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IMPLEMENTATION UPDATE GUIDE FOR CHCS S/W VERSION 4.51 TO VERSION 4.6 FOR CLN

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COMPOSITE HEALTH CARE SYSTEM

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How To Use This Document

The Implementation Update Guide (IUG) is a reference manual for the implementation of CHCS Version 4.6. There is an IUG for each functionality. This IUG is applicable to the Clinical subsystem.

The Table of Contents provides an outline of the information contained in this guide. The document is divided into the following sections:

HOW TO USE THIS DOCUMENT - A description of the document and how to use it.

1. SUMMARY OUTLINE - Brief overview of changes-this can be used as a hand-out to all users.

2. SUBSYSTEM CHECKLIST - This is a step by step list of pre and post install implementation activities.

3. CHANGES AND ENHANCEMENTS - a description of each change with subsections including an Overview, Detail of Change, and File and Table Change.

4. APPENDIXES - applicable information pertaining to the implementation of Version 4.6 including Common Files changes, and a Master Checklist for all Subsystems.

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1. Summary Outline.

1.1 Ambulatory Procedure Visits (Same Day Surgery).

To support the new DOD requirements for Ambulatory Procedure Visits (APV), formerly known as Same Day Surgery Visits (SDS), CHCS will create a separate order entry page for the entry of orders associated with an APV visit. This new page will communicate an appointment request to the Patient Appointment Scheduling (PAS) module and link the APV page with the appointment. Minutes of service can be calculated by the authorized PAS or clinical user through a new option in the PAS module.

1.2 Consult Results.

The consulting physician may enter a note in response to a consult order and complete the consult process. The consulting physician can enter the note or the note can be transcribed by a nurse/clerk user and verified by the consulting physician. The completed consult will be available for review by any authorized CHCS user.

1.3 Problem Lists.

The clinical user will be able to enter and maintain a Problem List for any patient in CHCS. This list will be available for update and review by any authorized CHCS user.

1.4 Progress Notes.

The physician or nurse user will be able to enter a Progress Note on any patient in CHCS. Users can review or search for notes by title and date range.

1.5 Discharge Summary.

The clinical user will be able to enter a Discharge Summary on a patient with a past or current inpatient episode. The physician can enter the summary information or a summary can be transcribed by a nurse/clerk user and verified by the physician. Completed summaries will be available for review by the authorized clinical user.

1.6 Immunizations.

The authorized user will be able to enter and maintain immunization data for a patient. The user may also update or delete existing immunization data, document reactions to vaccinations, and transcribe information for immunizations given at other health care facilities.

Immunization data entered for the Active Duty patient will automatically be transmitted to DEERS. This will provide up-to-date immunization data on the Active Duty patient via the DEERS database.

1.7 Transportable Patient Records.

The authorized user will be able to generate an electronic record of patient data for transmittal between medical treatment facilities. This record will include laboratory and radiology results, allergies, medication profiles, problem lists, progress notes, discharge summaries, consult notes, immunization records, appointments, demographic information, and some information regarding inpatient episodes for the specified date range.

1.8 Add Duty Station to Results Printout.

The Active Duty sponsor's Military Duty Station Unit will now display in several areas within the Clinical Subsystem for the consult or scheduled ancillary procedure. This will aide the user in determining the appropriate record location for the patient.

1.9 Unit Identification Code (UIC) Change.

Changes to the Unit Identification Code (UIC) throughout CHCS will now prevent the user from entering an invalid unit for an Active Duty patient or Sponsor. This change is called the "UIC Total Solution," and screens past and future registrations for valid UIC codes. There is no direct affect on the Clinical Subsystem.

1.10 Inappropriate Requesting Location Screen.

The entry of a File Area location as a Requesting Location for outpatient orders has been a problem in the past for some sites. This location type points to an "E-level" MEPRS code which is considered inappropriate for this type of workload counting. CHCS will now screen for an 'Inappropriate Requesting Location' at the

'Requesting Location:' prompt during Order Entry and when the user attempts to define a Default Location and Default MEPRS Code for Order Entry (in Clinical Desktop or User Specific Customization).

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2. Subsystem Checklist.

2.1 User Training.

It is highly recommended the site request Implementation Support for training and user assistance in the new clinical enhancements before implementing.

It is highly recommended that HCP-level users (Physician and equivalent) and Nurse/Clerk-level users attend separate demonstrations for all clinical enhancements that will be utilized. (Maximum 4 Hours each)

Training sessions should include a brief introduction covering the Inappropriate Requesting Location changes, and an overview of the Transportable Patient Records, Military Duty Station and UIC enhancements. Session length will depend on what enhancements will be used at a site, by the parameters listed below.

HCP-Level users:

Progress Notes	(30 min)
Discharge Summaries	(30 min)
Problem Lists	(30 min)
Consult Results	(1 hour)
APV Order Entry	(30 min)

Nurse/Clerk-Level users:

Progress Notes	(15 min)
Discharge Summary	(30 min)
Problem Lists	(15 min)
Consult Results	(1 hour)
APV Order Entry	(15 min)
Immunization Enter/Review (Nurse-level)	(30 min)
Nursing Due Lists	(1 hour)

NOTE:

- Sites should cater a class to cover only the enhancements that will directly affect the target audience.

- Sites should incorporate extra time into training, if necessary, for teaching the order types (MED, IVP, IVD, IVF, DTS, and NRS) which clinicians will be able to enter in support of APV use.

- Supervisory personnel responsible for File and Table maintenance should attend a separate demo to cover the

requirements for Progress Notes, Immunizations, Clinical Site Parameters, Consult Procedures and Discharge Summaries.

- It is recommended that users who will be responsible for entering APV Minutes of Service attend the PAS demonstration covering this option.

2.2 Implementation Issues.

Before the Install.

____ 1. It is recommended that the site assess the way they are currently using Consult Orders and determine whether the Consult Results option will be used. Gather data for the File and Table build to be entered post load to include Consult Names and type; Consulting Clinics and Providers; Devices, etc.)

____ 2. It is recommended that the site gather data related to the Ambulatory Procedure Units that are currently in use for File and Table build post load. Coordination with PAS, PAD, MEPRS and Systems Admin is required for this effort to decide how the APV enhancements will be used.

____ 3. The site should establish what pre-positioned data will be entered for Patient Instructions and Discharge Summary Text to support the Discharge Summary enhancements. Patient Instructions can be entered before the load.

____ 4. It is highly recommended that the site appoint a contact person for Immunization file and table build. This information should be available post load for all immunization file and table requirements.

Post Install.

____ 1. Communicate with PAS, and Systems Admin to verify that all APV File and Table has been completed before use of this option is implemented.

____ 2. Assign the necessary security keys for Patient Notes, Consults, Immunizations, and Transportable Patient Records.

2.3 Integration Issues.

- CLN/PAS.

____ 1. Contact the PAS POC to verify that PAS Profiles have been updated and schedules have been updated for consulting providers who need to enter consult results for a particular clinic if consult resulting on CHCS is utilized.

____ 2. Contact the PAS POC to verify that PAS profiles and schedules have been updated to support the use of APV.

- CLN/PAD.

____ 1. Identify POC for transportable patient records.

- CLN/LAB.

____ 1. Inform users of the additional page for APV order entry. Orders on this page will be 'Future' until the page is activated and therefore cannot be acted upon until the appointment is made KEPT. Any orders which need to be completed before the page is activated must be written on the Outpatient Page. The APV Location should be entered as the 'Requesting Location' for these orders to capture the appropriate workload.

- CLN/RAD.

____ 1. Inform users of the additional page for APV order entry. Orders on this page will be 'Future' until the page is activated and therefore cannot be acted upon until the appointment is made KEPT. Any orders which need to be completed before the page is activated must be written on the Outpatient Page. The APV Location should be entered as the 'Requesting Location' for these orders to capture the appropriate workload.

- CLN/PHR.

____ 1. Inform users of the additional page for APV order entry. Orders on this page will be 'Future' until the page is activated but can be entered and Future Labels can be printed to support medication preparation.

2.4 File and Table Changes.

File and table for the clinical subsystem can be extensive depending on what enhancements a site chooses to activate and to what degree. It is recommended that each section of this IUG be thoroughly reviewed before deciding to utilize the Version 4.6 enhancements. Coordination with other subsystems will be necessary for some of the enhancements. Once a decision has been made, review the File and Table section before activating.

2.5 Security Keys.

DG TRANSPORTABLE RECORDS	Allows the user to send or request Transportable Patient Records (TCPR) for a single or for multiple patients.
NS CONSULT RESULTS	Allows the user to enter Consult Results and view results after verification.
NS DISCHARGE	Allows the Clinical user access to the Discharge Notes option.
NS IMM	Allows the user access to document immunizations from the IMM option and use the Multiple Immunization option.
SD APV	Allows the user access to the MAPV option.
SD APV MINSRV	Allows the clinical user to use the EDA option to emergently disposition an APV patient from the ORE action prompt to support an inpatient episode that results from an APV visit.

Refer to PAS IUG for details on the MAPV options if clinical users will be required to perform these functions.

Refer to PAD IUG for details on the TCPR functions.

3. Changes and Enhancements.

3.1 Ambulatory Procedure Visits (Same Day Surgery).

3.1.1 Overview of Change.

Recent Department of Defense policy changes have resulted in the way Medical Treatment Facility's manage Ambulatory Procedure Visits (APV), formerly referred to as Same Day Surgery (SDS). The CHCS software has now been enhanced to support the new APV policy.

A new Order Type, Ambulatory Procedure Request (APR) will generate a separate Ambulatory Procedure Visit (APV) page for entering orders associated with the patient encounter. Once the order is activated, CHCS will communicate an appointment request to the Patient Appointment Scheduling (PAS) software. This will link the APV page to the clinic appointment and the APR order in CHCS.

An APV page and APR order can also be generated when a PAS user independently books an appointment or walks-in the patient to an Ambulatory Procedure Clinic location. If the order is written the PAS user should process the request, if an order is not written and a patient is booked or walked-in, an order will be transparently written. One or the other procedure should be used.

The APV page will allow the entry of order types not generally available from the Outpatient Page. Diet Orders (DTS) Nursing Orders (NRS) and Unit Dose Medications (MED) are a few examples. Orders for Admission/Disposition/Transfer (ADT) and Laboratory (LAB) orders with a collection method of LAB COLLECT as well as APV orders are not available on this page.

The APV Minutes of Service (MAPV) option is new to the PAS software. This option can be used to activate the APU page and the orders on the page once the patient arrives on the unit for the procedure. The user will also use this option to document the times that reflect when: Nursing Intervention began, the patient departed for the procedure, patient returned from the procedure, and disposition. The PAS IUG should be referenced for more detailed information.

When an inpatient episode becomes necessary as the result of the APV encounter, the authorized order entry user will be able to use the new EDA action to immediately disposition the patient and close the APV page.

3.1.2 Detail of Change.

Any Clinical user can enter an Ambulatory Procedure Request (APR) order from the patient order entry option (ORE). This APR order will send a valid appointment request to the PAS software. This request must then be scheduled by the PAS software from the AOP option. Before the APU page and the orders on the page can be activated the PAS user must make the appointment KEPT, usually when the patient arrives in the APU. The orders on the APU page will not be active and cannot be completed until the page is activated. Once the APV appointment is scheduled, the requesting provider will receive a mailman message.

Sample Screen

```
STEVENS,SAMANTHA      Age:42    20/801-66-0329          APR ORDER
AMBULATORY PROCEDURE REQUEST                          010621-00001
==============================================================
 Requested APV Location : APU GENERAL SURGERY
 Requested APV Date/Time: 21 Jun 2001
 APV Procedure          :
  BIOPSY  (This is a 78 character free text field. Enter the name
           of the APV Procedure to be performed on the patient.)
 ** This information will display as the Reason for Appointment.

 Requested APV Physician: (Not required)

 Appointment Comment :
  (This is a free-text word processing field of unlimited length.
   Enter any appropriate comments regarding this APV procedure.)


[File/exit]  Abort  eXit
File changes and exit.
```

End screen

Once the APR order is filed, an APU POL page is created and will appear to the left of the 'Outpatient' page. This page will temporarily become the current page for entering orders until the user 'Quits/Activates' the order. The user may enter any orders which are planned to be completed during the APV encounter. The status of the APR order will be 'Active/Pending Appointment' regardless what signature class the user entering the order holds. Orders placed on the APV page will have a status of 'FUTURE' until the appointment is marked 'KEPT' by the PAS user, or the authorized MAPV user.

The APU page may alternatively be created from the PAS subsystem pathway. When a PAS user books an APV appointment, the page appears in ORE as it would if a Clinical user created the page with an order as described above.

It is recommended that the clinical user placing orders on an inactive APU page, use 'ADT' as the start date and time for all orders. If 'NOW' or 'Today' is used, the orders will immediately be placed on 'HOLD' when the page is activated because the 'NOW' date has past. The order will have to be modified or re-written before it can be processed.

Any unsigned orders entered by the clerk level user (Signature Class 0), except the APR order, will change from the status of 'Future' to 'Inactive/Pending Signature' when the page is activated. These orders should be signed by a Nurse or HCP user before the patient arrives to prevent delay in processing.

Note: The expiration dates for orders placed on the APU page will not reflect the typical 24 hour period for which an APV encounter is designed unless the user makes a manual adjustments to the expiration date.

Sample Screen

```
STEVENS,SAMANTHA        Age:42    20/801-66-0329          GEN-APV POL
  1 APR  APPT,FOR: APU GENERAL SURGERY on 21
         Jun 2001 {BIOPSY}
          ~Pend.Appointment~  . . . . . . . .   DOCTLA  21JUN@1444
  2 LAB  CBC PROFILE~WARD/CLINIC COLLECT~BLOOD
         ~LAV Starting ADT
          ~FUTURE~  . . . . . . . . . . . . .   DOCTLA  21JUN@1444
  3 RAD  CHEST, PA/LAT~MAIN RADIOLOGY~AMB
         Starting ADT
          ~FUTURE~  . . . . . . . . . . . . .   DOCTLA  21JUN@1444
+ 4 DTS  CLEAR LIQUID DIET  Starting on ADT

 GEN-APV  *OUTPAT*


ACTION:
```

End screen

The use of Order Sets for frequently entered orders will assist the user in remembering to include the 'ADT' start date/time for all orders.

The Clinical Desktop patient source choices have been modified to include APV sources similar to the Outpatient Clinic Sources.

APU	PATIENTS SCHEDULED FOR AN APU
APUM	PATIENTS SCHEDULED FOR MY APU
APUMT	PATIENTS SCHEDULED FOR MY APU TODAY
APUP	PATIENTS SCHEDULED FOR AN APU BY PROVIDER

If an APV appointment is 'Canceled', or marked as 'No-Show' by the PAS user, and there are 'Future' orders on the APV page, the APR order status will change to ~Pend.Appointment~. The appointment can be re-scheduled if the patient is to return at a later date and the orders will be preserved. If the patient will not be returning, the clinical user can cancel the APR order from the Outpatient Page and the orders on the APV page will be canceled as well. (The APR order displays on both pages but only exist on the Outpatient Page.) If there are no orders on the APV page when the appointment is canceled by PAS, the page and the order will be canceled.

When the APV encounter is completed, the MAPV user will enter a date/time of departure. This will inactivate the APV page. Orders that are not completed on the page at the time of inactivation will be moved to the Outpatient page until they are completed or expire.

If at any time during the APV encounter the patient must be admitted to the hospital, the APU page must be inactivated before an Admission order can be entered. To inactivate the page, the user must disposition the patient. The authorized order entry user can use the new order action 'Emergency Disposition from APU' (EDA) from the POL to inactivate the page. This will immediately disposition the patient. This new action is locked by the SD APV MINSRV security key.

Once the APV page is inactivated, it will remain a 'Past Page' for a period of time to allow the clinical user to resolve due lists and shift care plans. This time frame is defined in the Clinical Site Parameters and can range from 1 to 30 days. Once the page is collapsed and moved to a historical position among the other collapsed pages no further actions can be completed.

The Nursing Documentation menu has also been revised to accommodate APV orders. Due lists may be printed out and nursing results entered from the APU page. Due Lists and Due List results have only accommodated inpatient wards in previous versions and not all sites have chosen to use Due Lists if they were not using Clinical inpatient functions.

3.1.3 File and Table Changes.

To support the use of Nursing Due lists, there is a new field in the Clinical Site Parameters to define how long the APV page remains a 'Past' page for users to result Due Lists on patient's before the page is collapsed.

The new field is called 'Days to Collapse the Past APV Page:'. The time frame can range from 1 to 30 days. This parameter should be set before the site begins using the nursing due list options.

CHCS determines the POL name for the APV page by taking the first three characters of the abbreviation field in the Hospital Location File (#44) and adding '-APV'. The abbreviations entered for these locations should not begin with the same three characters (i.e. 'SDS...' or 'APU...') to avoid confusion.

If the site plans to use Nursing Documentation options, file and table for the Nursing Procedure file should be reviewed.

3.1.4 Implementation Issues.

The Nursing Documentation menu has been enhanced to support APV encounters. Once the APV orders are activated, the Nursing user will be able to generate a list of orders for a patient's visit, record vital signs, medication administration, and generate end of stay reports that summarize the visit. When used along with Progress Notes, this will create an entirely electronic record of the patient's visit. It is recommended that sites evaluate the Nursing Documentation Menu options for use on site.

3.2 Consult Results.

3.2.1 Overview of Change.

Consult order types (CON) were used in previous versions of CHCS to document the request for a consult but the result could not be entered in CHCS by the consulting provider. The clinical user can now enter a note in response to a consult request and complete the consult process in CHCS.

HCP-level users (Signature Class 2-4) may enter a note and complete the consult or the Nurse/Clerk-level user (Signature Class 0-1) can transcribe a note and the consulting HCP can verify that note and complete the result. Nurse/Clerk- level user's may not complete consult results. The completed consult will generate a Mailman notification to the provider who requested the consult. The result will be available for review by any authorized CHCS user.

3.2.2 Detail of Change.

The Consult Results function will enable the Clinical user (Class 0-4) to enter/edit, save, print, and view results for a scheduled or unscheduled consult order. Within this option users may also enter/edit allergies, update problem lists and copy/paste results to the note.

The setup and use of Consult orders may vary from site to site. Some sites may not be familiar with the use of this order type. Before reading this section, assess how your site is currently using Consult orders on CHCS.

Consults can be defined as Scheduled or Unscheduled (One-Time, PRN, or Continuous). Each site should compare the advantages and disadvantages of both before deciding how to proceed with the file and table build. All consults are specific to the clinic they are defined for. If several clinics perform the same type of consult, separate procedures must be created to support this. Detailed instruction on building consults is provided in the File/Table Build section (Section 3.2.3).

A. ORDERING A CONSULT

When the clinical user enters the Order Type 'Consult Order' (CON) the order can be processed one of two ways - scheduled or unscheduled. The Ancillary Procedure file will determine whether the Consult is a Scheduled or Unscheduled procedure.

The scheduled procedure will generate a request to the PAS software for an appointment. Once the appointment is scheduled and the date of the appointment arrives, the consult will be available for result entry.

The unscheduled procedure (One-Time, PRN, or Continuous) will not generate an appointment request, nor will it connect to the PAS software in any way. The consult will become available on the requested date and can be accessed from the clinic unscheduled queue by any provider in the consulting clinic profile.

The consult order must begin with the entry of a CON order on the patient's profile in order entry, no matter how the consult procedure is defined. At the action prompt on the patient POL, enter NEW ORDER and the ORDER TYPE: CON.

Sample Screen

```
ADAMS,GOMEZ           Age:52    20/200-20-7514      CONSULT ORDER
CARDIOLOGY CONSULT                                     010621-03380
==================================================================
 From: GENERAL MEDICINE CLINIC         To: CARDIOLOGY CLINIC
 Date of Request: 20 Jun 2001@1345     Requested HCP: BURNS,FRANK
 Requested Date of Consult: 21 Jun 2001     Exact Date: NO
 Reason for Consult:
 CHEST PAINS


 Provisional Diagnosis: ANGINA ('Reason for Appointment')

 Requesting HCP: PIERCE,BENJAMIN     Priority: ROUTINE
                                     Expiration Date: 20 Jul 2001



[File/exit]   Abort  Exit
File changes and exit
```

End screen

The 'Requesting Location' defined when the user enters the ORE option will be the 'From' location for the consult. The 'To' location is clinic where the consulting provider will see the patient. This is defined in the ancillary procedure file for the consult.

The 'Requested Date of Consult' defines the date when the unscheduled consult will appear in the consult queue or when the scheduled consult will be available for appointment booking. The 'Reason for Consult' is a free text field for the requesting user to describe to the consulting clinic the reason for the consult.

The 'Exact Date' field should be changed to 'YES' if the requesting user would like this consult scheduled for the specific date requested. The 'Provisional Diagnosis' will display as the Order Comment on the POL and to the PAS user who is making the appointment for the scheduled consult as the 'Reason for Appointment'.

If the PAS user initiates a CON appointment, the consult will not display and the consulting provider will not be able to enter a result in CHCS.

Sample Screen

```
ADAMS,GOMEZ       Age:52      20/200-20-7514            OUTPAT POL
  1 CON  CARDIOLOGY CONSULT at DIV A -TRAINING
         HOSPITAL on 20 Jun 2001@1345 {ANGINA}
         ~Scheduled for 21JUN@0700 . . . . . . PIERBE  20JUN@1345




*OUTPAT*



ACTION:
```

End screen

The Scheduled CON order will have a status of ~Pend.Appointment~ until the appointment is scheduled by the PAS user. The date it is scheduled for will be the date the consult will appear on the consulting provider's Scheduled Consult Display.

When the appointment is made for the Scheduled Consult, the requesting provider will receive a Mailman message indicating that the appointment was scheduled. If the appointment is not made within the time period set in the Clinical Site Parameters, the requesting provider will get a message stating that the appointment has not been scheduled.

Sample Screen

```
Subj: APPOINTMENT SCHEDULED  Thu, 20 Jun 2001 15:07:23   5 Lines
From: POSTMASTER (Sender: OREILY,WALTER) in 'IN' basket.  **NEW**
-------------------Expires: 06 Jul 2001--------------------------
Order #010621-03380 CARDIOLOGY CONSULT at DIV A - TRAINING HOSP
on 20 Jun 2001@1345

The requested appointment for ADAMS,GOMEZ  has been scheduled.
    DATE/TIME:  21 Jun 2001@0700
          HCP:  BURNS,FRANKLIN D

Select MESSAGE Action: IGNORE (in IN basket)//
```

End screen

B. ENTER CONSULT RESULTS (CON).

Users with access to the Physician Menu can access Scheduled and Unscheduled Consults from the Document Patient Care Menu (DOC), then Enter/Review Patient Notes (NTE), then Enter Consult Results (CON). The CON option is locked by the NS CONSULT RESULTS security key.

Users with access to the Nursing Menu can access Scheduled and Unscheduled Consults from Enter/Review Patient Notes (NTE), then Enter Consult Results (CON). The Nurse/Clerk-level user (Class 0-1) will be prompted to enter a location (MEPRS Code) for the clinic they wish to result consults, regardless of which menu path they use to access the CON option.

C. SCHEDULED CONSULT APPOINTMENTS

Scheduled Consults are procedures for which the clinic requires an appointment before it can be completed. These consults are clinic and provider specific. The consult cannot be resulted nor will it display until an appointment is booked by the Patient Appointment Scheduling (PAS) subsystem.

The scheduled provider on the Consult appointment is the only provider who can complete the consult. Consults cannot be forwarded. If another provider consulted, the appointment should be canceled and another order should be written and booked for the other provider to complete. Once an appointment is booked by the PAS user the order cannot be canceled or modified from the POL. The PAS user must cancel the appointment which will cancel the order.

Scheduled Consults will display first when the HCP-level user (Class 2-4) enters the CON option. Only consults scheduled for that provider will display. Patient's who have an appointment on the current day will display under the heading, 'New Consult(s) for Today'.

Consults not resulted on the day of the appointment will display under the heading, 'Past Consult(s) - Unresulted.' Consults that have been acted upon, but not completed will display under the heading, 'Past Consult(s) - Saved/Transcribed.' The transcribed consult can be identified by the (T) next to the name. Future scheduled consult orders will not display until the date of the appointment. Use the Roster option to view future appointments.

Consult appointments that are canceled or re-scheduled will still display on the consult list. This is a known software problem that was under investigation when this guide was written.

Sample Screen (Physician and equivalent, Class 2-4)

```
BURNS,FRANKLIN M    Scheduled Consult Appointments    21 Jun 2001

Patient                 Consult    Age/Sex  Pt Loc  Date of Appt
New Consult(s) for Today
 1. ADAMS,GOMEZ........ CARDIOLOGY  51Y M    OUTPAT  21 Jun @0700

Past Consult(s) - Unresulted
 1. HOWELL,THURSTON.... CARDIOLOGY  52Y M    OUTPAT  20 Jun @0700

Past Consult(s) - Saved/Transcribed
 1. GRUMBY,JONAS....(T) CARDIOLOGY  63Y M    OUTPAT  19 Jun @0830



(T) = Transcribed

[Note]  Results  Written  Unscheduled  rosTer  Print  Help  eXit
Enter a consult report for this patient.
```

End screen

Scheduled Consults will also display first when the Nurse/Clerk-level user (Class 0-1) enters the CON option. All scheduled consults will display, for all consulting providers in the clinic defined upon entry to the CON option. Patient's who have an appointment on the current day will display under the heading, 'New Consult(s) for Today'. The name of the consulting provider is listed under the heading "PhyID".

Consults not resulted on the day of the appointment will display under the heading, 'Past Consult(s) - Unresulted'. Consults that have been acted upon, but not completed will display under the heading, 'Past Consult(s) - Unresulted'. Once a consult is transcribed, it will not display for the Nurse/Clerk-level user. Future scheduled consult orders will not display until the date of the appointment. Use the Roster option to view future appointments.

If a different provider consulted, the original appointment should be canceled and a new order should be written and scheduled for the other provider. Consult appointments that are canceled or re-scheduled will still display on the consult list. This is a known software problem that was under investigation when this guide was written.

Sample Screen (Nurse/Clerk, Class 0-1)

```
CARDIOLOGY CLINIC   Scheduled Consult Appointments   21 Jun 2001
-------------------------------------------------------------------
Patient                    PhyID   Age/Sex Pt Loc   Date of Appt
 New Consult(s) for Today
  1.  ADAMS,GOMEZ......... BURNFR  52Y M   OUTPAT   21 Jun @0700
  2.  ADAMS,MORTICIA...... POTTSH  47Y F   OUTPAT   21 Jun @0700
  3.  ADAMS,PUGSLY........ HUNNBJ  12Y M   OUTPAT   21 Jun @0700
  4.  ADAMS,WEDNESDAY..... PIERBE  08Y F   OUTPAT   21 Jun @0700

 Past Consult(s) - Unresulted
  1.  HOWELL III,THURSTON. BURNFR  52Y M   OUTPAT   20 Jun @0700
  2.  HOWELL,LOVEY W...... POTTSH  51Y F   OUTPAT   20 Jun @0700
  3.  SUMMERS,MARY ANN.... HUNNBJ  21Y F   OUTPAT   20 Jun @0700
  4.  GRANT,GINGER........ PIERBE  26Y F   OUTPAT   20 Jun @0700

 Past Consult(s) - Saved/Transcribed

-------------------------------------------------------------------
[Note]  Results  Unscheduled  rosTer  Print  Help  eXit
Enter a consult report for this patient.
```

End screen

D. UNSCHEDULED CONSULTS APPOINTMENTS

Unscheduled Consults can be completed without an appointment. There is no connection between these consults and the PAS software. Unscheduled consults will not generate workload even when they are completed. These require an independent appointment to be made in the PAS software or that the patient be "walked-in" to the clinic as an unscheduled visit.

