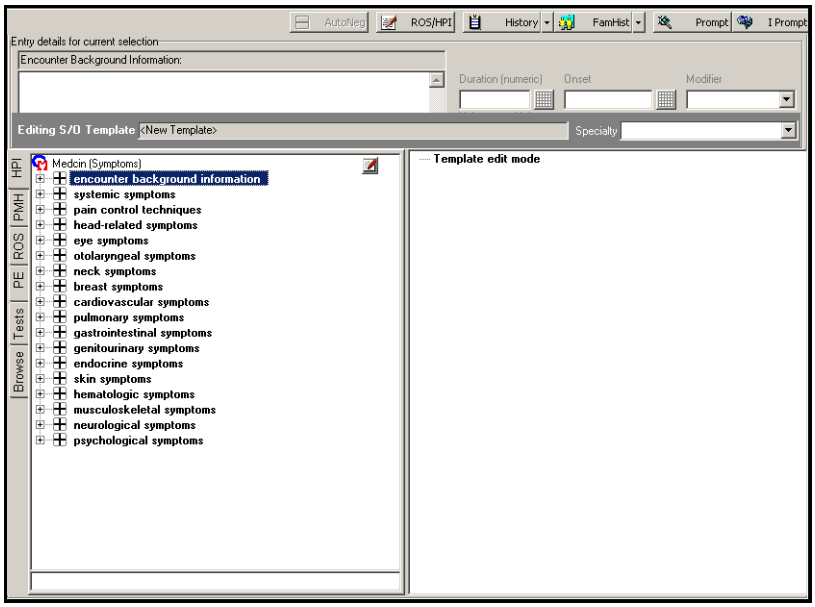


Figure 36-29: Template Edit Mode

3. Click **Find Term** from the Action bar and type Chief Complaint in the Search String window (see Figure 36-30: Find Term Search String).

Tip:
Entering CC pulls up the term Chief Complaint.

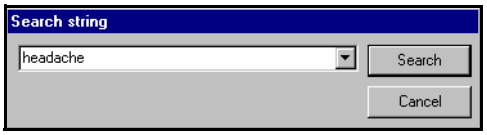


Figure 36-30: Find Term Search String

4. Click **Search** to view the Chief Complaint finding on the HPI Tab. Click the large plus next to the term Chief Complaint to add it to the template. The Chief Complaint is left blank to the generic nature of this template. It is filled out when using this template to document a visit.
5. The component templates that have already been built need to be added. Click **Add In Template** from the Action bar to return to S/O Template Management.
6. Select a generic PE, comprehensive ROS, and PMH template. Multiple templates can be selected by holding down the **Ctrl** key (see Figure 36-31: Selecting Multiple Templates).

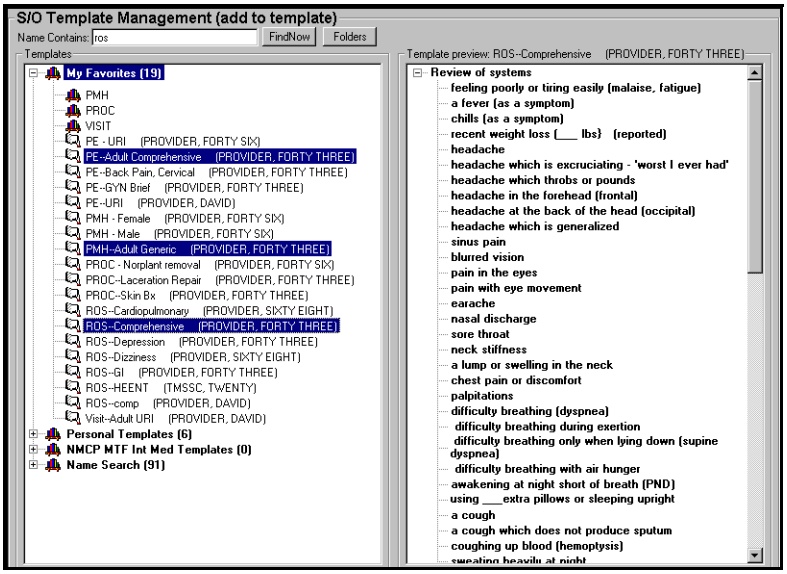


Figure 36-31: Selecting Multiple Templates

7. Click **Add** from the Action bar to load the selected templates into the Template Edit mode. Notice the component templates are shown in the Narrative window and are now one template.

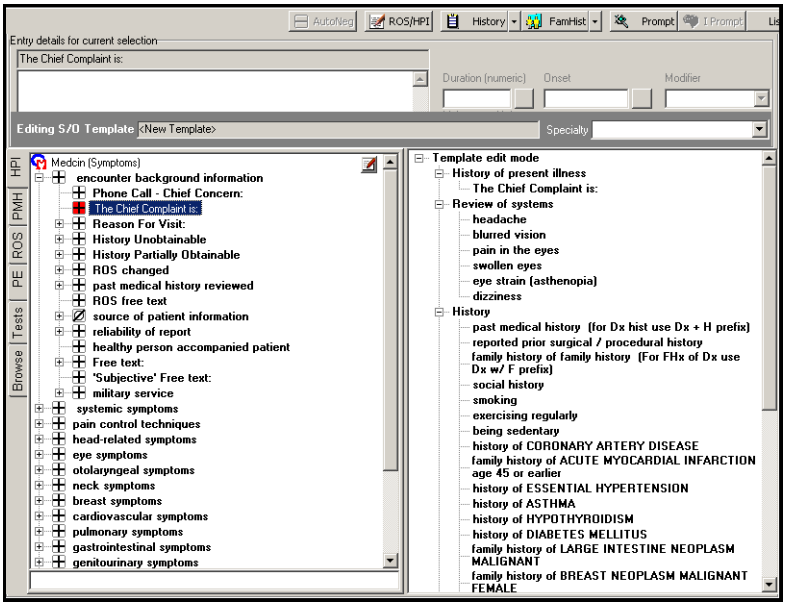


Figure 36-32: Generic Visit Component Templates

8. Click **Save As** from the Action bar and save the template as 'VISIT—Generic.'

9. Test the use of this template by loading it into an encounter. When using the Generic Visit Template, click the large plus next to Chief Complaint and add the reason for the visit in the free-text field in the Dashboard.

Note: Use the ROS tab to locate terms relative to the chief complaint and HPI. Highlight these terms and flip them into the HPI by clicking **ROS** from the Dashboard. Use the PMH and PE components in the normal fashion.

36.4.8 Creating a Standard Visit Template

A Standard Visit template is used for common clinical visits and consists of a chief complaint, HPI terms, and relevant PMH, ROS, PE, and PROC templates. Examples are asthma follow-up or school physicals (see Figure 36-33: Standard Visit Template).

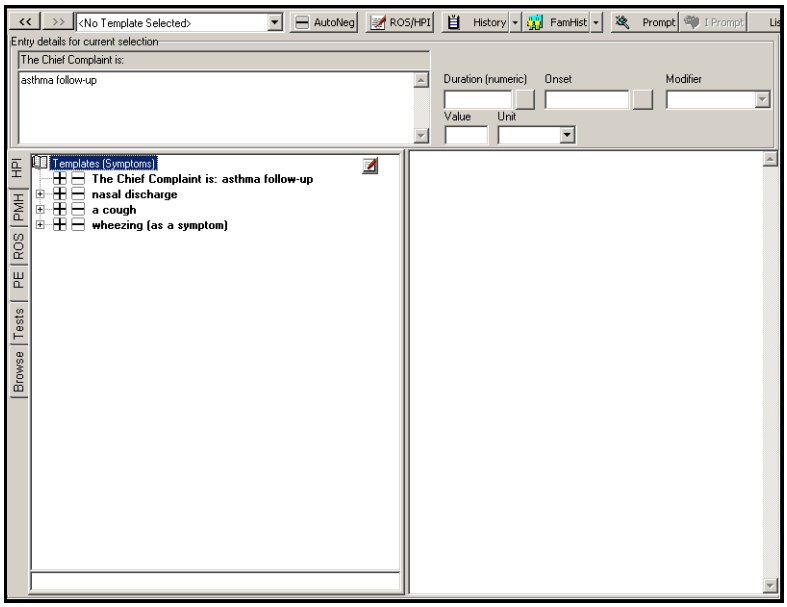


Figure 36-33: Standard Visit Template

To build a Standard Visit template:

1. Click **Templates** from the Action bar to enter S/O Template Management.
2. Click **New** from the Action bar to enter Template Edit mode.
3. Click **Find Term** from the Action bar and enter Chief Complaint in the Search String window.
4. Click **Search** to view the Chief Complaint finding on the HPI Tab. Click the large plus next to the term Chief Complaint to add it to the template. Enter the reason for the specific visit in the free-text field in the Dashboard (e.g., Asthma follow-up) (see Figure 36-34: Chief Complaint).

Tip:
Entering CC pulls up the term Chief Complaint.

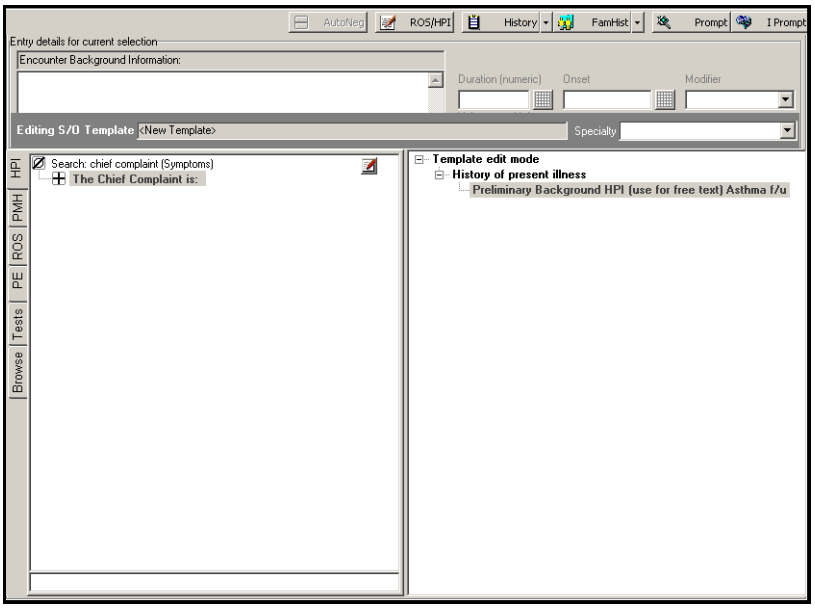


Figure 36-34: Chief Complaint

5. Since this is a template for a specific type of visit, HPI terms can be added. Use the Dx Prompt functionality to create a list of terms for possible selection. Click **Dx Prompt** from the Action bar, type in the specific diagnosis and click **Search**. Select the diagnosis, click **OK**, and then **Finish**.
6. Add terms to the template from the search results or use **Find Term** to locate additional items.
7. The component templates that have already been built need to be added. Click **Add In Template** from the Action bar to return to S/O Template Management.
8. Select the appropriate PE, ROS, PMH, and PROC templates. Multiple templates can be selected by holding down the **Ctrl** key (see Figure 36-35: Selecting Multiple Templates).

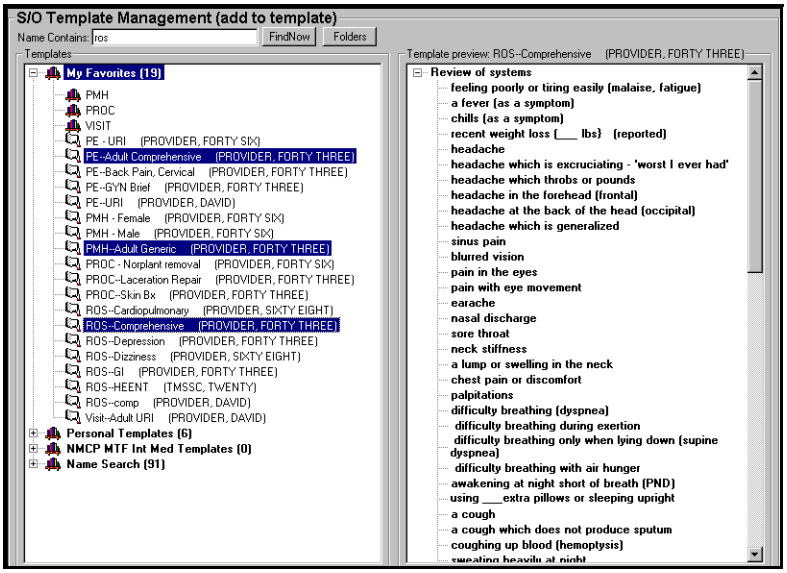


Figure 36-35: Selecting Multiple Templates

9. Click **Add** from the Action bar to load the selected templates into the Template Edit mode. Notice the component templates are shown in the Narrative window and are now one template (see Figure 36-36: Standard Visit Component Templates).

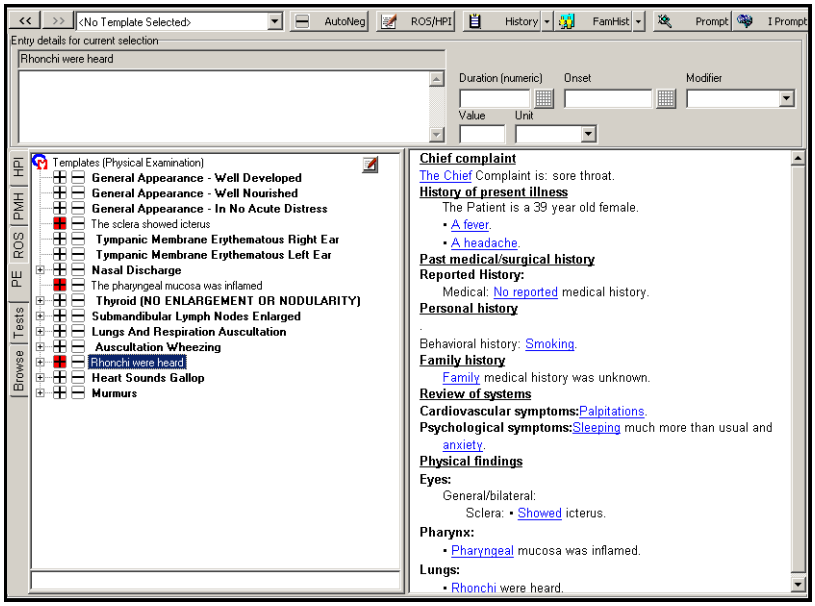


Figure 36-36: Standard Visit Component Templates

10. Click **Save As** from the Action bar and save the template as 'VISIT--[name].'
11. Test the use of this template by loading it into an encounter and documenting a typical encounter.

36.4.9 Editing a Template

A template can be edited using Template Edit mode. It allows for quick addition or removal of terms as well as easy merging of component templates.

To edit a template:

1. From the S/O Template Management window, highlight the template and click **Edit** from the Action bar to view the template in Edit Mode (see Figure 36-37: Template Edit Mode).

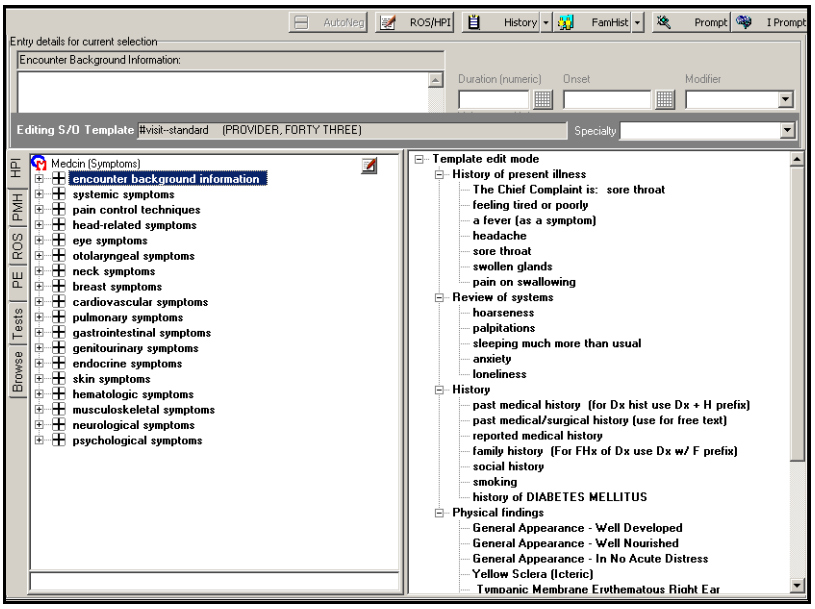


Figure 36-37: Template Edit Mode

2. To remove a finding, locate and click the finding in the outline on the right. The finding is displayed in the findings list on the left.
3. Select the current sign (plus or minus) to remove the finding.
4. To add a new finding, use one of the search capabilities to locate and select the finding. Once selected, the new term is added to the outline on the right.
5. When finished editing, click **Save As** from the Action bar to save the modified template.

