Ancillary Reference User Guide

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TruBridge
54 St. Emanuel Street
Mobile, AL 36602
T(877) 424-1777
trubridge.com

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge and TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

Chapter 2 Overview

This Ancillary Reference User Guide provides information on the functionality of the ancillary applications, including the setup of many tables.

If the user or a TruBridge Customer Professional makes any additions or changes, it is recommended that the changes be tested using TruBridge to ensure that the system is working as the user desires.

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used on all date fields in all Ancillary applications. Where four-digit dates display, a date format of MMDD, DDMM, or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the applications. A TruBridge representative should be contacted in order for the date format to be changed.*

Chapter 3 AHIS Control Record

3.1 Overview

The AHIS (American Hospital Information System) Control Record is a nine-page table used to define many financial and clinical options. Please refer to AHIS Control Table in the Control Information Tables chapter of the Business Office Tables User Guide for more information on this topic with special consideration for the following fields that provide ancillary functionality:

Page 3:
- Order Entry Department and Charge Number Identification
- Use Military (24hr) Time in O.E.
- Chartlink C/S tab
- EKG tab
- TO min
- Clinical Notes Grouping

Page 4:
- Master Patient Index
- Notify Dept At Order Time
- Enterprisewide/or Sched
- Esign Start Date

Page 5:
- Company Code
- Reference Lab Names
- Keep Inc Lab
- Retain Lab Days

Page 6:
- Running Dietary OE
- 2nd Diet Column
- MR Chart Perm.Loca.
- Depts with Interface systems - Order Entr
- Food/Drug Interaction

Page 7:
- Reverse Chg F/C
- Reversal Item #
- Check Duplicate Numbers

Page 8:
- Company name for Clinical Reports
- Clinical History Reverse Chronological

Page 9:
- Use Electronic file Management Software

- Pathology Application

Chapter 4 Department Table Maintenance

4.1 Overview

Specific fields in the Department table are used for ancillary departments to define:

- TTY for incoming orders, reports, notices, or mail
- Default charge point for department's items
- Printer options for ancillary reports
- Default frequency times
- Turn-around-time report options
- Report distribution options
- Transfer/Discharge Notices and canceling of orders of discharged patients
- 22 most common orders for that department.
- Cancel reasons

Please refer to Department Table in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 5 Physicians

5.1 Overview

Please refer to Physicians in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 6 Diagnosis Codes Tables