A requested provider is optional for this consult. These consults will display on the requested date, for any provider associated with the consulting clinic, even if a provider is requested. Unscheduled consults can be accessed by invoking the Unscheduled option from the action bar on the Scheduled Consult display.

Consults for which the HCP was requested will display first under the heading, 'Requested Provider Consult(s)'. Consults for which no provider is requested or where another provider was requested will also display under the consulting clinic name. If the provider is in the clinic profile for more than one clinic, both clinic's unscheduled consults will display, sorted by the clinic name.

Sample Screen (Physician and equivalent, Class 2-4)

```
POTTER,SHERMAN T   Unscheduled Consult Appointments   21 Jun 2001

Patient                  Consult     Age/Sex Pt Loc  Request D/T
Requested Provider Consult(s)
  1. STEVENS,SAMANTHA..  NUTRITIONAL 37Y F   OUTPAT   21 Jun

GENERAL MEDICINE CLINIC Clinic Consult(s)
  1. STEVENS,DARRIN....  NUTRITIONAL 34Y M   OUTPAT   20 Jun
  2. STEVENS,TABITHA...  NUTRITIONAL 05Y F   OUTPAT   20 Jun
  3. STEVENS,ADAM......  NUTRITIONAL 02Y M   OUTPAT   20 Jun

(T) = Transcribed

[Note]   Results   Written   rosTer   Print   Help   eXit
Enter a consult report for this patient.
```

End screen

There is no indication on the display that another provider was requested. It is possible for a provider to select a consult where another provider was requested. In this case, the provider who selects the consult will become the consulting provider regardless of the Requested Provider name and only this provider can complete the consult.

If the consult is Saved but not completed it will display under the 'Past Consult Saved/Transcribed' section of the Scheduled Consult screen. This consult will no longer display on any other provider's unscheduled consult display. To return the consult to the unscheduled display, the provider must exit the note before saving.

When the Nurse/Clerk-level user (Class 0-1) enters the Unscheduled display, consults will be shown for the clinic defined upon entering the CON option. The requested provider will display in the "PhyID" column. If no provider is requested this column will be blank.

Sample Screen (Nurse/Clerk user, Class 0-1)

```
GENERAL MEDICINE   Unscheduled Consult Appointments    21 Jun 2001

Patient                   PhyID   Age/Sex  Pt Loc   Request D/T

 1. STEVENS,SAMANTHA....  POTTSH  37Y F    OUTPAT   21 Jun
 2. STEVENS,DARRIN......  HUNNBJ  34Y M    OUTPAT   20 Jun
 3. STEVENS,TABITHA.....  PIERBE  05Y F    OUTPAT   20 Jun
 4. STEVENS,ADAM........  BURNFR  02Y M    OUTPAT   20 Jun



[Note]   rosTer   Print   Help   eXit
Enter a consult report for this patient.
```

End screen

If the consult is saved but not completed it will display under the Past Consult Saved/Transcribed section for the Clerk/Nurse level user and the consulting provider. This consult will no longer display in the unscheduled queues for any other provider. To return the consult to the unscheduled queue, the user must exit the note before saving.

The Roster action allows the user to print/display a clinic schedule or roster for a designated provider to see future or past CON appointments. This option is identical to the Print/Display Provider Roster from the PAS Operational Reports Menu and the Appointment roster Print option in Clinical Desktop.

E. CONSULT RESULT ENTER/EDIT.

When the authorized user enters the CON option and selects a scheduled or unscheduled consult for resulting an adaptive action bar will be available at the bottom of the screen. The user must select (*) the consult(s) they want to result followed by a carriage return. The 'Note' action will be invoked since it is the default action.

Then the Nurse/Clerk level user selects an unscheduled consult, the appointment date/time and consulting provider are required entries. Once the user defines the consulting provider, this becomes the only provider who can complete the consult. It is possible for a user to select a consult where another provider was requested and change the consulting provider. In this case, the new provider becomes the consulting provider and only this provider can complete the consult.

When the 'Note' action is invoked by the physician, nurse or clerk user for a scheduled consult, the initial screen will display the consult appointment date, provisional diagnosis, requesting HCP, and Reason for Consult. This information is not editable here.

When the 'Note' action is invoked by the physician user for an Unscheduled Consult, the 'Appointment Date' is required before continuing. The 'Consulting HCP:' is understood as the user selecting the consult, regardless of the Requested Provider, and is not editable. If necessary, the user may abort the consult and return it to the unscheduled consult queue for another provider to complete by selecting the 'eXit' option before saving.

When the 'Note' action is invoked by the Nurse/Clerk user for an Unscheduled Consult, the user will be required to enter the 'Appointment Date' as well before continuing. This user will however be able to choose the consulting provider.

If no HCP was requested when the consult order was written, the 'Consulting HCP:' name will be required. If an HCP was requested, and a different HCP consulted, the user can replace the requested name with another name. Either way, the provider defined will be the only provider who can complete the consult.

All users will be able to enter/edit allergy information and document patient problems during the note process. Press the 'Up Arrow' from the action bar to access these options.

Sample Screen (Physician, Nurse, or Clerk)

```
ADAMS,GOMEZ        20/200-20-7514    52Y M        MASTER SERGEANT

Appointment Date: 21 Jun 01@0700  Requesting HCP: PIERCE,BENJAMIN
Clinic: CARDIOLOGY CLINIC         Consulting HCP: BURNS,FRANKLIN
Provisional Diagnosis: ANGINA
Reason for Consult:
  CHEST PAINS



Allergies:
 PENICILLINS



Active Problem List:
 OTHER AND UNSPECIFIED ANGINA PECTORIS



Save  Allergy  proBlem  Results  [pgDn]  Print  Help  eXit
Display the next screen of this consult
                            Press <Up Arrow> to re-enter screen
```

End screen

When the HCP user invokes the 'pgDn' action a free-text word-processing screen appears where the user can enter the narrative consult note.

Sample Screen (Physician or equivalent, Class 2-4)

```
ADAMS,GOMEZ        20/200-20-7514    52Y M        MASTER SERGEANT
 Note:

  (This is a free-text word processing field of unlimited length.
   Use the Results option to cut and paste results to a note.)




[Verify]  Save  Allergy  proBlem  Results  Print  Help  eXit
Verify and print this consult, and go to next patient.
                             Press <Up Arrow> to re-enter screen
```

End screen

The following actions are available for the HCP-level user:

Verify:	Verify and print this consult, and go to the next patient (Provider Class 2-4 only)

Save: Save this unfinished consult to the `Past Consults - Saved list

Allergy: Enter or edit patient allergies

proBlem: Enter or edit patient problems

Results: View prescriptions and results for this patient

Print: Print this unfinished DRAFT consult report

Help: Obtain helpful information about the action bar

eXit: Exit this option. Abort consult without saving.

Sample Screen (Nurse/Clerk user, Class 0-1)

```
ADAMS,GOMEZ         20/200-20-7514    52Y M  MASTER SERGEANT
 Note:

   (This is a free-text word processing field of unlimited
    length.  Use the Results option to cut and paste results to a
    note.)


[Save]  Transcribe  Allergy  Results  Print  Help  eXit
Save this unfinished consult
                              Press <Up Arrow> to re-enter screen
```

End screen

The following actions are available for the Nurse/Clerk user:

Save: Save the unfinished consult to the 'Past Consults - Saved/Transcribed' list of consulting provider and the Clerk/Nurse level user.

Transcribe: Indicates the note is complete and ready for verification. The consult is moved to the 'Past Consults - Saved/Transcribed' List and marked with a (T) designator. A notification is sent to the consulting provider for verification.

Allergy: Enter or edit patient allergies

proBlem: Enter or edit patient problems.

Results: View allergies, prescriptions and results for this patient

Print: Print this unfinished DRAFT consult report

Help: Obtain helpful information about the action bar

eXit: Exit this option or abort consult without saving

The 'Results' search option is identical to that used for Telephone Consults with the addition of a copy/paste function to import lab and radiology result text, outpatient prescriptions, or allergies into the consult note.

To utilize the copy/paste function, place a select mark (*) at the beginning of the text and another select mark (*) at the end of the text to copy. Press the 'PF1' key, then the letter 'C'. This will place the text in the copy buffer. To paste the buffer contents in the consult note, place the cursor in the note where the text is to be pasted and press the 'PF1' key and the letter 'C' again. The text you selected will paste into the note then prompt the user to "...clear the buffer?" Type 'Y' to clear the buffer unless the same text needs to be pasted again in another location.

The Written action is designed to support those consults which were written on paper (typically the SF-513). If the result was written the HCP-level user may remove the consult from their consult list by selecting (*) the patient and invoking the 'Written' action on the Scheduled or Unscheduled Consult screen. The user will see the following warning message:

CAUTION: Notes for this consult appointment will be deleted.
Do you want to verify/remove this consult from your list? NO//

F. VERIFYING TRANSCRIBED RESULTS

When the Nurse/Clerk-level user chooses the Transcribe action, the consult is removed from the Consult Appointments display for all other Nurse/Clerk-level users. The consulting provider will then receive a sign-on message, the next time they enter CHCS, that a consult requires verification.

Sample Screen

```
Good morning HAWKEYE, you last signed on today at 07:30

    You have new mail in the Mailman system.

    You have Consult Results that require verification.

  ORE    Enter/Maintain Orders
  ORS    Sign Orders
  RNR    Review New Results
  TEL    Telephone Consults
  RCR    Review Clinical Results and Orders Menu
  DOC    Document Patient Care Menu
  ADT    Admissions/Dispositions/Transfers Menu
  REF    Reference Information Menu
  USR    User-Specific Customization Menu

Select Physician Menu Option:
```

End screen

When the user enters the CON option, the consult result awaiting verification will appear on the Scheduled Consult Appointments display under the heading 'Past Consult - Saved/Transcribed' with a '(T)' designator.

The user should enter the 'Note' action to review and/or edit the transcribed note. Select the 'Verify' action to complete the consult.

If the Provider has not defined an electronic signature block the following prompt will appear when the 'Verify' or 'Written' action is invoked :

```
You do not have a signature block defined.
Do you wish to define one now? YES//
```

Verified results will automatically print to several locations defined by the site.

1) The consulting clinic will get a copy if the clinic printer has been defined.

2) The requesting clinic will get a copy, if the requesting location has a device defined.

3) The Record Room defined in the patient's registration will get a copy if the patient is an outpatient.

4) The Inpatient Ward will get a copy if the patient is an inpatient.

5) The user may also print a copy to any addressable CHCS printer from the 'Device:' prompt.

Refer to the File and Table section for how devices are defined.

If the clinic, ward or outpatient record room printers are not defined, the following messages will be displayed after the Verify action is selected:

Sample Screen

```
Clinic printer not defined! Unable to print.

Outpatient record room printer not defined! Unable to print.
                                                (outpt. only)
Ward printer not defined! Unable to print.
                                                (inpt. only)
```

End screen

The completed consult will trigger a MailMan message from the Postmaster, via the consulting provider, to the requesting provider, informing that the consult has been completed.

Sample Screen

```
Subj: CONSULT RESULT COMPLETED 21 Jun 2001 15:19:07  10 Lines
From: POSTMASTER (Sender: BURNS,FRANKLIN) in 'IN' basket.
-----------------------------------------------------------------
Order #010621-03380 CARDIOLOGY CONSULT on 21 Jun 2001@0700

 The requested consult order for ADAMS,GOMEZ has been completed
 and verified.
```

End screen

Once the consulting provider verifies a consult it is considered complete and cannot be retrieved for further results entry.

G. REVIEW CONSULT RESULTS

The completed consult is viewable under the Review Patient Notes (RPN) option on the Review Clinical Results and Orders Menu (RCR). Consult results may also be viewed by expanding <F9> the order on the POL and through Review Orders (RVO).

The NS CONSULT RESULTS security key that locks the Enter Consult Results (CON) option also allows the user to view the consult result. Users who do not hold the key will not be able to view the result.

To use the RPN option, enter the patient's name and invoke the 'Consults' action from the action bar. A list of completed consults will display, most recent first. The user can display all notes or select (*) the note(s) to display.

Sample Screen

```
ADAMS,GOMEZ         AGE 52Y    20/200-20-7514     Consult Results

 21 Jun 2001@0700  CARDIOLOGY CONSULT  COMPLETE  BURNS,FRANKLIN
 12 Dec 2000@1130  ALLERGY             COMPLETE  MCINTYRE,JOHN F
 30 Dec 1999@0830  ALLERGY UNSCH CON   COMPLETE  BLAKE,HENRY
 06 Feb 1998@1500  ALLERGY (A)         COMPLETE  PIERCE,BENJAMIN


Select Item = SELECT

 [All]   Selected   Help   eXit
 View all patient notes
```

End screen

The user can scroll through the text using the [F7] and [F8] keys or the [PgUp] and [PgDn] actions.

The RVO option or the expanded order on the POL (F9), will display the result the same as the RPN option.

Completed consults can be re-printed to any addressable device through the RPN option. Hard copy printouts of a consult report will have a report header, which will include the consulting provider's name. The consulting provider name will also appear in the 'Verified by:' field of the note. If the provider chose not to define a signature block, the Provider ID from the Provider file (#6) will be used (ex. BURNFR). The standard report footer will be printed at the end of the hard copy report.

If an unfinished consult is printed via the CON option, the Verified by: field will be blank. Unverified consults can also be identified by the '** DRAFT**' header on the report.

If the consult was verified using the 'Written' action, the consult result text in RPN will display the appointment date/time, the date/time the consult was verified, and the verifying provider's signature block or provider ID. The note text will read, 'HARDCOPY ON FILE'.

Sample Screen

```
ADAMS,GOMEZ         AGE 52Y     20/123-45-6789    Consult Results
Appointment Date: 06 Feb 1998@1500  Requesting HCP: MCINTYRE,JOHN
Clinic: ALLERGY (A)                 Consulting HCP: PIERCE,BENJAM

Reason for Consult:
SKIN TEST FOR ALLERGIES
Provisional Diagnosis: R/O Anaphylaxis

Problem List:


Note:
This patient is highly allergic to dust, pollen and mold. He
works in and outdoor environment and will need desensitization
shots. Schedule clinic visit to begin treatment.

Verified by: BENJAMIN F. PIERCE, CPT MC USA

[Nxtnte]   Print   PgDn   Help   eXit
View Next Note
```

End screen

3.2.3 File and Table Changes.

File and Table for the implementation of Consult Results involves coordination between Common Files (DAA), Patient Appointment Scheduling (PAS) and Clinical (CLN) personnel.

Consults must be defined for a specific clinic to result. Consults are considered ancillary procedures and are entered through the Ancillary Procedure (ANC) option on the Table Maintenance Menu (TAB). The TAB option can be found under the Nursing or Physician Management Menu (MNG).

Previously defined consults in this file should be reviewed to ensure the information is updated before using the consult. To build or edit an Ancillary Procedure enter the name of the Ancillary Procedure (consult). If it already exist use that entry and edit the fields outlined below.

The minimum required fields are: Name, Mnemonic, Special Procedure Type (Consults), Schedule Type, and Clinic.

Sample Screen

```
ANCILLARY PROCEDURE: CARDIOLOGY C ANCILLARY PROCEDURE MAINTAIN

NAME: CARDIOLOGY CONSULT              MNEMONIC: CARD
SPECIAL PROCEDURE TYPE: CONSULTS  SCHEDULE TYPE: SCHEDULED
CLINIC: CARDIOLOGY CLINIC
SERVICE: CARDIOLOGY SERVICE           ORDER PREVIEW REQUIRED:
DEVICE: CARD1
DESCRIPTION:

Select AUTHORIZED ORDERING CLASSES:

COUNTERSIGNATURE:            AUTHORIZATION KEY:
UNAVAILABLE:


Ask for Help = HELP   Screen Exit = F10  File/Exit = DO
```

End screen

FIELD:	DESCRIPTION:
NAME:	Free Text Field with 3-30 Characters.
MNEMONIC:	Abbreviation. 1-8 Characters.
SPECIAL PROCEDURE TYPE:	Enter a 'C' for Consults. This field must be set to 'Consults' to identify consult procedures.
SCHEDULE TYPE:	Answer with SCHEDULED(3)or ONE TIME (2). Unscheduled Consults are defined as ONE TIME.
CLINIC:	Enter a valid HOSPITAL LOCATION from the Hospital Location File (#44). This defines the clinic queue for this consult.
SERVICE:	Enter the name of a SERVICE from the Department and Service File (#45.7). This field identifies the service associated with this consult. This field is not required for Consults.
ORDER REVIEW REQUIRED:	Answer with Yes or No. This field indicates whether the procedure must be reviewed. This field is not required for Consults.
DEVICE:	Enter the name of a device from the DEVICE File (# 3.5). This field

	identifies the Printer at the Clinic location which will receive the order notice and completed consult.
DESCRIPTION:	Free Text. Enter a detailed description for this consult.
AUTH. ORDERING CLASSES:	Enter a Provider Class from the PROVIDER CLASS File (#7). To restrict the ordering of the consult to only the class defined.
COUNTERSIGNATURE:	Set Flag to '1' if a Countersignature is required to process this order.
AUTHORIZATION KEY:	Enter the name of a valid SECURITY KEY from the Security Key File (#19.1). This restricts ordering of a consult to users who hold the security key.
UNAVAILABLE:	Enter a '1' if this Consult is unavailable in this division. This field allows the site to restrict consult procedures by division.

To support the automatic printing function of consults the Hospital Location File (#44) must be edited to define what device should receive the result. For Outpatients the result will print to the Outpatient Record Room location defined in the patient's registration. For Inpatients the result will print to the Internal Ward Location printer.

3.2.4 Implementation Issues.

Assess how consults are currently used at the site. Are they scheduled or unscheduled? If a change to the set up is desired, consult with appropriate personnel to assist in File/Table build of consults. If changing a consult from unscheduled to scheduled, the PAS users must be trained to book the appointment through the PAS-Clerk-AOP option.

The NS CONSULT RESULTS security key must be assigned to any user who needs to use the CON option to enter/edit results. This key should also be assigned to users who will need to review completed consults through the Review Patient Notes (RPN) option,

on the expanded (F9) CON order from the Patient Order List (POL), or through RVO.

Clinical users must be in the PAS Provider profiles of the clinic defined in order to access the queue for that clinic's unscheduled consults. The PAS personnel will need to build the necessary provider profiles, add appointment types, and create schedules for consult providers to complete Scheduled consults. Schedules are not necessary for the Unscheduled consults.

3.3 Problem Lists.

3.3.1 Overview of Change.

This enhancement will allow the clinical user to maintain a Problem List on any patient in CHCS. Problems can be marked as Chronic or Acute and Active or Inactive. These problems can be accessed by any authorized user to update the list.

3.3.2 Detail of Change.

The clinical user will be able to maintain a Master Patient Problem List (PPL) for individual patients. The user can maintain these lists by adding comments, updating the problem status and documenting the resolution of a problem. If the clinical user chooses, the user can create Problem Selection Lists which contain a list of problems frequently managed by their clinic and assign the list to a clinic for use by other clinicians.

1. PROBLEM SELECTION LISTS MAINTENANCE

Creating a Problem Selection List is not necessary to add problems to a patient's record. This option will aide users in finding problems that are frequently managed a clinic.

The Problem Selection List Maintenance (PLM) option can be accessed from the Physician Menu or the Nursing Management Menu on the Nursing Menu. When the user enters the PLM option they will be prompted for a list name. This is a 30-character free text field. The user is then prompted to enter a location the list is to be associated with.

The PLM option will walk you through creating your first list by defaulting each step. From editing the list, to adding categories, to entering problems, to assigning other locations, and finally exiting your new list.

Sample Screen

```
                Problem Selection List Maintenance
Cardiac List                                  Created: 04 Dec 97
Location: CARDIOLOGY CLINIC                  Modified:




[EditList]   AssignList   NextList   Help  eXit
Enter and edit categories and problems on a list.
```

End screen

Once the 'EditList' action is invoked, another action bar appears. The 'Add' option allows the user to add customized categories for problems and establish a sort sequence for how they appear on the list. One or more categories can be created and sequenced.

Sample Screen

```
                Problem Selection List Maintenance
 Cardiac List                                  Created: 04 Dec 97
  Location: CARDIOLOGY CLINIC                 Modified:

  ____________________________________________________________________
 |                                                                    |
  Enter a new Category name: Cardiac
    Sort Sequence: 1
  Enter a new Category name:
 |____________________________________________________________________|


[Add]   Edit   Delete   Help  eXit
 Add categories to Problem Selection List
```

End screen

After the desired number of categories are entered, press return at the blank 'Enter new Category name:' prompt. The display will show the categories entered in their defined sequential order on the screen. The 'Edit' option will be the default action and all the categories entered will be marked with the Select mark (*) for editing.

When the user invokes the 'Edit' action, the user is prompted with the category's sort sequence again, to change if desired. The user is then prompted to enter problems for this category. Type the name or partial name of a problem and a list of matches from the Lexicon file is presented for selection. The user must select their choice from this list.

After the problem is selected the user will have the opportunity to enter a sort sequence in which this problem will appear under the category. Once the user has completed the problem selection process, the user can press return, at the blank 'Enter a new Problem:' prompt. The screen will then be updated to display the entries just made.

Sample Screen

```
                Problem Selection List Maintenance
 Cardiac List                                  Created: 04 Dec 97
 Location: CARDIOLOGY CLINIC                  Modified:
  ____________________________________________________________________
 |                                                                    |

    Category: Cardiac
      Sort Sequence: 1// 1
    Enter a new Problem: HTN
   The following 73 matches were found:
       1:  Gestosis, PEH *
       2:  Hypertension, Goldblatt
       3:  Hypertension *
       4:  Hypertension due to oral contraceptive
       5:  Hypertension, Malignant *

   Choose 1-5: 3
      Sort Sequence: 2

   Enter a new Problem: <RETURN>
 |____________________________________________________________________|


 Add   [Edit}   Delete   Help  eXit
 Add problems to a category
```

End screen

Once this process is completed, the default action will be to exit. The following screen shows what the completed Problem Selection List would look like.

Sample Screen

```
                 Problem Selection List Maintenance
 Cardiac List                                  Created: 04 Dec 97
  Location: CARDIOLOGY CLINIC                 Modified:

    Category:
    1. Cardiovascular
       1. OTHER AND UNSPECIFIED ANGINA PECTORIS (ICD 413.9)
       2. ESSENTIAL HYPERTENSION, NOS (ICD 401.9)
       3. PERIFERAL VASCULAR DISEASE, UNSPECIFIED (ICD 443.9)
    2. Pulmonary
       1. PNEUMONIA DUE TO UNSPECIFED BACTERIA (ICD 482.9)
       2. OTHER AND UNSPECIFIED SLEEP APNEA (ICD 780.57)
    3. Gastrointestinal
       1. GASTRIC ULCER, CHRONIC/UNSPECIFIED W HEMORRHAGE W
          PERFORATION (ICD 531.60)
    4.  Endocrine
       1. DIABETES MELLITUS WITHOUT MENTION OF COMPLICATIOON,
          TYPE II (NON-INSULIN DEPENDENT TYPE) (NIDDM TYPE)
          (ADULT-ONSET TYPE) OR UNSPECIFIED, UNCONTROLLED (ICD
          250.02)



 Add   Edit   Delete   Help  [eXit]
 Return to Problem Selection List Maintenance
```

End screen

The 'Delete' option can be used to delete a selected problem or delete the entire list. If the user chooses the 'Delete' action without selecting either categories or problems to delete, the user will be prompted to delete the entire list. At this point, if the user chooses not to delete the entire list, the user will be prompted to 'select' categories and their associated problems or select problems from categories to delete.

The 'Exit' option returns the user to the Problem Selection List where the default option will be to 'AssignList'. The user may assign a list to as many clinics as they choose. A display of clinics the list is currently assigned to will appear and the user may choose to assign another clinic or delete a clinic from the current assignments list.

2. THE PATIENT MASTER PROBLEM LIST.

The Patient Master Problem List (PPL) option is found on the Enter/Review Patient Notes Menu (NTE) or from the POL in Order Entry (ORE) with the new action, Problem List (PL).

Whichever route the clinical user takes to access the patient's problem list, they will arrive at the same screen. This screen will display the patient's current problems with the date of onset, sorted in reverse chronological order by the date they were added to the list and ward/clinic location where the problem was entered. The problems will be sorted by their Active or Inactive status with a last date modified indicator.

Sample Screen

```
KRAVITZ,ABNER       AGE:76   20/123-45-6789   Problem List: ALL

Problem                                Location  Acuity   Updated
 Active
  1. Noct. Leg Cramps, Onset 4/25/95  CARD     Acute    07 May 95
  2. Diabetes Mellitus Onset 3/12/59  PCC      Chronic  12 Apr 95

 Inactive
  1. Pneumonia, Viral, Onset 12/13/92 IMC      Acute    20 Dec 92



Expand = F9   Select = SELECT

[Add]   Edit   Inact   Display   deLete   pRint   Help   eXit
Add a new problem to the patient's problem list
```

End screen

When the user chooses the default action to 'Add' they will be prompted to enter a location that a Problem Selection List is assigned to and select a problem from their custom list or to enter a new problem from the Lexicon file. If the user enters a location for a list, they will be prompted to select problems associated from the list.

To enter a new problem without using the selection lists, press <Return> at the Enter Location prompt and type the name or partial name of a problem at the 'Enter new Problem' prompt. A list of matches from the Lexicon file will be presented for selection. The user must select a choice from this list.

When each problem is entered the user must enter the date of onset, status of the problem, acuity of the problem, and a comment. The comment field is a free text field of unlimited length.

The 'Edit' option allows the user to edit information pertaining to a specific problem already on the list. The user can add additional notes to update or correct an error in a previous

entry but will not be allowed to edit a note once it has been filed.

The 'Inactivate' option allows the user to resolve a problem on a patient's list. The inactive status of a problem indicates that it is resolved. The user can also resolve a problem by changing the status to 'inactive' through the 'Edit' option. Both options offer the user the ability to enter an additional note regarding the problems status.

The 'Delete' option is specifically designed for removing a problem that was entered in error. When selecting a problem to delete a reason is required to explain the deletion. The default reason is, 'This problem entered in error' to remind users of the result. Problems that have been resolved should be inactivated instead of deleted.