37.0 TELEPHONE CONSULTS

37.1 Overview of Telephone Consults

The Telephone Consults module enables telephone calls to be recorded and tracked. The Telephone Consult (telcons) window displays telephone consults for specified clinics, providers, dates, and statuses. From the Telephone Consults module, telcons can be created, viewed, transferred to another provider, and cancelled. Phone numbers can be edited, notes viewed, and an encounter can be opened for that appointment (see Figure 37-1: Military Clinical Desktop - Telephone Consults Module).

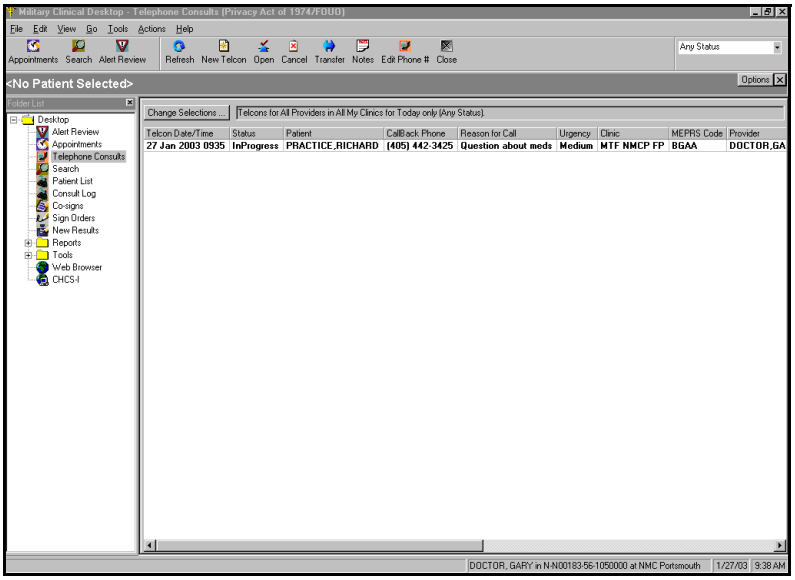


Figure 37-1: Military Clinical Desktop - Telephone Consults Module

37.2 Action Bar Icons

	Refresh	Refreshes the window with updated information.
	New Telcon	Allows a new telephone consult to be created.
	Open	Opens the encounter associated with the telephone consult.
	Cancel	Allows a telephone consult to be canceled.
	Transfer	Allows a telephone consult to be transferred.
	Notes	Allows notes associated with the telephone consult to be viewed.

	**Edit Phone #**	Allows the call back number to be changed. The system defaults to the home number.
	**Close**	Closes the Telephone Consult module.

37.3 Setting the Properties of the Telephone Consults Module

Similar to the Appointment function, Telephone Consults can be filtered for the following:

- **Default:** Customized default settings from the Telephone Consult Search Selections dialog box.
- **All Outstanding:** Telephone consults with the status 'outstanding.'
- **Today:** Today's telephone consults.
- **Today + Incomplete:** Today's telephone consults that have a status of incomplete.
- **Any Status:** Telephone consults that meet any status and meet the date criteria set in the Telephone Consult Log Selections window.
- **Pending Only:** Telephone Consults that have a status of pending and meet the date criteria set in the Telephone Consult Log Selections window. No note has been initiated.
- **In Progress Only:** Telephone Consults that have a status of In Progress and meet the date criteria set in the Telephone Consult Log Selections window. The note has been initiated.
- **Completed Only:** Telephone consults that have a status of complete and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been signed.
- **Updated Only:** Telephone consults that have a status of updated and meet the date criteria set in the Telephone Consult Log Selections window. The encounter document has been completed and then amended.

Use this function to filter the telephone consult list for the current session. Use the Change Selections function to select a filter to use as the default.

To filter the list of telephone consults, select a filter from the drop-down list in the top, right corner on the Telephone Consults window.

37.4 Setting the Telephone Consult List Selection Criteria

The Change Selections function allows you to customize the Telephone Consult list.

To set the telephone consult list selection criteria:

1. On the Telephone Consult window, click **Change Selections**. The Telephone Consult Search Selections window opens (see Figure 37-2: Telephone Consult Search Selections Window).

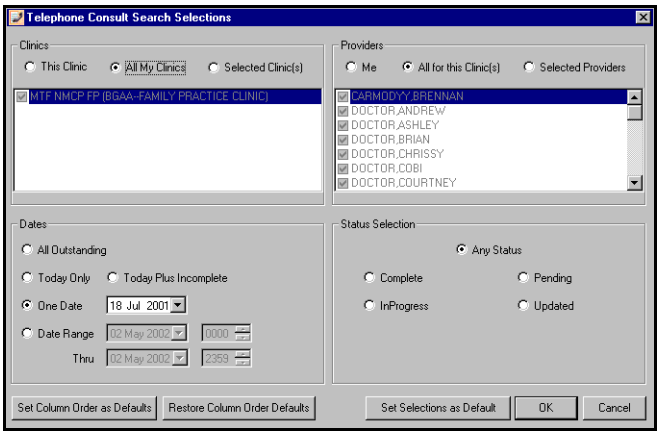


Figure 37-2: Telephone Consult Search Selections Window

2. Select the applicable option in the Clinics area.
3. Select the applicable option in the Providers area.
4. Select the applicable option in the Dates area.
5. Select the applicable option in the Status Selection area.
6. To display the telephone consults that meet the requested criteria on the Telephone Consult window, click **OK**.

Tip:
*If the column headings have been re-ordered on the Telephone Consults window, click **Set Column Order as Defaults** to keep this heading order each time the Telephone Consults window is opened. Click **Restore Column Order Defaults** to return the column heading order to the system default.*

37.5 Canceling a Telephone Consult

To cancel a Telephone Consult:

1. Select the **Telephone Consult** to be cancelled.
2. On the Action bar, click **Cancel**. The Cancel Telcon window opens (see Figure 37-3: Cancel Telcon Window).

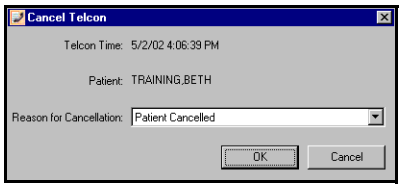


Figure 37-3: Cancel Telcon Window

3. Select a **reason for the cancellation** from the drop-down list.
4. Click **OK**.

37.6 Editing the Call Back Phone Number

The Callback Number is pre-populated with the patient's home number taken from the Demographics module.

To edit the call back phone number:

1. Select the **Telephone Consult** to be modified.
2. On the Action bar, click **Edit Phone #**. The Change Callback Number window opens (see Figure 37-4: Change Callback Number Window).

Tip:
This does not change the patient's home phone number in the Demographics module.

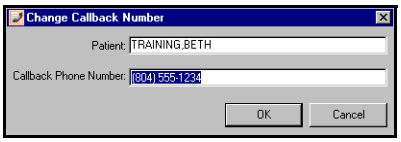


Figure 37-4: Change Callback Number Window

3. In the Callback Phone Number field, enter the new phone number.
4. Click **OK**.

37.7 Opening an Encounter

If a telephone consult is selected and the Open Encounter option is chosen, the Patient Encounter window for that patient opens.

To open an encounter:

1. Select the **telephone consult** on the Telephone Consult window.
2. On the Action bar, click **Open**. The Patient Encounters window for the selected patient opens.

37.8 Creating a New Telephone Consult

To create a new telephone consult:

1. Search for the patient for which you want to schedule a telephone consult.
2. On the Action bar, click **New Telcon**. The New Telcon window opens (see Figure 37-5: New Telcon Window).

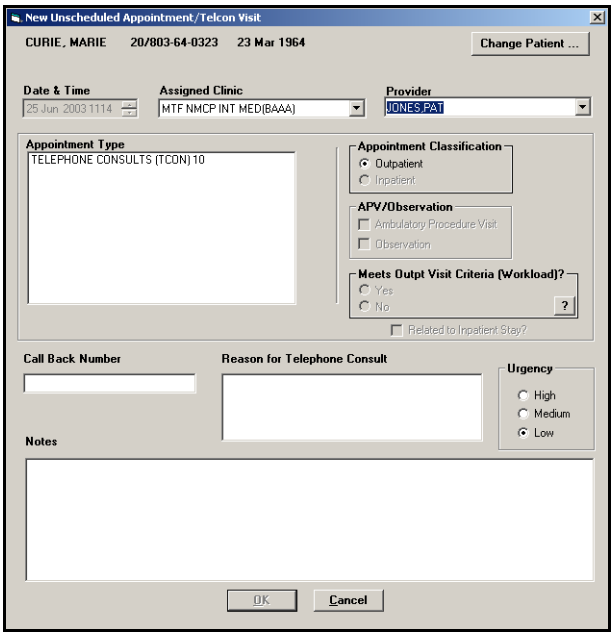


Figure 37-5: New Telcon Window

3. Complete the following fields:
   - **Appointment Type:** Select the appointment type.
   - **Date and Time:** This field cannot be changed. It defaults to the current date and time.
   - **Assigned Clinic:** Select the assigned clinic from the drop-down list.
   - **Provider:** Use the drop-down list to select the desired provider.
   - **Appointment Classification:** This will default based on the patient's appointment classification.
   - **Call Back Number:** Enter the phone number where the patient can be reached. The default number is the patient's home phone.
   - **Reason for Telephone Consult:** Enter a short description of the problem for the patient called.
   - **Urgency:** Select the High, Medium, or Low option.
   - **Note:** Enter any comments pertaining to the telephone consult.

4. To save the appointment, click **OK**.

Note: To open the Patient Search window, click **Change Patient** to search for a new patient. If you click **Change Patient** before clicking **OK**, the telephone consult for the patient cannot be created.

Note: If you have privileges to view encounter information, the Telcon Quick Entry window opens, allowing for continued documentation.

37.9 Completing the Telcon Quick Entry Screen

To complete the Telcon Quick Entry screen:

1. Double-click the desired telephone consult from the list.

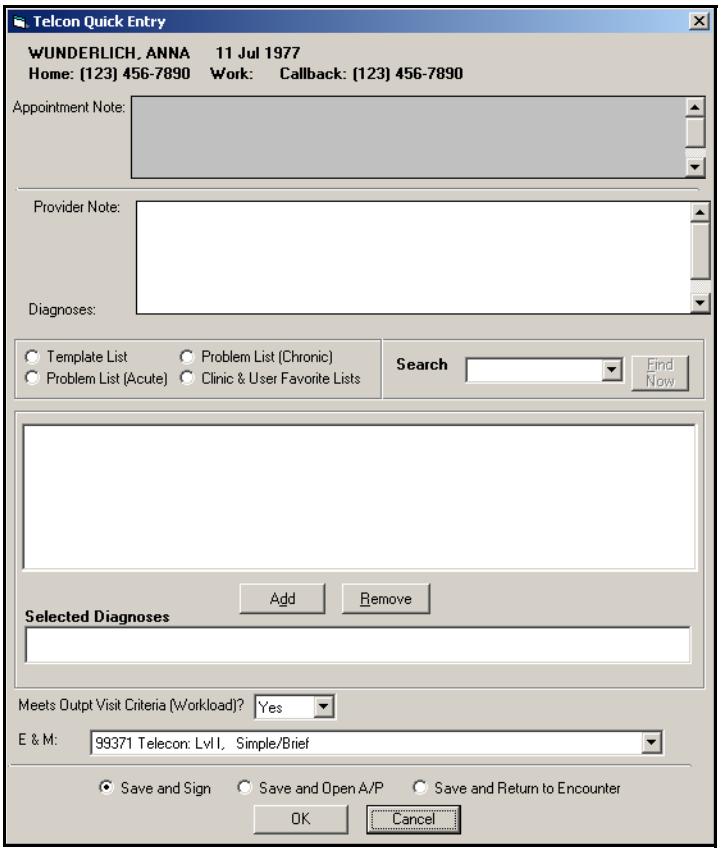


Figure 37-6: Telcon Quick Entry Window

2. Complete the applicable fields:
   - **Provider Note:** Enter free-text to document the S/O portion of the encounter.
   - **Diagnoses:** The diagnoses can be selected from the Template List, Problem List (Acute or Chronic), or Clinic and User Favorite Lists. You can also search for the diagnosis by entering the diagnosis in the Search field and clicking **Find Now**. Select the diagnosis and click **Add** to add the diagnosis to the Selected Diagnosis list.
   - **E&M:** Select an **E&M code** from the drop-down list.
3. Select the desired **Save** option:
   - **Save and Sign:** Saves the information and opens the Sign Encounter window.
   - **Save and Open A/P:** Saves the information, writes it into the Patient Encounter window, and opens the Assessment and Plan module.
   - **Save and Return to Encounter:** Saves the information and returns you to the encounter document.
4. Click **OK**.

Note: Once information has been entered and saved via the Quick Entry Screen, the Quick Entry Screen will not be available to document additional data.

37.10 Transferring a Telephone Consult

The Telcon Transfer window enables an individual telcon or a group of telcons to be transferred to a different provider within the same clinic.

To transfer a telephone consult:

1. Select the **telephone consults** to be transferred.
2. On the Action bar, click **Transfer**. The Telcon Transfer window opens (see Figure 37-7: Telcon Transfer Window).

Tip:
If transferring multiple telcons, the patients must be from the same clinic.

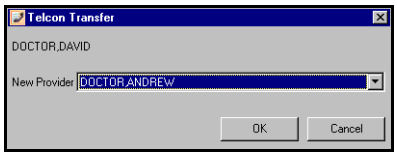


Figure 37-7: Telcon Transfer Window

3. Select a new provider from the New Provider drop-down list. Only providers assigned to the specific clinic are available.
4. To execute the transfer, click **OK**. The telephone consult is added to the new provider's telephone consults list.

37.11 Viewing a Telcon Note

If a comment was added on the New Telcon window, the full text of the comment cannot be seen on the Telephone Consults window.

To view a telcon note:

1. Select the **telephone consult** on the Telephone Consult window.
2. On the Action bar, click **Notes**. The Appointment Note window opens containing the comment (see Figure 37-8: Appointment Note Window).

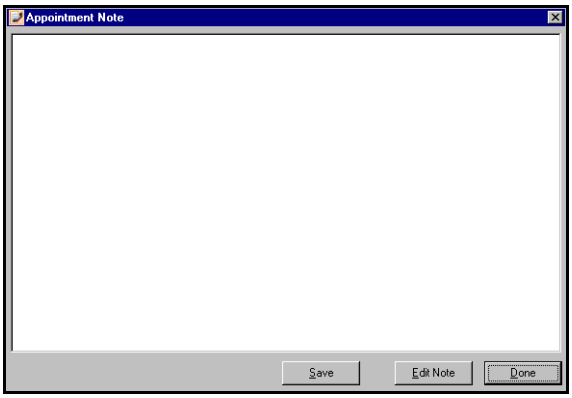


Figure 37-8: Appointment Note Window

3. To close the window and return to the Telephone Consults window, click **Done**.

Note: To edit information in the note, click **Edit Note**. When all edits have been made, click **Save**.

38.0 TEMPLATE MANAGEMENT

38.1 Overview of Template Management

Templates are used to streamline the encounter documentation process. Each encounter template contains placeholders for diagnoses, procedures, orders, S/O Notes templates, and autocited items. Once an encounter template has been selected and loaded into the encounter, the pre-selected lists are available within S/O and A/P. The Template Management module (see Figure 38-1: Military Clinical Desktop - Template Management Module) is generally accessed while in an encounter after the screening process and before any charting is completed. The Encounter templates can be viewed and edited without an open encounter.