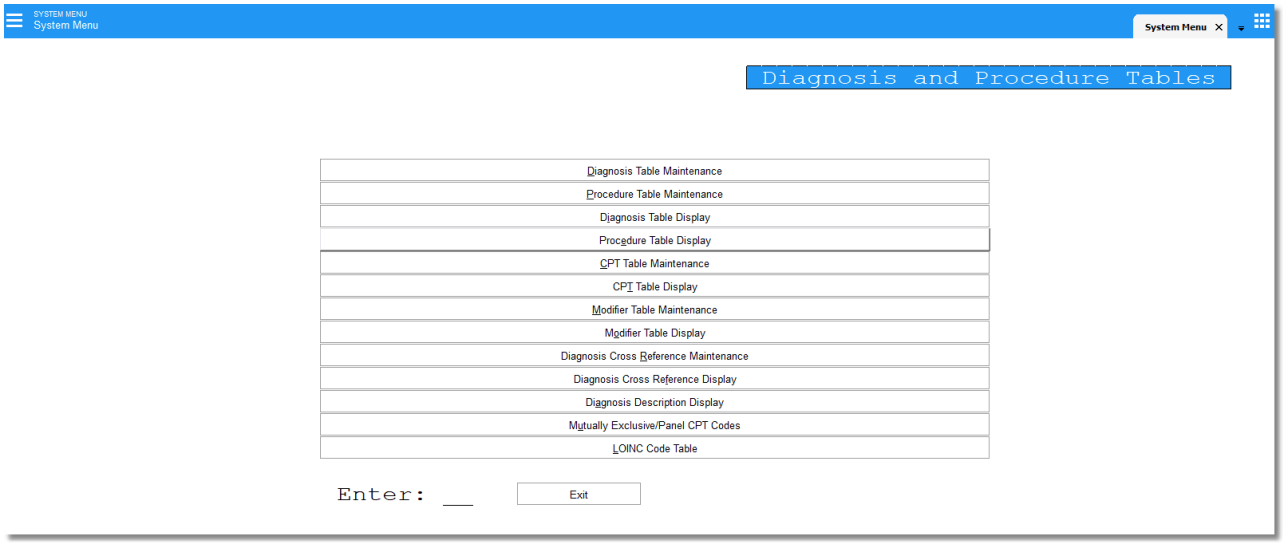
6.1 Overview

This chapter covers the tables including ICD10 codes, the Diagnosis Cross Reference Maintenance, the Mutually Exclusive/Panel CPT codes, and the LOINC Code Table. These tables are used by the Financial and Clinical Software Support.

6.2 Diagnosis and Procedure Tables

The Diagnosis and Procedure Tables are used by Financial and Clinical Software Support. All valid International Classification of Disease-10th Revision (ICD-10) Diagnosis and Procedure codes, Current Procedural Terminology (CPT), and Modifier codes are maintained in this table. In addition, there is a Diagnosis cross-reference table used in the Medical Necessity application. There is also a table to define Mutually Exclusive/Panel CPT codes. Access to these tables requires security to the Business Office Tables. Notify the site contact or Medical Records manager to change or add entries. Contact TruBridge Financial Support for questions about the Diagnosis, Procedure, CPT, and Modifier tables. Contact TruBridge Support for questions about the Diagnosis Cross Reference and Mutually Exclusive/Panel CPT codes.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Diagnosis Codes**



Diagnosis and Procedure Tables

Please see Table Maintenance - HIM for more information.

6.3 Diagnosis Cross Reference Maintenance

The Diagnosis Cross Reference Maintenance table allows multiple descriptive pointers to be created for an ICD-10 code. This is necessary within the Medical Necessity application, as the actual code description may not be familiar to the person placing the order. From this table, users can also view existing descriptions for a specific diagnosis code.

Example: *If Coumadin treatment is submitted as a diagnosis, the person placing the order may not know that Coumadin is an anticoagulant or that it is listed under "LT" (long term) Use of Anticoagulants. Keywords Anticoagulant, Coumadin and any other pertinent descriptions for this ICD-10 coded can be defined in the Cross Reference table.*

- From the Diagnosis and Procedure Tables, select **Diagnosis Cross Reference Maintenance** to add a description or select **Diagnosis Cross Reference Display** to view existing entries. The search for existing entries is case sensitive.

- Enter a diagnosis code in the **Diagnosis Code** field. When a diagnosis code is entered in the maintenance table, an additional description may be entered.

- If user defined descriptions exist, a box displays, listing each in alphabetic order. This helps prevent the same or similar descriptions being entered multiple times. The actual diagnosis code description is displayed first in a highlighted area of the box.

- To add a new description, enter it in the **Description** field; then select **Enter**. The new description will display below.
  - The description can be up to 80 characters.
  - If spelling is incorrect, select the applicable sequence number and change the description.
  - To delete an entry, select the applicable sequence number and select the **Delete** button at the top of the screen.
  - To enter a new diagnosis code, enter the code into the **Diagnosis** field.

6.4 Mutually Exclusive / Panel CPT Codes

The Mutually Exclusive/Panel Code table is available to establish criteria for the Compliance Billing Report that is available for Clinical Ancillary applications. When the Compliance Billing Report is generated, the system will find all patients with a Medicare financial class (M*) and look for duplicate CPT codes, panel and component CPT codes, and mutually exclusive CPT codes. Conflicts are detected based on charge times of less than 24 hours.