The expand option [F9] is available from the Problem List screen. When the user presses the [F9] key next to a problem, the name of the provider who entered the problem and all comments regarding the problem will display on the screen.

When the user selects the 'Display' option, all problems will be displayed and the user will be presented with another action bar that allows them to change the display. The user can display only active problems, problems entered by location, by a specific provider, or display the entire problem list in the expanded format.

3.3.3 File and Table Changes.

There are no File and Table issues.

3.3.4 Implementation Issues.

The Problem Selection List option is available to any clinical user with the Nursing or Physician Menu. This option should be managed like the Order Set file to prevent over population and confusion.

3.4 Progress Notes.

3.4.1 Overview of Change.

The authorized physician or nurse user (Provider Classes 1-4) will be able to maintain Progress Notes on any patient in CHCS. A

title will be required for each note and the site can determine what titles it wants to use for categorizing their notes. Users can then search for notes according to title and date range, much like looking up laboratory results.

3.4.2 Detail of Change.

Users who have access to the Physician Menu can access the Progress Note option from the Document Patient Care Menu (DOC) then the Enter/Review Progress Notes (NTE) option. Users who have access to the Nursing Menu can just use the NTE option. This option is also available from the patient's POL using the new ACTION: PRG (Progress Note Enter/Review).

Each progress note must have a title, for example Pre-op Note, Progress Note, Nursing Note, etc. which are built by each site from the Progress Note Title Enter/Edit (PNM) option found on the Table Maintenance Menu (TAB).

A. PROGRESS NOTE ENTER/REVIEW

When the user enters the Progress Note Enter/Edit (PRG) option, there will be a split screen display. The top half will allow read-only access to previously entered notes. The bottom half is a word processing field for entering new notes. You must assign a title to the note before filing. Titles cannot be created here, they must be created through the PNM option before they will be available here. Once the user files a progress note, it is not editable.

Only Nurse/HCP-level users (Class 1-4) can enter/edit progress notes. Clerk level users (Class 0) can only print/display progress notes.

Sample Screen

```
NELSON,ANTHONY        AGE:34     20/123-45-6789       Progress Notes

Previous Progress Notes:
  19 Jun 2001@1317     OUTPT                    PHYSICIAN
  Progress Note
     34yo AD aviator with c/o pain in R ankle after he twisted it
     while running this morning PFT's.  No other complaints.  Plan
     for x-rays, ice, anti-inflammatories and elevation. Down chit
     for 2 days. Return to clinic in 2 days for re-eval.
  Signed: BENJAMNIN F PIERCE, CPT MC USA


Title: PROGRESS NOTE
Note:
 This is a 34yo AD aviator who was in normal state of health
 until two days ago when he twisted his ankle while running. X-
 rays were negative.  States he is still having some difficulty
 bearing weight. Plan: Continue with down chit for 2 more days.
 Re-eval in 2 more days.



[File]   Print   Edit   Results   Help   eXit
File this Progress Note
```

End screen

The 'Results' format is identical to that used for Consults including the addition of the copy/paste function to import results, prescription information, and/or allergies into the progress note.

To utilize the copy/paste function, place a select mark (*) at the beginning of the text, then place another select mark (*) at the end of the text. Press the 'PF1' key, then the letter 'C'. This will place the text in the copy buffer. To paste the buffer contents in the progress note, place the cursor in the note where the text is to be pasted and press the PF1 key and the letter 'C' again. The text you selected will be placed in the note and the user will be prompted to "...clear the buffer?" Yes. Press return for 'Yes' to clear the buffer unless the same text needs to be pasted again in another location.

Notes will be further classified as inpatient or outpatient based on the patient's status when the note was written and by the Provider Class of the user entering the note.

The Review Patient Notes (RPN) option is also available to view progress notes through the 'Progress' action. The user can choose to view all progress notes, select specific notes or search for

more notes. The default date range for the initial display is 2 days.

Sample Screen

```
NELSON,ANTHONY       AGE:34     20/123-45-6789      Progress Notes

 19 Jun 01@1317    Progress Note               PIERCE,BENJAMIN
 21 Jun 01@1230    Progress Note               WINCHESTER,CHARLES



[All]    Selected   seaRch    Help    eXit
Browse all progress notes
```

End screen

The 'seaRch' option is a useful tool for finding notes in a particular date range, either inpatient or outpatient notes, by the class of provider that entered the note, and by the type (title) of note.

Note: The 'Provider Type' prompt should be left blank since many sites have modified the Provider Class file to include more than the basic 'Physician' and 'Clinical Nurse' classes.

Sample Screen

```
 NELSON,ANTHONY        AGE:34     20/123-45-6789


 Earliest Date: 19 Jun 2001
 Latest Date:   21 Jun 2001

 View all Progress Notes?:  No

 Inpatient or Outpatient Notes:  Inpatient

 Provider Type(s):
   PHYSICIAN


 Note Type(s):
   PROG NOTES
```

End screen

3.4.3 <u>File and Table Issues</u>.

The Progress Note Title (PNM) option must be populated before users will be able to enter progress notes. This file can be

accessed on the Table Maintenance Menu (TAB) from the Nursing or Physician Management Menu' (MNG).

3.4.4 Implementation Issues.

The site should decide how Progress Notes will be titled at their site. The Progress Note Title file is not division specific. Decisions made will affect all divisions on the host system. If there are several MTF's attached to your the host system, consider collaborating on title names or name-spacing.

3.5 Discharge Summary.

3.5.1 Overview of Change.

The authorized clinical user will be able to enter a Discharge Summary on any patient in CHCS who has had an inpatient episode. The summary can be entered by the physician user or transcribed by the Nurse/Clerk user, then verified by the Physician.

A new summary can only be created for the patient with a current or past inpatient episode for which no completed summary exist. Once a summary is filed, it cannot be edited. If an additional note is necessary for a completed summary, the authorized user can attach an addendum.

3.5.2 Detail of Change.

The authorized clinical user will be able to enter a Discharge Summary on a patient by using the 'Discharge Summary Enter/Edit' (DIS) option. This option can be found by accessing the Document Patient Care (DOC) then the Enter/Edit Patient Notes Menu (NTE). Only users who hold the NS DISCHARGE security key will have access to this option.

When the Physician or equivalent user (Class 2-4) selects the DIS option, a screen similar to the Telephone Consult Screen will display. The user will be able to select the 'Create New Summary' option or select from a list of unfinished summaries.

When the Nurse/Clerk-level user selects the DIS option, they will be prompted to enter the name of a 'Dictating HCP' before the above screen will display. Patient summaries created during that session can only be completed by that Dictating HCP. If the Nurse/Clerk user is transcribing for several HCP's be careful to exit the option and begin again when changing HCP's.

Sample Screen

```
 FREEDMAN,SIDNEY T        Discharge Summary          21 Jun 2001

 Patient                       Age/Sex     FMP/SSN    Date of Adm
  New Discharge Summaries
   1.  (Create New Summary)

  Unfinished Summaries
   1.  CLEAVER,WALLY           35Y/M       20/2354    19 Jun 01
   2.  CLEAVER,BEAVER          27Y/M       20/6789    19 Jun 01



[Enter]   Append    Print    Help   eXit
```

End screen

From the above screen select (*) the 'Create New Summary' option or select one or more patient names to edit an unfinished summary. Choose the 'Enter' option from the action bar and the complete the screens for the summary.

Once a summary is created and saved it can only be accessed by the Dictating HCP and/or the Nurse/Clerk user selecting that Dictating HCP. This HCP is the only physician who can complete the summary. The user can invoke the 'Exit' action and abort the summary before saving any changes. This will make the summary available to another provider or allow the Nurse/Clerk user to redefine a Dictating HCP.

Sample Screen 1

```
CLEAVER,BEAVER     AGE:27     20/123-45-6789   Discharge Summary

Attending Physician: FREEDMAN,SIDNEY    Registration #: 12345
Admission Date: 19 Jun 01               Discharge Date: 21 Jun 01
Admission Diagnosis:
 MANIC DISORDER, MODERATE EPISODE (ICD 296.02)

Discharge Diagnosis:
 MANIC DISORDER, MODERATE EPISODE (ICD 296.02)
 DISLOC WRIST NOS-CLOSED (ICD 833.01)

ICD Operations/Procedures:
 OPEN REDUC-WRIST DISLOC (ICD 79.83)

Allergies:
 NKDA

Active Problem List:
 MANIC DISORDER, SINGLE EPISODE,MODERATE DEGREE   Onset 01 Jan 95

Save  Allergy  proBlem  Results  [PgDn]   Print  Help  eXit
Display the next screen of this Discharge Summary
```

End screen

The fields on this screen (Attending Physician, Admission Date, Discharge Date, Admission Diagnosis, Discharge Diagnosis) are populated by the Patient Admissions Office (PAD) during admission and are not editable here. This data can be edited by the PAD office if any discrepancies are discovered before the summary is completed.

The 'Allergy' option functions as normally found throughout CHCS. The 'Problem' and 'Result' options function as previously discussed. Use the up/down arrow keys to navigate through the editable fields on this screen. The 'Print' option allows the user to print a DRAFT copy of the summary. The 'PgDn' option moves to the next screen.

Sample Screen 2

```
CLEAVER,BEAVER     AGE:27     20/123-45-6789   Discharge Summary

Active Outpatient Medications:
 LITHIUM -- PO 300MG TAB                   T2 TABS PO TID RF2

Pending at time of Discharge (F9 = Review COMPLETE Results Only):

Lab Test(s)             Ordered For             Status
 LITHIUM                21 Jun 01@0800          PENDING
 URINALYSIS             21 Jun 01               COMPLETE

Radiology Exams
 WRIST,LEFT             20 Jun 01               EXAMINED

Test Statuses will be updated until summary is completed.

Save  Allergy  proBlem  Results  pgUp  [pgDn]  Print  Help  eXit
Display the next screen of this Discharge Summary
```

End screen

The 'Active Outpatient Medications' field will display the patient's current outpatient medication profile. This information can be maintained through the order entry option, it is not editable here. This information will update any changes until the summary is completed.

The 'Pending at Discharge' field will display tests which had not been completed before the PAD office entered a disposition. After the patient is dispositioned, the tests will remain under this field and their status will update until the summary is completed.

If the test results are completed before the summary is completed, users can place the cursor next to a Lab Test or Rad Exam and press the [F9] key to view the results of the test.

Users may access the allergy, problem, results and print options from the 'Action Bar' as described above. Use the up/down arrow keys to navigate through the editable fields on this screen. The PgDn option will take the user to the next screen.

Sample Screen 3

```
CLEAVER,BEAVER      AGE:27     20/123-45-6789   Discharge Summary

Enter Principal Diagnosis (Word Processing):


Enter Secondary Diagnosis (Word Processing):


Enter Principal Procedures/Operations (Word Processing):


Enter patient's condition at time of Discharge (Word Processing):


Save  Allergy  proBlem  Results  pgUp  [pgDn]  Print  Help  eXit
Display the next screen of this Discharge Summary
```

End screen

The fields on this screen are all free-text word processing fields. The user can enter an unlimited amount of information in the respective fields to summarize the inpatient episode.

Users may access the allergy, problem, results and print options from the 'Action Bar' as described above. Use the up/down arrow keys to navigate through the editable fields on this screen. The PgDn option will take the user to the next screen.

Sample Screen 4

```
CLEAVER,BEAVER      AGE:27     20/123-45-6789   Discharge Summary

Clinic/Div          Provider      Date/Time      Type   Status

MENTAL HEALTH/ADIV  FREEDMAN,SIDN 06 Jul 01@1200 F/U    PENDING



Enter Activity Limitations:
 No driving for:                   No long walks for:
 No jogging for:                   No stair climbing for:
 No swimming for:                  No shower/bath for:
 No golf,tennis,similar sports for:
 No sexual intercourse for:

 Do not return to work for:

Save  Allergy  proBlem  Results  pgUp  [pgDn]  Print  Help  eXit
Display the next screen of this Discharge Summary
```

End screen

The 'Clinic/Div' field will display all future appointments for the patient that have been entered through the PAS software before the summary is completed. This field can not be edited

here but will continue to update until the summary is completed. The fields for activity limitations are optional free text fields which allow up to 15 characters.

Users may access the allergy, problem, results and print options from the 'Action Bar' as described above. Use the up/down arrow keys to navigate through the editable fields on this screen. The PgDn option will take the user to the next screen.

Sample Screen 5

```
CLEAVER,BEAVER     AGE:27     20/123-45-6789   Discharge Summary

Enter Diet:

Enter Patient Instructions (F9 to import instructions):

Save  Allergy  proBlem  Results  pgUp  [pgDn]  Print  Help  eXit
Display the next screen of this Discharge Summary
```

End screen

The user may choose to enter any valid entry from the DIET file for the patient's diet instructions. The 'Patient Instructions' field is a free text field of unlimited length. The user may import prepositioned data from the 'Patient Instructions' file. Press the [F9] key anywhere in this field to import instructions.

Users may access the allergy, problem, results and print options from the 'Action Bar' as described above. Use the up/down arrow keys to navigate through the editable fields on this screen. The PgDn option will take the user to the next screen.

Sample Screen 6

```
CLEAVER,BEAVER      AGE:27     20/123-45-6789   Discharge Summary

Was Discharge Summary Dictated?: YES

Responsible Physician: FREEDMAN,SIDNEY//

Enter Discharge Summary (F9 to import instructions):




[Verify] Save  Allergy  proBlem  Results  pgUp  Print  Help eXit
Verify/complete and print Discharge Summary
```

End screen

The field, 'Was Discharge Summary Dictated?', is a required field. When the user answers 'Yes', a new field, 'Responsible Physician:', will appear with a default answer. The default answer will be the name of the 'Attending Physician' entered by the PAD office when the patient was admitted. This answer may be replaced with another HCP-level user name from the PROVIDER file.

The Discharge Summary field is a word processing field of unlimited length. Users may import predefined summary templates from the Discharge Summary Text file. Press the [F9] key anywhere in this field to import instructions.

Users may access the allergy, problem, results and print options from the 'Action Bar' as described above. Use the up/down arrow keys to navigate through the editable fields on this screen. The PgUp option will take the user to the previous screen.

The 'Verify' action will appear for HCP-level users to complete the summary and print a copy to the inpatient record room defined for this patient. The 'Verified By:' field will be populated with the signature block entry of the user who invokes the Verify command.

If the Inpatient Record room printer is not defined the user will get a message stating:

'Cannot print to record room. There is no printer defined.'

The user will also be prompted to print copies for their own records from the 'Device:' prompt to any addressable printer. Verified Discharge Summaries can also be reprinted through the

Review Patient Notes option (RPN) under the Review Clinical Results and Orders Menu (RCR).

Once verified, the summary is considered complete. The body of the Discharge Summary cannot be edited. Additional notes or corrections to the completed summary can be entered by using the 'Append' option on the first screen.

3.5.3 File and Table Changes.

Authorized users must have the NS DISCHARGE security key in order to access the 'Discharge Summary Enter/Edit' option.

The Patient Instructions file will need to be populated with predefined instructions before the user may import them into a summary. The 'Patient Instruction Maintenance' (PTM) option can be found under the 'Table Maintenance Menu' (TAB) under the nursing or physician '...Management Menu' (MNG).

Patient Instruction names are case-sensitive and can be defined for a specific clinic and or provider. The instructions field is a free-text field of unlimited length.

The 'Discharge Summary Text' file will need to be populated with predefined summary templates before the user may import them into a summary. The 'Discharge Summary Text Enter/Edit' (DIS) option can be found under the 'Table Maintenance Menu' (TAB) under the Nursing or Physician Management Menu (MNG).

3.5.4 Implementation Issues.

Key personnel will need to be identified as responsible for the file and table build before implementing this section. The appropriate security keys should be assigned to the authorized users.

Once the appropriate keys have been assigned, HCP's should provide instructions for what should be populated in the Patient Instructions and Discharge Summary Text files if they will be utilized at the site.

3.6 Immunizations.

3.6.1 Overview of Change.

The authorized user will be able to enter and maintain immunization data for a patient, update or delete existing immunization data, document reactions to vaccinations, and transcribe information for immunizations given at other health care facilities.

Immunization data entered for the Active Duty patient will automatically be transmitted to the Defense Enrollment Eligibility and Reporting System (DEERS) through an interface with the Healthcare Communications Inc. (HCI) Cloverleaf interface engine. This will provide up-to-date immunization data on the Active Duty patient via the DEERS database.

3.4.2 Detail of Change.

The documentation of immunizations and skin tests within the Department of Defense (DOD) is generally the responsibility of the Immunization clinic. CHCS will support guidelines set by the Center for Disease Control (CDC) and the American Pediatric Association (APA) for the documentation and maintenance of immunization data. In addition, the Department of Defense policies and procedures in place to deal with the special immunization needs of Active Duty Military personnel, are also supported here.

All users who have access to the Nursing Menu (OR-MD-MAIN) will have access to the new Immunization/Skin Test Enter/Review (IMM) option. This option will provide view and/or print capabilities only for those users.

Users who hold the NS IMM security key additionally be able to select one or more immunization/skin tests and document the administration data, update and delete tests, transcribe past data, enter test results and update allergy information through the IMM option.

A second new option, Multiple Patient Immunization (MIM), will appear to allow the user who holds the NS IMM security key to select one or more immunization/skin tests and define multiple patients who have received this immunization/skin test.

A. IMMUNIZATION/SKIN TEST ENTER/REVIEW

When entering the IMM option, the user will be prompted for the patient name and a performing location. The default Performing Location is established by the entry in the user's Provider File 'Location:' field. The user may enter another location, if desired, to capture the appropriate workload credit. This prompt is similar to the Requesting Location prompt in Order Entry.

Sample Screen

```
KLINGER,MAXWELL    AGE 35y  20/456-78-9012  Immunization Profile

Record of Most Recent Immunizations/Skin Test
 Type                Date Given   Date Due  Results/Date

Immunizations

 Hep-B               08 Oct 94    NA         Titer POS/21 Dec 94
 Influenza           06 Nov 94 T  Nov 95
 Plague              08 Aug 90    Aug 93
 Typhoid             08 Aug 90 T  Aug 93
 Yellow Fever        29 Mar 86    Mar 96

Skin Tests

 PPD TB (5TU)        08 Jun 94    Jun 95     Zero MM/10 Jun 94


T = Transcribed  a = Amended                          Expand = F9

[Give] Result Print Transcribe aMend  Allergies VacRxn Help eXit
Document immunizations and skin tests given
```

End screen

When the user chooses the 'Give' action, a list of available tests will display. If the patient is over the age of 7 years, the display of tests will default to tests defined for adults. If the patient's age is under 7 years, the pediatric tests will display first. The adult tests will display at the bottom of the list. Skin tests will always display at the top of the list.

Sample Screen

```
KLINGER,MAXWELL    AGE 35y  20/456-78-9012     Immunization Profile

Select Immunization/Skin Tests given

  TB PPD (5TU)

  Adult Frequently used:
  HEP B (ADULT)                            TYPHOID (IM)
  INFLUENZA (WHOLE)                        TYPHOID (PO)
  PLAGUE                                   YELLOW FEVER
  TD (ADULT)

  Miscellaneous Immunizations:
  ANTHRAX                                  ISG/IGG
  BCG                                      JAPANESE ENCEPHALITIS
  BOTULINUM ANTITOXIN                      MENINGOCOCCAL
  CHOLERA                                  PNEUMOCOCCAL
  CMVIG                                    RABIES (ID)
  DIPTHERIA ANTITOXIN                      RABIES (IM)
  HBIG                                     RIG
  HEP A                                    SMALLPOX
  HEP B (DIALYSIS)                         TETANUS TOXOID
  HEP B (OTHER)                            TIG
  INFLUENZA (SPLIT)                        VZIG
  IPV

  Miscellaneous Skin Tests:
  CANDIDA (1:10)                           TB PPD (1 TU)
  CANDIDA (1:100)                          TB TINE
  COCCIDIODIN (1:100)                      TETANUS (1:10)
  HISTOPLASMIN                             TETANUS (1:100)
  MUMPS (FS)                               TRICHOPHYTON (1:30)

  Pediatric:
  DAPT                                     MEASLES
  DPT-HIB                                  MMR
  DT (PED)                                 MUMPS
  DTP                                      OPV
  HEP B (HIGH RISK)                        PERTUSSIS
  HEP B (PED)                              RUBELLA
  HIB                                      RUBELLA/MUMPS
  M/R                                      VARICELLA

  Pediatric PANELS:
  PANEL WELL BABY 1 (DTP,OPV,HEP B,HIB)    PANEL WELL BABY 4 (OPV,HIB,DAPT)
  PANEL WELL BABY 2 (DTP,HEP B,HIB)        PANEL WELL BABY 5 (OPV,DAPT,MMR)
  PANEL WELL BABY 3 (DTP,OPV,HIB)
```

End screen

* Pediatric and Adult Panels must be defined for each host platform.
The user can select individual or multiple test and/or panels of tests to be given on the same visit or to be documented at the same time. Once the user finishes selecting the test(s) given, an input screen for each test will display where the user can enter specific details about the test(s) given.

Sample Screen

```
KLINGER,MAXWELL    AGE 35y  20/456-78-9012   Immunization Profile
HEP B (ADULT)

Lot Number:  H1234                 Manufacturer:      ABBOTT
Number of Doses Given: 3           Consent Signed?:   Yes
Dose:      1                       Dose Unit:         ML
Site:      RIGHT DELTOID           Route:             IM
Date Administered:  08 Oct 94      Next Dose Due:     NA
Administered By:   HOULAHAN,MARGARET
Ordered By:        BURNS,FRANK
Comments:

Important Information:
HEPATITIS B:  Hepatitis B vaccination is given in a 3 dose
series.  The second dose is given 1 month after the first.  The
third dose is given 5 months after the second dose. To determine
if the vaccine has been effective, a Hepatitis B surface
antibody lab test can be done one month or later after the
completion of the series.

Common Side effects:  Soreness at the injection site.

   Help = HELP          Abort = F10          File/Exit = DO
```

End screen

The 'Lot Number' will default from the last lot number used (in any Location/Division) for that test or the most recently entered lot number entered throughout the Test file. The user can type '??' at the Lot Number prompt to display a pick list of available lot numbers. If the user holds the ORMGR security key, a new lot number can be entered at this prompt. The information entered for that lot will default to the screen.

The 'Next Dose' field will default to a date as determined by the schedule template for that particular test. The number of doses given will increment with each dose given in a series through the 'Give' option. The user will be able to change this field to indicate where the patient is in the series if the series began at another facility.

The 'Date Administered' can be back-dated up to 5 days. The default for 'Administered by:' will be the user who is signed on to the current CHCS session. This entry may be changed to another user from the Provider file. The default for 'Consent Signed?:' will be 'Yes'.

The 'Site' field allows the user to enter the location on the body where the test was administered. Common locations for Intramuscular, Subcutaneous and Intradermal administrations,

including the site 'Oral' for oral administration can be entered here.

The 'Comments' field is a free text word processing field. 'Important information' can be entered about this test through the Immunization Test file.

After filing, the user will be returned to the 'Record of Most Recent Immunizations/Skin Tests' where the newly entered test(s) will be updated to the profile. Any authorized user will be able to result, enter reactions, amend or delete the test. The default action on the action bar will be to exit.

Note: Immunization/Skin Test activity for the Active Duty patient will be transmitted to DEERS automatically when the user files the administration data on the 'Give' screen. No additional user action will be necessary for this process.

The 'Transcribe' option is available to document information about tests administered at another health care facility or tests that were administered more than 5 days ago. When the user selects this option, the standard list of tests will also display. The user may select any test from the list to document.

Sample Screen

```
KLINGER,MAXWELL   AGE 35y  20/456-78-9012     Immunization Profile
THYROID

  Date Given:  08 Aug 90
  Dose Amount: .5
  Dose Unit:   ML
  Route:       INTRADERMAL
  Site:        LEFT FOREARM
  Number of Doses given: 1
  Name of Clinic or Physician: MOBLE ARMY SURGICAL HOSPITAL

  Address:  4077TH MASH UNIT

  ZIP Code: 91142      City: APO            State: AE

  Results:

  Comments:

        Help = HELP           Exit = F10        File/Exit = DO
```

End screen

After the transcribed information is entered and filed, the date on the patient's profile will be appended with a 'T' designator to indicate that this entry was transcribed. The entry can be expanded (F9) from this screen to see details.

The 'aMend' action will allow the authorized user to correct certain discrepancies to new or transcribed tests or delete the test data. The date on the profile will be appended with an 'a' to indicate that the entry was amended. When the user selects the 'aMend' action ('M' on the action bar), the following prompt will display:

```
Select: (D)elete test from patient profile, (A)mend test and
        correct the error, or (Q)uit:
```

If the user selects the (A)mend action, the 'Give' screen will appear or the associated 'Transcribe' fields will display, depending on how the information was entered. The original values will display for the user to make corrections.

If the user selects the (D)elete option, the following comment will display:

```
Delete Comment: Immunization entered in error//
```

The user may accept the default or enter up to a 60 character comment. The name of the user who amended/deleted a test will be stored in the 'Immunization Events' file. This information will only be available to authorized users through FileMan inquiry to the file.

B. IMMUNIZATION/SKIN TEST RESULTS/REACTIONS

Certain Immunizations/Skin Tests have results associated with them (ex. Hepatitis titer, TB skin test, etc.). The result of these tests can be placed on the display under the 'Results/Date' field on the profile. For most tests the 'Result' action will allow a free-text result comment (up to 60 characters). The date automatically reflects the date when the result was entered. This date is not editable. Each site can define whether a result is required for a tests. If the user selects a test where no result is required, the following message will appear:

```
No results are associated with this type of immunization/skin
test.
```

There is one exception to how results are entered. When the Tuberculin Skin test is given, the result will display as 'Pending' in the 'Results/Date' field. This status will change to 'Incomplete' if a result is not entered within 72 hours of the date administered. A result can still be entered for this test. The result codes for this test are numerically based on the transverse in duration length noted by the user ('Zero mm' to '99

mm') at the site of administration. An additional free text field is available for comments to be added (up to 30 characters).

Sample Screen

```
KLINGER,MAXWELL     AGE 35y  20/456-78-9012  Immunization Profile

Record of Most Recent Immunizations/Skin Test
   Type                  Date Given   Date Due  Results/Date


| TB PPD (5 TU)                                                |

  Enter the mm of induration measured in the transverse plane: 0
  Enter comment: 15mm of redness noted.
|_____________________________________________________________|


Give  Result  Print  Transcribe  aMend  Allergies  VacRxn  Help  eXit
Enter Results of an immunization or skin test
```

End screen

The 'VacRxn' option allows the user to document a reaction that resulted from the administration of an immunization/skin test. This option will allow users to enter the appropriate information required, according to guidelines established by the Department of Human Services and the CDC. Reactions are categorized by type and allow free-text comments to be attached.