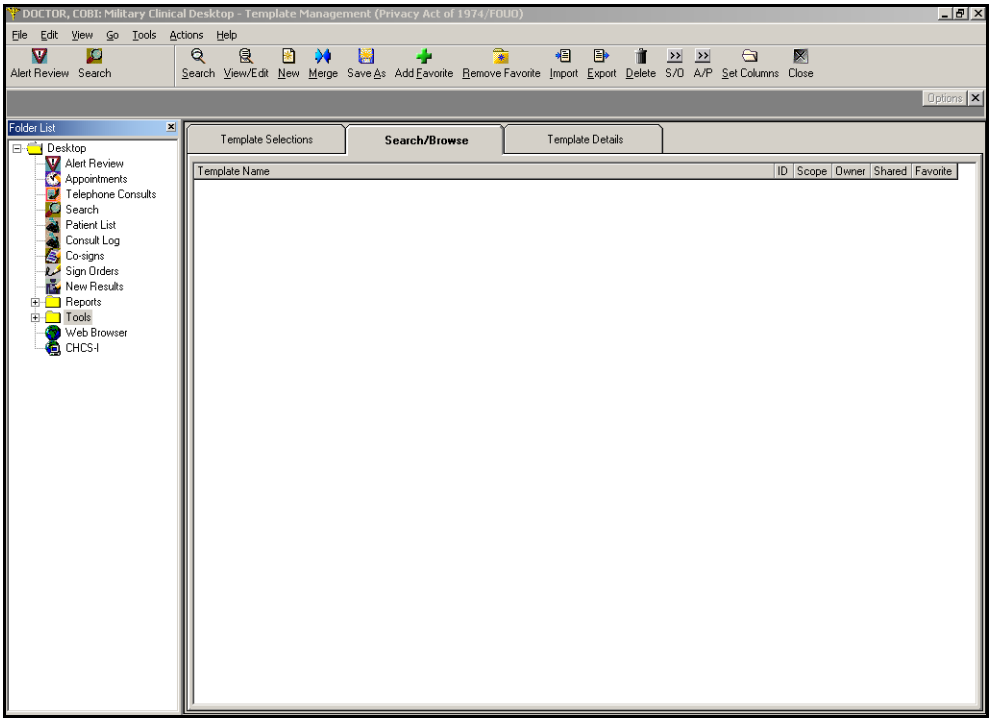


Figure 38-1: Military Clinical Desktop - Template Management Module

38.2 Action Bar Icons

	Search	Allows you to search for a template from the Template Selections or Search/Browse tabs.
	View/Edit	Allows you to view or edit a selected template.

	New	Transfers you to the Template Details tab to create a new template.
	Merge	Allows you to combine two or more templates to create a new template.
	Save As	Allows you to save an existing template as another template name.
	Add Favorite	Allows you to add the selected template to your Favorites List on the Template Selections tab.
	Remove Favorite	Allows you to remove the selected template from your Favorites List.
	Import	Allows you to import a template from an outside area.
	Export	Allows you to export a selected template from the Template Management module to an outside area.
	Delete	Allows you to delete a selected template.
	Set Columns	Saves the current column order as default.
	Cancel	Cancels any changes made to a template in the Template Details tab.
	Close	Closes the Template Management module.

38.3 Selecting an Encounter Template

An Encounter Template can be selected and loaded into an encounter. The Encounter template contains details of the encounter in terms of AutoCite items, diagnoses, procedures, S/O templates, orders, and patient instructions. The system provides suggested templates based on the reason for visit and the patient problems associated with the current, open encounter. Typically, the provider selects an encounter template from the Patient Encounter window before documenting the exam.

Tip:
*If the desired template is not listed in any of the folders a search can be conducted. In the top portion of the window type in the name of the template in the Name Search field. Click **Find Now** to view the results in the Name Search Results folder.*

To select an encounter template from the Patient Encounter window:

1. Click **Templates** on the Action bar. The Template Management window opens with the Template Selections tab defaulted (see Figure 38-2: Template Management Window—Template Selections Tab).

Note: The top portion of the window shows the criteria for the suggested templates. The Reason for Visit and Problems are included in the criteria by default. To

remove them, click the checkboxes. If changes are made to the criteria, the system displays an updated list.

The Template Selection tab auto-refreshes when a template is imported, displaying the imported plate in the template list.

The suggested templates are listed in the Autosearch Results folder. Templates denoted as favorites or in the clinic list are displayed in the applicable folder.

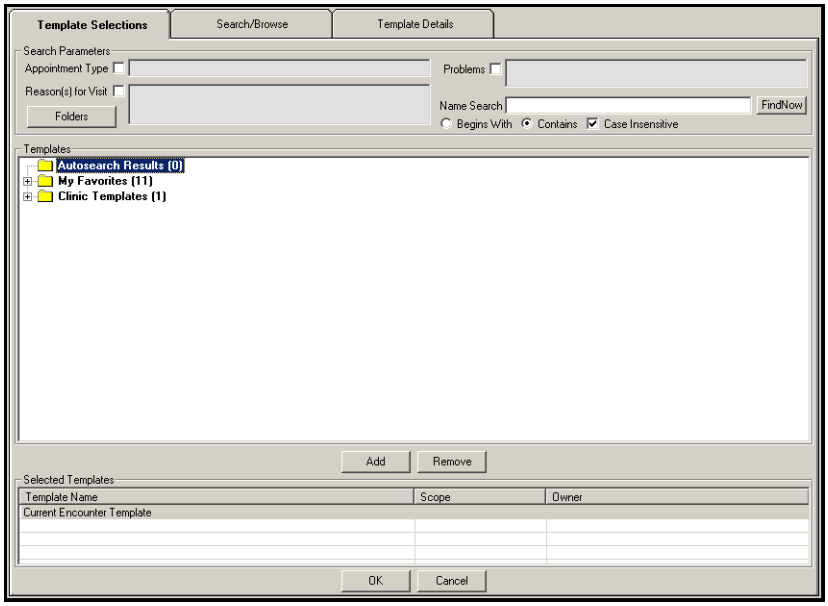


Figure 38-2: Template Management Window—Template Selections Tab

2. To add, edit or delete a folder select the **Folders** button. The Template Folder Management window will open.
   - In the Template Folder Management window, click **New**. The New Folder window will open
   - In the New Folder window, enter the name of the new folder and click **OK**. The new folder will be added to the Template Folder Management window.
   - To add a sub-folder, highlight the folder and click **New.** The New Folder window opens.
   - Enter the name of the sub-folder and click **OK.** The sub-folder is added in the Templates Folder Management Window.
   - Add additional sub-folders in the same manner. When finished, click **Close**. The new folders and sub-folders are added to the Template Selections tab of the Templates Management module.
3. Select the template to be used in the encounter from one of the folders or through a template search.

4. Click **Add** to move the template into the Selected Templates area. More than one template can be added to an encounter.
5. Click **OK** to load the template(s) into the encounter. The Patient Encounter module opens with the embedded template(s).

Note: The template details are displayed within the Patient Encounter (AutoCite), S/O (notes template) and A/P (diagnoses, procedures, orders, and patient instructions) modules.

38.4 Setting an Encounter Template as a Default

Any encounter template may be designated to load for every encounter. This eliminates the need to open the Template Management module to load a template. Typically, the most common diagnoses, procedures, and orders are included in this default encounter template. Once an encounter template is designated as the default template, it can be reset so that no encounter template is automatically loaded.

To set an Encounter Template as a default:

1. On the Search/Browse tab or the Template Selections tab, highlight the desired template in the Encounter Template list.
2. Right click on the highlighted template and select **Default Encounter Template** from the right-click pop-up menu.

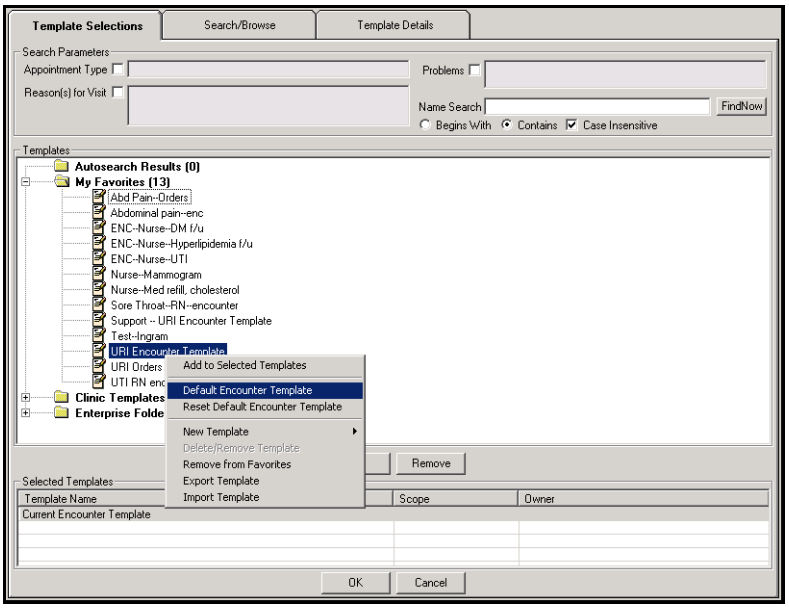


Figure 38-3: Setting the Default Encounter Template

3. The highlighted template is now followed with the indication of Default Encounter Template.

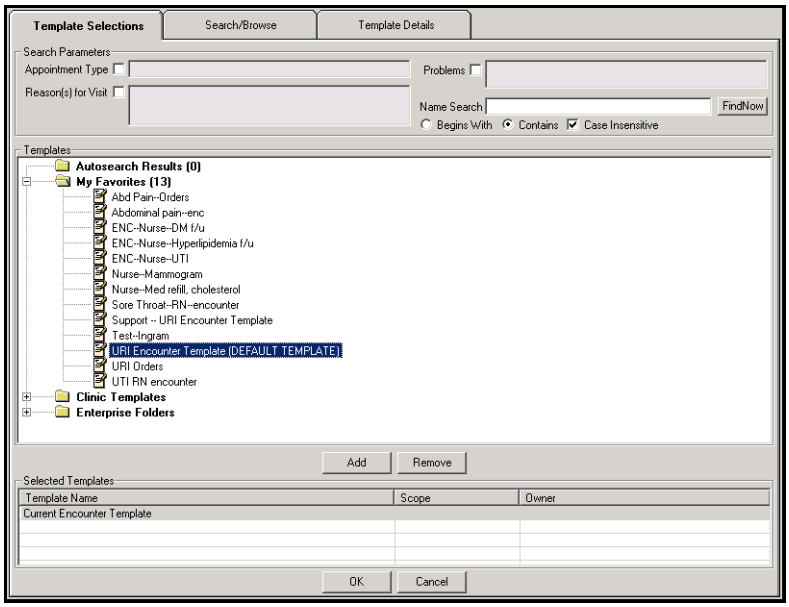


Figure 38-4: Default Encounter Template Set

To reset the default encounter template:

1. On the Search/Browse tab or the Template Selections tab, highlight the current default encounter template.
2. Right click on the highlighted template and select **Reset Default Encounter Template**.
3. The default template designation is removed from the template.

38.5 Creating a New Template

To create a new template, begin on the Template Selections or Search/Browse tabs.

1. Click **New** on the Action bar. The Template Details tab displays (see Figure 38-5: Template Management Window—Template Details Tab).

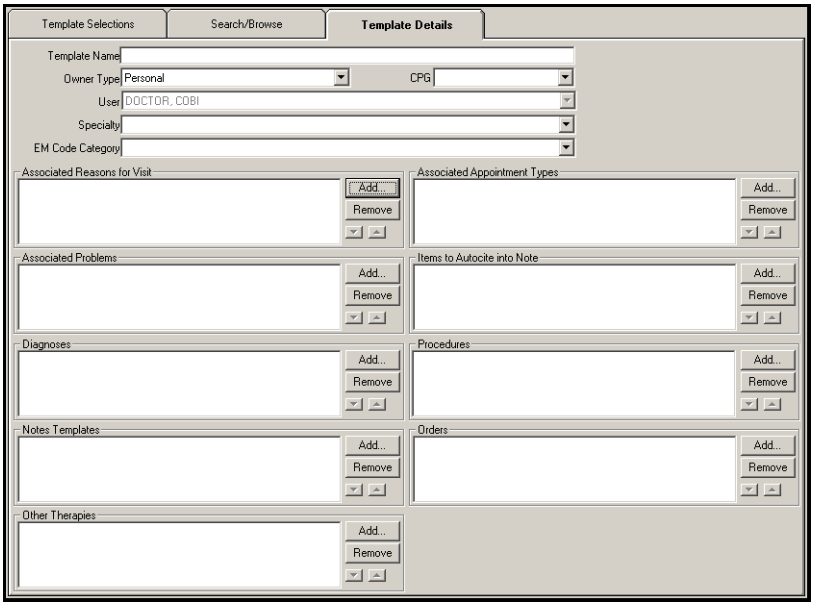


Figure 38-5: Template Management Window—Template Details Tab

2. Complete the following fields on the Template Details tab, if desired:
   - **Owner Type:** Select the desired owner type from the drop-down list. Options include Personal, Clinic, MTF, or Enterprise. The user's role determines whether the template can be saved as clinic, MTF, or enterprise.
   - **Specialty:** Select the specialty to which the template belongs from the drop-down list. This is a required field.
   - **E&M Code Category:** Select the desired codes for the template from the drop-down list.

Note: The template name is added upon saving and the User field is read-only. Templates can only be shared between providers in the same clinic.

3. Click **Add** to add details to the template in the following areas, where applicable:
   - **Associated Reasons for Visit:** In the Search Term field, enter the first few letters of the complaint and click **Search**. Select the complaint from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Associated Problems:** In the Search Term field, enter the first few letters of the problem and click **Search**. Select the problem from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
   - **Associated Appointment Types:** In the Search Term field, enter the first few letters of the appointment type and click **Search**. Select the appointment type from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

Tip:
The Associated Reasons for Visit, the Associated Problems, Associated Appointment Types and Items to Autocite into Note areas lend limited support in the creation and use of an encounter template.

- **Items to AutoCite into Note:** Select an AutoCite selection from the list and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Diagnoses:** In the Search Term field, enter the first few letters of the diagnosis and click **Search**. Select the diagnosis from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Notes Templates (S/O Templates):** Click **Search** to open the List Note Template Search window. Enter search criteria in the window and click **Search**. Select the note template and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Other Therapies:** In the Search Term field, enter the first few letters of the therapy and click **Search**. Select the therapy from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.
- **Procedures:** In the Search Term field, enter the first few letters of the procedure and click **Search**. Select the procedure from the search results and click **Add Items**. Click **Done** to return to the Template Details tab.

Note: Orders can only be added from the A/P module or when saving an encounter as a template. Once orders are added, they can be managed in the Template Details tab.

4. Click **Save As**. The Save Encounter Template window opens (see Figure 38-6: Save Encounter Template Window).

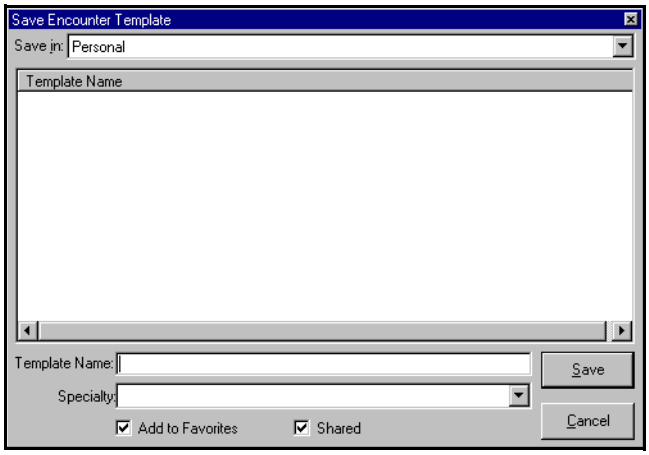


Figure 38-6: Save Encounter Template Window

5. Select a **template type** from the Save in drop-down list.
6. In the Template Name field, enter the template name.

7. Select a **Specialty** from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites List. Click **Shared** to allow other providers to use the template.

8. Click **Save**.

38.6 Searching for a Template

In order to do any work with a template, you must select a template with the Template Selections or Search/Browse tabs.