The Mutually Exclusive/Panel Code table is also used to establish criteria for the Duplicate Order Check that is available for the Clinical Ancillary application. The system looks for duplicate CPT codes, panel and component CPT codes, and mutually exclusive CPT codes. Conflicts are detected based on duplicate order check times defined on each item.

- From the Diagnosis and Procedure Tables, select option **Mutually Exclusive/Panel CPT Codes**.
- The system will prompt for a starting description of a Panel or Group of tests.

To View/Edit

- Enter part of a panel (group) name in the **Enter starting description** field or press **Enter** to display a current list of panels.
- Select a panel description to view or change an existing entry.

To Create A New Panel

- Select **Add**.
- Enter the new panel or group description up to 40 characters.
- Enter the CPT code of the panel in column 1.
- Enter the CPT codes of the component tests in column 2. Mutually exclusive tests are defined by putting all the conflicting CPT codes in column 2. Only valid CPT codes as found in the default CPT code table are allowed.
- Select **Exit** to save the panel/group or select **Delete** to remove the panel/group.

Examples of Mutually Exclusive combinations

- Comprehensive Metabolic Panel with its own CPT code in column 1 and individual tests in column 2.
- CBC w/manual differential, CBC w/auto differential, CBC, WBC/H & H CPT codes in column 1. Individual CPT codes in column 2.

- Bone Imaging, whole body CPT code in column 1, and mutually exclusive CPT codes for bone imaging in column 2.

6.5 LOINC Code Table

NOTE: *LOINC stands for Logical Observation Identifiers Names and Codes*

The LOINC nomenclature provides a standard set of universal names and codes for identifying individual laboratory and clinical results. LOINC codes allow users to merge clinical results from many sources into one database for patient care, clinical research, or management. The LOINC database currently contains about 41,000 observation terms. Nearly 31,000 of these observational terms relate to laboratory testing. Each record in the LOINC database identifies a clinical observation and contains a formal 6-part name, a unique name for tests identifying code with check digit, synonyms, and other useful information. LOINC records apply to all tests with equivalent clinical results. They are not unique per company.

From the LOINC code table screen, users can upload the LOINC files from the server via the **Import** option in the action bar or, if the files are already loaded, can use the available smart search. To upload from the server, TruBridge must provide the daily password.

Users can search using the LOINC Code magnifying glass and **Sort** drop-down by codes or by description. Select the **More** option to continue the search for the user's choice.