Select type(s) of reaction:

Fever	Lethargy
Irritability	Convulsions
Local/Swelling	Arthritis/Arthralgias
Vomiting	Respiratory Distress
Rash/Itching	Other

Comments:

C. IMMUNIZATION PROFILE PRINT

The 'Print' option will allow the user to provide an official printed copy of their profile. The user can print the expanded profile that contains all administration data, including comments and reactions, or they can print a compressed profile that lists only the tests, date given, date due, administered by, and results. Each print type includes a signature field for a Health Care Provider to officiate. The signature line will be blank, no electronic signature will be available.

D. MULTIPLE PATIENT IMMUNIZATION ENTRY (MIM).

The Multiple Patient Immunization option (MIM) is available to users who hold the NS IMM security key and is designed to allow the user to select a test or a panel and give to several patients at once.

When the user enters the MIM option, they will be prompted to select the test(s) being given, enter the information on the 'Give' screen, select a performing location, and then enter the names of patients that the test(s) was administered to. The user will be continually prompted for a 'Patient Name:' until they are done. As the user enters each name, the patient's profile(s) will be updated.

3.6.3 File and Table Changes.

Authorized users must have the NS IMM security key in order to access the 'Immunization/Skin Test Enter/Edit' option for the purpose of entering or updating information.

The immunization file in the 'Immunization Maintenance' option (IPM) can be found under the 'Table Maintenance Menu' (TAB) from the Nursing or Physician Management Menu (MNG).

When the user enters the IPM option an action bar will allow the user to enter/edit immunization tests, maintain lot numbers and manufacturers, create/edit panels, build schedules that will calculate the next dose due dates, and enter/edit administration sites.

The 'Immun/Skin' option will prompt the user to enter the name of the test to enter/edit. There is already a standard list of immunization and skin tests. Each site should verify that the standard file is built according to the site's current policies. If the entry is a new entry the user will be prompted to add this entry before continuing.

The Normal Use field defines what category the test will display under on the screen. Classification and CPT code allow CHCS to identify the test, regardless of the Test Name. The results field determines whether a user can enter a result for that test.

Note: When entering/editing tests that require a schedule template, create the schedule first using 'SchedMaint'.

Sample Screen

```
Select 0: DTP
 'Are you adding 'DTP' as a new Immunization/Skin Test?: Y


DTP                                     IMMUNIZATION MAINTENANCE

Normal Usage:  Pediatric
Classification:  Diphtheria, Tetanus, Pertussis
Abbreviation: DTP
CPT Code:  90749
Current Lot Number: D8723
Results: No
Schedule Template:

IMPORTANT INFORMATION:
DIPHTHERIA, TETANUS, PERTUSSIS:  This childhood immunization is
given in a series of 3 doses. Normally given at 2 months, 4
months and 6 months of age.

Common Side Effects: Soreness at injection site, low grade fever.
```

End screen

When the user selects the 'LotMaint' (Lot Maintenance) option, they will be prompted to enter a free-text lot number for which they would like to enter or make changes to. Lot numbers can also be entered within the 'Immun/Skin' option at the 'Lot Number' prompt and through the IMM 'Give' action at the 'Lot number:' prompt by users who hold the ORMGR security key).

Sample Screen

```
W36542                                          Lot Maintenance

Standard Immunization or Skin Test:  PLAGUE
Expiration Date of Lot:              23 Jul 99
Manufacturer:                        WYETH
Default Dose:                        0.5
Default Unit:                        ML
Default Route:                       IM
Default Site:                        RIGHT DELTOID
Inactivation Date:
Available:                           Yes



[File/Exit]   Abort    Edit
 File and Exit
```

End screen

The name of the test a lot number is associated is a required field but will not be asked when entering a lot number through the 'Immun/Skin' or through the 'Give' action since a test is

already selected. The expiration date is required to define when the lot will no longer be available for selection . The default dose, unit, route and site can be entered to save the user steps while entering a test. These fields are editable through the IMM option.

If a lot runs out before the expiration date, the 'Inactivation Date' and the 'Available?' fields can be used to prevent the test from being available for selection. Also, if the site wishes to enter multiple lot numbers, the available prompt can be used to restrict selection of that lot until it needs to be used. The default for the 'Available?' prompt (if no value is entered) is 'Yes'. This prompt does not appear when entering a lot through the 'Immun/Skin' or the 'Give' options.

The new lot number will be available for users to select from the 'Give' option. If the number was entered through the Immun/Skin option, it will default to the 'Give' screen the next time a user selects the test. This lot number will remain available until the expiration date or inactivation date arrives, or until the 'Available?' field is set to 'No'.

Note:

Only valid entries will be accepted for the 'Default Unit' field, but there is no picklist of valid entries. The message, 'Answer must be 1-15 characters in length' indicates you have entered an invalid response.

A schedule allows the site to define what time frames will be used to calculate the 'Next Dose Due:' date. The default will display when the user selects the test but the user will be able to change the date if for some reason the patient is on a different schedule.

When the user selects 'SchedMaint' from the action bar they will be prompted to enter the name of a schedule they wish to modify or enter a new schedule. A schedule template can be made for each individual test or a group of tests that may have the same schedule. (Ex. an 'ANNUAL' template can be created for use with all test given once a year.)

Schedules fall into three categories, the choices are as follows:

Series: Tests which are given in a series of shots with no follow up booster. The dosing interval for this schedule type includes: Days, Weeks, Months, and Years.

Annual: Test which are given in annual increments such as every year, every 3 years or every 10 years. The only dosing interval available is Years.

Combo: Tests which are given in a series and have annual booster associated with them. The dosing interval is similar to the Series (Days, Weeks, Months, and Years).

Sample Screen

```
Name: EXAMPLE                            Schedule Type: COMBO

Total Number of Doses in Series: 2       Interval Length: MONTHS
Annual Interval:
Booster interval: 1
Booster Interval Length: YEARS

Doses:
Dose number 2 is due:  1  MONTH
```

End screen

A panel contains groups of immunizations or skin tests that are frequently given on the same visit. Childhood immunizations are one of the prime examples of panel immunizations.

The 'Panel' option will prompt the user to enter a name and then define which tests are in that panel.

Sample Screen

```
Panel Name: PANEL WELL BABY 1
Panel Type: PEDIATRIC

Immunizations/Skin Tests contained in this panel:

     DPT
     HIB
     OPV
     HEP-B (PEDIATRIC)




     Help = HELP          Exit = F10       File/Exit = DO
```

End screen

The 'Panel Type' field determines where the panel will display on the list (Adult Panel or Pediatric Panel). To add a test, type the name of the test you wish to add to the panel. To delete, move the cursor next to the test and press the remove key. Confirm that you want to delete the test.

The 'Sites' file comes populated with standard anatomical sites for administration of intramuscular, subcutaneous, intradermal test and the site 'Oral' for orally administered tests. If more site options are needed, the user can add them through this option. Once a site name is created and filed it cannot be deleted since the entry may have been used. Only the abbreviation can be edited for a site entry that has been filed. The manufacturer file ('Manuf') comes populated with standard manufacturers. If more names are needed, they can be added here. Once a manufacturer is added it cannot be edited or deleted.

3.6.4 Implementation Issues.

Standard entries for immunization/skin tests, manufacturers, and sites are available once the software is loaded. If the site desires, it may add to or edit these files to meet their specific needs. In most cases, current entries are not editable.

The site should build panels, schedules and lot numbers before implementing the IMM option.

At some sites it may be necessary to build an Immunization Clinic as a Performing Location. If this is the case, contact your MEPRS personnel to determine the appropriate MEPRS code for use. Typically the FBIA code is used for Immunizations. Once the clinic location is built, the immunization personnel should have their Provider file location updated to reflect the appropriate default location for them when they enter the IMM option and ensure the appropriate workload credit gets counted.

3.7 Transportable Patient Records.

3.7.1 Overview of Change.

The Transportable Computer-based Patient Record (TCPR) allows the authorized user to compile existing data from CHCS, laboratory and radiology results, documented allergies, patient notes, immunization records, demographic information, medication profiles, appointment records, as well as past hospitalization information in a computer-based patient record for electronic transmittal between medical facilities.

3.7.2 Detail of Change.

Authorized users can be given the options necessary to generate computer-based patient records and export these records to

another facility. Authorized users at the receiving facility can view/print these records to evaluate patients being transferred to their facility. This will allow the receiving facility to obtain access to patient data before the patient arrives.

TCPRs can be created by a PAD clerk, Clinical user or Systems Manager for individual patients or a group of patients whether active duty, family member, or retired. The record(s) can be created as soon as it is known that the patient is relocating, traveling, or for when another provider at another facility needs to review the patient record.

A. MANAGE TRANSPORATBLE PATIENT RECORDS (CPR)

The Manage Transportable Patient Records (CPR) option on the Physician or Nursing Menu allows the user to create a TCPR, send the TCPR to another Military Treatment Facility (MTF), or request a TCPR from another MTF. The file created contains all data for the specified date range for selected patient(s). This option is locked by the DG TRANSPORTABLE RECORDS security key.

Note:
The data for immunization and outpatient medications will be included regardless of date range selected.

1. Generate a TCPR.

Once the user enters the CPR option, the 'Generate' option will default. This option prompts for a date range from which to search for data to be included in the record. The default 'Latest Date:' will be the current date. The 'Earliest Date:' defaults 180 unless the user enters another date. The next prompt is for 'Patient Name:'. If the user selects a patient for which a record already exist, the following message will appear:

```
A transportable Computerized Patient Record was already generated on 21 Jun 2001
for date range 23 Dec 2000 to 21 Jun 2001. Do you wish to delete the existing
record and create a new Transportable Computerized Patient Record for this
patient?  NO//
```

If the existing record is accepted, the user will be taken back to the 'Patient Name:' prompt to select more patients. If the existing record is overwritten, a new record is created. The existing record is overwritten to ensure that unnecessary copies of a record do not accumulate in CHCS. The user should consider if new information has been resulted on the patient since the last record generation when determining to overwrite a record.

Note:
TCPR's generated will be purged automatically by the system once the date range in the Clinical Site Parameters (CSM)

for 'Purge TCPR Records:' is reached. The default is 7 days. Records received from other sites will not be purged during this process.

The prompt to 'Save above list of patient's in a batch:' allows the user who selected more than one patient to save that group of names to a batch for ease of retrieval. If no batch name is enter, the records can be retrieved by patient name.

Sample Screen

```
Create TCPR Date Range:
       Latest Date: 21 Jun 2001
     Earliest Date: 23 Dec 2000

Enter Patient Name(s):
  ADAMS,GOMEZ
  ADAMS,MORTICIA
  ADAMS,WEDNESDAY
  ADAMS,PUGSLY

Save above list of patient names in batch: ADAMS FAMILY
```

End screen

2. Send a TCPR.

After a TCPR is generated, it can be sent to a remote site, or to a device such as a printer. The Send option allows the user to select a patient(s) or a batch of patient records to send.

The 'Batch' action displays a list of batches that are available to send to another site. The (F9) action allows the user to see what records are contained that batch. The 'Select' action displays a list of patients with a generated TCPR (regardless of batch) that are available to send to another site.

After selecting the patient(s) or batch(es) to send, you can send it to a Remote Location or an addressable device. When you select the 'Remote Loc' option, the system prompts you to 'Select MTF Site to Receive Report:'. (You can only select and MTF that has been predefined by the Systems Manager to receive records.) After you enter the site name, the system will return to the TCPR option screen. The report will be transmitted automatically.

When the device option is selected, the system will prompt for an addressable 'Device' to print the record to. The user can 'Queue' this to print to a Spool File, Clinical Desktop View Text, or File name. This record can then be sent via conventional mail or courier.

3. Request a TCPR.

A user may request a TCPR from another predefined MTF. When a user selects the 'Request' option, all fields on the screen will be required for this process, except the patient's date of birth. The Sponsor's SSN is required for a dependent record. The default date range is six months. When the user files the request, the system will send a request to the other site for a TCPR. The other site will then send a TCPR back in response to the request.

4. Receive a TCPR.

When a record is received it will automatically register the demographic data of the patient through Mini-Registration, unless the Clinical Site Parameter that controls this action is set to 'No' or the patient is already registered. (See Section 7.4.3)

Note:
Records received will not be purged according to the parameter set in the Clinical Site Parameters.

B. REVIEW TRANSPORTABLE PATIENT RECORDS

TCPRs can be reviewed using the Review Transportable Patient Records (RTR) option on the Review Clinical Results and Orders (RCR) Menu. When the user enters this menu and enters a patient name, the system display the date range and data elements of the TCPR for the user to select and review. If no record exist, the system will no recognize the patient's name. This option is not locked by a security key.

After the Date Range and Data Elements are selected, the user can Browse or Print the data. The user can use the (F11) key to select all date ranges and/or all data elements.

Sample Screen

```
ADMAS,GOMEZ         07 May 1949    52y/o male     20/200-20-7514

Date range for record:   Received from:
  23 Dec 00-21 Jun 01    NATIONAL NAVAL MEDICAL CENTER



Select Data to Review:
  Laboratory Results                        Allergy Information
  Radiology Results                         Progress Notes
  Inpatient Medications and IV History      Discharge Summary
  Outpatient RX History                     Patient Problem List
  Immunization History                      Past Hospitalizations
  Consultation Results                      Outpatient Appointment Summary


  Select Item = SELECT     Select All = F11
 Help = HELP      Exit = F10     File/Exit = DO
```

End screen

3.7.3 <u>File and Table Changes</u>.

The Site Manager will have access to the Manage TCPR Interface (MTA) menu under the Site Manager Menu (SM). This option will allow the manager to control and maintain the TCPR interfaces. This includes, starting up and shutting down the transmitter process, displaying the status of the transmitter, viewing the interface queue sizes, printing TCPR transmission error logs, maintaining the transmission destination file, viewing incoming and out going messages, and maintaining the TCPR process control file.

The Clinical Site Parameters for this option should be set to insure proper handling of TCPRs. The following Fields need to be reviewed for this effort:

- Enable TCPR Mini-Registration: YES (default)

  Defines whether the demographic data for a TCPR that is received by the site will be automatically registered, if not already in the Patient File.

- Purge TCPR Records: 7 (default)

  Defines the number of days before a TCPR will be purged after it is generated.

3.7.4 Implementation Issues.

Coordination with the PAD POC and the Systems Manager is required for this effort. The site parameters must be defined to send and receive TCPRs. The other sites must be using CHCS Version 4.6 to send or receive records. Sites on V4.6 can use this option to generate and send printed records to sites not yet on V4.6.

The Transportable Records Management (CPR) option is locked by the DG TRANSOPRTABLE RECORDS security key. The Review Transportable Records (RTR) option is not locked. The site should choose how these options will be utilized and who will have access to which options.

For example:

> The System Manager may choose to be responsible for the generation of TCPRs and their transmission or request between sites, through the CPR option, while the user only has access to review the records, through RTR.
>
> The site can allow the Clinical or PAD user access to the CPR option for generating, sending, requesting and printing records, with systems involvement for sending and receiving.
>
> The Clinical or PAD user can access the CPR option to generate a TCPR and send it to a device. This requires no file and table or systems involvement. The printed record can be delivered by mail or courier to another site.

There are no known negative or positive aspects involved with the above examples. It is recommended that the Clinical Site Parameter to purge TCPR's within 7 days is defined and the TCPR interfaces are set up correctly, if applicable.

3.8 Add Duty Station to Results Printout.

3.8.1 Overview of Change.

The Active Duty Sponsor's Military Duty Station will now display in several areas throughout the Clinical Subsystem for Consult and Scheduled Ancillary Procedure Printouts to assist in determining the appropriate record locations.

3.8.2 Detail of Change.

The user will be able to identify the Military Duty Station/Unit of the patient's sponsor.

The Station/Unit is entered during patient registration in CHCS for Active Duty sponsors and their dependents. The information will automatically display on order printouts and within the <F9> expanded order display for CON and scheduled ANC orders.

When a user enters, updates or prints a CON order, the Station/Unit will display. Any updates to the Station/Unit (in the patient's registration) will automatically be reflected on the CON and scheduled ANC order printouts.

Sample Screen

```
Personal Data  - Privacy Act of 1974 (PL 93-579)
-----------------------------------------------------------------
1    CON 010621-03392     20/700-70-7605    MILLER,BARNEY
     CARDIOLOGY CONSULT on 21 Jun 2001@1423
     Duty Station/Unit: NATNAVMEDCEN

     POTTER,SHERMAN MD/PENDING
```

End screen

The Duty Station/Unit will also appear on the following reports or displays:

- **Individual Order Display** option. (Menu Path: RCR>IOD)

- **Patient Order List Printouts.** Individual orders are printed out when the user quits and activates orders, when the user enters a "P" next to an order on the Patient Order List in order Entry or when POR is entered at the ACTION prompt, all orders on the page are printed.

- **Expanded Order Display.** When the F9 key is used to expand an order in the order list, the order display or CON and scheduled ANC orders will now include the Duty Station/Unit.
- **Single order print.** For canceled CON orders and scheduled ANC orders only.

- **Result Search**, for Scheduled ANC orders only.

3.8.3 File and Table Change.

There is no file/table required in the Clinical subsystem for this effort.

3.8.4 Implementation Issues.

Inform users that they will now find the Duty Station/Unit on Consult and scheduled Ancillary Procedure printouts for Active Duty Sponsors and their family members.

3.9 Unit Identification Code (UIC) Change.

3.9.1 Overview of Change.

Changes to the Unit Identification Code (UIC) throughout CHCS will correct data inconsistencies associated with the UIC. The overall changes are called the "UIC Total Solution" which benefit several subsystems throughout CHCS.

3.9.2 Detail of Change.

When a patient is registered in CHCS, the Station/Unit is a required entry for both Active Duty patients and any family member dependents who are patients. This information is stored in the patient file of CHCS. In past versions of CHCS, the field entry for Unit Identification Code (UIC) was a free text entry. If it was a non-standard entry, the user was prompted "Use as is?" and the free-text entry was stored. After Version 4.4, the user had to choose a standard UIC from a picklist so that a pointer relationship could be established with a valid entry in the Unit Ship ID file. The subsequent problem was that the files containing free text entries from past versions were not understood by the system as valid UIC entries. This created problems in MCP enrollments when accurate UIC data was required. The solution to the UIC data problem is corrected in version 4.6 by the project called "UIC Total Solution." A conversion will be run to convert the free text UIC's in the system to valid UIC entries. The Clinical portion of this project was to make changes where necessary throughout the Clinical subsystem to accommodate this data fix.

This change will be transparent to Clinical users and have no impact on their workflow. The Clinical (OR*) input templates, print templates and subroutines will be modified to reflect the changes to the Patient file (#2). The Clinical software will utilize the data from the Unit Ship ID field of the Patient File.

3.9.3 File and Table Change.

No file and table is required for this effort.

3.9.4 Implementation Issues.

None.

3.10 Inappropriate Requesting Location Screen.

3.10.1 Overview of Change.

An Inappropriate Requesting Location (IRL) is defined as a hospital location that has a location type of File Area with an 'E-level' MEPRS code. The entry of a File Area location as a Requesting Location for outpatient orders has been a problem in the past. The system will no longer accept the entry of an IRL at the 'Requesting Location:' prompt in ORE or where a default location and default MEPRS code is entered in the User Order Entry Preference (USR) or the Desktop Order Entry Preferences option (UOP).

3.10.2 Detail of Change.

When a Clinical user enters the Enter/Maintain Orders option to place an order on the system, the "Requesting Location:" prompt. For outpatients, this prompt is blank (unless a default is set as the user's Order Entry Preference). For inpatients, the patient's ward location is defaulted. In all cases, the entry should be the hospital location (MEPRS code, or Cost Pool) within the system, that identifies the location that should be credited for the order request. The 'E-level' code is not a valid requesting location.

Since the system has no way of knowing where the user is requesting the order from, the entire hospital location list is available to choose from. However, File rooms with an 'E-level' MEPRS code should not be a valid entry in any case. This enhancement screens out the 'E-level' MEPRS codes to eliminate this an incorrect entry at the Requesting Location prompt.

The default outpatient requesting location may be set in the UOP parameter by Clinical users. The 'Default Location' should be input with the primary location the provider treats patients. This parameter can be set through the Desktop UOP action. The USR option should not be used to set this default. This is not a

new feature but is a good practice to decrease the possibility of entering a wrong location when ordering.

3.10.3 File and Table Change.

None required.

3.10.4 Implementation Issues.

Remind Clinical users that accuracy is important when they enter a MEPRS code or location name at the requesting location prompt for orders. Accurate requesting location and performing location relationships are extremely important to support the Workload Assignment Module (WAM).

Users should be encouraged to enter a default location in the Clinical User Order Entry preferences parameters or verify that their current default is correct.

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APPENDIX A:

GENERIC/COMMON FILE CHANGES

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A.1 SUMMARY OUTLINE.

This Section provides a brief summary of the software changes in CHCS

A.1.1 UIC TOTAL SOLUTION.

The ability for users to use free text to designate a Station/unit in mini and full registrations (The "Use as is?" option) has led to a number of coding and data inconsistencies across all of CHCS. Changes have been made to force users to select entries which are contained within the Unit Identification Code file. In addition, a conversion has been written to try to convert all of the free text entries to valid entries. Many new options have been developed to maintain the UIC file and make it easier for users to select an appropriate Unit for patients.

A.1.2 MTF DATA NO LONGER SUPPORTED.

The Medical Treatment Facility (MTF) File has been used historically in CHCS to designate the Medical Treatment Facilities belonging to the Department of Defense and other facilities with which they associate. As such, entries in this Class 1 file have been used throughout the software to not only designate individual facilities but to also designate the CHCS platform at an individual site. This file will now be editable. Sites will no longer have to choose a value from this file to define their site, instead they will be able to create a "Host Platform Name".

A.1.3 PROVIDER AND PLACE OF CARE INACTIVATION.

CHCS presently allows authorized CHCS users to inactivate providers and hospital locations by more than one method. CHCS will now maintain consistency when inactivating a provider either by entering an inactivation date in the Provider file, or when DBA-Inactivating Providers. There will also be consistency for the inactivation of Hospital Locations.

A.1.4 E-LEVEL MEPRS EDIT.

CHCS will prevent the entry of an inappropriate requesting location in the DEFAULT LOCATION field in the User Order-Entry Preferences option and in the LOCATION field in the Provider file.

CHCS will also produce two new reports to identify discrepancies for existing data in the Hospital Location file. One report lists hospital locations, when the Group IDs for the location and the location's MEPRS code are not equal. The second report lists hospital locations that have an inappropriate MEPRS code based on the Location Type.

A.1.5 MEPRS PARENT ADDED TO DMIS ID FILE.

SAIC will modify the CHCS DMIS ID Codes file #8103 to include all fields currently provided in the source data file which CHCS receives. CHCS will be modified to use the MEPRS (EAS) PARENT field (new) to determine if a division's workload is eligible for Workload Assignment Module (WAM) workload reporting.

A.1.6 CHANGES TO SUPPORT APV.

When patients are surgically treated and released within twenty-four hours, workload reporting is processed as outpatient workload under the new category entitled "Ambulatory Procedure Visit" (APV). This enhancement requires that the Ambulatory Procedure Units (APU) be set up as unique hospital locations. These APUs have a location type of "Ambulatory Procedure Unit," that replaces the existing "Same Day Surgery" location type.

When defining MEPRS Codes, the system allows the user to flag the appropriate MEPRS Codes as APU MEPRS codes. Additionally, the system allows the user to define the corresponding DGA* MEPRS Code for hospital locations defined as "Ambulatory procedure units" that also utilize an "APU" MEPRS code. This will enable CHCS to record minutes of service for APV workload, and attribute it to the appropriate MEPRS code.

If the patient's APV encounter requires an inpatient admission, the system allows the user to assign the new corresponding Source of Admission Code, "APA - Admission Resulting from APV."

A.1.7 REVISE PROVIDER SCREENS AND PROVIDER FILE.

This change redesigns the Provider File Enter/Edit screens and removes obsolete data elements from the provider file. Obsolete data elements have been removed from the provider screens and remaining elements have been rearranged for a more logical grouping.

MailMan Enhancements

The List New Messages (LNM) option on the CHCS user's Mailman menu now offers the user a window screen format for viewing and selecting messages and responses to read. This window allows the user to scroll through back and forth through the list to decide which messages to read. Press the select key, only, next to the subject and the message will display. Once the user is finished reading the message and chooses a Message Action the new message window will return for the user to select another message.

Scrolling options include the standard uses of the up or down cursor keys, the [F7] key for bottom of the list, the [F8] key for top of the list and the NextPage/Previous Page keys.