To search for a template:

1. Click **Search**. The Encounter Template Search window opens (see Figure 38-7: Encounter Template Search Window).

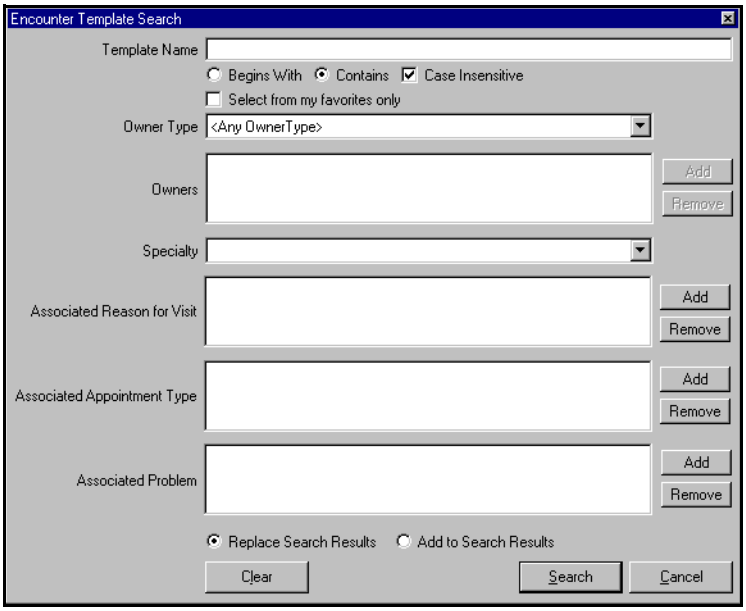


Figure 38-7: Encounter Template Search Window

2. Complete the following search criteria fields, as necessary:
   - **Template Name:** Enter the name or the first word of the template. Click the applicable radio button to denote if the template name begins with or contains entered text. The search is case insensitive by default. Deselect the checkbox to make the search case sensitive.
   - **Select from My Favorites Only:** Click the checkbox to search Favorite templates only.
   - **Owner Type:** Use the drop-down list to select the desired type. Options include:
     — Personal

— Clinic

— MTF

— Enterprise

- **Owners:** Click **Add** to open the Template Owner Lookup window and select another provider. This enables you to search another provider's templates.
- **Specialty:** Select the specialty to which the template belongs from the drop-down list.
- **Associated Reason for Visit:** Click **Add** to add a reason for visit by which to search.
- **Associated Appointment Type:** Click **Add** to add an appointment type by which to search.
- **Associated Problem:** Click **Add** to add problems by which to search.
- **Replace Search Results or Add to Search Results:** Click a radio button to either show results from the current search (Replace) or add the current results to the list of templates (Add).

3. Click **Search** to view the templates that match the criteria. The templates are displayed on the Search/Browse tab.

Note: Once a template has been found and selected, the following actions can be taken:

- View and edit the template
- Set a template as the default encounter template
- Merge templates (more than one template must be selected)
- Copy a template
- Remove or add to the Favorites List
- Export a template
- Delete a template
- Select an Encounter template

38.7 Editing a Template

To edit a template:

1. Search for the template you want to edit using the Template Selections or Search/Browse tab.
2. Select the desired template.
3. Click **View/Edit** on the Action bar. The Template Details tab displays (see Figure 38-8: Template Management Window—Template Details Tab).

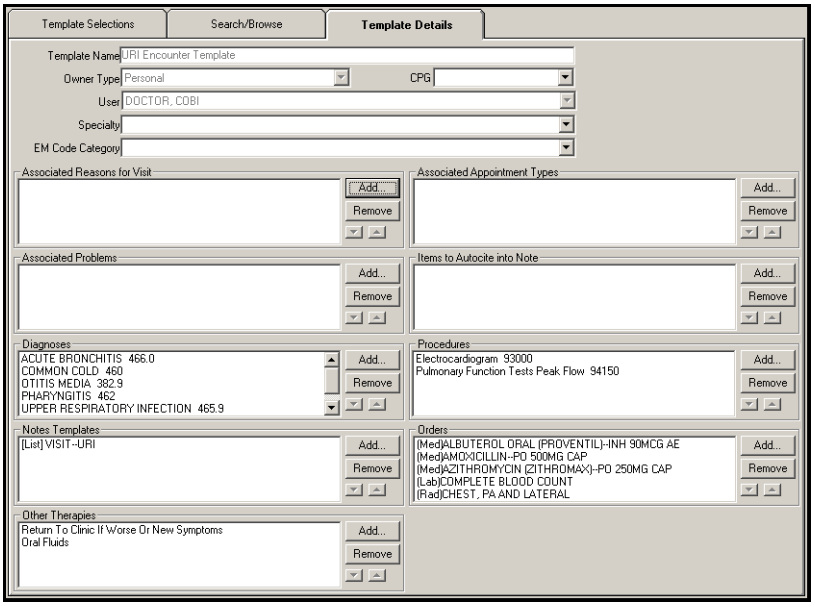


Figure 38-8: Template Management Window—Template Details Tab

4. Add or remove information in the following fields, as necessary:
   - Associated Reasons for Visit
   - Associated Problems
   - Diagnoses
   - Notes Templates
   - Other Therapies
   - Associated Appointment Types
   - Items to AutoCite into Note
   - Procedures
5. Click **Save** on the Action bar.

Tip:
*Click **Save As** to save the template under a new name.*

38.8 Merging Templates

Templates can be combined to create a completely new template.

To merge templates:

1. Search for the templates you want to merge. The templates appear in the Search/Browse tab.
2. Select the templates by pressing the **Ctrl** key on your keyboard and clicking on each template you want to merge.
3. Click **Merge** on the Actions menu.The Template Details tab displays the details from the selected templates.
4. Edit the template if necessary.

5. Click **Save As** on the Action bar. The Save Encounter Template window opens (see Figure 38-9: Save Encounter Template Window).

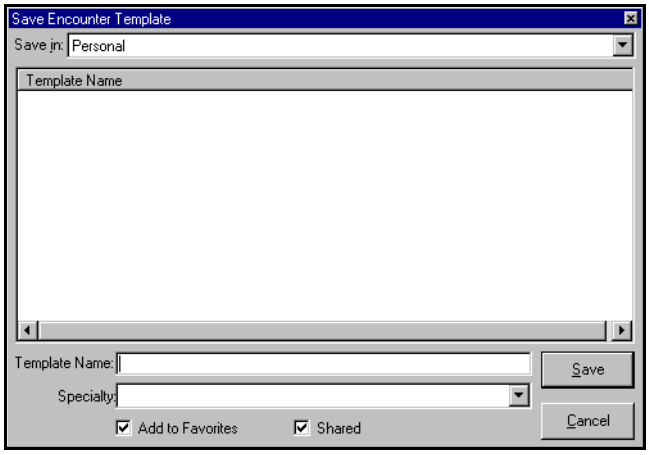


Figure 38-9: Save Encounter Template Window

6. Select a **template type** from the Save in drop-down list.
7. In the Template Name field, enter the template name.
8. Select a **Specialty** from the drop-down list.
9. Click the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
10. Click **Save** to save the template.

38.9 Copying a Template

A current template can be copied, edited, and renamed to create a new template.

To copy a template:

1. Search for the template you want to copy.
2. Select the template in the Search/Browse tab.
3. Perform a right mouse click and point to **New Template** and then click **Copy from Selection**. The Template Details tab displays with the selected template details.
4. Edit the template if necessary.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
6. Select a **template type** from the Save in drop-down list.
7. In the Template Name field, enter the template name.
8. Select a **Specialty** from the drop-down list.
9. Click the checkbox to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
10. Click **Save** to save the template.

Tip:
The title of the template changes to Copy of …(selected template).

38.10 Removing/Adding to Favorites

Templates can be added to the Favorites List to be seen as suggested templates for every encounter. A template search can also be conducted with only the Favorites List. Templates can be added to or removed from the Favorites List from either the Template Selections or Search/Browse tab.

To add a template to the Favorites List:

1. Search for the template you want to add.
2. Select the template in the Search/Browse tab.
3. Click **Add Favorite** on the Action bar. The Favorite column on the Search/Browse tab changes from No to Yes and the template is added to My Favorites folder on the Template Selections tab.

To remove a template from the Favorite List:

1. Search for the template you want to remove.
2. Select the template in the Search/Browse tab.
3. Click **Remove Favorite** on the Action menu.
4. At the confirmation prompt, click **Yes**.

38.11 Importing/Exporting a Template

A template can be imported from or exported to an electronic storage device for use at another location. All of the details of the template are included when it is imported or exported. Since the template contains all details, the order sets included are specific to the originating clinic. If the template is imported/exported to another clinic, the receiving locations for the orders are updated upon import. You can import/export a template from the Template Selections or Search/Browse tab.

To import a template:

1. Click **Import** on the Action bar. The Import Encounter Template window opens (see Figure 38-10: Import Encounter Template Window).

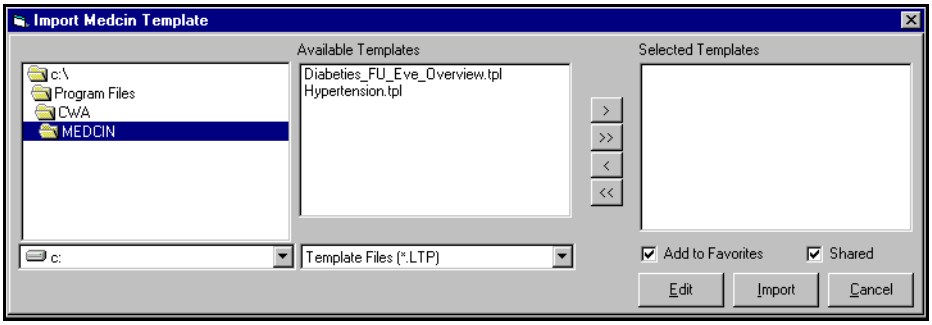


Figure 38-10: Import Encounter Template Window

2. Select a template from the Available Templates list.

Note: If the template is not in the defaulted folder, browse to the folder where the templates are located.

3. Click the arrow buttons to move the selections to the Selected Templates list.
4. Do one of the following:
   - If you want to edit the selected template before you save it:
     a. Click **Edit**. The Template Details tab displays with the details of the imported template.
     b. Add or remove information in the following fields:
        - Associated Reasons for Visit
        - Associated Problems
        - Diagnoses
        - Notes Templates
        - Other Therapies
        - Associated Appointment Types
        - Items to AutoCite into Note
        - Procedures
   - If you want to import the template as is, click **Import**. The Template Details tab displays with the details for the imported template.
5. Click **Save As** on the Action bar. The Save Encounter Template window opens.
6. Select a **template type** from the Save in drop-down list.
7. In the Template Name field, enter the template name.
8. Select a **Specialty** from the drop-down list.

Note: Click **Add to Favorites** if you want the template to be added to the Favorites list to be shared with other Clinical Team members.

9. Click **Save**.

To export a template:

1. Search for the template you want to export.
2. Select the template from the Search/Browse tab.
3. Click **Export**. The Export Encounter Template window opens (see Figure 38-11: Export Encounter Template Window).

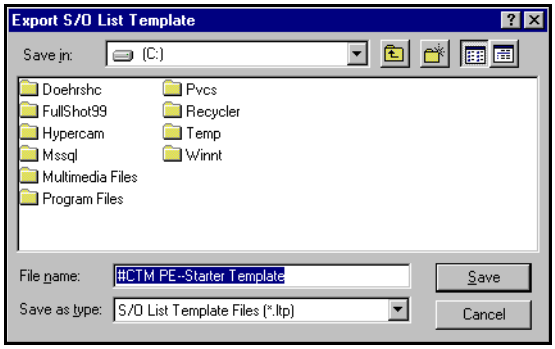


Figure 38-11: Export Encounter Template Window

4. Browse to the folder location where you want to export the template.
5. Click **Save**.

38.12 Deleting a Template

A template can be deleted from the Search/Browse tab.

To delete a template:

1. Search for the template you want to delete.
2. Select the template from the Search/Browse tab.
3. Click **Delete** on the Action menu.
4. At the delete confirmation prompt, click **Yes**.

38.13 Saving an Encounter as a Template

After an encounter has been documented, the structure can be saved as an encounter template. No patient-specific information is saved. This action can be performed from the Patient Encounter and Previous Encounter modules.

To save an encounter as a template:

1. Document the encounter. Prior to signing, return to the Patient Encounter screen.

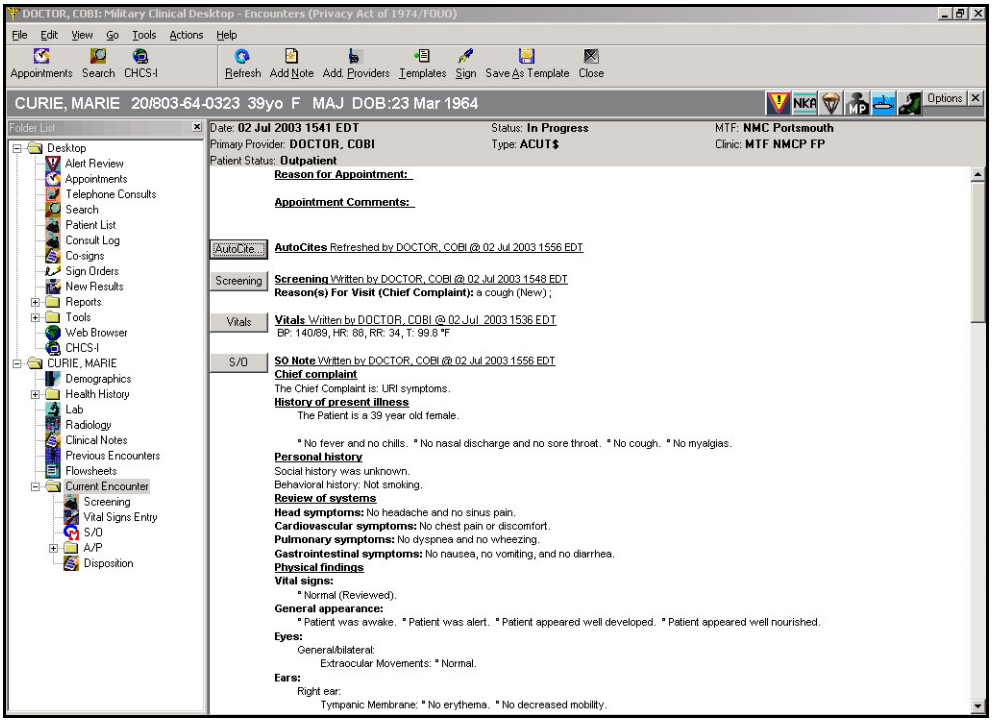


Figure 38-12: Encounter Summary

2. On the Actions bar, click **Save As Template**. The Template Details tab on the Template Management module opens (see Figure 38-13: Template Management Window—Template Details Tab).

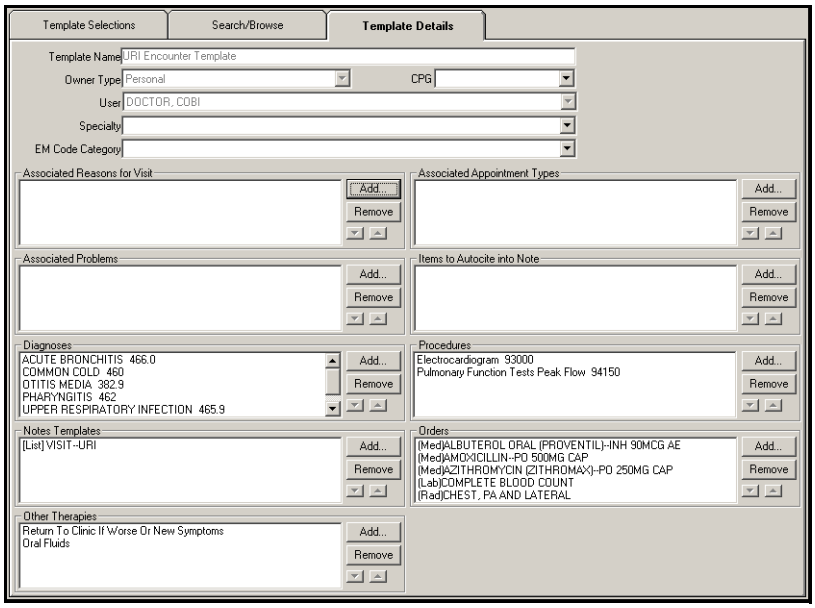


Figure 38-13: Template Management Window—Template Details Tab

3. Select an **owner type** from the drop-down list, if necessary.
4. Select a **specialty** from the drop-down list, if necessary.