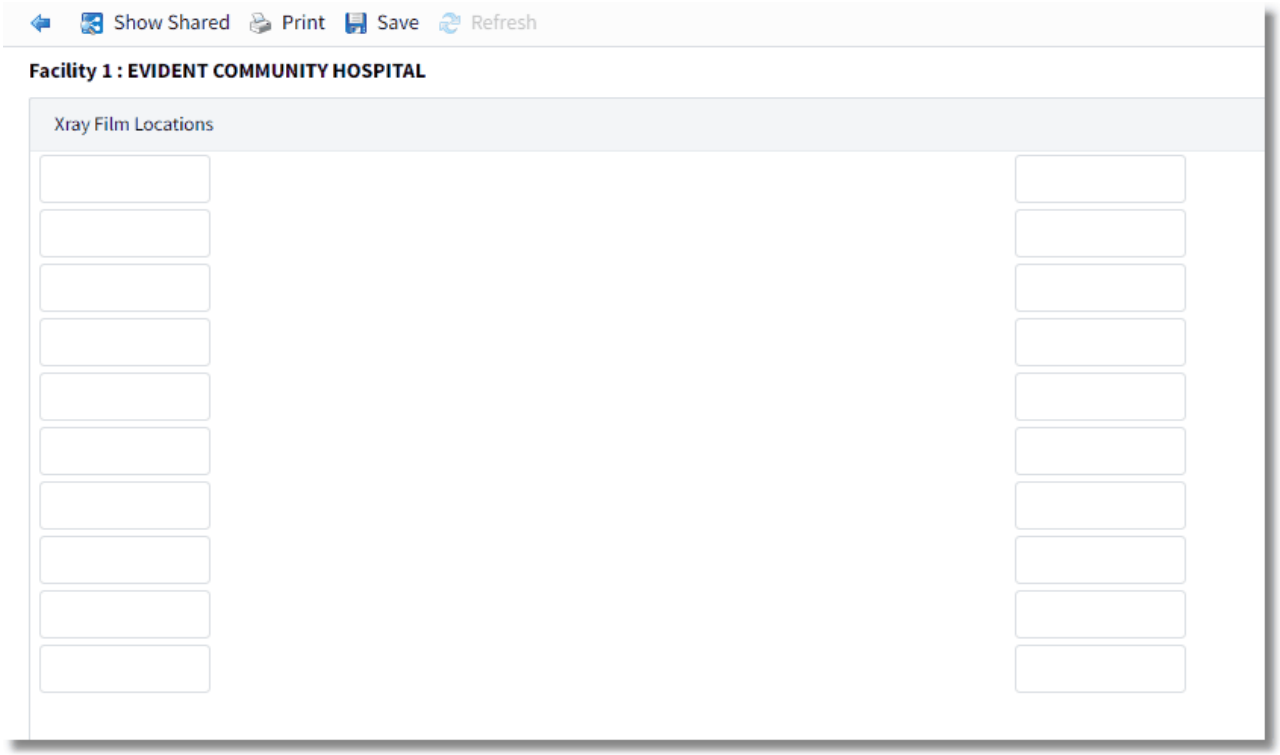
Chapter 7 Chart/Film Locations

7.1 Overview

The Xray Film Locations Table allows Radiology to sign out Xray films. A report is available (**Film Location List**) from the Radiology department's Print Reports option. The Radiology application has the capability to change film location when a patient's Xray films are sent to a physician's office or clinic. This may be done in mass or by patient. Up to 20 different locations may be defined. Appropriate security is necessary to access Xray Film Locations. Notify your site contact or TruBridge if security changes are necessary.

7.2 Accessing the Chart/Film Location Table

Select **Web Client** > **Tables** > **HIM** > **Xray Film Locations**



Xray Film Locations

- The screen lists any previously defined locations. If no locations have been defined, the system will display a blank line.
- The first line must match the entry made in the **MR Chart Perm.Loca.** field on page 6 of AHIS. This defines the permanent location for patient files. Example: MAIN FILE
- Up to 20 different locations may be defined. Each location description may not exceed 10 characters. It is recommended that locations be entered in alphabetical order to facilitate sign out.

- Once locations have been entered, select **Save**. Selecting the back arrow on the action bar without saving will display the prompt, "Are you sure you wish to exit without saving? Select **Yes** to return to the HIM screen or **No** to remain in the Xray Film Locations screen.
- To remove an entry, type # in the first line position of the entry.
- Select the back arrow on the action bar to return to the HIM screen.