Sample Screen

```
 New Messages for DOCTOR,LAMP
   @TRAINING.SAIC.COM                    Thu, 21 Jun 2001 12:15:44
 ____________________________________________________________________
|                                                                    |
    1) Subj: APPOINTMENT SCHEDULED
             Thu, 21 Jun 2001 11:54:02     5 Lines
       From: POSTMASTER   Not read, in IN basket
    2) Subj: MISSING SIGNATURE
             Sat, 10 Jan 2099 17:26:05     3 Lines
       From: POSTMASTER   Not read, in IN basket
    3) Subj: MISSING SIGNATURE
             Sat, 10 Jan 2099 17:26:05     3 Lines
       From: POSTMASTER   Not read, in IN basket
    4) Subj: NOTIFY NON-COMPLIANT RX
+             Sun, 17 Jun 2001 10:23:27    10 Lines
|____________________________________________________________________|
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APPENDIX B:

MASTER CHECKLIST

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GENERIC CHECKLIST ITEMS FOR ALL USERS

B.1 USER TRAINING.

B.1.1 CLN.

It is recommended the site request Implementation Support for training and user assistance in the new clinical enhancements for this activation.

It is recommended that HCP-level users (Classes 2-4) and Nurse/Clerk-level users (Class 0-1) attend separate demonstrations for clinical enhancements that will be utilized.

Training sessions should include a brief introduction demo covering the Inappropriate Requesting Location changes, and an overview of the Transportable Patient Records, Duty Station and UIC enhancements. Classes should be organized to include the topics below.

HCP-Level users: (Determine length of class by topics)

Introduction Demo	(15 min)
Progress Notes	(30 min)
Discharge Summaries	(30 min)
Problem Lists	(30 min)
Consult Results	(1 hour)
APV Order Entry	(30 min)

Nurse/Clerk-Level users: (Determine length of class by topics)

Introduction Demo	(15 min)
Progress Notes	(15 min)
Discharge Summary	(30 min)
Problem Lists	(15 min)
Consult Results	(1 hour)
APV Order Entry	(15 min)
Immunization Enter/Review (Nurse-level)	(30 min)
Nursing Due Lists	(1 hour)

It is recommended that supervisory personnel, responsible for File and Table maintenance, attend a separate demo to cover the requirements for Progress Notes, Immunizations, Clinical Site Parameters, Consult Procedures, Discharge Summaries and Transportable Patient Records. Transportable Patient Records training is not covered in the core classes.

It is recommended that users who will be responsible for entering APV Minutes of Service attend the PAS demonstration covering this option.

B.1.2 COMMON FILES.

It is recommended that Data Base Administrators attend a two hour demo.

B.1.3 LAB .

There are two LAB IUG documents to reference for this upgrade:

(a) IPDWC Interface to COMED AP: MPL Enhancement DS-IMPL-5000
(b) This IUG: Upgrade to CHCS Version 4.6

A 1.5 hr. demo of general 4.6 changes is recommended for Lab Supervisory Personnel prior to activation. The familiarization training plan is recommended as an alternative if a demo is not possible.

If APCOTS is not ACTIVATED or if the MPL enhancement has already been implemented, a 2 to 3 hour block of time for demo or self study is estimated for a user familiar with CHCS Lab F/T maintenance to prepare for this upgrade. Sites without users familiar with Lab F/T maintenance have two logical choices, (1) subscribe to standard CHCS training {est 2-3 days} or (2) request onsite outside assistance.

If the site is preparing to activate APCOTS, an additional 2-3 hours is recommended for demo and to answer site questions.

Attendance: Lab KEY POC's: Managers, F/T maintenance, Anatomic Pathology, senior supervisory personnel, Quality Assurance and Lab Trainers.

B.1.4 MCP.

USE CURRENT END ELIG DATE TO DETERMINE AD DISENROLLMENT

1. MCP Supervisors, MCP F/T personnel -Screen #1 of change	5 min demo Handout

SET PCM CAPACITY FOR MEDICARE ENROLLEES

1. Enrollment Clerks	Demo	15 mins
2. MCP Supervisors & F/T personnel (includes Enr clerk's demo)	"	30 mins
3. Systems/MCP Sup./F&T personnel Handout: Exception Report		

LIST ONLY PCM GROUP MEMBERS IN HELP TEXT

1. MCP Booking Clerks	15 mins
2. Health Care Finders	15 mins
3. MCP Supervisors	15 mins

DISPLAY DEERS INFO IN MTF BOOKING FOR MEMBERS NOT ENROLLED

1. All Users	Handout of the new screens ...

AUTOMATIC ELIGIBILTY CHECK FOR CONDITIONAL ENROLLMENT

1. MCP SUPEVRVISORS	Handout - This Change

AD ASSIGNMENT TO EXTERNAL PCM

1. Tricare Enrollment Clerks	15 mins
2. Tricare/MCP Supervisors	30 mins
3. MCP F/T personnel	60 mins

(Class for F/T includes Clerks & Supervisors demo)

PROVIDER PLACE OF CARE INACTIVATION

1. PAS and MCP Supervisors	30 mins

UIC TOTAL SOLUTION

1. MCP Clerks	15 mins
2. DBA Common Files	Refer to CF IUG

EBC

Refer to EBC IUG.

B.1.5 PAD/MSA.

It is recommended that PAD supervisors attend the 1 hour supervisory demo plus the 1.5 hour clerk/general user demo. MSA supervisors and clerks should attend the 1 hour MSA demo.

B.1.6 PAS.

A 2 hour demo is recommended (1 hour for APV users; 1 hour for other PAS users), to be attended by Facility Trainers, Booking personnel, Clinic Supervisors, and PAS file and table POCs.

(See MCP section as well. Sites using MCP may want to combine demos) it combined, schedule a 3 hr. time slot.

B.1.7 PHR.

The time required for training may vary from site to site depending on the functions utilized. Bar Code, the Dispensing Option Enhancement and/or Quick Dispense are optional. The latter two are dependent upon the use of the Ver 4.5 Dispensing Option. If the site chooses not to use any of these, then the remaining changes, except for RX Number Consistency and FDB III, are either passive in nature or will affect supervisory personnel only.

A 1 hour demo is recommended for familiarization training. An additional hour is estimated to demo the Dispensing Option Enhancement, Quick Dispense, and Bar Code changes.

B.1.8 RAD.

RAD USERS: File and Table supervisors should attend a two-hour training demonstration for both modifications to the Print Pull List and Scheduling Parameters Modifications. Both will require file and table maintenance.

File room personnel should attend a one-half hour demonstration on the new Print Pull List option.

B.1.9 MRT.

PAD USERS: Users who are responsible for retiring records to NPRC or transferring records within their CHCS network should attend a two-hour functionality demo/training. This would include all PAD POCs, file room supervisors and personnel responsible for performing transfer/retire tasks.

PAD USERS: If MRT clerks will be creating APV records, they should be available for an APV record creation demonstration of about 30 minutes.

PAS/MCP USERS: If PAS supervisors are going to create a file room for APV records, they need one on one training (if they do not know how to create a file room) of about 30 minutes.

SITE MANAGERS and SYSTEM SPECIALISTS: It is recommended that site personnel responsible for formatting the Record Index/Shipment Data File to ASCII attend a one on one demo of about 30 minutes.

B.2 IMPLEMENTATION ISSUES.

B.2.1 CLN.

Before the Install:

____ 1. It is recommended that the site assess the way they are currently using Consult Orders and determine whether the Consult Results option will be used. Gather data for the File and Table build to be entered post load to include Consult Names and type; Consulting Clinics and Providers; Devices, etc.)

____ 2. It is recommended that the site gather data related to the Ambulatory Procedure Units that are currently in use for File and Table build post load. Coordination with PAS, PAD, MEPRS and Systems Admin is required for this effort.

____ 3. The site should establish what pre-positioned data will be entered for Patient Instructions and Discharge Summary Text to support the Discharge Summary enhancements. Patient Instructions can be entered before the load.

____ 4. It is highly recommended that the site appoint a contact person for Immunization file and table build. This information should be available post load for all immunization file and table requirements.

Post Install:

___ Communicate with other areas and verify that all APV File and Table has been completed before use of this option can be implemented.

___ Assign the necessary security keys for Patient Notes, Consults, transportable records and APV order entry.

___ Identify personnel for each clinic to be responsible for the Problem Selection List entries if this enhancement will be utilized on site.

___ Decide how the Transportable Patient Records options will be utilized at the site.

B.2.2 COMMON FILES.

Pre Load:

___ A meeting must take place between the different sites on the CHCS system to determine if a host platform will be defined and, if so, what values will be used.

___ A meeting must take place between the Data Base administrator and the MEPRS office to determine which MEPRS codes will need to have the "APU Flag:" set to YES and DGA* MEPRS that the APU locations will be linked to.

Post load:

___ In the case of hospital locations with inappropriate MEPRS codes, a determination will need to be made as to who uses the location if anyone. If no one uses the location, it should be inactivated. If the location is being used or orders are being made using it as a requesting location then a determination should be made as to what MEPRS code it should be using and whether the "Location Type" is correct.

___ Hospital Locations with the MEPRS code or Cost pool Code inconsistent with the Group ID of the hospital location will need to be fixed. All divisions on the data base need to address this issue.

___ For the APV project, the building of APV MEPRS codes and APU Locations must be complete before other sub systems can do their file and table builds.

B.2.3 LAB.

___ Quality Control Report Menu Option Enhancements

Verify that Quality Controls are defined with a Lab Section. Note that this field in the Quality Control file is not required for defining a Quality Control Specimen ... but is needed for this new enhancement to work properly!

___ LAB HOST PLATFORM PARAMETERS (#8700) - **NEW FILE**

For any site needing to activate APCOTS, FileMan Enter/Edit is still required, but this is now done by accessing file #8700 instead of the LAB MTF (#69.9) file.

___ DBSS activation

(1) The CHCS Program Office will direct when/which sites can activate DBSS. This is not a site decision.

(2) In terms of technical requirements, to support this interface, the minimum DBSS S/W version is 2.01.

(3) Recipients to receive discrepancy BLOOD TYPE bulletin:

For each Lab Division DBSS site, the determination will need to be made concerning appropriate entries to receive the Blood Type Bulletin, bearing in mind that Mail Users and Groups may be division specific and Device file entries are MTF-wide.

___ CHCS BLOOD TYPE TEST

If not already defined, a {non-DBSS} laboratory test can be created for CHCS result entry of a patient's Blood Group and Rh Type. The name of this test can be entered in the Lab Host Platform Parameters file. As this test will be shared system-wide, sites will need to reach an agreement for the name.

Note, if existing CH subscript tests already exist, caution needs to be exercised to ensure that test replacements do not compromise existing ORDER SETS. If an order set is defined with an existing lab test that is going to be inactivated, the order set will need to be edited to delete the old test and to add the new one.

One final note is that certain characters (symbols) may need to be avoided when defining the name of the new test. For example, if "&", "\", or "+" are incorporated into the test name, the result will not be received into CliniComp.

___ DAC Results Report {Amended Results}

As a result of version 4.6 s/w changes, laboratory results amended before the upgrade will not be captured on the DAC report for Amended Results. Since this historical data will not be available after the upgrade, it is suggested that Lab Managers (in each Lab Work Element) print the standard DAC

report for Amended Results if this report is presently being used/monitored by QA. If this is done on a daily basis for the week preceding the upgrade, then on the day prior to the upgrade, there will be only one days worth of data to be compiled and printed {and the report should complete quickly}.

___ DII/LSI Interface

A new Mail Group should be created by DBA to receive DII Error Message bulletins. Depending upon the needs of the site for those bulletins, consideration should be given for division specific mail groups. DII type entries in the Lab System Interface file would subsequently need to be populated correctly with the appropriate mail group for each division. It is NOT recommended that these mail groups be added in the Bulletin file.

After the upgrade, error messages from DII interfaced instruments will begin to display to lab users during TAR as a part of routine operation. These error messages will also begin to populate the DII ERROR INITIALIZATION and the AUTO INSTRUMENT files. In the Auto Instrument file, this instrument generated error message will populate the ERROR CODE and the associated ACTION CODE and ERROR TEXT. The Action Code populated by the error message is the default, "Display Error/Do Not File". Lab F/T action is required to change this Action Code as needed and enter the User Definable Error Message for each error. The User Definable Error Message field is 'free text' and gives Lab F/T users the means to clarify the error display text and to specify the suitable course of action for the lab user to take when the error is encountered. The Lab F/T interaction will continue until all possible errors have been encountered by the DII interfaced auto instrument and as instrument software upgrades are installed with new and/or different error messages.

___ Routine preparations for version upgrades are done:

Verify there are no outstanding Transmittal Lists, Collection Lists and Work Documents. One of the enhancements of version 4.6 is SIR 14744, which establishes an upper limit on batches as 9999. Any Work Document batches greater than 9999 will not be accessible after the load. Even though a laboratory may have work document batch #'s less than 9999, it is still recommended that all work documents are unloaded as a normal precaution prior to the upgrade.

B.2.4 MCP.

USE CURRENT END ELIG DATE TO DETERMINE AD DISENROLLMENT

POST LOAD

___ Decide on the Grace Period for AD enrolled patients and set the parameter via menu option PARA.

SET PCM CAPACITY FOR MEDICARE ENROLLEES

POST-LOAD

___ Print the Exception Report BENFICIARY CATEGORY/PATIENT CATEGORY DISCREPANCY REPORT.

___ Review the report to correct Patient Categories or registration.

___ Review PCM Groups and revises PCM capacities as needed.

AD ASSIGNMENT TO EXTERNAL PCM

Pre-Load:

___ Determine which external PCMs will be allowed ACTIVE DUTY patients and establish capacities.

Post-Load:

___ Review all external PCMs with agreements of NET and SUP.

___ Define AD capacities for these providers if limit .....

___ Assign new Security Key to appropriate users (sec 2.5).

PROVIDER PLACE OF CARE INACTIVATION

___ CHCS users (i.e., PAS Supervisors, and Managed Care Supervisors) will use the system as they do presently to inactivate and reactivate PAS providers and clinics and MCP providers and places of care. The end result is the same. The process in achieving the end is different.

UIC TOTAL SOLUTION

Pre-Load:

___ Ensure all registrations are correct when feasible

Post-Load:

___ DBA should review reports to correct registrations.

B.2.5 PAD/MSA.

Before the install:

___ Run the MSA and TPC Active Accounts Receivables (AAR) the day prior to the software load.

___ Run the MSA Balance Check two days prior to the software load and log a Support Center Call for any problem accounts.

___ Sites can make good use of Post Master Mailman Messages in order to emphasize key changes which will affect the users after the software load, i.e.: MASCAL Phase II, DD7A Functions, Station/Unit Code Changes, etc.

___ Sites who want to create a DD7A Billing Report for the month during which CHCS version 4.6 is loaded, should take steps to record all applicable outpatient visits which can then be added to the report via the DD7A Monthly Outpatient Billing Process (MBP).

___ Sites may want to run off all templates for Ad Hocs created to support the MASCAL Functionality.

During the install:

___ Track all PAD/MSA activity to be backloaded when the system is returned to the users.

B.2.6 PAS.

___ Sites need to define the HOST PLATFORM NAME, but don't need to do so until after the installation of Version 4.6.

___ File and Table personnel need to review the clinic profiles to ensure they are set up with the correct service.

___ The Service Type file must be populated through BFIL.

___ PAS clinic and provider profiles, templates and schedules must be created and maintained for each APV clinic.

B.2.7 PHR.

If a site plans on using Bar Code:

___ Before deciding to implement Bar Code on all printers, users should plan on a trial period using a limited number. Bar Coded label generation by Datasouth printers will take significantly longer than they are accustomed to(three times as long). And, even if the site has acquired an Intermec printer exclusively for Bar Code, a non-bar coding printer should be kept available for a period of time.

If a site plans on using Dispensing software:

___ It is likely that most sites will have delayed implementing Dispensing Option (Ver 4.5) awaiting the availability of Bar Code. At those sites where this is true, it would probably be prudent to not enable Dispensing Option/Dispensing Option Enhancement II and Quick Dispense until the Bar Code trial has been completed and the label generation time increase has been evaluated by the site.

___ Pharmacy users should be encouraged to mark RXs noncompliant via the DRX option rather than via Noncompliance Data (NON). This will combine multiple RXs for the same patient into one mail message. If this is done via NON, one message will be generated for each RX.

Dispensing Option/Dispensing Option Enhancement and Quick Dispense are enabled at the Division level. It is either on or off for all outpatient sites in a particular division.

___ Caution sites that disabling dispensing software will permanently erase dispensing data recorded to that point.

B.2.8 RAD.

___ Schedule templates will require modification prior to implementing 24-hour scheduling.

___ Existing labels will require re-formatting if new print fields will be implemented.

___ Clinics requiring Radiology to pull records for SCHEDULED APPOINTMENTS MUST be in the BORROWERS SET-UP FILE.

B.2.9 MRT.

PRE-LOAD

___ It is recommended that old retirement indices be deleted prior to V4.6, as they cannot be deleted once V4.6 has been loaded.

___ Review current record types in the Type of Record Setup. Decide if any new record types need to be created. The PAD POC should check with other divisions prior to the load to see if they will use any new record types and either enter that information into the files or have the individual division POC's enter that into the files after the load.

___ Will PAD or PAS be creating APV records? The APV record must be created using the Create APV menu options from the PAS menu to ensure that the APV record is linked to the ambulatory procedure itself. If APV records are created through the PAD CV option, they will not be tied to the PAS appointment and the APV record tracking number will not be assigned. It must be decided who will create the APV records and if PAD will do so the APV menu can be assigned as a secondary menu.

POST-LOAD

___ Any medical record stored in a file room which does not have a corresponding electronic entry on CHCS MUST be entered onto CHCS or retired using the current manual process.

If there is no electronic record on CHCS and the site wishes to use CHCS to retire these records:

Access the 'Record Initialization' Menu:

1. PAD -> MRM -> TM -> OR -> CB {Create/Edit Batch Lists}
2. Enter patient's name for whom there is no record
3. Record creation date can be 'back-dated' to indicate when the patient was last seen at the MTF. The retire list searches the last patient activity date to put records on the list.
4. Then, PAD -> MRM -> TM -> OR -> NR {Create New Records/Print Labels}

You should now be able to create electronic retire lists using the appropriate search dates. When the RECORD INDEX is created using the Transfer-Retire menu, it will now include these records as eligible to retire.

___ Many facilities have been retiring records electronically on CHCS prior to this software upgrade. If those sites wish to create or recreate a retirement list for those records, the actions listed below can be taken. It will be up to the POC to evaluate how records have been retired and if they desire to do any cleanup.

There have been a number of ways that sites have retired records. Depending on which method was used, the following actions can be taken:

o If records were retired using: MRM-FE-PR
Movement type = Inactivate

No further action is required.

o If records were retired using: MRM-FE-PR
Movement type = Move to Another file area and you've indicated NPRC as an 'Additional MTF' in your files:

Then generate an ADHOC (see software specialist) where 'current borrower' = the NPRC and Home Division = unknown. There has been a software error which sends these record into limbo because of the 'unknown' division. Now have software specialist use FileMan Enter/Edit and input the correct Home Division for those records. Those records will then show when doing an inquiry and the NPRC will be the destination.

o If records were retired using: MRM-TM-TR (Transfer to Other MTF)

No further action should be required.

o If records were retired using: MRM-TM-AC (Inactivate/reactivate Records).

No further action should be required.

o If records were retired using: MRM-TM-MR (Move Records to Other File room).

Just access the file room where those records are located and generate a Retire list.

___ When records are added to the Record Index, they are added to the bottom of the list. If records are added AFTER box numbers have been assigned, those records will automatically be assigned to the last box number on the list. Current

NPRC policy requires that all records be filed according to the SSN within boxes. However, Record Indices are easily deleted and can be re-generated so box numbers can be re-assigned.

___ When a Record Index is generated for the retirement of records and the associated Shipment Data File is NOT created, the system will allow the user to SEND the Record Index which will update the record status to RETIRE RECORD. However, under these circumstances, the NOTIFY action is not available and the ASCII fill will not be created.

___ Clinics requiring Medical Records for SCHEDULED APPOINTMENTS MUST be in the BORROWERS SET-UP FILE:

Menu Path: PAD Main Menu->MRM->{file room}->SD->BSU->Select BORROWER:

___ To add clinics to pull list functions so that pull lists can be generated by provider, the RECORD TYPE NEEDED: field in the Borrowers Setup File MUST be populated with the RECORD TYPE needed when 'Record Requests are made when making appointments.

Menu Path: PAD Main Menu->MRM->{file room}->SD->BSU->Select BORROWER: Input Clinic here. At the Records needed field: add appropriate record to be pulled.

___ PAD POC's need to check with POC's from all divisions to decide which record labels need patient address and division.

___ When retiring records, the system searches records for retirement based on Patient Category. Family members are lumped with retiree records. That can present a problem if just family members are being retired. Currently there is no way to differentiate between these two patient categories. The development team is currently looking at this problem.

As a workaround, file areas could maintain family member records separate from Retirees. And then a retirement list could be generated appropriately.

___ The O/P record location field on the mini-registration does not update when records are transferred or retired when the Transfer-Retire option is used. This is being addressed in a SIR being fixed now.

B.3 INTEGRATION ISSUES.

B.3.1 CLN.

CLN/PAS.

___ Contact the PAS POC to verify that PAS Profiles have been updated and schedules have been updated for consulting providers who need to enter consult results for a particular clinic if consult resulting on CHCS is utilized.

Contact the PAS POC to verify that PAS profiles and schedules have been updated to support the use of APV.

CLN/PAD.

___ Identify POC for transportable patient records.

B.3.2 COMMON FILES.

CF/WAM

___ Database administrators, MEPRS personal and WAM personnel will need to coordinate with each other to determine correct default locations for providers, correct MEPRS codes for the CHCS MEPRS file, and correct MEPRS codes for hospital locations.

CF/APV AREAS (CLN, PAD, PAS, MRT)

__ For the APV project, the building of APV MEPRS codes and APU Locations must be complete before other sub systems can do their file and table builds.

Refer to PAS, PAD, CLN, and MRT IUGs

B.3.3 LAB.

___ LAB/INTERFACES

Regarding APCOTS, refer to the MPL Enhancement (Lab IUG).

Regarding DBSS Blood Bank interfaced sites, there are screen changes as a result of this upgrade to the laboratory test ordering screens and results retrieval.

B.3.4 MCP.

A. USE CURRENT END ELIG DATE TO DETERMINE AD DISENROLLMENT

MCP/CONTRACTORS

___ Sites must coordinate with the Lead Agent/Tricare contractors to determine how long a grace period, if any, should be established for AD patients before disenrollment occurs.

B. SET PCM CAPACITY FOR MEDICARE ENROLLEES

MCP/PAS

___ Sites enrolling Medicare patients may now establish PCM capacities for each PCM.

C. LIST ONLY PCM GROUP MEMBERS IN HELP TEXT

MCP/PAS

___ If no provider shows in the "Referred by" field, a user can display a list of PCM providers.

D. DISPLAY DEERS INFO IN MTF BOOKING FOR MEMBERS NOT ENROLLED

MCP/DEERS/PAS

___ CHCS will interface with DEERS. DEERS Information stored in the Patient File for patients not enrolled on the local system will be updated every time a DEERS check for that patient is made.

___ Enrollee Lockout must be activated in the clinics to utilize enrollee lockout screen enhancements.

___ All users performing new registrations, full or mini-reg, may be able to view a patient's Tricare status.

E. AUTOMATIC ELIGIBILTY CHECK FOR CONDITIONAL ENROLLMENT

MCP/DEERS

___ Users may still process conditionally enrolled patients manually as before, although CHCS performs DEERS checks and updates enrollment status every 7 days if appropriate.

F. AD ASSIGNMENT TO EXTERNAL PCM

MCP/DEERS

___ DEERS will count AD personnel assigned to contractor PCMs as being assigned to the contractor and will display that DMIS ID.

MCP/CLN

___ Active Duty Personnel may now be assigned to Providers with Agreement types of NET and SUP.

G. PROVIDER PLACE OF CARE INACTIVATION

MCP/PAS

___ PAS Clinics/MCP Places of Care and providers can be inactivated in a similar manner now.

___ PAS inactivation of Clinics and Providers will affect MCP Places of Care and MCP Providers. MCP Supervisors should be members of PAS Supervisors Mail Groups or have their mail also attached to the PAS bulletins SD INACTIVATE PROVIDER and SD INACTIVATE PLACE OF CARE.

___ MCP inactivation of providers via the PAS PROVIDER PROFILE screen in GNET will affect PAS Providers.

___ MCP Inactivation at the Group and Place of Care Level within the menu option GNET ARE NOT PAS inactivations.

___ Inactivation of providers via any other CHCS functionality will affect PAS and MCP. CHCS will display a message informing the user if the provider has open appointments, wait list requests or linked enrollments.

H. UIC TOTAL SOLUTION

MCP/ALL

___ All functionalities will be affected.

___ MCP UIC/PCM links must be reviewed and corrected where necessary.

I. EBC

Refer to EBC IUG.

B.3.5 PAD/MSA.

___ Confirm that all Common File data related to PAD/MSA is entered.

___ Workflow associated with the new APV software is strongly integrated amongst several functional areas. PAD Supervisors would be advised to initiate communication with their counterparts in the Patient Appointment Scheduling workcenters to assure efficient utilization of this software.

___ Workflow associated with the new DD7A software is strongly integrated amongst the PAD and PAS functional areas. PAD Supervisors would be advised to initiate communication with their counterparts in the Patient Appointment Scheduling workcenters to assure efficient utilization of this software.

B.3.6 PAS.

___ APV clinic build must be coordinated with CLN and MRT functionalities.

B.3.7 PHR.

PHR/CLN

___ If the site decides to use dispensing software, pharmacy needs to communicate the impact on physician/nurse users. The Patient Order List (POL) displays RX dispensing information and mail messages are generated when RXs are marked non-compliant.

___ Drug lookup of a compounded drug via CLN option DRUG will display the title 'Compounded Drug' and a listing of all the drug products it contains and their respective American Hospital Formulary Service (AHFS) Classifications. Drug lookup by means of '.[therapeutic class]' will include any compounded drugs containing members of the specified class. Compounded drugs will not generate a Patient Medication Instruction Sheet(PMIS).

PHR/CLN/PAD/PAS

___ Discuss procedures for entry of APU orders between Pharmacy, Clinical and PAS/PAD supervisors to ensure the timely ordering and processing of medication and IV orders on APV patients.

PHR/INTERFACES

___ The fill cost is transmitted to CEIS and MCHMIS.

PHR/CF

___ The Provider Screen Changes should be reviewed in the 4.6 Common Files IUG.

B.3.8 RAD.

___ The development of the Ambulatory Procedure Unit will now allow CLN/LAB/RAD/PHR to place and process orders on a new page - Ambulatory Procedure Visit (APU) on the Patient Order List (POL) screen. The APV page is created at the time the Ambulatory Procedure Request is made via Order Entry or by a PAS user when an appointment is 'booked.' When the order is activated, CHCS will communicate a request to schedule an APV appointment through the PAS software. However, the APU page will not be activated until PAS completes the appointment process - KEPT appointment. If pre-op orders are entered on this page but the appointment has not been KEPT, Radiology will NOT be able to see or process these orders, which may result in duplicate order entry once the APU page has been activated.

It is recommended that pre-op x-rays continue to be placed on the 'Outpatient Page'.

B.3.9 MRT.

___ Appropriate file rooms should be created to STORE the NEW Standard Record Types (APV, etc.). Will PAD or PAS create these file rooms?

___ All PAS/MCP personnel responsible for creating APV records must have access to APV file rooms storing those records. This means assigning them file room security keys (if any are assigned to APV file rooms).

___ It must be decided which file/table POC (PAS or MRT) will enter APV file rooms into the system.

B.4 FILE AND TABLE CHANGES.

B.4.1 CLN.

File and table time for data collection and build may be extensive, depending on what enhancements a site chooses to activate and what files were built previous to 4.6. It is recommended that each section of this IUG be thoroughly reviewed before deciding to utilize it's enhancements.

Coordination with other subsystems will be necessary for some of the enhancements. Once a decision has been made, review the File and Table section before activating.

Note: Some F/T build may be done pre or post-load.

___ To support the use of Nursing Due lists, make entry in a new field in the Clinical Site Parameters called 'Days to Collapse the Past APV Page:'. This parameter should be set before the site begins using the APV page options.
Est. Time: 1 minute

___ Work with builder of Common Files to name the APV page by using the first three characters from the abbreviation field in the Hospital Location File (#44) and adding '-APV'. The abbreviations entered for these locations should not begin with the same three characters (i.e. 'SDS...' or 'APU...'). (Refer to Common Files Sections on F/T)

___ If the site plans to use Nursing Documentation options, file and table for the Nursing Order file should be reviewed. (1-4 hrs.)

___ Consults must be defined for a specific clinic to result and designated as SCHEDULED if not currently with that Schedule type (do this post-load so as not to upset current Consult processing). Consults in CHCS are maintained as ancillary procedures.
Est. Time: 1-2 hrs.

___ The Progress Note Title (PNM) option must be populated before the users will be able to document notes.
Time Est.: 1 min./note title

___ Assign the NS DISCHARGE security key for authorized users to access the 'Discharge Summary Enter/Edit' option. Any Nurse/Clerk users who transcribe D/C summaries and all doctors who discharge patients require this key.
Time Est.: 10min/20users

___ Populate the Patient Instructions file with discharge summary instructions. Populate the 'Discharge Summary Text' file with predefined summary templates for import into summaries.
Time Est.: 1 hr. - 1 week (depending on number)

___ Assign NS IMM security key to authorized users who must access the 'Immunization/Skin Test Enter/Edit' option for the purpose of documenting.
Time Est.: 10 min/20 users

___ Review the immunization file in the 'Immunization Maintenance' option (IPM) before the use of this option.
Time Est.: 4 hrs.

___ Assign the DG TRANSPORTABLE RECORDS security key to the appropriate Clinical personnel for this effort.

___ Coordinate with the Systems personnel to define TCPR parameters regarding the IP addresses of sites you wish to communicating with.

___ Ensure that the Clinical Site parameters to enable TCPR Mini-Reg and Purge TCPR records are set. Defaults are Yes and 7 days.

___ Ensure that the Clinical Site parameter for purging Problem Selection Lists is set. Default is 365 days.

B.4.2 <u>COMMON FILES</u>.

Pre Load:

___ Determine which Divisions have inappropriate MTF entries. These will need to be fixed.

___ Determine which hospital locations have inappropriate MTF entries. These will need to be fixed.

Post Load:

___ After all sites on a given CHCS system agree on one name to designate for the System, and values for the other fields in the file, then they can enter a Host Platform.

___ In the case of hospital locations with inappropriate MEPRS codes, A determination will need to be made as to who uses the location if anyone. If no one uses the location, it

should be inactivated. If the location is being used or orders are being made using it as a requesting location then a determination should be made as to what MEPRS code it should be using and whether the "Location Type" is correct.

___ Hospital Locations with the MEPRS code or Cost pool Code inconsistent with the Group ID of the hospital location will need to be fixed.

___ Medical treatment Facility file entries can be edited as necessary.

___ APU MEPRS codes will need to be edited.

___ APU Hospital Locations will need to be linked to DGA* MEPRS.

___ Mail bulletins need to be attached to appropriate mail groups for inactivated providers or places of care to insure that system generated messages get to the appropriate people.

B.4.3 LAB.

Concerning Anatomic Pathology and APCOTS, this upgrade will not affect sites that have already completed File/Table for MPL. There are no software changes from CHCS versions 4.52 to 4.6.

___ For all DOD-selected and funded sites using APCOTS that have not performed File/Table for MPL, complete file and table build.
Time Est: 1-2 hours.

B.4.4 MCP.

A. USE CURRENT END ELIG DATE TO DETERMINE AD DISENROLLMENT

___ Set Grace Period Parameter field if needed. Default is 120 days if no action is taken.

Menu Path: CA>PAS>MCP>FMCP>FTAB>PARA

B. SET PCM CAPACITY FOR MEDICARE ENROLLEES

___ Reset PCM Capacities if necessary. 5 mins per PCM Group

C. LIST ONLY PCM GROUP MEMBERS IN HELP TEXT

None

D. DISPLAY DEERS INFO IN MTF BOOKING FOR MEMBERS NOT ENROLLED

None

E. AUTOMATIC ELIGIBILTY CHECK FOR CONDITIONAL ENROLLMENT

None

F. AD ASSIGNMENT TO EXTERNAL PCM

___ Define AD capacities for External PCMs with agreement types of NET and SUP via menu option GNET unless unlimited capacities are desired. 15 mins. per Provider Group.

G. PROVIDER PLACE OF CARE INACTIVATION

___ Ensure PAS TaskMan Bulletin, SD WEEKLY CLEANUP, is tasked to run weekly.

___ Attach PAS/MCP Supervisory Mail Groups to the new Mail Bulletins SD INACTIVATE PROVIDER and SD INACTIVATE PLACE OF CARE.

H. UIC TOTAL SOLUTION

None

I. EBC

Refer to EBC IUG.

B.4.5 PAD/MSA.

Post-load PAD/MSA File and Table changes:
Estimated time: 10-20 minutes

___ Verify that all necessary MASCAL File and Table information has been relocated in the new MASCAL Parameters (MAS). Menu Path: PAD>SDM>MAS

___ The DD7A Outpatient Billing Table should be populated with the correct rates for each B and C level MEPRS code. Menu Path: MSA>D7A>DTE

___ The APV Record Parameters should be populated by authorized Clinical Records Department supervisors.

B.4.6 PAS.

___ The Host Platform name must be entered into the Hospital Location file.

___ The clinic profiles need to be reviewed to ensure that they are set up with the correct service so that booking can search across divisions.

___ The site must populate the Service Type file through PAS post install.

___ APV clinics must be set up in the PAS profiles.

___ Record tracking file rooms must be created for APV records. Any file room security keys need to be assigned APV PAS users.

___ A PAS bulletin SD WEEKLY CLEANUP should be tasked to run weekly. Attach bulletins SD INACTIVATE PROVIDER and SD INACTIVATE PLACE OF CARE to the appropriate PAS and MCP mailgroups.

B.4.7 PHR.

Pre-Load:

___ All items issued as stock should be defined as either 'BULK' or 'CLINIC'. This can be done post-load if the user prefers, however, it must then be done via MSI.

Post-Load: (Can be done at users' discretion, will not affect pre 4.6 functionality)

___ If the site intends to use Bar Code, the 'BAR CODE ENABLED' field, in the Outpatient Site Parameters, must be set to 'YES'.

___ The printer(s) that will print bar coded labels must be defined in the Device File.

___ If the site intends to use Dispensing Option/Dispensing Option Enhancement or Quick Dispense, Dispensing Options must be ENABLED for the appropriate Division(s).

___ Compounded drugs in use should be defined via ADN to include all applicable NDC numbers(to a maximum of 8 NDCs or 8 ingredients). If this is done the Clinical Screening software will act against each ingredient. If it is not the

software will process a compounded drug as if it were a single product.

___ The site should be made aware of the new format of the Refill Grace Period and Scheduled Refill Grace Period fields. The defaults of 75% may be accepted or changed.

___ Non-professional users, e.g., volunteers may be assigned Quick Dispense (QRX) as a secondary menu option.

___ Enter APU clinics in Ward Groups.

___ The local cost field in the Formulary must be populated for accurate cost reporting.

B.4.8 RAD.

___ All Radiology Location schedule templates utilizing 24-hour scheduling will require start and stop time template modification.

___ Enter any record types to be pulled for clinics into the Borrowers Setup File.

___ Add new print fields to Label Print formats if they will be used.

B.4.9 MRT.

1. INPUT STANDARD RECORD TYPES IN TYPE OF RECORD SETUP FILE

___ Populate the STANDARD RECORD TYPE FIELD in the TYPE OF RECORD SETUP FILE for all record types currently utilized, as well as any NEW Standard Record Type to be implemented.

2. CREATE AN 'ASCII NOTIFICATION' MAILGROUP:

___ The System Mail Manager does this. (Menu path: EVE->MM->MGE)

The mailgroup members will be receive a bulletin notifying them that the Record Index/Shipment Data File is ready to be converted to ASCII format and placed on a diskette for shipment to NPRC.

3. ADD 'ASCII' MAILGROUP NAME TO MRT APPLICATION SETUP: (Menu Path: PAD-> MRM->{file room}->SD-> APP->second

screen)

___ After creating RT ASCII NOTIFY mailgroup, enter name of the mailgroup the new ASCII File Mail Group FIELD in the Record Tracking Application Setup.

4. ALLOW BATCH PROCESSING (Menu Path: PAD->MRM->{file room}-> SD->MTS->Movement Type Set-up)

___ The 'Allow Batch Processing' specifies whether a Movement can be utilized when records are retired or transferred.

The 'Allow Batch Processing' field for the NEW Movement Type of RETIRE RECORDS MUST be set to YES by the File room Supervisor

5. CREATE FILEROOMS FOR STANDARD RECORDS TYPES THAT WILL BE USED IN RECORD TRACKING

___ Enter Menu Path: MRM->{file room}>SD->FSU) and create any new file rooms which will be storing new records.

___ Enter new any new record types in the Type of Record Setup (Menu Path: PAD->MRM->{file room}->SD->TYS).

Make sure File room has been added as 'File room Allowed to Store Record.

___ Add Standard Record Type to the Application Setup File (Menu Path: PAD->MRM->{file room}->SD->APP->select DIVISION ->RECORD TYPES screen)

___ Add file room to Borrowers Setup File (Menu Path: PAD->MRM-
>
file room}->SD->BSU)

___ The Database Administrator must complete the Service and MEPRS code fields in the Hospital Location File for all APV File rooms created (Menu Path: CA->DAA->CFT->CFM->HOS)

B.5 SECURITY KEYS.

B.5.1 CLN.

NS CONSULT RESULTS	Allows the user to enter Consult Results and view results after verification.

NS IMM	Allows the user access to document immunizations from the Nursing Menu.
NS DISCHARGE	Allows the Clinical user access to the Discharge Notes option.
GP EUROP1	Allows the user access to problem lists and progress notes from the Order Entry action prompt.
OR MD MNG	Allows the user to access the Table Maintenance Menu option from the Physician menu.
SD APV	Allows the user access to the MAPV option.
SD APV MINSRV	Allows the clinical user to emergently disposition an APV patient from the ORE action prompt to support an inpatient episode that results from an APV visit.

B.5.2 COMMON FILES.

No new Security Keys for CF.

B.5.3 LAB.

No new Security Keys for LAB.

B.5.4 MCP.

CPZ PCM AGR LOCK

This Key is intended for users allowed to assign AD personnel to External PCMs.

Menus Affected:
ER Enrollments
BMCP Batch PCM Reassignment
UBER Batch Enroll AD
UICP UIC/PCM Maintenance
GNET Provider Network

Suggested users: Enrollment Clerks, MCP File/Table personnel, Personnel performing Batch Enrollments, PCM reassignments.

CPZ MCSC

This key is intended only for use with the MCSC interface in selected regions. This is here for documentation only.

DO NOT ISSUE UNLESS TOLD TO DO SO

CPZ DISENROLL-CANCEL CORRECT (EBC related)

This key locks the menu option DCAN (Cancel Disenrollment).

Menus Affected:
CAN Disenrollment Cancellation/ Correction

CPZ TSC LOADER

DO NOT ASSIGN

This key was initially for use with MCSC I and the HL7 MCP transfer. This key should not be assigned to anyone.

B.5.5 PAD/MSA.

MSA DD7A BILLING	Locks access to the DD7A Monthly Outpatient Billing Process (MBP). This key should be given to any/all MSA personnel responsible for processing and finalizing the new DD7A Billing Report
DG APVOUT	Security key restricts access to the report menu of the APV Delinquent Record Tracking Menu. This key should be given to All Clinical Records personnel responsible for APV record completion.
DG APVSUPER	This security key restricts access to the APV Parameters option of the APV Delinquent Record Tracking Menu. This key should be given to the Clinical Records Supervisor
DG APVUSER	This security key restricts access to the APV Delinquent Record Tracking Options. This key should be given to All Clinical Records personnel responsible for APV record completion.

MSA DD7A BILLING	This key will allow a user access to produce an end of month bill for the new DD7A function. This key should be given to MSA personnel responsible for processing this End of the Month DD7A Report.

B.5.6 PAS.

SD APV: Accesses the APV menu.

SD APV KEPTROSTER: Accesses roster of Kept APV appointments.

SD APV MINSRV: Accesses the APV minutes entry/edit screen.

Attach any APV file room security keys to PAS APV users.

B.5.7 PHR.

There are no new Pharmacy security keys for Ver 4.6

B.5.8 RAD.

No New Security Keys for RAD

B.5.9 MRT.

SD APV	Accesses the APV menu Assigned to PAS or PAD users who create APV records.

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APPENDIX C:

TRAINING AND FILE/TABLE BUILD MATRIXES

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TRAINING MATRIX (Version 4.6)

	Demos	Hours	Users	Training	Hours	Users	Handouts*
CLN	Y[1]	4	Nurses/Clks Physicians CLN Spvrs	N	-	-	-
COMMON FILES	Y	2	DBA	N	-	-	-
DTS	N	-	-	N	-	-	-
LAB	Y	1.5	QA/LAB Tnrs F/T POCs	N[2]	-	-	-
MCP	Y	2[3]	MCP/Tricare Enrlmt Clks HCF	N	-	-	-
MRT	N	-	-	Y	2.5[4]	MRT POCs	-
MSA/TPC	Y	1	MSA POCs	N	-	-	-
PAD	Y	2.5[5]	PAD POCs	N	-	-	-
PAS	Y	2	PAS POCs	N	-	-	-
PHR	Y	.5-1.5[6]	PHR POCs	N	-	-	-
RAD	Y	2	RAD POCs	N	-	-	-
WAM	N	-	-	N	-	-	-

*Handouts may be used to supplement demos/training or, in some cases, be used in lieu of training. Appendix E includes the familiarization training plan.

1 -Recommending separate sessions for Nurses/Clerks, Physicians, and CLN Supervisors.

2 - If APCOTS is to be activated, additional 2-3 hours Training for key LAB POCs and F/T Build personnel.

3 - MCP/Tricare Supervisors 2 hours, Enrollment Clerks 1 hour (can also attend portion of above session), Health Care Finders .5 hour.

4 - 2 hours, personnel that retire records; F/T Supervisors, 2 hours (can also attend the same session as personnel that retire records); Site Manager or System Specialist .5 hour; PAS Supervisor (if they will enter APV file rooms in system, .5 hour.

5 - First 1.5 hours are for Clerks, an additional hour for Supervisors.

6 - If Bar Code and Dispense Options ARE used, demo will be 1.5 hours. If they are not being used, a .5 hour demo for PHR supervisors only.

FILE AND TABLE BUILD MATRIX (Version 4.6)

	PRE LOAD	TIME	POST LOAD (PRE-USER)	TIME	POST LOAD (POST-USER)	TIME
CLN	DC	8hrs-1 week	N/A	-	FT	4-8 hrs.
CF	DC/FT	8 hrs.	N/A	1 hr.	FT	-
DTS	N/A	-	N/A	-	N/A	-
LAB	N/A	-	N/A	-	FT[1]	1-2 hrs.
MCP	N/A	-	N/A	-	FT	1 hr.
MRT	N/A	-	N/A	-	N/A	1 hr.
PAD/MSA	N/A	-	FT	10-20 Min.	N/A	-
PAS	N/A	-	N/A	.5[2]	FT	1 hr.
PHR	N/A	-	N/A	-	FT	.5 hr.+ [3]
RAD	N/A	-	N/A	-	N/A	1 hr.
WAM	N/A	-	N/A	-	N/A	-

Note: The File and Table build estimates may vary. This is an estimated time line for planning purposes. Use the appropriate sections of the IUGs for detailed information.

DC = Data Collection FT = File/Table

1 - LAB file and table is only necessary if APCOTS is being used at site and MPL file and table build is not complete.

2 - For PAS, this time can be used for MRT instead (depending on who builds the file rooms.

3 - PHR file and table estimates will depend on which functions are being used (Dispensing option, Barcode, etc.)

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APPENDIX D:

DATA COLLECTION FORMS

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Data Collection Forms

I. AMBULATORY PROCEDURE MAINTENANCE.

Coordinate with Common Files File and Table if input is desired for APV page names generated off the Abbrev. field of the Hospital Location File. The device entry will assist users in sending results to the location.

HOSPITAL LOCATION FILE (CA-DAA-CFT-CFM-HOS)

HOSPIITAL LOCATION NAME:

ABBREV:
(1-6 CHARACTERS)

DEVICE:

II. CONSULT RESULTS.

Minimum required fields to use Consult Results option.

ANCILLARY PROCEDURE FILE: (CA-CLN-Physician-MNG-TAB-ANC)

ANCILLARY PROCEDURE NAME:
(3-30 Characters)

SPECIAL PROCEDURE TYPE: CONSULTS
(Required Entry)

SCHEDULE TYPE:
(Scheduled, One-Time, PRN, Continuous)

CLINIC:
(Consulting Clinic Name - Hospital Location)

DEVICE:

III. PROGRESS NOTE TITLE ADD/EDIT. (CA-CLN-Physician-MNG-TAB-PNM)

CODE: _____ (Short Name)
(3-10 Characters)

DESCRIPTION:
(3-30 Characters)

AVAILABLE: YES / NO
(Circle One)

IV. IMMUNIZATION SCHEDULE TEMPLATE:
(CA-CLN-Physician-MNG-TAB-IPM)

Note: Not all fields are required for each schedule type. Complete only those fields which apply.

TEMPLATE NAME:
(3-30 Characters)

SCHEDULE TYPE:
(Annual, Series, Combo)

NUMBER OF DOSES IN SERIES: _____ (Required for Series/Combo)

INTERVAL LENGTH: _____ (Time Between Doses)
(Days,Weeks,Months,Years)

ANNUAL INTERVAL: _____ (Years between doses)

BOOSTER INTERVAL: _____ (Time between Boosters)
(Dys,Wks,Mos,Yrs)

BOOSTER INTERVAL LENGTH: _____ (Time between interval)

DOSES: (Interval defaults from Interval Length Entered above)
Enter the number of days, weeks, months, or years for when the next dose is due.

DOSE NUMBER	2	IS DUE:	_____ (Time)	DEFAULTS (Interval) (After first)
DOSE NUMBER	3	IS DUE:	_____	" " (After second)
DOSE NUMBER	4	IS DUE:	_____	" " (After third)
DOSE NUMBER	5	IS DUE:	_____	" " (After fourth)
DOSE NUMBER	6	IS DUE:	_____	" " (After fifth)
DOSE NUMBER	7	IS DUE:	_____	" " (After sixth)
DOSE NUMBER	8	IS DUE:	_____	" " (After seventh)
DOSE NUMBER	9	IS DUE:	_____	" " (After eighth)
DOSE NUMBER	10	IS DUE:	_____	" " (After ninth)
DOSE NUMBER	11	IS DUE:	_____	" " (After tenth)

V. IMMUNIZATION/SKIN TEST MAINTENANCE.
(CA-CLN-Physician-MNG-TAB-IPM)

IMMUNIZATION TEST NAME:
(3-30 Characters)

NORMAL USAGE:
(Category for Display)

CLASSIFICATION: Select appropriate category

ABBREVIATION:
(2-5 Char.)

CURRENT LOT NUMBER:
(2-16 Alpha/Numeric Char.)

LOT EXPIRATION DATE:

LOT MANUFACTURER:

DEFAULT DOSE: _____ DEFAULT UNIT:

DEFAULT ROUTE: _____ DEFAULT SITE:

RESULTS REQUIRED: YES / NO
(Circle One)

SCHDULE TEMPLATE:
(Name of Template)

IMPORTANT INFORMATION: (Directed an administering user)

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APPENDIX E:

FAMILIARIZATION TRAINING PLAN

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Familiarization Training Plan

The Clinical changes with Version 4.60 will require formal training of users. The following Training plan and data may be used to demo or train a class of 10 users on the Version 4.60 Training Data Base.

Some users may be familiar with the concept of Consult Results, Progress Notes, Problem Lists, and Discharge summary entry from other software enhancements in previous versions. The enhancement in Version 4.60 for these options are similar, but not the same. Users should attend training to determine what changes apply to the use of these options.

DEMO DATA:

1. USER ACCESS/VERIFY CODES:

   These are the only clinical users who have the necessary security keys for demonstration.

   a. Provider with only Division A allowable: DOCTOR,LAMP
      Access/Verify Codes: DRLAMP/DRLAMPV

   b. Nurse user with only Division A allowable: NURSE,AARON
      Access/Verify Codes: NURSEAARON/NURSEAARONV

2. Patient Families For Demonstration:

   Use patient's who have NO active orders for Consult, Problem, Immunization and Progress Note demonstrations. Typically these patient's will not have ancillary results to demonstrate the Copy/Paste option. You may use any patient who has Lab, Pharmacy or Radiology results to demonstrate the Copy Paste functions.

   - Patient's with NO active orders: BEAN (A-J)
     JONES (A-J)

   - Patient with APV appointment booked by PAS: NEWTON (A-J)

   - Patient with active APV POL: NEARY (A-J)

   - Discharge summary patient's: ROBINSON (A-J)
     ROBINSON,SCOTT

I. Ambulatory Procedure Visits

The following plan may be used to demo the Ambulatory Procedure order entry procedures. Explain to users that Order entry procedures for APR orders are the same for HCP-level users, Nurse-level users and Clerk-level users. APR orders entered by any level ORE user will always be active/pending appointment or scheduled.

A. APV ORDER ENTRY PROCEDURES.

1. SIGN IN AS **DRLAMP** or **NURSELAMP**.

2. Select Physician (Nursing) Menu Option: **ORE**

3. Select PATIENT NAME: **BEAN,LINDA** (Use student letters A-J)

   The instructor may take this opportunity to demonstrate the Inappropriate Requesting Location Screening that is now done in version 4.6 at this prompt by entering OUTPATIENT RECORDS as the requesting location. The EKAA MEPRS code for this location will not be accepted, prompting the user for a CLINICAL SERVICE/MEPRS CODE. The instructor can demonstrate the error message by having the user type EKAA at the MEPRS code prompt.

4. Select REQUESTING LOCATION: **BHAA** (PRIMARY CARE CLINICS)

5. ACTION: **NEW**

   (Nurse user) Select Ordering/Authorizing HCP: **DOCTOR,LAMP**
NOTE: You may be prompted to link the new order to an appointment, depending on the patient. This is not new to V4.6. If this is the case, follow the prompts and link the order to any appt.)

6. ORDER TYPE: **APR** (AMBULATORY PROCEDURE REQUEST)

7. Select APV LOCATION: **BAA5** (APU INTERNAL MEDICINE)

8. Requested APV Date/Time: **T**(oday)

9. APV Procedure: **BRONCHOSCOPY** (30 character free-text)

   The information entered in this field will appear for the Patient Appointment (PAS) users as the Reason for Appointment when the appointment is scheduled and as the Order Comment on the POL.

10. Requested APV Physician: **<RETURN>** (Leave Blank)

    The Requested APV Physician is not a required field. The user may enter the name of a provider who is in the requested APV Location's provider profile). This request will display to the PAS user scheduling the appointment but can be overridden by the PAS user when booking the appointment. When the appointment is scheduled, the

scheduled provider will appear in this field when the order is expanded.

11. Appointment Comment: (enter procedure history)

The user may enter unlimited-character free-text descriptive information for this visit. This will display on the expanded order.

12. File/Exit.

Note that a new APU page is created to the left of the outpatient page when the APV order is filed. The default page will be the INT-APV where the user can proceed to enter orders for this visit. The orders are inactive and flagged "FUTURE" until the APR order is processed and the appointment status marked KEPT by PAS.

B. <u>THE APV PATIENT ORDER LIST (APV POL)</u>.

The APU page allows for the entry of inpatient order types. Users may not be familiar with the procedures for entering NRS, MED, IV, or DTS orders. Additional time may need to be allotted. Order Sets and Macros can be used to help in the ordering process.

Orders entered on the inactive APV page will be flagged FUTURE orders. ADT should be used as the Start Date/Time for orders entered on the inactive APV page so that the start time will begin when the APV page is activated (i.e., when PAS clerk enters the appointment as KEPT).

If a time/date other than "ADT" is entered as a start time, the order(s) may be placed ON HOLD when the page is activated. This will occur if the date/time of the order has passed before the date of the page activation. If this happens, the orders will have to be modified to change the date/time to a date/time after the POL activation date/time so the order can be completed. Show the user that ADT will be the default start date/time for MED, RAD and NRS orders.

1. ACTION: **NEW**

(Nurse user) Select Ordering/Authorizing HCP: **DOCTOR,LAMP**

2. ORDER TYPE: **LAB** (LABORATORY TESTS)

DATE/TIME OF TEST (NOW, AM, QAM, or Date&Time): **ADT**

Collection Method: WARD/CLINIC COLLECT & DELIVER//**LAB COLLECT**
  LAB COLLECT is not allowed for APV patients.
Collection Method: WARD/CLINIC COLLECT & DELIVER//**<RETURN>**
COLLECTION PRIORITY: ROUTINE//
PROCESSING PRIORITY: ROUTINE//
ORDER COMMENT: (BLANK)
Select LABORATORY TEST: **CBC** CBC PROFILE BLOOD LAV
Select LABORATORY TEST: **<RETURN>**

3. ORDER TYPE: **RAD**

Select Radiologic Procedure: **CXR** (CHEST, PA/LAT)

CLINCAL IMPRESSION:
PRE-OP BRONCHOSCOPY (accept defaults, press 'Do')

COMMENTS:

```
SCHEDULE TYPE      : ONE TIME  PRIORITY         : ROUTINE
REQUESTED DATE/TIME: ADT       IMMEDIATE READING: NO
PORTABLE           : NO        MOBILITY STATUS  : AMBULATORY
RADIOLOGY LOCATION : MAIN RADIOLOGY
```

4. ORDER TYPE: **MED**

Select INPATIENT MEDICATION: **TYL325** (ACETAMINOHEN-PO 325MG TAB)

CODE: **<RETURN>** (Leave Blank)

ROUTE: **ORAL**
PRIORITY: **ROUTINE**
NUMBER of MG(s) per Dose: **325**
DOSAGE COMMENT:
POST OP FOR PAIN MANAGEMENT
SCHEDULE TYPE: **PRN**
ADMIN TIME(S):
TID
FREQUENCY: **QD** DURATION: 99//**1**
START DATE/TIME: **ADT**

5. ORDER TYPE: **DTS**

Select DIET: **NPO**
Start NPO related task at: **ADT**

MEAL LOCATION: ROOM
DIETARY COMMENT:
PRE OP ON ARRIVAL TO UNIT

Select DIET: **CLEAR LIQUID DIET**
Start date/meal: **ADT**

MEAL LOCATION: ROOM
DIETARY COMMENT:
POST OP AS TOLERATED

6. ORDER TYPE: **NRS** (NURSING ORDERS)

   Select NURSING PROCEDURE: **VS** (VITAL SIGNS - BP, T, P, R)

   COMMENT: (BLANK)
   PRIORITY: ROUTINE//
   SCHEDULE TYPE: CONTINUOUS//
   TIMING TEXT: QSHIFT// **Q4H**
   TASK TIMES: Q4H//
   FREQUENCY: QD//
   DURATION: 7// **1**
   START DATE/TIME: ADT//

File the order and return to the Patient Order List (POL).

7. ACTION: **Q**UIT AND ACTIVATE YOUR ORDERS

   Print order group? YES// **<RETURN>**

   Show the user that only the APR will print in the order group because the other orders are FUTURE orders. To Print the FUTURE orders, enter POR at the ACTION prompt on the INT-APV POL)

8. Explain to the user that the APR order must be scheduled by the PAS user. Once this is done, the APV page can be activated when the patient is checked in to the unit.

Note: Orders entered by a Clerk-level user, other than the APR order, will not become active when the page is activated, unless an HCP or Nurse-level user signs the order before the APV page is activated.

9. Several APR orders can be written and scheduled at the same time but the APR order must be signed by the Requesting HCP before a subsequent APV page can be activated and only one page can be active at a time.

C. <u>APV POL ACTIVITIES</u>.

The unscheduled APR order will display on the Outpatient POL as well as the APV POL.

1. Select Physician Menu Option: **ORE**

2. Select PATIENT NAME: **<SPACE BAR> + <RETUTN>** (same patient)

3. Move to the INT-APV POL by using the **left cursor** key. (APV Page(s) are located to the left of the Outpatient Page).

4. ACTION: **NEW**

   (Nurse user) Select Ordering/Authorizing HCP: **DOCTOR,LAMP**

   ORDER TYPE: **ADT** ?? (cannot be entered on the APV page)

ORDER TYPE **APR** ?? (cannot be entered on the APV page)

5. Press **[F9]** next to the APR order (from either page), then "O" to expand and show the Appointment Comment.

6. Move to the APV POL using the **left cursor** key.

   ACTION: **CANCEL** (C) (APR order not displayed)

   The unscheduled APR order cannot be canceled or modified from the APV page.

7. Move to the OUPAT POL using the **right cursor** key.

8. ACTION: **CANCEL** (C) (Select the APR order)

   The unscheduled APR order can be canceled or modified here. When the user attempts to cancel an APR order, a message will display warning that 'canceling the APV order cancels the APV page and all APV orders'.

   For this exercise it is not necessary to cancel the order.

D. ALTERNATE ORDER ENTRY PROCEDURES

1. Select Physician (Nursing) Menu Option: **ORE**

2. Select PATIENT NAME: **NEWTON,LINDA** (Use student letters)

3. Select REQUESTING LOCATION: **BAA5** (APU INTERNAL MEDICINE)

Sample Screen

```
NEWTON,LINDA L            Age:33    20/100-10-7357    OUTPAT POL

1 APR  APPT.FOR: APU INTERNAL MEDICINE on
        20 Jun 2001@0804 {BRONCOSCOPY}~Nurse
        ~HCP Sig.Needed~Scheduled for 21Jun
        @1800. . . . . . . . . . . . . . .  sDRLAMP 21JUN@1731


+*OUTPAT*

    APU Page(s) are located to the left of the Outpatient Page.