5. Select an **E&M code category** from the drop-down list, if necessary.
6. Add or remove information from the following areas:
   - Associated Reasons for Visit
   - Associated Problems
   - Diagnoses
   - Notes Templates
   - Other Therapies
   - Associated Appointment Types
   - Items to AutoCite into Note
   - Procedures
7. Click **Save As** on the Action bar. The Save Encounter Template window opens (see Figure 38-14: Save Encounter Template Window).

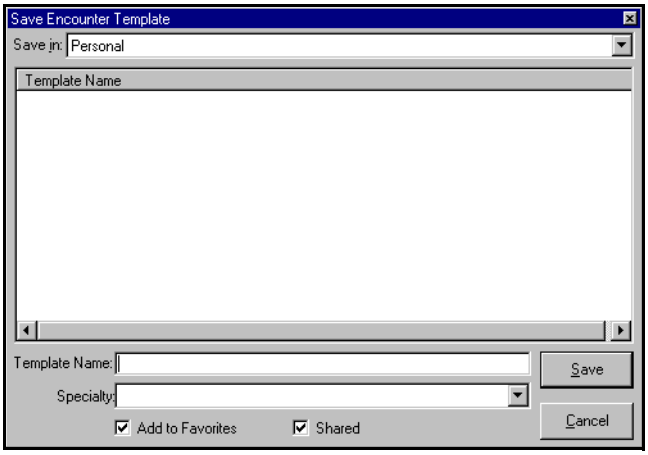


Figure 38-14: Save Encounter Template Window

8. Select the **template type** from the Save-in drop-down list.
9. In the Template Name field, enter the template name.
10. Select the **specialty** from the drop-down list.
11. Click the checkboxes to denote whether the template should be added to the Favorites List or shared with other Clinical Team members.
12. Click **Save**.

39.0 VITAL SIGNS

39.1 Overview of Vital Signs

The Vital Signs module allows past vitals to be displayed and graphed, and provides the opportunity for new vitals to be entered. When you enter the Vital Signs module, two tabs are presented: Review and Entry (see Figure 39-1: Military Clinical Desktop - Vital Signs Module—Entry Tab).

The Vital Signs icon is located in two different places on the Folder List, under Health History and under Current Encounter. If the Vital Signs module is accessed under Health History, only past vitals can be reviewed. If accessed through the current encounter, vital signs can be reviewed and entered.

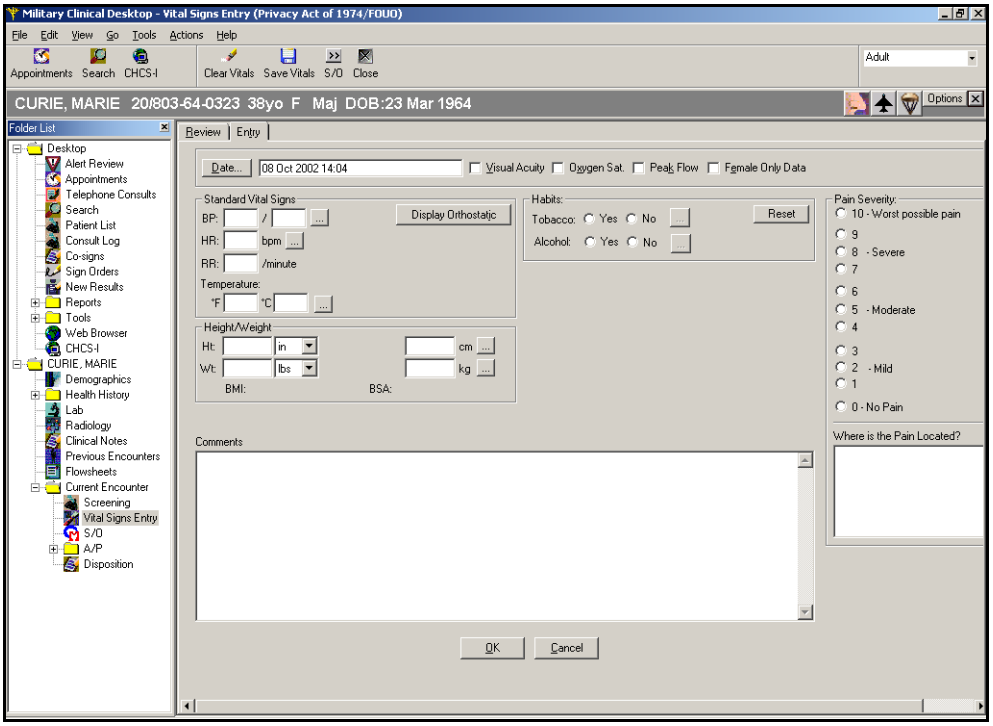


Figure 39-1: Military Clinical Desktop - Vital Signs Module—Entry Tab

39.2 Action Bar Icons (Vital Signs Review)

	Graph Vitals	Allows you to graph a set of vitals. More than one set must be selected to graph vital signs.
	Temp	Allows you to toggle the temperature values between °C and °F.

	Close	Closes the Vitals module.

39.3 Action Bar Icons (Current Encounter)

	Edit Vitals	Opens the Entry tab, where you can edit the vital signs from the current, unsigned encounter.
	Delete Vitals	Deletes vital signs from the current, unsigned encounter.
	Graph Vitals	Allows you to graph a set of vitals.
	Clear Vitals	Allows you to clear vital signs displayed in the Entry tab.
	Save Vitals	Saves vital signs entered in the Entry tab.
	Temp	Allows you to toggle the temperature values between °C and °F.
	S/O	Navigates directly to the S/O module.
	Close	Closes the Vitals module.

39.4 Setting the Properties of the Vital Signs Module

When accessing the Vital Signs module from the Health History folder in the Folder List, you can customize the default settings for both the Entry and Review tabs.

To set the properties of the Vital Signs module:

1. On the Vital Signs window, click **Options** in the top right corner. The Properties window opens (see Figure 39-2: Vital Signs—Properties Window).

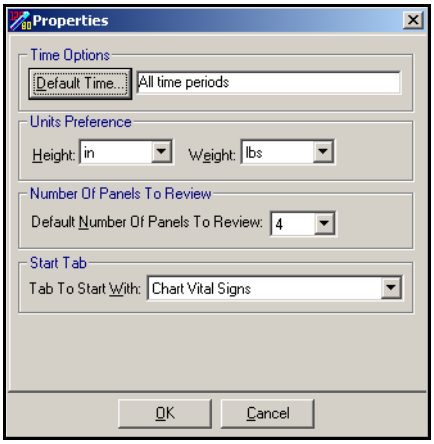


Figure 39-2: Vital Signs—Properties Window

2. Set the following preferences:
   - **Default Time:** Click **Default Time** to view the Time Search window. Select the desired option for the date range of the records to be viewed on the Review Tab.
   - **Temperature, Height, and Weight:** Using the drop-down lists, select the Temperature, Height, and Weight units displayed on the Entry tab.
   - **Default Number of Panels to Review:** Use the drop-down list to select the desired number of panels to be reviewed on the Review tab.
   - **Tab to Start With:** Use the drop-down list to select the tab (Review or Entry) that appears when you open the Vital Signs module.
3. Click **OK** to save the selected settings as the default settings.

39.5 Entering New Vital Signs

The Entry tab allows vital signs to be entered under three different categories:

- Adult
- Obstetric
- Pediatric

The default view is Adult, which displays Standard Vital Signs, Height/Weight, and Tobacco Use. Selecting either **Obstetric** or **Pediatric** brings up additional panels specific to their respective category. Vital signs must be entered in the Current Encounter Vital Signs window in an open encounter.

Tip:
*You can also access the Vitals window by opening the Current Encounter folder and clicking **Vital Signs** on the Folder list.*

To enter new vital signs:

1. Open a patient encounter.
2. On the Patient Encounters window, click **Vitals**. The Vitals window opens and the Review tab is displayed by default.
3. Select the Entry tab (see Figure 39-3: Vitals Signs Module - Entry Tab).

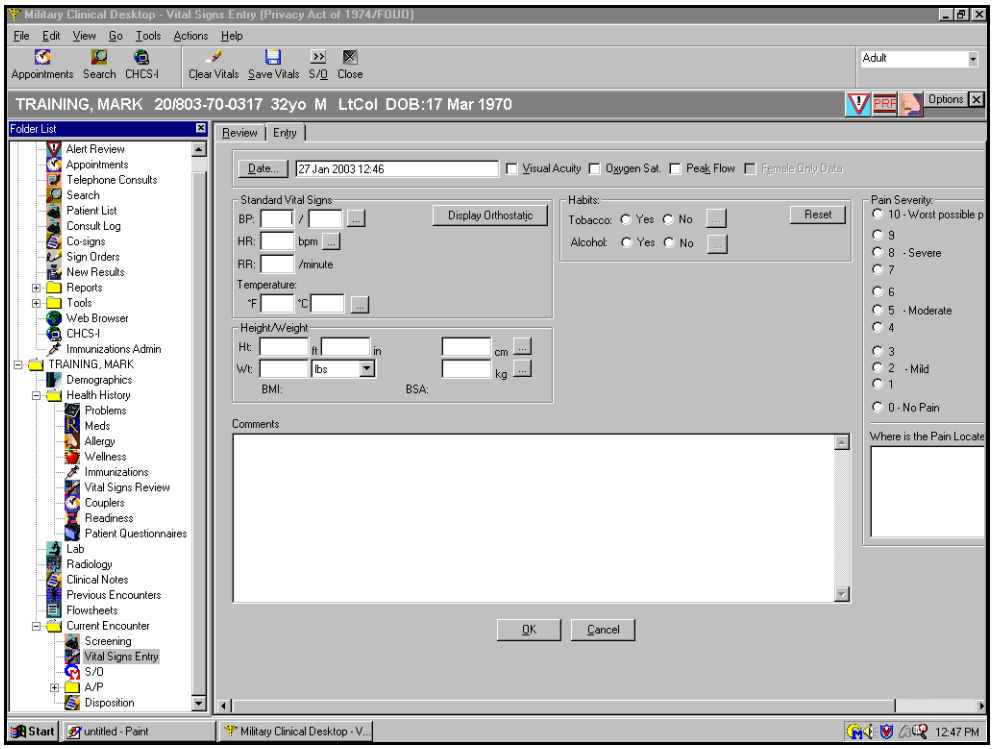


Figure 39-3: Vitals Signs Module - Entry Tab

4. Select the category for which you are entering vitals from the drop-down list to the right, on the Action bar.

Note: The default is Adult. The Obstetric option includes the adult panels plus the Urine Dip Stick panel. The Pediatric option includes the adult panels plus the Head Circumference panel.

---

5. Click the checkbox for any of the following to display additional vital sign input fields, if necessary (see Figure 39-4: Vitals Window—Entry Tab).
   - Visual Acuity
   - Oxygen Saturation
   - Peak Flow
   - Female Only Data

Note: Female Only Data is automatically selected if the patient is female and 12 years or older.

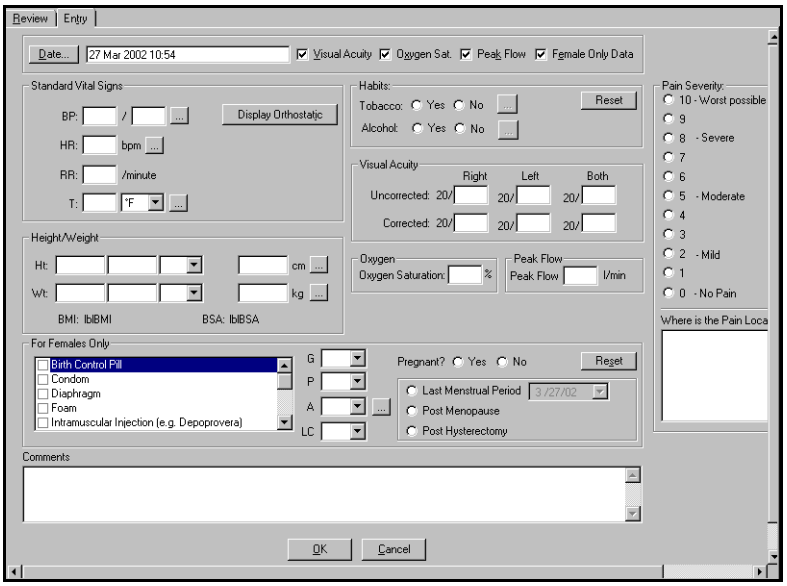


Figure 39-4: Vitals Window—Entry Tab

6. Enter the correct data in the following fields and tab to the next field.

   - **Standard Vital Signs:** Enter blood pressure, heart rate, respiratory rate (how many breaths the person takes in a minute), and temperature (in Celsius or Fahrenheit). The Blood Pressure, Heart Rate, and Temperature fields allow you to add modifiers. Click **Display Orthostatic** if you want to enter orthostatic vital signs for the patient.
   - **Habits:** Click the radio button to denote the usage of tobacco and/or alcohol. Click the **Ellipsis** button to document the frequency/duration.
   - **Height/Weight:** Enter patient height information in inches, feet, or centimeters and weight in pounds, ounces, grams, or kilograms. The height and weight can be entered using decimals (e.g., 75.6) or fractions (e.g., 175 ½). You can add modifiers to both the height and weight categories. The system automatically calculates the Body Max Index (BMI) and the Body Surface Area (BSA).
   - **Comments:** Enter any comments.

Note: If the data is abnormal, a Vital Sign Range Warning appears. Click **Yes** to continue with the entered data. Click **No** to go back and re-enter the data.

Click the **Ellipsis** button to add modifier information to the associated vital sign.

---

7. Click **Save Vitals** on the Action bar.

39.6 Editing Vital Signs

You can only edit vital signs for the current encounter.

To edit vital signs:

1. On the Review tab, select the vital signs you want to edit.
2. Click **Edit Vitals** on the Action bar. The Entry tab automatically opens.

Note: The Edit Vitals option is not available if you access the Vital Signs module from the Health History folder on Folder List.

3. Enter any additional comments or add any values in the following areas:
   - Standard Vital Signs
   - Habits
   - Height/Weight
   - Comments
   - Visual Acuity
   - Oxygen Saturation
   - Peak Flow
   - Female Only Data
   - Pain Scale
4. Click **OK** to save the information. The edits are documented in the Change History portion of the Encounter Document.

39.7 Deleting Vital Signs

You can only delete vital signs for the current encounter.

To delete vital signs:

1. On the Review tab, select the vital signs you want to delete (see Figure 39-5: Vital Signs Window—Review Tab).

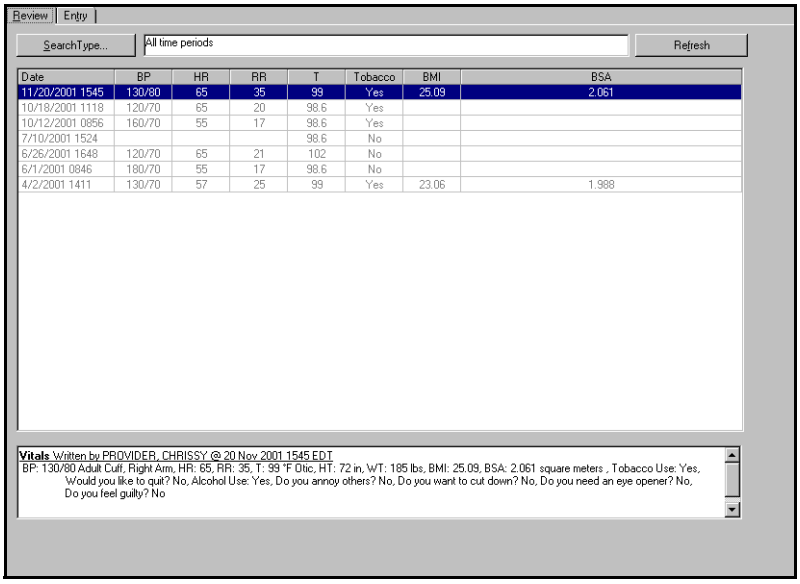


Figure 39-5: Vital Signs Window—Review Tab

2. Click **Delete Vitals** on the Action bar. A confirmation message appears.
3. Click **Yes**. The deletion is documented in the Change History portion of the encounter document.