Chapter 8 Group Standing Orders

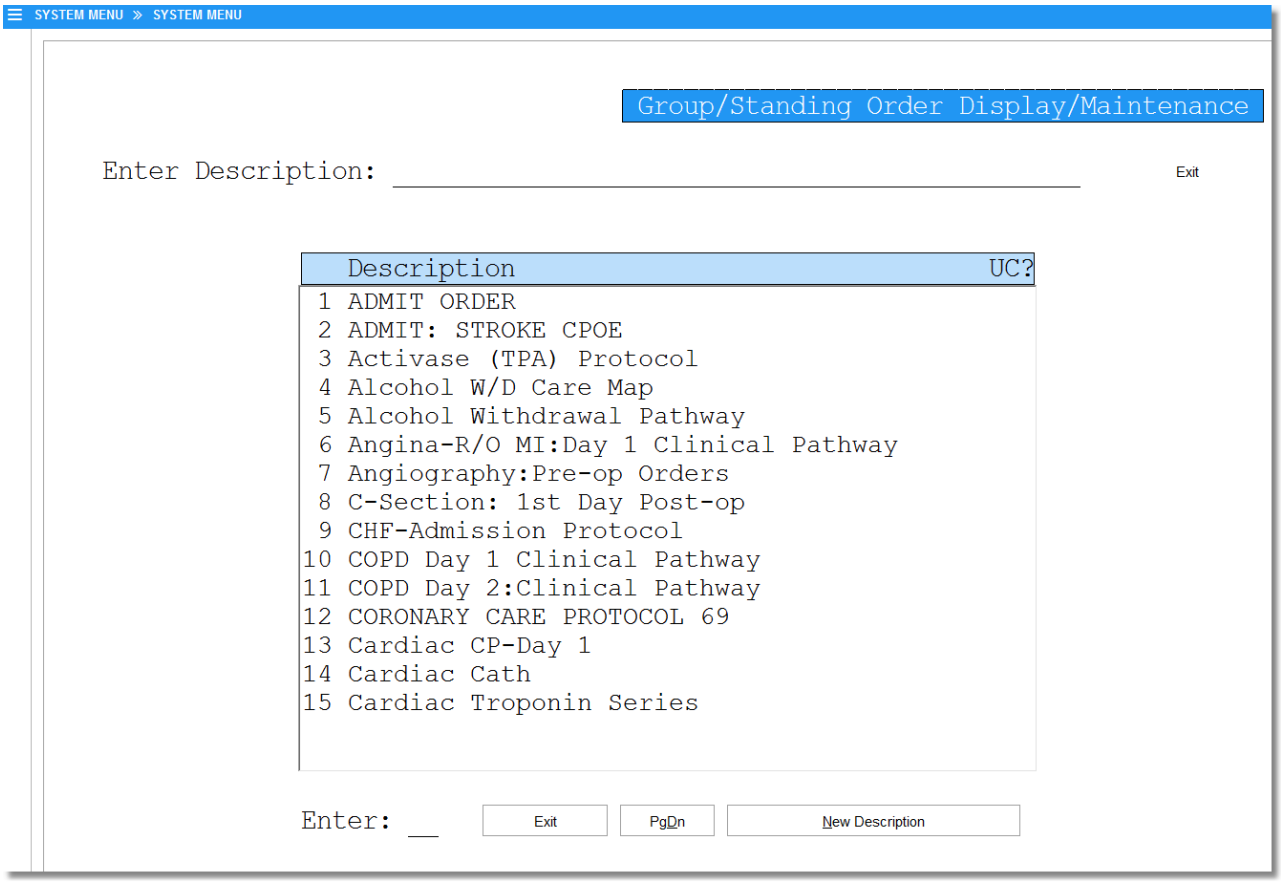
8.1 Overview

Group Standing Orders are used by clinical ancillary departments to provide a quick and easy mechanism for ordering tests or procedures that are routinely placed together. Ancillary departments can create Group Standing Orders for any ancillary items. Group Standing Orders may be set up for multidisciplinary functions. Defining (setting up) Group/Standing Orders requires access to the Business Office Tables. Notify the site contact or TruBridge Support to change or add Group Standing Orders.

8.2 Maintenance

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Group Std Ords**

The Group/Standing Order Display/Maintenance screen is displayed.



Group/Standing Order Display/Maintenance

- The cursor on this screen stops on the **Enter Description:** line. Type the beginning letters of the desired Group Order or press **Enter** to display an alphabetic listing of existing defined Group Orders.

- If the desired standing order description appears on the screen, choose the sequence number appearing to the left of that item.

To Create a New Group Standing Order

- To define a new Group Standing Order, select **New Description**. The cursor will move to the bottom of the screen and the system will prompt: **Enter New Description:**

- Type the description (name) of the new group. The system will then display the list of orders assigned to the Group. A new Group Order will have no orders listed.