ACTION:
         Personal Data - Privacy Act of 1974 (PL-93-579)
```

End screen

Explain to the clinical user that when the PAS user books an APV appointment, an APR order is written on the Outpatient page and an APU page is generated. The Provider that the appointment

is scheduled for will receive a Mailman bulletin message when the appointment is booked. The order will display under the Order Signing option for this provider.

The APR order will have a status of ~NURSE~HCP Signature Needed~ and a scheduled date/time for the appointment. The Requesting and Ordering HCP will be the Provider the appointment is booked for but this order can be signed by any HCP-level user using the SIGN/VERIFY (SV) option from the Action prompt.

Note: If the APR order is written in this manner and it is not signed, the patient's next APV page cannot be activated until the previous APR order is signed.

4. ACTION: **SV** (SIGN/VERIFY ORDERS)
Do you want to sign (A)ll orders or just those on the OUTPAT? OUTPAT// **<RETURN>**

Select **(*)** the APR order to sign.

Note: If the APV Page is activated using the APV Minutes of Service enter/Edit (MAPV) option by a Nurse-level user, the APR order is transparently signed by that Nurse-level user but must still be signed by a HCP-level user.

Note: If the APV Page is activated using the MAPV option by an HCP-level user, the APR order is transparently signed by that user and does not have to be signed by another HCP-level user.

5. ACTION: **CANCEL** (C) (The APR order will not display.)

The scheduled APR order cannot be canceled or modified by the clinical user from the POL. The appointment must be canceled by the PAS user to preserve the connection between the PAS and CLN software.

When the PAS user cancels the appointment, the APR order and the APV page, that has no orders on it will be canceled as well. If there are orders on the APV page, the APR order status will simply change to ~Pend.Appointment~ and the orders will remain intact.

E. <u>THE ACTIVE APV PATIENT ORDER LIST</u>.

1. Sign in as **DRLAMP** or **NURSELAMP**

2. Select Physician (Nursing) Menu Option: **ORE**

3. Select PATIENT NAME: **NEARY,LINDA L**

4. Select REQUESTING LOCATION: **BAA5** (APU INTERNAL MEDICINE)

5. The INT-APV will be the default POL for order entry POL when the APV page is activated. All orders on this page should be active.

6. Explain to the user that should the patient need to be admitted as a result of this APV, the APV POL must be closed (inactivated) before an admission order can be activated.

7. ACTION: **EDA** (EMERGENCY DISPOSITION FROM APU)

8. Select OUTPATIENT DIPOSITION CODE: **ADMT**

   Once the user enters an Outpatient Disposition Code, the APV page is closed, the patient is dispositioned from the APU and the Outpatient Page becomes the active POL. The INT-APV will remain a Past Page, to the left of the OUTPAT POL (according to the time limit in the Clinical Site Parameters) and then it will be collapsed. All orders that are not complete will be canceled due to disposition (with the exception of some orders that have begun to process through the ancillary such as an accessioned Lab order).

F. <u>CLINICAL DESKTOP</u>.

1. Sign in as **DRLAMP** or **NURSELAMP**

2. Select Physician (Nursing) Menu Option: **DSK** (Clinical Desktop)

3. DESK ACTION: **+** (ADDEND)

4. Select PATIENT SOURCE: **??**

   APU PATIENTS SCHEDULED FOR AN APU
   APUM PATIENTS SCHEDULED FOR MY APU
   APUMT PATIENTS SCHEDULED FOR MY APU TODAY
   APUP PATIENTS SCHEDULED FOR AN APU BY PROVIDER

5. Select PATIENT SOURCE: **APU**

6. Select APU: **BBA5** (APU INTERNAL MEDICINE)

7. Add which patient(s) to the Desktop (A=all): **A**

8. **<RETURN>** twice to display the Desktop.

   The new sources are similar to the Outpatient Clinic appointment sources that the user should be familiar with.

[STOP HCP-LEVEL TRAINING HERE]
or
[CONTINUE FOR NURSE/CLERK-LEVEL]

G. NURSING DOCUMENTATION.

Explain to the user that the Nursing Documentation Menu for generating and resulting Due Lists has been enhanced to support Ambulatory Patient Visits by removing the dependency on patient bed assignment. (The target audience for this exercise is the nursing documentation user).

1. Sign in as **NURSELAMP**

Note: This exercise can be taught from the Clinical Desktop by using the APU option to add patients, selecting a patient name from the list, then using the NSDUE or NSEDR options. Skip #2, #3, #7 and #8 if using the Clinical Desktop.

2. Select Nursing Menu Option: **DOC**

3. Select Document Patient Care Menu Option: **DUE**

4. Select Generate Due Lists Menu Option: **SC** (Shift Care Plan)

5. Select Ward or APU: **BAA5** (APU INTERNAL MEDICINE)

6. FROM: 0700// (default from current time, current shift.)
   TO: 1459//

7. SELECT PATIENT: **??**

   Enter 'S' for a PATIENT selection screen.
   Enter 'A' or, if a ward was entered, <RETURN> to accept all patients.
   Enter '/' to use full screen Patient Candidate Search
   Enter '.' first to use Partial Last Name, Partial first Name look up.
   Enter the Full Name of a patient.

8. SELECT PATIENT: **S** (go get selection screen)

   PATIENTS AT APU: APU INTERNAL MEDICINE

   1 NEARY,ALTHEA A
   2 NEARY,BARBARA B
   3 NEARY,CHRISTINE C
   4 NEARY,DONNA D
   5 NEARY,ELIZABETH E
   6 NEARY,FLORENCE F
   7 NEARY,GRACE G
   8 NEARY,HOLLEY H
   9 NEARY,ILSA I
   10 NEARY,JACKIE J
   11 NEARY,LINDA L
   SELECT PATIENT(S): **11**

9. DEVICE: HOME// **<RETURN>**

Sample Screen

```
                      Shift Care Plan
LOC: INT                                  FROM: 21 Jun 2001@0700
PRINT DATE: 21 Jun 2001@0730              TO: 21 Jun 2001@1459

INT    NEARY,LINDA L  [AO3]  20/222-33-4506  REG#
  21 Jun 2001
     1. CHEST, PA/LAT~MAIN RADIOLOGY~AMB...............
0812 2. CBC PROFILE~WARD/CLINIC COLLECT~BLOOD~LAV......PENDING
     3. VITAL SIGNS (BP,T,P,R).......................PENDING
                      BP______ T______ P______ R______
     4. NPO DIET.....................................PENDING
        PRE OP ON ARRIVAL TO UNIT
1100 5. VITAL SIGNS (BP,T,P,R).......................PENDING
                      BP______ T______ P______ R______
PRN  6. ACETAMINOPHEN-TAB (TYLENOL) <ORAL> 325MG TID {QD}PRN..
          POST OP FOR PAIN MANAGEMENT

End of Report
```

End screen

The items on the Shift Care Plan will have a status of PENDING until a nursing result is entered. This PENDING status should not be confused with the order status. (Ex. the LAB test on the above Shift Care Plan display is PENDING the nursing result for WARD/CLINIC collection, not the laboratory's result and completion of the test.

9. Select Generate Due List Menu Option: **<RETURN>**

10. Select Document Patient Care Menu Option: **EDR**
    (or NSEDR from the Desktop action prompt)

11. Enter Due List Results Menu Option: **SC**

12. Select Ward or APU: **BAA5** (APU INTERNAL MEDICINE)

    FROM: 0700//
    TO: 1459//

    SELECT PATIENT: **S** (go get selection screen)
    (Same procedure as above)

    SELECT PATIENT(S): **11**

13. Results taken by: NURSE,LAMP// **<RETURN>**

Sample Screen

```
           INDIVIDUAL SHIFT CARE PLAN RESULTS ENTRY
LOC: APU INTERNAL MEDICINE                 FROM: 21 Jun 2001@0700
TASK DATE: 21 Jun 2001                     TO: 21 Jun 2001@1459

21 Jun 2001

RAD CHEST, PA/LAT~MAIN RADIOLOGY~AMB
Result time: N(ow) (When the patient went to RADIOLOGY)
Done? : YES  (Was this order completed, YES or NO)
Result comment: (3-78 Character free-text field)

0700  NRS
VITAL SIGNS (BP,T,P,R)
BP: 120/80  T (F): 98.6  P: 60  R: 12 (ENTER THE VITAL SIGNS)
COMMENT:

20/222-33-4506   NEARY,LINDA L
                 15 Dec 1971  F
                 [AO3]

             Personal Data - Privacy Act 1974 (PL-93-579)
```

End screen

14. Select E)dit, U)nscheduled, or Q)uit: E//

    Edit the entries just made or select unscheduled to choose another patient, or quit. Edits will be amended with an (*) indicator.)

15. Select Document Patient Care Menu Option: **GSR**

16. Select Ward or APU: **BAA5** (APU INTERNAL MEDICINE)

    FROM: 0700//
    TO: 1459//

17. SELECT PATIENT: **S** (go get selection screen)
    (Same procedure as above)

    SELECT PATIENT(S): **11**
    DEVICE: HOME//

Sample Screen

```
                  Generate Shift Care Report
LOC: INT                                   FROM: 21 Jun 2001@0700
PRINT DATE: 21 Jun 2001@0830               TO:  21 Jun 2001@1459

UNK    NEARY,LINDA L  [AO3]  20/222-33-4506  REG#
NRS
   21 Jun 2001
 0700 1. VITAL SIGNS (BP,T,P,R)......................LAMP@0730
                    BP 120/80 T 94.2* P 60 R 12
      2. NPO DIET....................................LAMP@0730
         PRE OP ON ARRIVAL TO UNIT
 1100 3. VITAL SIGNS (BP,T,P,R)......................LAMP@0730
                     BP ______ T _____ P _____R _____
LAB
 0715 1. CBC PROFILE~WARD/CLINIC COLLECT~BLOOD~LAV...LAMP@0717
RAD
      1. CHEST, PA/LAT~MAIN RADIOLOGY~AMB............LAMP@0723
MED
 PRN  1. ACETAMINOPHEN-PO (TYLENOL) <ORAL> 325MG TID {QD} PRN.
```

Nursing Documentation is not new in Version 4.6, therefore this training is not complete. Sites should review these procedures completely before implementing at their site.

H. APV FILE AND TABLE TRAINING (Supervisor)

NOTE: This portion of training should be demo'd only. Only one user can access this option at the same time.

1. Clinical Site Parameters.

There is a new field in the Clinical Site Parameters to support the resulting of Patient Due Lists. This field will allow the site to define how many days the APV page will remain a PAST page after the patient has been dispositioned from the APU. This parameter provides a window to continue entering results on a due list after the APV page is inactivated. Once the parameter is reached, the page is collapsed and due lists cannot be resulted.

a. Select Nursing Menu Option: **MNG**

b. Select Nursing Management Menu Option: **TAB**

c. Select Table Maintenance Menu Option: **CSM**

d. Select CLINICAL SITE PARAMETER NAME: **1**

e. Go to **page 3** of the Clinical Site Parameters:

SITE PARAMETER MAINTENANCE -- CONTINUATION

Number Hours When Task Is Past Due: 120
Days to Check Past Due Tasks: 10
IV Modify/Renew: OLD ORDER REMAINS
Future Nursing Result Window: 120
Allow Batch Processing: YES
Warning Check At Page Activation:
Continuous Radiology Order Duration: 3
Continuous Nursing Order Duration: 7
Lab Collection Default: WARD
Continuous Lab Order Duration:
Continuous Ancillary Order Duration:
Days to Notify HCPs of Pending Adm Order Cancellation: 14
Days to Cancel Past Dated Admission Orders: 60
Days to Collapse the Past APV Page: 7 (between 1 & 30 days)
Start Time for the 24 Hour Report: 0700
24 Hour Report Shift 1 Name (0700): DAY
24 Hour Report Shift 2 Name (1500): EVENING
24 Hour Report Shift 3 Name (2300): NIGHT

Explain that the parameter sets the number of days the APU page will remain before collapsing in the Order Entry option.

2. Nursing Procedure Maintenance.

If the site plans to use Nursing Orders (NRS), they should created and/or edit the Nursing Procedure File. This is not new to V4.6. The Clinical Implementation Guides may also be referenced for detailed file build instructions on Nursing Orders.

a. Select Nursing Menu Option: **MNG**

b. Select Management Nursing Menu Option: **TAB**

c. Select Table Maintenance Menu Option: **NRS**

d. Select NURSING/INTRAWARD PROCEDURE NAME: **VITAL SIGNS**

VITAL SIGNS Nursing Procedure File Maintenance

Name: **VITAL SIGNS (BP,T,P,R)**

Order type: **BOTH**
(indicate whether this is a nurse initiated order, an MD initiated order, or both.)

Procedure Not Available:
(is this procedure performed at your MTF, if NO it will not show on any picklist during ordering.)

Quick Code: **VS**

(a 1-5 character abbreviation)

Synonym:
VS (a 1-30 character "abbreviation")

Prompt Label:
(a label for this procedure to display on the Due List)

Description:
Vital Signs include: Blood Pressure, Pulse, Temperature, Respirations.

Authorized Ordering Class:
(restricts ordering by provider class)

Authorization key:
(restricts ordering to users who hold this security key)

Countersignature Required?
(Is a cosignature required for this order to be completed?)

Maximum Days Duration:
(number of days before this order must be renewed)

Default Schedule Type: **CONTINUOUS**
(how will this be ordered)

Select Schedule Type(s) to define defaults:

CONTINUOUS
PRN
ONE TIME
AM
NOW

[END APV TRAINING]

II. Patient Problem Lists

A. CREATING PROBLEM SELECTION LISTS

1. Sign in as **DRLAMP** or **NURSELAMP**

2. Select Physician Menu Option: **PLM** (Physician only)

   Select Nursing Menu Option: **MNG** (Nursing only)
   Select Management Nursing Menu Option: **PLM**

3. Select Problem Selection Lists Name or Location: **PROBLEMS**
   Are you adding 'PROBLEMS' as
   a new PROBLEM SELECTION LIST (the 1st)? **YES**
   Location: **BACA** (CARDIOLOGY CLINIC)

4. Press **<RETURN>** to invoke the **EditList** action and add entries.

5. Press **<RETURN>** to invoke the **Add** action to create categories.

6. Enter a new Category name: **CARDIAC** (a group name for problems)
   Sort Sequence: **1** (the display order on list)
   Enter a new Category name: **PULMONARY**
   Sort Sequence: **2**
   Enter a new Category name: **GI**
   Sort Sequence: **3**
   Enter a new Category name: **<RETURN>**

Sample Screen

```
                    Problem Selection List Maintenance
PROBLEMS                                        Created: 21 Jun 2001
Location: CARDIOLOGY CLINIC                    Modified:

 Category:
*1. CARDIAC
*2. PULMONARY
*3. GI



Add  Edit  Help  eXit
```

End screen

7. Press **<RETURN>** to access the **Edit** action and add problems to the categories that are already selected.

8. Category: CARDIAC
   Sort Sequence: 1// (reorder the category, if desired) **<RETURN>**

9. Enter a new Problem: **HYPERTENSION**
   Type '^' to stop, or

```
   Choose 1-30:
         31  HYPERTENSION,  410.9     HYPERTENSION NOS
         32  HYPERTENSION,  642.11     RENAL HYPERTEN PG-DELIV
         33  HYPERTENSION,  642.12     RENAL HYPERTEN-DEL P/P
         34  HYPERTENSION,  642.13     RENAL HYPERTEN-ANTEPART
         35  HYPERTENSION,  642.14     RENAL HYPERTEN-POSTPART
   Type '^' to stop, or
   Choose 1-35: 31
     Sort Sequence: 1
   Enter a new Problem: <RETURN>

10. Category: PULMONARY
   Sort Sequence: 2// (reorder the category, if desired) <RETURN>

11. Enter a new Problem: PNEUMONIA

   Type '^' to stop, or
   Choose 1-5:
         6  PNEUMONIA  480.8     VIRAL PNEUMONIA NEC
         7  PNEUMONIA  480.9     VIRAL PNEUMONIA NOS
         8  PNEUMONIA  482.1     PSEUDOMONAL PNEUMONIA
         9  PNEUMONIA  482.2     H.INFLUENZE PNEUMONIA
        10  PNEUMONIA  482.4     STAPHYLOCOCCAL PNEUMONIA
   Type '^' to stop, or
   Choose 1-7: 7
     Sort Sequence: 1
   Enter a new Problem: <RETURN>

12.Category: GI
   Sort Sequence: 3// (reorder the category, if desired) <RETURN>

13. Enter a new Problem: ULCER
   Type '^' to stop, or
   Choose 1-35:
         36  ULCER  532.30        ACUTE DUODENAL ULCER NOS
         37  ULCER  532.40        CHR DUODEN ULCER W HEM
         38  ULCER  532.50        CHR DUODEN ULCER W PERF
         39  ULCER  532.60        CHR DUODEN ULC HEM/PERF
         40  ULCER  532.70        CHR DUODENAL ULCER NOS
   Type '^' to stop, or
   Choose 1-7: 40
     Sort Sequence: 1
   Enter a new Problem: <RETURN>
```

Sample Screen

```
                    Problem Selection List Maintenance
PROBLEMS                                      Created: 21 Jun 2001
Location: CARDIOLOGY CLINIC                  Modified:

 Category:                                                Created:
 1. CARDIAC                                             21 Jun 2001
    1. ESSENTIAL HYPERTENSION, NOS (ICD 401.9)
 2. PULMONARY                                           21 Jun 2001
    1. PNEUMONIA DUE TO VIRUS NOS (ICD 480.9)
 3. GI                                                  21 Jun 2001
    1. CHRONIC DUODENAL ULCER (ICD 532.70)


Add  Edit  Delete  Help  eXit
```

End screen

14. Press **<RETURN>** to eXit.

15. Press **<RETURN>** to access the **AssignList** action.

Sample Screen

```
               Problem Selection List - Assign Locations
PROBLEMS                                       Created: 21 Jun 2001
Location: CARDIOLOGY CLINIC                   Modified:

 Location
  1. CARDIOLOGY CLINIC          DIV A - TRAINING HOSPITAL   BACA



Assign   Delete   Help  eXit
```

End screen

16. Press **<RETURN>** to assign the list to another clinic.

    The list was assigned to Cardiology Clinic when you entered this option and defined the Location. You can assign this list to as many other clinic as you like.

17. Enter a location name: **BHAA** (GENERAL MEDICINE CLINIC)
    Enter a location name: **<RETURN>**

Sample Screen

```
               Problem Selection List - Assign Locations
PROBLEMS                                    Created: 21 Jun 2001
Location: CARDIOLOGY CLINIC                Modified:

 Location
  1. CARDIOLOGY CLINIC           DIV A - TRAINING HOSPITAL   BACA
  2. GENERAL MEDICINE CLINIC     DIV A - TRAINING HOSPITAL   BHAA


Assign   Delete   Help  eXit
```

End screen

18. Press **<RETURN>** to exit the Assign List screen and Press **<RETURN>** to exit the Problem Selection List Maintenance option.

B. ASSIGN PATIENT PROBLEMS

Note: Problems can also be assigned from the ACTION prompt in Order Entry (ORE).

1. Select Physician Menu Option: **DOC** (Nurses start with #2)

2. Select Document Patient Care (Nursing) Menu Option: **NTE**

3. Select Enter/Review Patient Notes Option: **PPL**

4. Select PATIENT NAME: **BEAN,LINDA L**

5. Select REQUESTING LOCATION: **BHAA**

6. Press **<RETURN>** to **Add** Patient Problems.

7. Enter Location for Problem Selection List or Press <RETURN> to enter a problem: **BHAA**

8. Select **(*)** the **PROBLEMS** list, press **<RETURN>**.

9. Select **(*)** a Problem from the List, press **<RETURN>**.

10. Complete the fields on the screen.

Sample Screen

```
BEAN,LINDA L       AGE:37y     20/500-50-7631      Problem List
ESSENTIAL HYPERTENSION, NOS  (ICD 401.9)

Date of Onset: T(oday)
Status of Problem: Active
Acuity of Problem: C(hronic)

Previous Comment(s):


Comment:
Patient is currently on Procardia XL 30MG QID to control BP.
Most recent BP (170/95) 21Jun01.

File/Exit  Abort  Edit
File changes and exit.
```

End screen

11. Enter Location for Problem Selection List or
Press <RETURN> to enter a problem: **<RETURN>**

Enter a new problem: **BACK**
Type '^' to stop, or
Choose 1-20:

```
      21  BACKACHE,  724.5    BACKACHE NOS
      22  BACKGROUND  362.01     DIABETIC RETINOPATHY NOS
      23  BACKGROUND  362.10     BACKGRND RETINOPATHY NOS
```

Choose 1-23: **21**

Sample Screen

```
BEAN,LINDA L      AGE:37y     20/500-50-7631        Problem List
BACKACHE, UNSPECIFIED (ICD 724.5)

Date of Onset: T(oday)
Status of Problem: Active
Acuity of Problem: A(ctive)

Previous Comment(s):

Comment:
Patient c/o back pain. Playing touch football at picnic last weekend. Prescribed
TYLENOL 325MG Q4-6H PRN pain. F/U in 10days.

File/Exit   Abort   Edit
File changes and exit.
```

End screen

12. Enter a new Problem: **<RETURN>**

13. Select **(*)** the Backache problem and press the letter '**I**' to inactivate this problem.

14. Problem: BACKACHE, UNSPECIFIED, Onset 06/21/0
    Date Resolved: TODAY// **<RETURN>**
    Comment: **Pt has no further c/o pain**

15. Press the letter **'X'** to exit.

[END PROBLEM LIST TRAINING]

III. Consult Results.

A. ENTER A CONSULT ORDER.

Enter an order for an Unscheduled consult. HCP's should select the provider next them as the Requested HCP. Nurse/Clerk users should use the DOCTOR for their neighbor.

1. Sign in as **DRLAMP** or **NURSELAMP**.

2. Select Physician/Nursing Menu Option: **ORE**

3. Select PATIENT NAME: **BEAN,LINDA**

4. Select REQUESTING LOCATION: **BHAA** (GENERAL MEDICINE CLINIC)

5. ACTION: **N**EW (Use DRLAMP for Ordering/Authorizing HCP)

6. ORDER TYPE: **CON** (Consult Order).

7. Select CONSULT PROCEDURE: **NUTRITIONAL CONSULT**

```
   1  NUTRITIONAL CONSULT         DIV A - TRAINING HOSPITAL
   2  NUTRITIONAL CONSULT         NAVAL HOSPITAL
Choose 1-2: 1
```

Sample Screen

```
BEAN,LINDA L       Age:37   20/500-50-7631          CONSULT ORDER
NUTRITIONAL CONSULT                                  010621-03390

From: GENERAL MEDICINE CLINIC         To: GENERAL MEDICINE CLI
Date of Request: 21 Jun 2001@0800     Requested HCP: DOCTOR,AARON
Requested Date of Consult: Today       Exact Date: NO
Reason for Consult:
DIABETIC


Provisional Diagnosis: IDDM (Reason for Appointment)

Requesting HCP: DOCTOR,LAMP          Priority: ROUTINE
                                     Expiration Date: 21 Jul 2001


File/Exit   Abort   Edit
File changes and exit.
```

End screen

8. NOTE: the Nutritional Consult is not a "scheduled" consult. Now you will enter an order for a Scheduled consult. Leave the Requested HCP prompt blank for this exercise.

9. Select CONSULT PROCEDURE: **CARDIOLOGY CONSULT**

```
  1  CARDIAC SURGEION CONSULT   DIV A - TRAINING HOSPITAL
  2  CARDIOLOGY CONSULT         DIV A - TRAINING HOSPITAL
  3  CARDIOLOGY CONSULT         DIV B - PENTAGON BRANCH CLIN
Choose 1-2: 1
```

Sample Screen

```
BEAN,LINDA L      Age:37    20/500-50-7631          CONSULT ORDER
CARDIOLOGY CONSULT                                   010621-03391

From: GENERAL MEDICINE CLINIC          To: CARDIOLOGY CLINIC
Date of Request: 21 Jun 2001@0815      Requested HCP: <RETURN>
Requested Date of Consult: Today       Exact Date: NO
Reason for Consult:
CHEST PAINS


Provisional Diagnosis: ANGINA (Reason for appointment)

Requesting HCP: DOCTOR,LAMP          Priority: ROUTINE
                                     Expiration Date: 21 Jul 2001

File/Exit   Abort   Edit
File changes and exit.
```

End screen

9. File/Exit the order and return to the POL display.

Sample Screen

```
BEAN,LINDA   Age:37      20/500-50-7631  OUTPAT PRE-ACTIVE ORDERS

 1 CON  NUTRITIONAL CONSULT at DIV A - TRAINING
        HOSPITAL  on 21 Jun 2001@0800 {IDDM}
        ~PRE-ACTIVE . . . . . . . . . . . . . . DRLAMP 21JUN@0817
 2 CON  CARDIOLOGY CONSULT at DIV A - TRAINING
        HOSPITAL  on 21 Jun 2001@1956 {ANGINA}
        ~Pend.Appointment~PRE-ACTIVE. . . . . . DRLAMP 21JUN@0817



*OUTPAT*


ACTION:
```

End screen

10. QUIT AND ACTIVATE YOUR ORDERS. (Q)
    Print order group? YES//
    DEVICE: HOME

Sample screen

```
TRAINING MEDICAL TREATMENT FACILITY       21 Jun 2001@0910 Page 1
Personal Data - Privacy Act of 1974 (PL 93-579)

NEW ORDER
1  CON  010621-03390    20/500-50-7631    BEAN,LINDA L
    NUTRITIONAL CONSULT at DIV A - TRAINING HOSPITAL on
    21 Jun 2001@0817
   Duty Station/Unit: NR NAV SPACE COMMAND 0266
    IDDM
   DOCTOR,LAMP  SCD/PRE-ACTIVE

2  CON  010621-03391    20/500-50-7631    BEAN,LINDA L
    CARDIOLOGY CONSULT at DIV A - TRAINING HOSPITAL on
    21 Jun 2001@0817
   Duty Station/Unit: NR NAV SPACE COMMAND 0266
    ANGINA
   DOCTOR,LAMP  SCD/PRE-ACTIVE
```

(Show the user that the patient's Duty Station will display on the printout to aide in determining the appropriate record filing procedures)

End screen

[GO TO SECTION C. FOR NURSE/CLERK-LEVEL TRAINING]

B. HCP-LEVEL USER CONSULT RESULT ENTRY.

The scheduled consult ordered in the first exercise must be booked by the PAS user before it will be available to result. If a Scheduled CON order is written by a Clerk-level user, it will have to be signed by the Nurse or HCP-level user before the appointment can be booked.

An Unscheduled CON order can be ordered by a Clerk-level user and resulted by an HCP-level user without needing a signature, but it should be signed by an HCP at some time.

1. Select Physician Menu Option: **DOC**

2. Select Document Patient Care Menu Option: **NTE**

3. Select Enter/Edit Patient Notes Option: **CON**

4. Scheduled Consults will display first. (CARDIOLOGY CONSULTS)

5. Select **(*) SAWYER,LINDA L** (sign on message was for this one)

6. Press **<RETURN>** to invoke the Note action on the Action bar.

Sample Screen

```
SAWYER,LINDA L       20/600-60-7602       35y  F  CHIEF PETTY

Appointment Date: 20 Jun 2001@0730  Requesting HCP: HARTMAN,CHRIS
Clinic: CARIOLOGY CLINIC            Consulting HCP: DOCTOR,LAMP
Provisional Diagnosis: ANGINA
Reason for Consult:
  CHEST PAINS

Allergies:
  (use the up down arrow to enter/edit problems and allergies)

Active Problem List:
  Enter the problem of 413.9 (ANGINA) for this patient.