Tip:
The Delete Vitals option is not available if you access the Vitals module from the Health History folder on the Folder List.

39.8 Graphing Vital Signs

You can only graph vital signs for a current encounter.

To graph vital signs:

1. On the Review tab, select the set of vitals you want to graph.
2. Click **Graph Vitals** on the Action bar. The Graph Vitals window opens (see Figure 39-6: Graph Vitals Window).

Tip:
More than one set of vital signs must be selected to generate the graph.

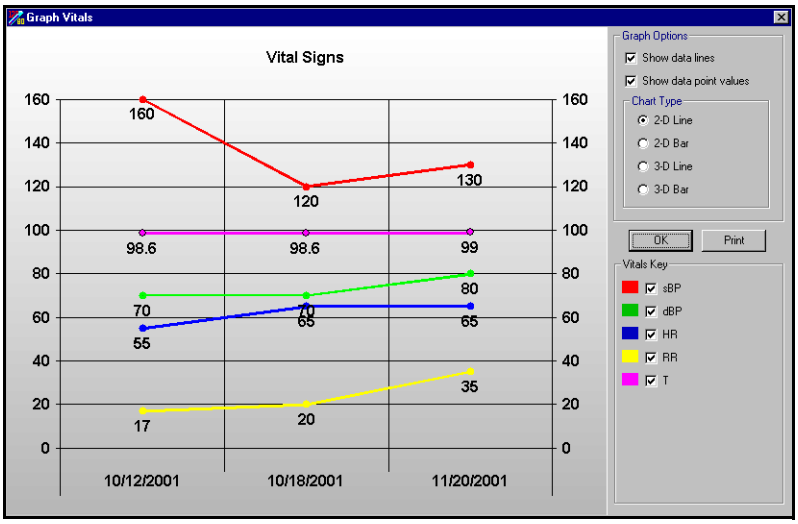


Figure 39-6: Graph Vitals Window

3. Click the checkbox(es) to change the graph options, if necessary. The default displays both data lines and data point values.
4. Click the radio buttons to change the chart type, if necessary. The default displays the chart in a 2-D line.
5. Click **Print** to print the current graph.
6. Click **OK** to close the Graph Vitals window and return to the Vital Signs window.

39.9 Reviewing Vital Signs

To review past vital signs:

1. On the Review tab, view past vital sign information.
2. Do one of the following:
   - If you want to customize the number of vital sign entries listed in the tab:
     a. Click **Search Type**. The Time Search window opens (see Figure 39-7: Time Search Window).

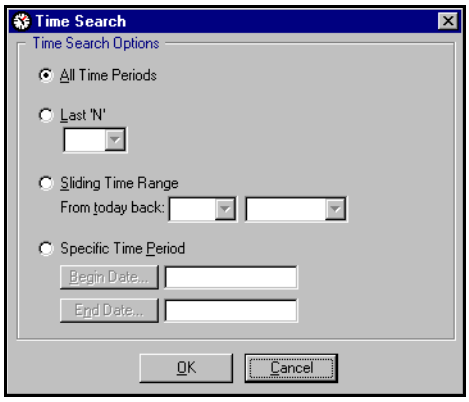


Figure 39-7: Time Search Window

b. Select the desired time option.

c. Click **OK**. The entries meeting the search criteria appear in the tab.

- If you want to view details on a specific set of vital signs:

  a. Select the set of vital signs for which you want to view detailed information.

  b. The details populate the text field in the bottom of the tab.

- If you want to change the unit of temperature values for a set of vitals:

  a. Select the set of vital signs.

  b. Click the **Temp** toggle button on the Action bar.

39.10 Vital Sign Ranges

The following are valid ranges for entering vital sign information in CHCS II.

Vital Signs	CHCS II Range
Blood Pressure:	
Systolic	80–200 mm Hg
Diastolic	Must be less than systolic and 40–120 mm Hg
Heart Rate	40–150 Beats per minute
Respiratory Rate	5–40 breaths per minute
Temperature	95–105° F
Height	12–84 inches
Weight	1–350 pounds
Visual Acuity	10–999
Oxygen Saturation	70–100 percent

Peak Flow	40–650 liters per min
Head Circumference (Pediatric)	10–22 inches
Pain Sensitivity	Adult: 0–10 (with 1 being pain free and 10 being the worst possible pain) Child: 0–5 (with 0 being no hurt and 5 be hurt worst)

40.0 WEB BROWSER

40.1 Overview of Web Browser

CHCS II is installed with the Internet Explorer Web Browser (see Figure 40-1: Military Clinical Desktop - Web Browser). This functionality enables you to access the Internet for the purpose of researching information from a variety of favorite medical sites without exiting CHCS II. Because the Web Browser is contained within CHCS II, the application does not time out while searching the Internet.

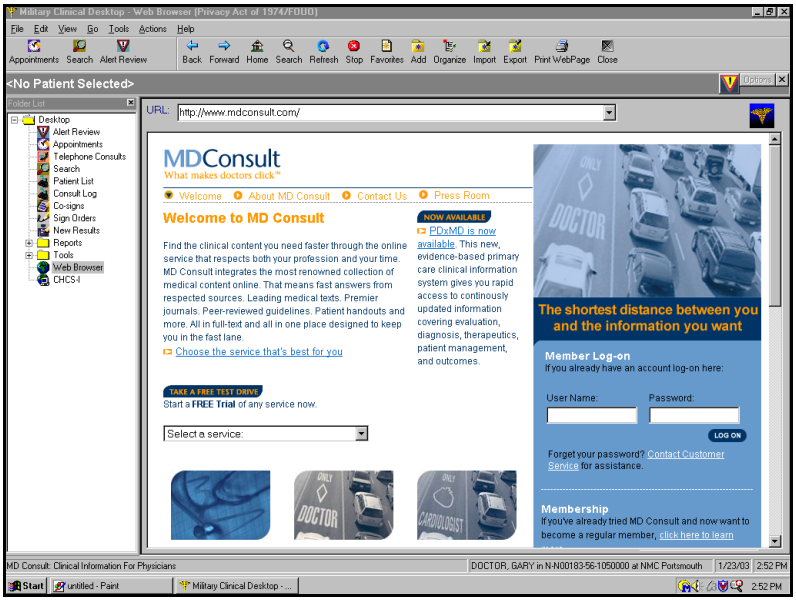


Figure 40-1: Military Clinical Desktop - Web Browser

40.2 Action Bar Icons

	Back	Connects to the Uniform Resource Locator (URL) accessed prior to the current address.
	Forward	Connects to the URL accessed prior to clicking Back.
	Refresh	Updates the window with the latest URL information.
	Home	Connects to the URL that is listed as the default site.
	Favorites	Connects to a favorite website.

	Search	Connects to a site that enables Internet search capabilities.
	Stop	Stops the download of the requested URL.
	Add	Adds the URL currently connected to the Favorites List.
	Organize	Allows you to edit and organize your favorites list.
	Import	Allows you to import a favorites list.
	Export	Allows you to export your favorites list.
	Print Web Page	Allows you to print the current web page.
	Close	Closes the Web Browser window.

40.3 Changing the Internet Home Page

Once the Web Browser has been accessed, the internet home page is displayed in the main window. The internet home page can be changed according to individual preference.

To change the home internet site:

1. On the Windows Task bar, click **Start**.
2. Point to Settings and click **Control Panel**. The Control Panel opens (see Figure 40-2: Control Panel).

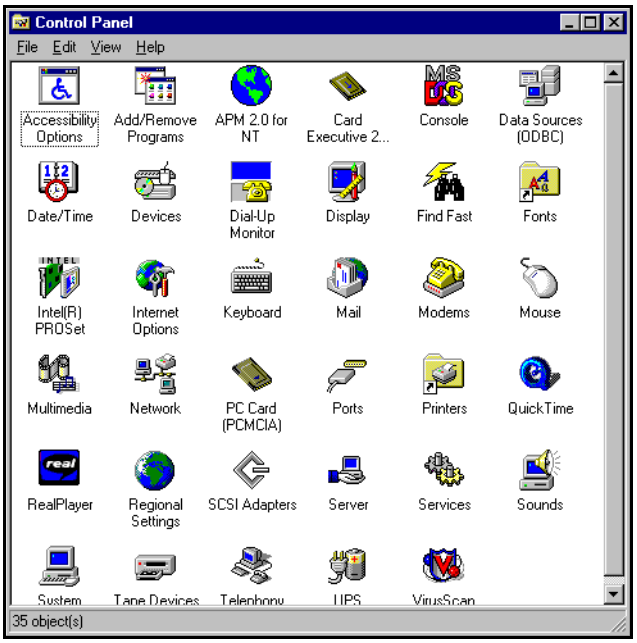


Figure 40-2: Control Panel

3. Double-click **Internet Options**. The Internet Properties window opens with the General tab defaulted (see Figure 40-3: Internet Properties Window).

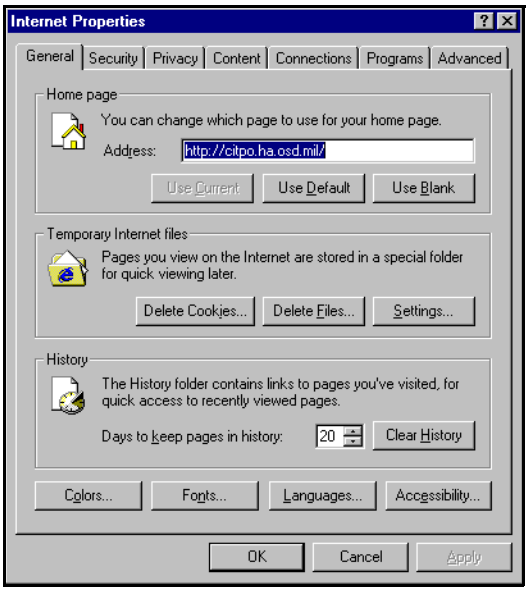


Figure 40-3: Internet Properties Window

4. In the Home Page area Address field, enter the desired URL.
5. Click **OK**. This is the webpage that displays when you access the Web Browser.

40.4 Accessing the Favorites List

The Favorites list is a shortcut to Internet sites that are frequently accessed.

To access the favorites list:

1. Click **Favorites** on the Action bar.
2. Select the desired URL. The site displays in the window.

40.5 Adding to the Favorites List

To add to the favorites list:

1. Click **Add Favorite**. The Add Favorites window opens (see Figure 40-4: Add Favorite Window).

Figure 40-4: Add Favorite Window

2. Enter the desired URL address.

Note: A default address displays in the field. You can use that address or type a new address in the field. It does not have to be the exact address for the web site, but something that reminds you of the site.

---

3. Click **OK**.

41.0 WELLNESS

41.1 Overview of Wellness

The Wellness module generates preventive health reminders for a patient (see Figure 41-1: Military Clinical Desktop - Wellness Module). These reminders are tied to the United States Preventive Services Task Force guidelines for the general population. Additionally, text-based reminders can be created to notify a provider of special information on a particular patient. Active wellness reminders are placed on the Patient's Problem List window in the Health Maintenance section. Reminders tied to a measurable clinic event, such as a lab test, are automatically addressed as the event is completed. Service that is performed at an outside facility can be manually addressed.

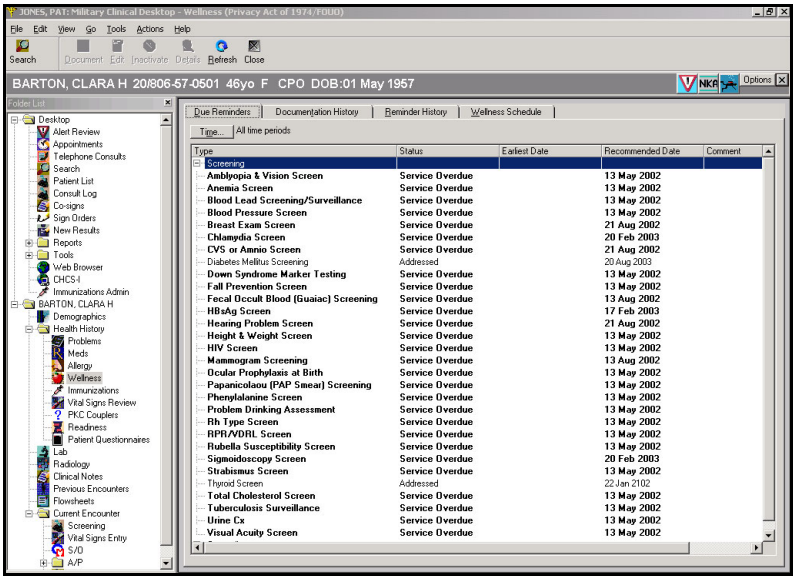


Figure 41-1: Military Clinical Desktop - Wellness Module

41.2 Setting the Filter for the Wellness Module

To open the Properties window in which display information can be customized, click **Options** on the Wellness window or **Filter** on the Documentation History tab (see Figure 41-2: Wellness Properties Window—Filter Tab).

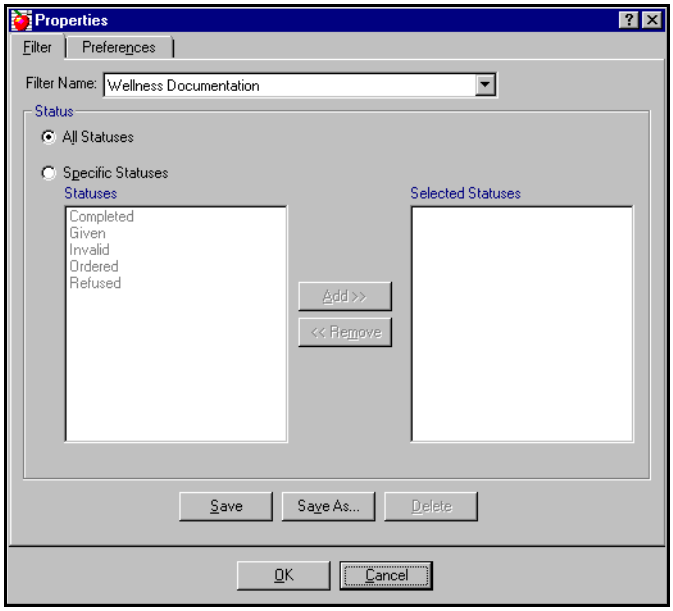


Figure 41-2: Wellness Properties Window—Filter Tab

The Filter tab provides the ability to select a previously saved filter from the drop-down list, or to create a new filter.

To set the filter for the Wellness module:

1. On the Filter tab, select a Filter Name from the drop-down list.
2. Do one of the following:
   - If you want all of the listed statuses to display, select **All Statuses**.
   - If you want to display specific statuses:
     — Select **Specific Statuses**.
     — Select a status from the list.
     — Click **Add** to move the status to the Selected Statuses column.
3. Do one of the following:
   - If this is a new filter selection:
     — Click **Save As**.
     — Enter a new name for the filter.
     — Click **Save**.
   - If this is a change to a pre-existing filter, click **Save**.

41.3 Setting Preferences for the Wellness Module

The Preferences tab allows the time period selection to be used when displaying documented wellness items on the Documentation History tab (see Figure 41-3: Wellness

Properties Window—Preferences Tab). Once a time period is selected, it becomes the default setting.

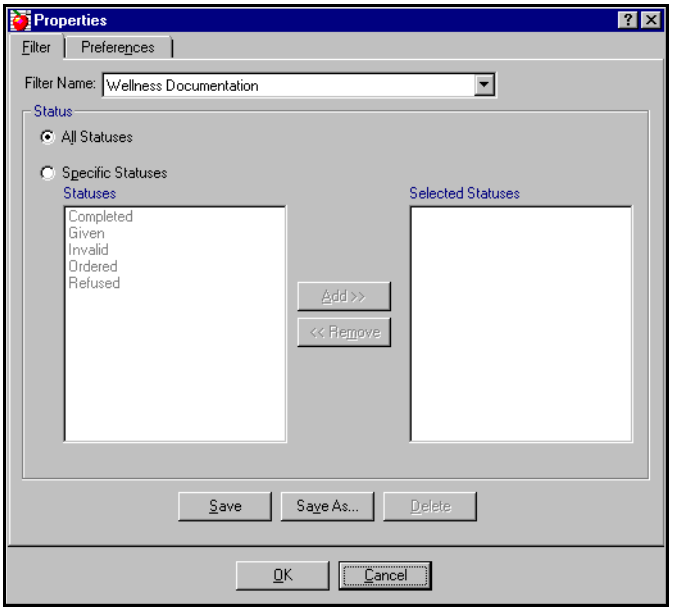


Figure 41-3: Wellness Properties Window—Preferences Tab

To set preferences for the Wellness module:

1. On the Properties window, select the **Preferences** tab.
2. In the Reminder Time Option, click **Default Time** to select a time option for reminders (see Figure 41-4: Time Search Window).

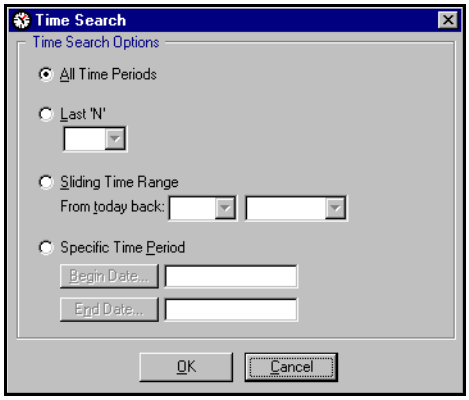


Figure 41-4: Time Search Window

3. In the Time Search window, select time search options for reminders.
4. Click **OK**.
5. In the Documentation Time Option, click **Default Time** to select a time option for documentation.
6. In the Time Search window, select time search options for documentation.

7. Click **OK**.
8. Click **OK** to set the time criteria. The data on the Documentation History window is refreshed according to the search criteria.

41.4 Due Reminders Tab

The Due Reminders tab allows you to display active reminders and documentation history (for documented reminders, either manually or automatically) for the current patient (see Figure 41-5: Wellness Window—Due Reminders Tab). The Due Reminders tab indicates services due in the future or due as of the current date. The tab allows you to alter the schedule of a reminder, as well as display reminders for either all patients or only the currently selected patient. The system displays the Due Reminders list grouped by wellness reminder type and then alphabetically.

Due Reminders are listed with the type of procedure, the status, the earliest date the procedure should be implemented and any comments.

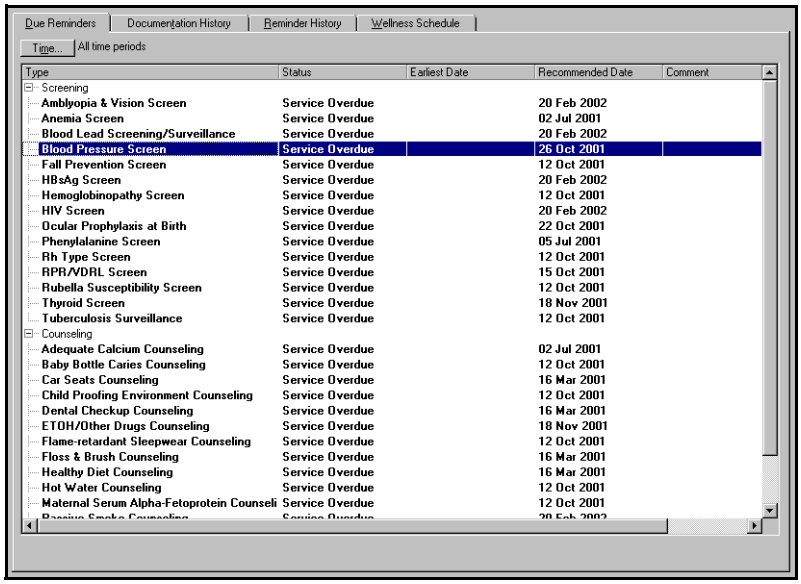


Figure 41-5: Wellness Window—Due Reminders Tab

41.4.1 Action Bar Icons in the Due Reminders Tab

	Document	Allows a due reminder to be documented. Documented due reminders display in the Documentation History tab.
	Edit	Allows a due reminder to be edited.
	Inactivate	Inactivates a selected reminder.
	Details	Displays the details of a selected reminder.

	Refresh	Refreshes data in the Due Reminders tab.
	Close	Closes the Wellness module.

41.4.2 Documenting a Due Reminder in the Due Reminders Tab

To document a due reminder in the Due Reminders tab:

1. Click **Document** on the Action bar. The Document window opens (see Figure 41-6: Due Reminder Window).

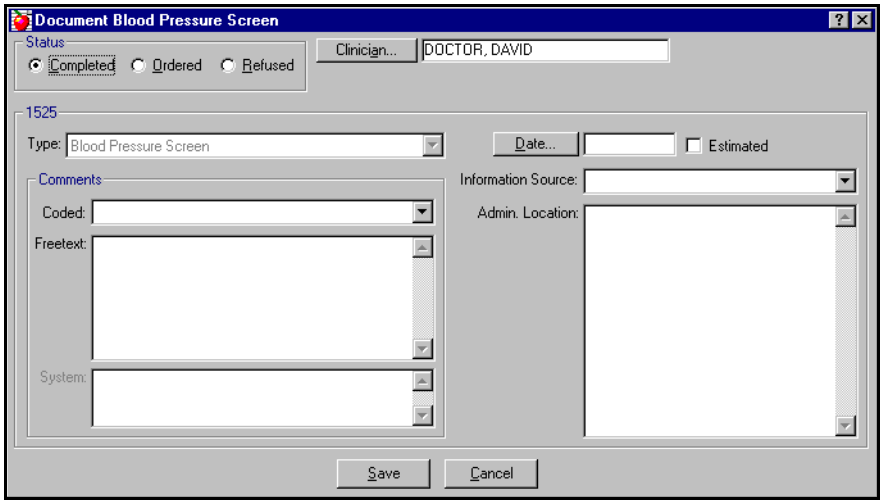


Figure 41-6: Due Reminder Window

2. Complete the following fields to document the reminder:
   - **Status:** Refers to the status of the reminder:
     - — **Completed:** The action has been taken.
     - — **Ordered:** The action has been ordered.
     - — **Refused:** The action has been refused by the patient.
   - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in. Click **Clinician** to search for a different clinician.
   - **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
   - **Coded:** Select a more detailed status of service from the drop-down list. For example, Preventive Service Completed Report Reviewed.
   - **Free-text:** Enter any additional comments in the field.
   - **Date:** Select the date the action occurred.
   - **Information Source:** Select the relationship to the patient reporting the action from the drop-down list.

- **Admin. Location:** Enter the location where the action occurred.

3. Click **Save**.

41.4.3 Editing a Due Reminder in the Due Reminders Tab

To edit a due reminder in the Due Reminders tab:

1. Select an item from the list on the Due Reminders tab.
2. Click **Edit** on the Action bar. The Edit window opens (see Figure 41-7: Edit Due Reminders Window). Coded and free-text Comments are the only two fields that can be changed.

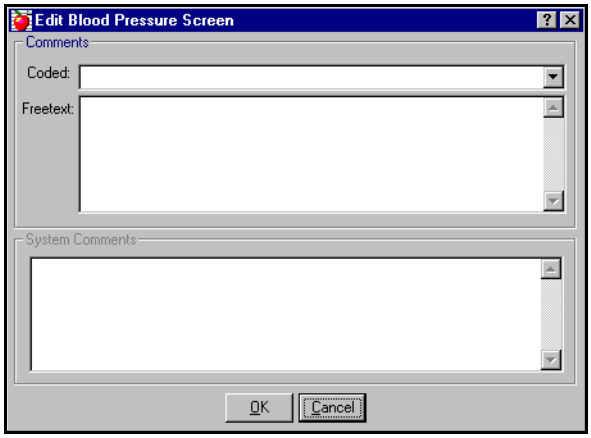


Figure 41-7: Edit Due Reminders Window

3. Select a code from the drop-down list.
4. Enter any free-text to further explain the code or in place of the code.
5. Click **OK**.

41.4.4 Inactivating a Due Reminder in the Due Reminders Tab

Inactivating a reminder prevents it from being generated.

To inactivate a reminder in the Due Reminders tab:

1. Select a reminder from the Due Reminder list.
2. Click **Inactivate** on the Action bar.
3. At the Confirm Inactivation prompt, click **Yes**. The Inactivation window opens (see Figure 41-8: Inactivate Due Reminders Window).

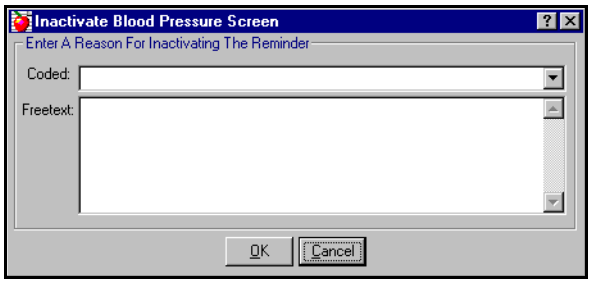


Figure 41-8: Inactivate Due Reminders Window

Tip:
To activate an item that has been inactivated, select the Wellness Schedule tab to activate the selected reminder.

4. Select a code from the coded drop-down list.
5. Enter any free-text to further explain the code or to take the place of a code.
6. Click **OK**.

41.5 Viewing Due Reminder Details in the Due Reminders Tab

To view due reminder details in the Due Reminder tab:

1. Select the reminder on the Due Reminders tab.
2. Click **Details** on the Action bar. The Detail Information window opens (see Figure 41-9: Due Reminders Detail Window).

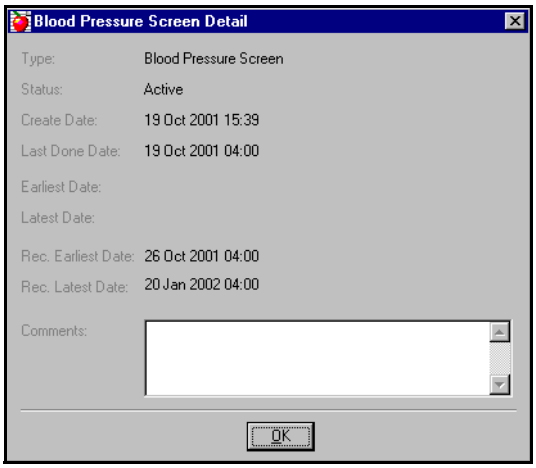


Figure 41-9: Due Reminders Detail Window

3. After viewing the due reminder information, click **OK** to close the window.

41.6 Adding a Wellness Schedule

To add a wellness schedule:

1. Select the Wellness Schedule tab.
2. Click **Add** on the Action bar. The Add Wellness Schedule window opens (see Figure 41-10: Add Wellness Schedule Window).

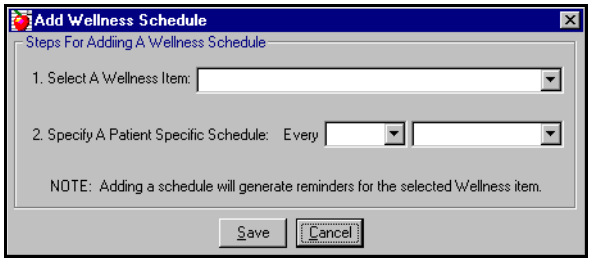


Figure 41-10: Add Wellness Schedule Window

3. Select a **Wellness Item** from the drop-down list.
4. Select a **Patient Specific Schedule** from the drop-down lists to document the frequency of the wellness item.
5. Click **Save** to save the new schedule.

41.7 Documentation History Tab

The Documentation History tab allows you to define all Wellness related events, including Immunizations or satisfaction of Wellness Reminders (see Figure 41-11: Wellness Window—Documentation History Tab). The Documentation History tab allows you to document the appropriate service for the selected reminder. The tab also allows you to select either a coded or free-text comment to associate with a Wellness Reminder.

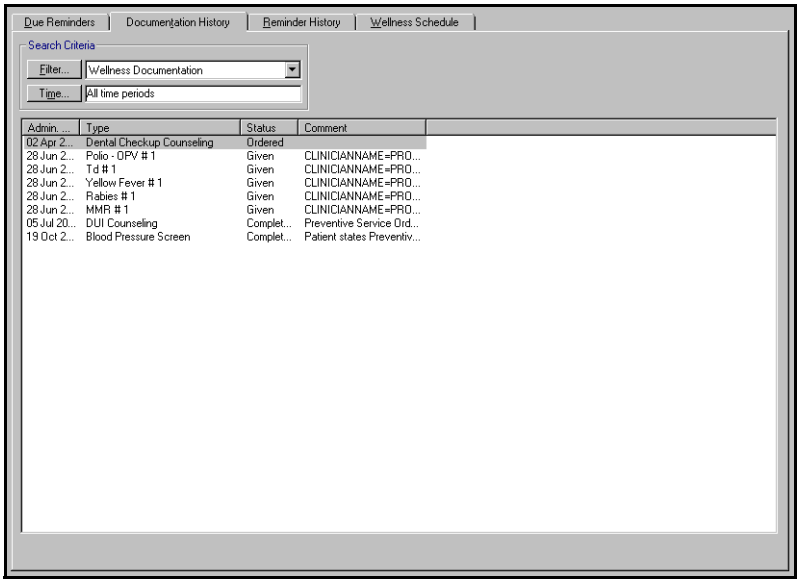


Figure 41-11: Wellness Window—Documentation History Tab

41.7.1 Action Bar Icons in the Documentation History Tab

	Add History	Allows documentation history to be added in the Documentation History tab.
	Edit	Allows a selected reminder history to be edited.
	Close	Closes the Wellness module.

41.7.2 Adding a Reminder History in the Documentation History Tab

To add a reminder history in the Documentation History tab:

1. Click **Add History** on the Action bar. The Select History Type window opens (see Figure 41-12: Select History Type Window).

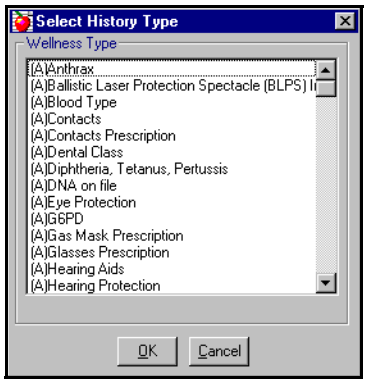


Figure 41-12: Select History Type Window

2. Select the desired procedure.
3. Click **OK**. The new History window opens with the clinician's name and type pre-filled (see Figure 41-13: History Window).

Note: The Date, Information Source and Status are required fields.

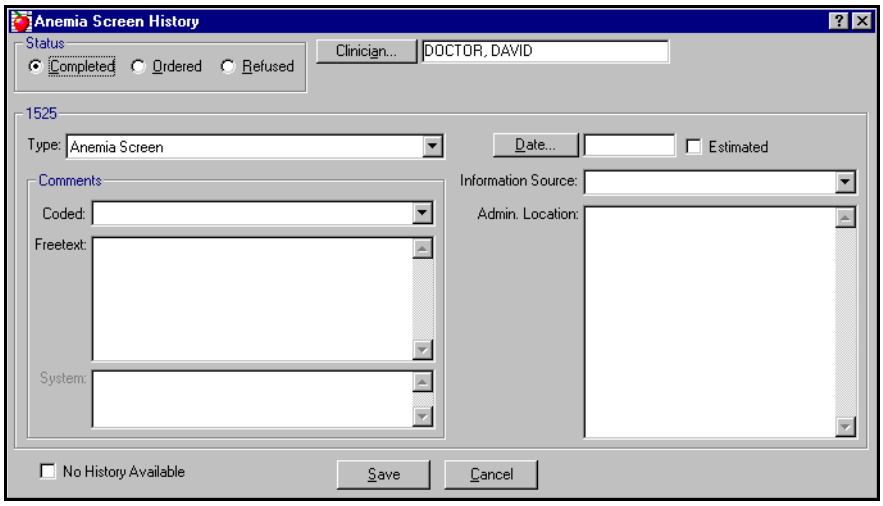


Figure 41-13: History Window

4. Complete the required fields.
   - **Status:** The status can be changed to Completed, Ordered, or Refused.
   - **Date:** Select the date the action occurred.
   - **Information Source:** Enter the relationship to the patient reporting the action.
5. Update information in the remaining fields, if necessary.
   - **Clinician:** Enter the name of the person administering the action. The default is whoever is currently logged in.