Save  Allergy  proBlem  Results  pgDn   Print   Help eXit
```

End screen

Note: The Results action allows a user to access results and cut/paste them to the Consult note using the F9 key. These patients have no results to demonstrate this function. This will be demonstrated during the Progress Note training.

7. Press **<RETURN>** to invoke the pgDn action.

Sample Screen

```
SAWYER,LINDA L       20/600-60-7602       35y  F  CHIEF PETTY

Note:

    This note was entered by a Nurse/Clerk-level provider and
    Transcribed for your approval.


Verify  Save   Allergy  proBlem  Results   Print   Help  eXit
```

End screen

8. Press **<RETURN>** to invoke the Verify action. This will complete the consult and send a message to the ordering HCP indicating that the requested consult is complete.

9. You do not have a signature block defined.
   Do you wish to define one now? YES// **<RETURN>**
   Define a signature block for the consult note.
   Review the verified Consult result.
10. Press the letter "**U**" to display Unscheduled consults.

11. Select **(*)** the patient under Requested Provider Consult(s) that was sent to you by your neighbor during the previous exercise (BEAN,(SL)).

12. Press **<RETURN>** to invoke the Note action and enter **T**(oday) for the appointment date that the patient was seen.

Sample Screen

```
BEAN,BARBARA B        20/500-50-6631   27Y          AIRMAN BASIC

Appointment Date: T(ODAY)           Requesting HCP: DOCTOR,BAKER
Clinic: GENERAL MEDICNE CLINIC      Consulting HCP: DOCTOR,LAMP
Provisional Diagnosis: IDDM
Reason for Consult:
  DIABETIC

Allergies:
  (use the up down arrow to enter/edit problems and allergies)

Active Problem List:
  (Observe problems enter in previous exercise)


Save  Allergy  proBlem  Results  pgDn   Print   Help eXit
```

End screen

13. Press **<RETURN>** to invoke the pgDn action.

Sample Screen

BEAN,BARBARA B 20/500-50-6631 27y F AIRMAN BASIC

Note:

A free-text screen will appear allowing the user to enter a note of unlimited length. When the note is complete, press <RETURN> until the action bar appears.

Verify Save Allergy proBlem Results Print Help eXit

End screen

14. Press **<RETURN>** to invoke the Verify action. This will complete the consult and send a message to the ordering HCP indicating that the requested consult is complete.

15. Select **(*)** the next Unscheduled Consult that you are a Requested Provider for (LADD,JOYCE), **REMEMEBER THE NAME.** Press the letter '**W**' to invoke the written action from the action bar. This will mark the consult as being completed on paper (typically the SF-513 Consult Note). A warning message will display:

CAUTION: Notes for this consult appointment will be deleted.
Do you want to verify/remove this consult from your list? NO//**YES**

[GO TO SECTION D TO COMPLETE HCP-LEVEL TRAINING]

C. NURSE/CLERK-LEVEL USER CONSULT RESULTS ENTRY.

The scheduled consult ordered in the first exercise must be booked by the PAS user before it will be available to result. If a Scheduled CON order is written by a Clerk-level user, it will have to be signed by the Nurse or HCP-level user before the appointment can be booked.

An Unscheduled CON order can be ordered by a Clerk-level user and resulted by an HCP-level user without needing a signature, but it should be signed by an HCP at some time.

1. Sign in as **NURSELAMP**.

2. Select Nursing Menu Option: **NTE**

3. Select Enter/Review Patient Notes Option: **CON**

4. Select Clinic: **BACA**

5. Scheduled Consults will display. (CARDIOLGY CONSULTS)

6. Select **(*)** the New Consult(s) for Today for **LENNON,LINDA L**.

7. Press **<RETURN>** to invoke the Note action on the Action bar.

Sample Screen

```
LENNON,LINDA L        20/200-20-7614       37y  F  LIEUTENANT C

Appointment Date: 21 Jun 2001@0730   Requesting HCP: HARTMAN,CHRIS
Clinic: CARIOLOGY CLINIC             Consulting HCP: DOCTOR,LAMP
Provisional Diagnosis: ANGINA
Reason for Consult:
  CHEST PAINS


Allergies:
  (use the up down arrow to enter/edit problems and allergies)

Active Problem List:
  Enter the problem of 413.9 (ANGINA) for this patient.

Save  Allergy  proBlem  Results  pgDn   Print   Help eXit
```

End screen

Note: The Results action is similar to the TelCon option with the addition of a cut/paste feature. These patients may have no results to demonstrate this function. This will be demonstrated during the Progress Note training.

8. Press **<RETURN>** to invoke the pgDn action.

Sample Screen

```
LENNON,LINDA L        20/200-20-7614       37y  F  LIEUTENANT

Note:

A free-text screen will appear allowing the user to enter a note
of unlimited length. When the note is complete, press <RETURN>
or the 'Do' key to show the action bar.


Save  Transcribe  Allergy  proBlem  Results   Print   Help  eXit
```

End screen

9. Press the letter '**T**' to invoke the Transcribe action. This will remove the consult from the clinic consult queue and send a sign-on message to the Consulting HCP indicating that the consult note is ready for verification.

10. From the Scheduled Consult Appointment Display screen press the letter "**X**" to exit the consults option.

11. Select Enter/Review Patient Notes Option: **CON**

    Select Clinic: **BHAA** (GENERAL MEDICINE CLINIC)

12. From the Scheduled Consult Display, press **<RETURN>** to access the unscheduled consult queue.

13. Select **(*)** the patient for entered by your neighbor during the previous exercise, **BEAN,(neighbor's SL)**.

14. Press **<RETURN>** to invoke the Note action.
    Enter **T** for today as the appointment date.

15. Change the Consulting HCP to another Doctor: **DOCTOR,AARON**

    (The Consulting Provider name can be changed by non-HCP's)

Sample Screen

```
BEAN,BARBARA B          20/500-50-6631   27Y    AIRMAN BASIC

Appointment Date: Today           Requesting HCP: DOCTOR,BAKER
Clinic: GENERAL MEDICINE CLINIC    Consulting HCP: DOCTOR,AARON
Provisional Diagnosis: IDDM
Reason for Consult:
  DIABETIC


Allergies:
  (use the up down arrow to enter/edit problems and allergies)

Active Problem List:
  (Observe problems entered in previous exercise)

Save  Allergy  proBlem   Results   pgDn   Print   Help   eXit
```

End screen

16. Press **<RETURN>** to invoke the pgDn action.

Sample Screen

```
BEAN,BARBARA B          20/500-50-6631      27y  F  AIRMAN BASIC

Note:

A free-text screen will appear allowing the user to enter a note
of unlimited length. When the note is complete, press <RETURN> until
the action bar appears.


Verify  Save   Allergy  proBlem  Results   Print   Help  eXit
```

End screen

17. Press the letter '**T**' to invoke the Transcribe action.

18. Press the letter "**X**" from the Unscheduled Consult display to return to the Scheduled Consult Display.

19. Press the letter "**X**" from the Scheduled Consult Appointment Display screen to exit the consults option.

D. REVIEW CONSULT RESULTS

(Review #1-7 for HCP only. Nurse/Clerk-level users begin with #8)

1. Select Physician Menu Option: **MailMan Menu**

2. Select MailMan Menu Option: **LNM**

   (Explain the MailMan changes for Version 4.6.)

3. Select listing device: **HOME**

4. Press the **[F7]** key to scroll to the end of the list.

5. Move the cursor next to the message indicating

   n) Subj: CONSULT RESULT COMPLETED
   Thu, 21 Jun 2001 09:31:19 4 Lines
   From: POSTMASTER Not Read, in IN basket

Note: There will be 2 messages. One for the Jones patient from DR Hartman and one for the Bean patient from this exercises. Use the Jones patient if there is a small class and not everyone received a request for consult.)

6. Press the Select key **(*)** to display the message.

7. At the message action prompt press **<RETURN>** three times to go back to the Physician Main Menu.

8. Select Physician (Nursing) Menu option: **RCR**

9. Select Review Clinical Results and Orders Menu Option: **RPN (Review Patient Notes)**

10. Select PATIENT NAME: **BEAN,LINDA L** (Nurses use **JONES,LINDA L**)

11. From the Review Patient Notes screen, Press the **C**onsults action to search for consults.

12. Press **<RETURN>** to invoke the Display ALL Notes action. The user can also select (*) one or more notes, when available and choose the Display Selected notes action.

    (Notes can be re-printed using this option.)

13. (HCP's) Review the result for the consult completed as Written. (LADD,JOYCE)

[END CONSULT TRAINING HERE]

IV. Progress Notes.

Clerk-level users can only print Progress Notes.

A. ENTER PROGRESS NOTE.

1. Sign in as **DRLAMP** or **NURSELAMP**.

2. Select Physician Menu Option: **DOC** (Nurses skip this step)

3. Select Document Patient Care (Nursing) Menu Option: **NTE**

4. Select Enter/Review Patient Notes Option: **PRG**

5. Select PATIENT NAME: **ZINN,MICHAEL** (any patient with results)

6. Title: **??**
   ANES NOTE
   NURSE NOTE
   PREOP NOTE
   PROG NOTES
   (Select any note type for this class)

7. Note: (Enter a free-text note of unlimited length.)

Sample Screen

```
ZINN,MICHAEL          AGE:35y    20/100-10-7125       Progress Notes
Previous Progress Notes:


 Title: Progress Notes
Note:
 Patient has been seen in the clinic repeatedly for c/o Back Pain
 measuring 7 on a scale of 1-10, with no known trauma. Examination
 has not revealed a source of this problem that can be attributed
 to the level of pain the patient complains of.

 Patient is currently on non-steroidal anti-inflammatory therapy but
 frequently requests "stronger" meds. Examination has not revealed a
 justification for stronger medication therapy.

 PLAN: Refill TYLENOL 650MG Q4-6H PRN PAIN for 10 more days.


File  Print  Edit  Results   Help   eXit
```

End screen

The Results action is similar to the TelCon option with the addition of a cut/paste feature.

8. Press the letter '**R**' to review results.

9. Press '**F11**' to select all Result types to review.

10. Accept the default 'T-14' days to review.

11. Move the **cursor down** next to the date of the STAT POTASSIUM result.

12. Press the Select key **(*)** next to the test date.

13. Move the **cursor down** to the date of the STAT WBC (the CBC results).

14. Press the Select key **(*)** here.

15. Press the '**PF1**' key, then press the letter '**C**'.
    (The select text was placed in the buffer. Nothing will happen that is apparent to the user.)

16. Press '**N**' to invoke the Note option.

17. **Move the cursor** to the first blank line below the last text entered.

18. Press the '**PF1**', then the letter '**C**' again.

    Do you want to 'PASTE' buffer's contents? Y
    (press **<RETURN>** and the text will paste to the screen)

    Want to purge your buffer? (enter '**Y**' to purge the buffer)

19. Press **<RETURN>** to File the Note.

B. REVIEW PROGRES NOTES.

1. Select Physician (Nursing) Menu Option: **RCR**

2. Select Review Clinical Results and Orders Menu Option: **RPN**

3. Select PATIENT NAME: **ZINN,MICHAEL**

4. Press **<RETURN>** to review Progress Notes (default action).

5. Press **<RETURN>** to Browse ALL Progress Notes (default action).

6. Demonstrate the search option to look for previous notes.

[END PROGRESS NOTE TRAINING]

V. The Discharge Summary

1. Sign in as **DRLAMP** or **NURSELAMP**.

2. Select Physician Menu Option: **DOC** (Nurses skip this step)

3. Select Document Patient Care (Nursing) Menu Option: **NTE**

4. Select Enter/Review Patient Notes Option: **DIS**

   a. (Nurse-level) Dictating HCP: **DOCTOR,(SL)**

5. Select **(*)** Create a New Summary.

6. Press **<RETURN>** to invoke the Enter action.

7. Select PATIENT NAME: **ROBINSON,SCOTT** (ROBINSON,A-J)
   18 Jun 2001
   Is this the correct admission? YES// **<RETURN>**

8. Move the **cursor up** into the screen to enter/edit allergies and inactivate the Patient Problem of ABD Pain.

   a. Press **<RETURN>** in invoke the pgDn action.

9. Move the **cursor up** into the screen and press the '**F9**' key next to one of the Radiology Exams to display the result.

   a. Press **<RETURN>** in invoke the pgDn action.

10. Move the **cursor up** into the screen to enter free-text in the fields on the screen.

    a. Press **<RETURN>** in invoke the pgDn action.

11. Move the **cursor up** into the screen to enter free-text discharge instructions for the activity fields.

    a. Press **<RETURN>** in invoke the pgDn action.

12. Move the **cursor up** into the screen to enter a discharge diet.

13. Move the **cursor down** to the Patient Instructions field.

14. Press the '**F9**' key to import instruction templates.

    Choose Text: **??**
    Do you want to see a list of choices? N (type '**Y**' to see list)

15. Select key **(*)** next to the GENERAL DISCHARGE INSTRUCTIONS (the text will be pasted to the screen).

16. Press **<RETURN>** to page down.

17. Enter '**Y**' for the discharge summary being dictated. The responsible physician name will default from the Admitting Physician entered by PAD. Change the name to **HARTMAN,CHRIS**. (This will not affect the summary)

18. Move the **cursor down** to Enter Discharge Summary field.

19. Press '**F9**' to import summary templates.)

    Choose Text: **?**
    Do you want to see a list of choices? N (type '**Y**' to see list)

20. Press the select key **(*)** next to POST-OP CHOLECYSTECTOMY (the template will paste onto the screen, note the blank fields)

20. (HCP-level) Press **<RETURN>** to Verify and complete the summary. (Cannot be printed to the screen. Use the **NL:** device)

NOTE: Nurse/Clerk-level users can only save the summary. The summary will display as Unfinished Summaries for the Dictating HCP defined when entering the DIS option.

[NURSE-LEVEL USER TRAINING - GOTO SECTION B]

21. (HCP-level) Press the letter '**A**' to append a summary.

22. Select Patient Name: **ROBINSON,(neighbor's SL)**

23. Press **<RETURN>** to Enter a note.

24. Type a note. Press **<RETURN>** to verify the note. (Cannot print to the screen. Use the **NL:** device)

25. Press the letter '**X**' to exit the summary option.

Note: An unfinished summary is assigned to only one HCP until it is completed. Only a completed summary can be appended and can be appended by any HCP-level user.

B. REVIEW DISCHARGE SUMMARY NOTES.

1. Select Physician (Nursing) Menu Option: **RCR**

2. Select Review Clinical Results and Orders Menu Option: **RPN**

3. Select PATIENT NAME: **ROBINSON,SCOTT** (ROBINSON, A-J)

4. Press the letter '**D**' to display Discharge summaries.

5. Press **<RETURN>** to display ALL discharge summaries.

6. (HCP-Level) Notice that after the 'Verified by:' field there is a short message identifying an addendum to the summary that was entered by your neighbor after your summary was complete.

VI. Immunization Training.

The Immunization options can only be accessed from the Nursing Menu.

1. Sign in as **NURSELAMP**.

2. Select Nursing Menu Option: **IMM**

3. Select PATIENT NAME: **BEAN,LINDA L**

4. Select Performing Location: IMMUNIZATION CLINIC// **<RETURN>**
   (Describe the Profile)

5. Press **<RETURN>** to invoke the Give action.

6. Move the **cursor down** to select **(*) INFLUENZA (WHOLE)** test.

7. Press **<RETURN>** to enter the test data screen.

8. Lot Number: **??** (there's only one there)

   a. Select **(*) I12345**

NOTE: The LOT information will default from the Lot File for this test. The user can change these defaults if desired.

9. Ordering HCP: **HARTMAN,CHRIS** <RETURN>, File and exit.

10. The profile will update the information for the INFLUENZA test.

11. Move the **cursor up** next to the INFLUENZA test and select it with (*).

12. Press the '**F9**' key to expand the test information.

13. Press '**F9**' again to see more information.

14. Move the **cursor down** to the TB TINE test.

15. Press the letter '**R**' to enter a result.

    TB TINE
    Enter the number of mm induration measured in the transverse plane: **0**
    Enter Comment: **(free-text)**

16. Press the letter '**T**' to transcribe a test entry.

17. Select **(*)** the **HEP B (ADULT)** test, press **<RETURN>**.

18. Complete the fields on the screen and **File**.

19. Select **(*)** the INFLUENZA test again and press the letter '**M**' to

amend the test.

Sample Screen

```
INFLUENZA (WHOLE)     21 Jun 2001

Select: (D)elete test from patient profile,(A)mend test and correct
        error, or (Q)uit: D
  Delete Comment: Immunization enter in error// <RETURN>
      (Comment field is free-text, prompt is only a suggestion)
```

End screen

20. Select **(*) HEP B** test, press the letter '**V**' to enter a reaction.

21. Enter **??** to access Vaccine Reaction Name List

22. Select **(*) ANAPHYLAXIS/COLLAPSE** reaction.
    Comment: **PT RECOVERED WITH AMMONIA PELET**

23. **File** the reaction. Use '**F9**' to review the reaction.

B. MULTIPLE PATIENT IMMUNIZATION.

Recommend demonstration by instructor only or have users select different tests.

1. Select Nursing Menu Option: **MIM**

2. Select **(*)** the INFLUENZA (WHOLE) test. Press **<RETURN>**.

3. Enter a Ordering HCP: **HARTMAN,CHRIS**.

4. Press **<RETURN>** and file the entry.

5. Select Performing Location: IMMUNIZATION CLINIC// **<RETURN>**

6. Select PATIENT NAME: **JONES,ALLAN**
   Select PATIENT NAME: **JONES,BARBARA**
   Select PATIENT NEME: **<RETURN>**

NOTE: Once the last patient is entered the profiles will be updated for the patients entered. Access one of the patients using the IMM option to demonstrate the entry.

C. FILE AND TABLE TRAINING (Supervisor)

1. Refer to Section 3.6.3 for detailed training issues.

****

APPENDIX F:

SAMPLE REPORTS

****

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has been left blank
intentionally.

Sample Reports

Sample Consult Printout

4077th MASH UNIT 21 Jun 2001@1504 Page: 1
Personal Data - Privacy Act 1974 (PL-93-579)
Consult Report
Report requested by: POTTER,SHERMAN

Appointment Date: 21 Jun 2001@0700 Requesting HCP: MCINTYRE,JOHN
Clinic: CARDIOLOGY CLINIC Consulting HCP: BURNS,FRANKLIN

Reason for Consult:
CHEST PAINS

Provisional Diagnosis: ANGINA

Problem List:

Note:
The patient has an old injury to the chest from a motor vehicle accident in 1994.
No cardiac involvement seen on examination.

Plan:
TYLENOL 325MG TID F10 days. Return to clinic if pains persist.

Verified by: FRNAKLIN M. BURNS, MAJ MC USA

20/123-45-6789	ADAMS,GOMEX	USA RETIRED OFFICER
	17 May 1950/ Male	H: 202-555-7878
	Loc:	W: 202-555-1234
	Spon: ADMAS,GOMEZ	Rank:
	Unit:	RR: OUTPATIENT RECORDS

Sample Expanded Immunization Printout

```
NATNAVMEDCTR BETHESDA MD                                    Page: 1
              Personal Data - Privacy Act 1974 (PL-93-579)
                      Immunization Profile

Report Requested by:  HOULAHAN,MARGARET

Record of Immunization/Skin Tests:
Immunization   Date Given Date Due Admin by:        Results/Date

HEP B (ADULT)  08 Apr 94  May 94  HOULIHAN,MARGARET
  Dose: 1.0ML  Route: IM  Site: RD
  Lot#: H4567             Manuf: ABBOTT
  Ordering HCP: PIERCE,BENJAMIN

HEP B (ADULT)  10 May 94  Oct 94  HOULIHAN,MARGARET
  Dose: 1.0ML  Route: IM  Site: LD
  Lot#: H4567             Manuf: ABBOTT
  Ordering HCP: PIERCE,BENJAMIN

HEP B (ADULT)  08 Oct 94          OREILY,WALTER     POS/12Nov94
  Dose: 1.0ML  Route: IM  Site: LD
  Lot#: H4567             Manuf: ABBOTT

INFLUENZA      06 Nov 95  Nov 96  HOULIHAN,MARGARET
  Dose: 0.5cc  Route: IM  Site: LD
  Lot#: C67543            Manuf: CN
  Ordering HCP: BURNS,FRANKLIN D

INFLUENZA      21 Nov 94  Nov 95   HOULIHAN,MARGARET
  Dose: 0.5cc  Route: IM  Site: RD
  Lot#: C45231            Manuf: CN
  Ordering HCP: WINCHESTER,CHARLES

SKIN TESTS
TB PPD (5 TU)  18 Jul 95  Jul 96   OREILY,WALTER    0 mm/20Jul95
  Dose: 5 TU   Route: ID  Site: LFA
  Lot#: E6512             Manuf: LE
  Ordering HCP: POTTER,SHERMAN


Signature:


20/456-78-9012   KLINGER,MAXWELL          USA RET ENLISTED
                 17 May 1966 / Male       H: 202-555-7878
                 Loc:                     W: 202-555-1234
                 Spon: KLINGER,MAXWELL    Rank: AE4
                 Unit:                    RR: OUTPATIENT RECORDS
```

Sample Discharge Summary Printout

NATNAVMEDCTR BETHESDA MD Page: 1
Personal Data - Privacy Act 1974 (PL-93-579)
Discharge Summary for: Cleaver,Beaver

Report requested by: HOULIHAN,MARGARET

Attending Physician: FREEDMAN,SIDNEY Registration #: 12345
Admission Date: 19 Jun 01 Discharge Date: 21 Jun 01

Admission Diagnosis:
MANIC DISORDER, MODERATE EPISODE (ICD 296.02)

Discharge Diagnosis:
MANIC DISORDER, MODERATE EPISODE (ICD 296.02)
DISLOC WRIST NOS-CLOSED (ICD 833.01)

ICD Operations/Procedures:
OPEN REDUC-WRIST DISLOC (ICD 79.83)

Active Problem List:
MANIC DISORDER, SINGLE EPISODE,MODERATE DEGREE Onset 01 Jan 95

Principal Diagnosis:

Free text entry by dictating HCP to further describe diagnosis.

Secondary Diagnosis:

Free text entry by dictating HCP describing secondary diagnosis.

Principal Procedures/Operations:

Free text entry by dictating HCP regarding procedures performed.

Patient's condition at time of Discharge: FAIR

Active Outpatient Medications:
LITHIUM -- PO 300MG TAB T2 TABS PO TID RF2

Pending at time of Discharge:

Lab Test(s)	Ordered For	Status
LITHIUM	21 Jun 01@0800	PENDING
URINALYSIS	21 Jun 01	COMPLETE

Radiology Exams		
WRIST,LEFT	20 Jun 01	EXAMINED

Sample Discharge Summary Printout

NATNAVMEDCTR BETHESDA MD Page: 2
Personal Data - Privacy Act 1974 (PL-93-579)
Discharge Summary for: Cleaver,Beaver

Report requested by: HOULIHAN,MARGARET

Future Appointments:

Clinic/Div	Provider	Date/Time	Type	Status
MENTAL HEALTH/ADIV	FREEDMAN,SIDN	06 Jul 01@1200	F/U	PENDING

Activity Limitations:
No driving for: 10 days
No long walks for: 10 days
No jogging for: 10 days
No stair climbing for: 10 days
No swimming for: 10 days
No shower/bath for: 10 days
No golf,tennis,similar sports for: 10 days
No sexual intercourse for: 10 days

Do not return to work until: 4 Jul 2001

Diet: LOW SODIUM

Patient Instructions:

Free text entry to describe the patient's discharge instructions.

Physician Responsible for Dictation: FREEDMAN,SIDNEY

Discharge Summary:

Free text entry to summarize patient inpatient episode.

Verified by: SIDNEY FREEDMAN, MD on 21 Jun 2001

NOTE The following note is an addendum written after the original Discharge Summary was completed and verified.

Note:
Free text note entered by any HCP-level user after completion.

Verified by: PIERCE,BENJAMIN, MD on 21 Jun 2001

20/123-45-6789	CLEAVER,BEAVER	USA RET ENLISTED
	17 May 1974 / Male	H: 202-555-8765
	Loc:	W: 202-555-2365
	Spon: CLEAVER,BEAVER	Rank: AE2
	Unit:	RR: OUTPATIENT RECORDS