- **Type:** Select the action to be taken from the drop-down list. The default is the task for which the reminder is being documented.
- **Coded:** Select a more detailed status of service by accessing the drop-down list.
- **Free-text:** Enter any additional comments.
- **Admin. Location:** Enter the location where the action occurred.

6. Click **Save** to add this reminder history information to the documentation history list.

41.7.3 Editing a Reminder History in the Documentation History Tab

To edit a reminder history in the Documentation History tab:

1. Select the reminder to be modified.
2. Click **Edit** on the Action bar. The Documentation History Edit window opens (see Figure 41-14: Documentation History Edit Window).

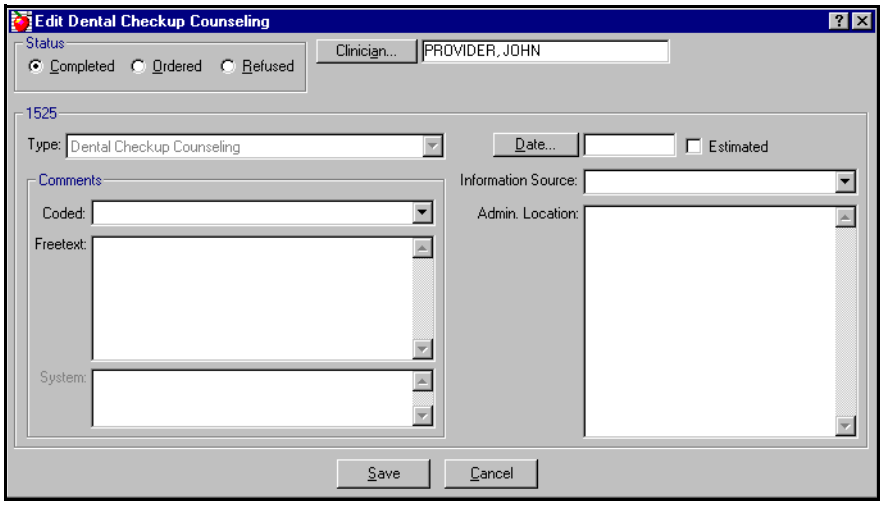


Figure 41-14: Documentation History Edit Window

3. Modify the desired data.
4. Click **Save**.

41.8 Reminder History Tab

The Reminder History tab displays a history of reminders (see Figure 41-15: Wellness Window—Reminder History Tab).

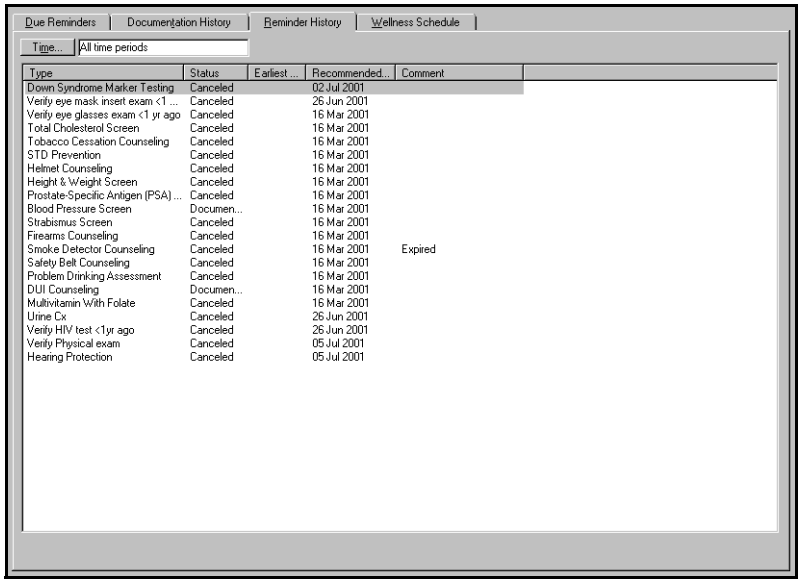


Figure 41-15: Wellness Window—Reminder History Tab

41.8.1 Action Bar Icons in the Reminder History Tab

	Edit	Allows a reminder history to be edited.
	Activate	Activates the selected reminder and places it in the Due Reminders tab.
	Details	Displays the historical details of the selected reminder.
	Refresh	Refreshes data in the Reminder History tab.
	Close	Closes the Wellness module.

41.8.2 Setting the Time Filter in the Reminder History Tab

To set the time filter in the Reminder History tab:

1. Click **Time**. The Time Search window opens (see Figure 41-16: Time Search Window).

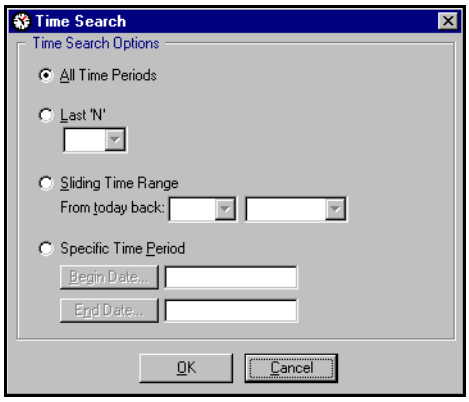


Figure 41-16: Time Search Window

2. Select **Time Search Options** for reminders.
3. Click **OK**. The data on the Reminder History List screen is refreshed according to the search criteria.

41.8.3 Editing a Reminder History in the Reminder History Tab

To edit a reminder history in the Reminder History tab:

1. Select the **Reminder History** to be modified.
2. Click **Edit** on the Action bar. The Edit Reminder window opens (see Figure 41-17: Due Reminder Edit Window).

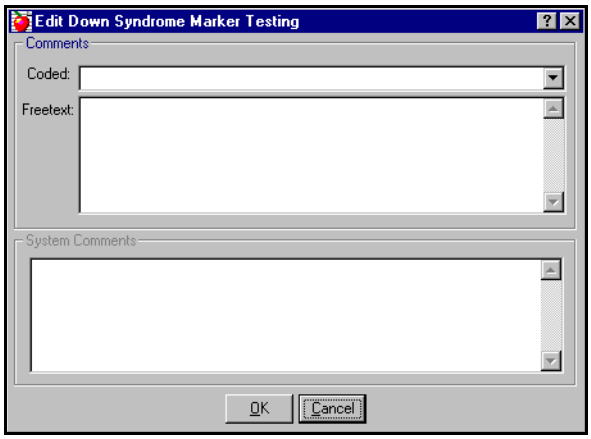


Figure 41-17: Due Reminder Edit Window

3. Select a code from the coded drop-down list.
4. Enter any necessary free-text to provide further explanation or to take the place of a code.
5. Click **OK**.

41.8.4 Activating/Inactivating a Reminder in the Reminder History 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 activate/inactivate a reminder in the Reminder History tab:

1. Select the inactive reminder.
2. Click **Activate**.
3. On the Confirm Reminder Activation window, click **Yes**.

To inactivate a reminder:

1. Select the active reminder.
2. Click **Inactivate**. The Inactivation window opens (see Figure 41-18: Inactivate Reminder Window).

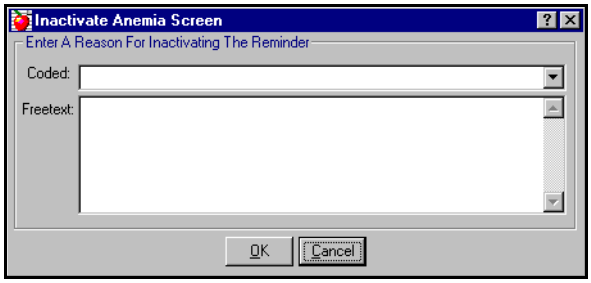


Figure 41-18: Inactivate Reminder Window

3. Enter a reason for the inactivation as a coded or free-text comment.
4. Click **OK**.
5. On the Confirm Inactivation window, click **Yes** to inactivate the reminder.

41.8.5 Viewing Reminder History Details in the Reminder History Tab

To view reminder history details in the Reminder History tab:

1. Select the reminder.
2. Click **Details** on the Action bar. The Detail Information window opens (see Figure 41-19: Due Reminder Detail Window).

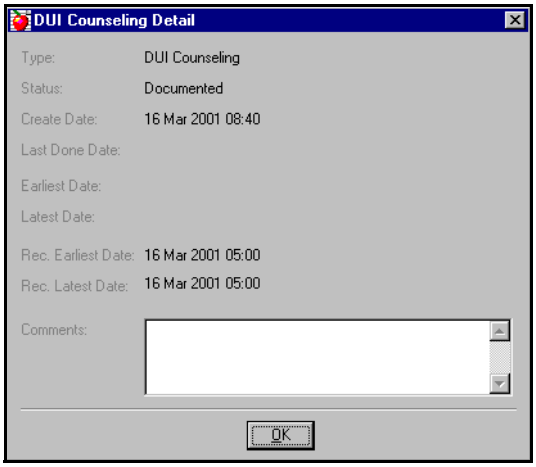
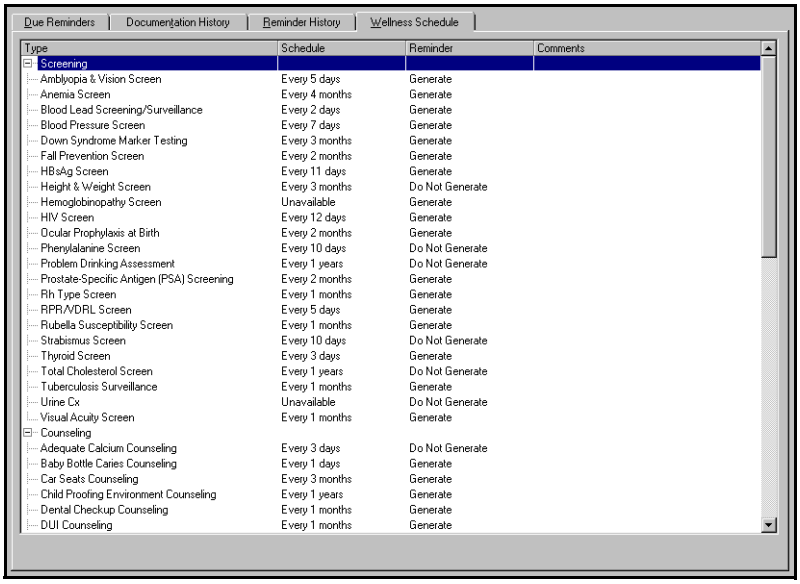


Figure 41-19: Due Reminder Detail Window

3. View the detailed reminder information in the window.
4. Click **OK**.

41.9 Wellness Schedule Tab

The Wellness Schedule tab displays the type of action, the administration schedule, the status of the reminder and a comment (see Figure 41-20: Wellness Window—Wellness Schedule Tab).



Type	Schedule	Reminder	Comments
Screening			
Amblyopia & Vision Screen	Every 5 days	Generate	
Anemia Screen	Every 4 months	Generate	
Blood Lead Screening/Surveillance	Every 2 days	Generate	
Blood Pressure Screen	Every 7 days	Generate	
Down Syndrome Marker Testing	Every 3 months	Generate	
Fall Prevention Screen	Every 2 months	Generate	
HBsAg Screen	Every 11 days	Generate	
Height & Weight Screen	Every 3 months	Do Not Generate	
Hemoglobinopathy Screen	Unavailable	Generate	
HIV Screen	Every 12 days	Generate	
Ocular Prophylaxis at Birth	Every 2 months	Generate	
Phenylalanine Screen	Every 10 days	Do Not Generate	
Problem Drinking Assessment	Every 1 years	Do Not Generate	
Prostate-Specific Antigen (PSA) Screening	Every 2 months	Generate	
Rh Type Screen	Every 1 months	Generate	
RPR/VDRL Screen	Every 5 days	Generate	
Rubella Susceptibility Screen	Every 1 months	Generate	
Strabismus Screen	Every 10 days	Do Not Generate	
Thyroid Screen	Every 3 days	Generate	
Total Cholesterol Screen	Every 1 years	Do Not Generate	
Tuberculosis Surveillance	Every 1 months	Generate	
Urine Cx	Unavailable	Do Not Generate	
Visual Acuity Screen	Every 1 months	Generate	
Counseling			
Adequate Calcium Counseling	Every 3 days	Do Not Generate	
Baby Bottle Caries Counseling	Every 1 days	Generate	
Car Seats Counseling	Every 3 months	Generate	
Child Proofing Environment Counseling	Every 1 years	Generate	
Dental Checkup Counseling	Every 1 months	Generate	
DUI Counseling	Every 1 months	Generate	

Figure 41-20: Wellness Window—Wellness Schedule Tab

41.9.1 Action Bar Icons in the Wellness Schedule Tab

	Add	Allows a wellness schedule to be added.
	Edit	Allows a selected wellness schedule to be edited.
	Activate	Activates the selected wellness schedule and displays it in the Due Reminders tab.
	Inactivate	Inactivates the selected wellness schedule.
	Close	Closes the Wellness module.

41.9.2 Adding a Wellness Schedule Reminder in the Wellness Schedule Tab

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

1. Click **Add** on the Action bar. The Add Wellness Schedule window opens (see Figure 41-21: Add Wellness Schedule Window).

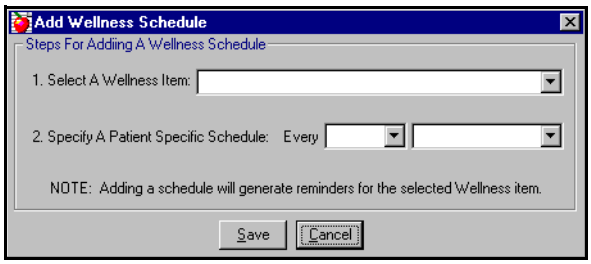


Figure 41-21: Add Wellness Schedule Window

2. Select a **wellness item** from the drop-down list.
3. Specify a patient schedule using the drop-down list to document the frequency of the wellness item.
4. Click **Save**.

41.9.3 Editing a Wellness Schedule Reminder in the Wellness Schedule Tab

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

1. Select the **reminder** to be modified.
2. Click **Edit** on the Action bar. The Reminder Schedule window opens (see Figure 41-22: Reminder Schedule Window).

Figure 41-22: Reminder Schedule Window

3. Do one of the following:
   - If you want the wellness schedule reminder to occur once a year, click the Recommended Schedule radio button.

Note: Recommended schedule varies based on the type of test—does not automatically set reminders to one year in all cases.

   - If you want to establish a patient specific schedule:
     — Select **Patient Specific**.
     — Select a time from the drop-down list.
4. Click **OK** to set the reminder schedule.

41.9.4 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 activate a wellness reminder in the Wellness Schedule tab:

1. Select the inactive reminder.
2. Click **Activate** on the Action bar. The Confirm Reminder Activation window opens (see Figure 41-23: Confirm Reminder Activation Window).

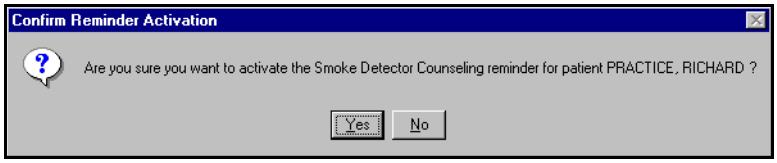


Figure 41-23: Confirm Reminder Activation Window

3. Click **Yes** to activate the reminder.

To inactivate a reminder in the Wellness Schedule tab:

1. Select a reminder.

2. Click **Inactivate** on the Action bar.
3. On the Confirm Inactivation window, click **Yes**. The Inactivation window opens (see Figure 41-24: Inactivation Window).

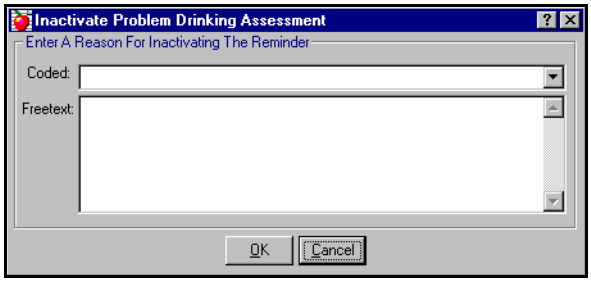


Figure 41-24: Inactivation Window

4. Select a code from the drop-down list or type free-text in place of the code.
5. Click **OK**.