- The system will prompt **just like?**, If **Y** is answered, a previous created Group Order may be selected to copy to the new Group Order.

- If the "just like" feature is not used, select **New Item** to define the first order for the Group. The system will prompt: **Add after seq#:__ (S-Stop, 0-Before Seq# 1).** Type the number **1** at the prompt.

- Enter the Order Type:
  - P - Pharmacy
  - A - Ancillary
  - N - Nursing Orders
  - 0 - Exit

- Type **A** to define Ancillary orders

- Enter Ancillary Order Type:
  - 1 - Lab
  - 2 - Radiology
  - 3 - Rehab Services
  - 4 - Respiratory Care
  - 5 - EKG
  - 6 - Central Supply
  - 7 - Dietary
  - 8 - Other Departments

- Type the sequence number to the left of the desired Ancillary Department. The system will display the Group/Standing Order display.

NOTE: *Displayed department names are retrieved from the Department Table of department numbers entered in AHIS, page 3.*

- **Item Desc:**
  - Type the name (or first few letters) of the item to select.

- The system will display an alphabetic listing at the bottom of the screen and will prompt: “Enter SEQ#, Return, or 0..:”
- If the desired item is displayed, choose the sequence number to the left of the item. Press **Enter** to continue the alphabetic listing.
- Continue the process until the desired item is selected.

- **CPOE Long Description:** Allows full description of the Group Order to pull to CPOE. This description is for CPOE only. If this field is not defined then the Item description will pull to the CPOE standing order select/deselect screen.

- **Stat?:**
  - For STAT orders, enter **Y**. *(NOTE: Selecting STAT zeros out future time selections.)*
  - For TIMED orders, enter **N**. The cursor will move to the next option.

- **Hours from now:**
  - When an order should be scheduled relative to admission or onset of symptoms, enter the desired time interval (in hours).
  - To define orders for a future date and specific time, press **Enter**.

- **Days from now...:Specified Time:**
  - This field is for orders scheduled for future dates at a specific time.
  - Enter desired number of days, entering the time in military time.
  - If the **Hours from now:** field has an entry, the **Days from now** field may not be entered.
  - Routine orders for today, press **Enter** to leave all scheduling options empty.

- **Description:** The system will apply the description to the first line of order entry questions only if the item has an existing data field (question) defined for this line and will display only the number of characters programmed for this Order Entry question. (For example, if the question is a yes/no question, the description must be a Y or N.) Other comments may be added if no defined questions exist on the item.

- **Batch:** If the item is a laboratory procedure, it may be assigned to a batch work list. If the item has an entry in the **Control Switch** field, control switch 1 of the Item Master it will be displayed in this **Batch** field.

- **# of Proc's:** If the procedure has the field selected for this prompt in the Order Entry Information, the system will prompt the user to enter a value in this field. If the procedure is not set up to prompt the user, this field will not display in the setup of the group standing order items.

- **Freq of Proc:** Enter one of the following defined frequencies: QD, BID, TID, QID, Q#H, 1X, PRN, or press **Enter** to leave the order entry maintenance Frequency field blank.

- At the bottom of the menu, the following prompts will appear:
  - **Exit & Update** will return to the Item Description so that additional orders for that department may be defined. Enter “0” and press **Enter** to return to Group Standing Order Maintenance.
  - **Delete** will delete all the information set up for the item. The cursor will then display in the **Item Description** field.

To Activate the Group Standing Order

- Select **Group Desc** at the bottom of the Group/Standing Order Maintenance screen.
- Press **Enter** to move the cursor to **Under Construction?**
- Enter **N**

The **Last Modified Date** field documents the last time the Group Standing Order was modified by Ancillary, Point of Care, or CPOE. The specific data changes may be reviewed from the Standing Order Log.

8.3 Standing Order Log

The Standing Order Audit Log displays any changes made to a Group Standing Order.

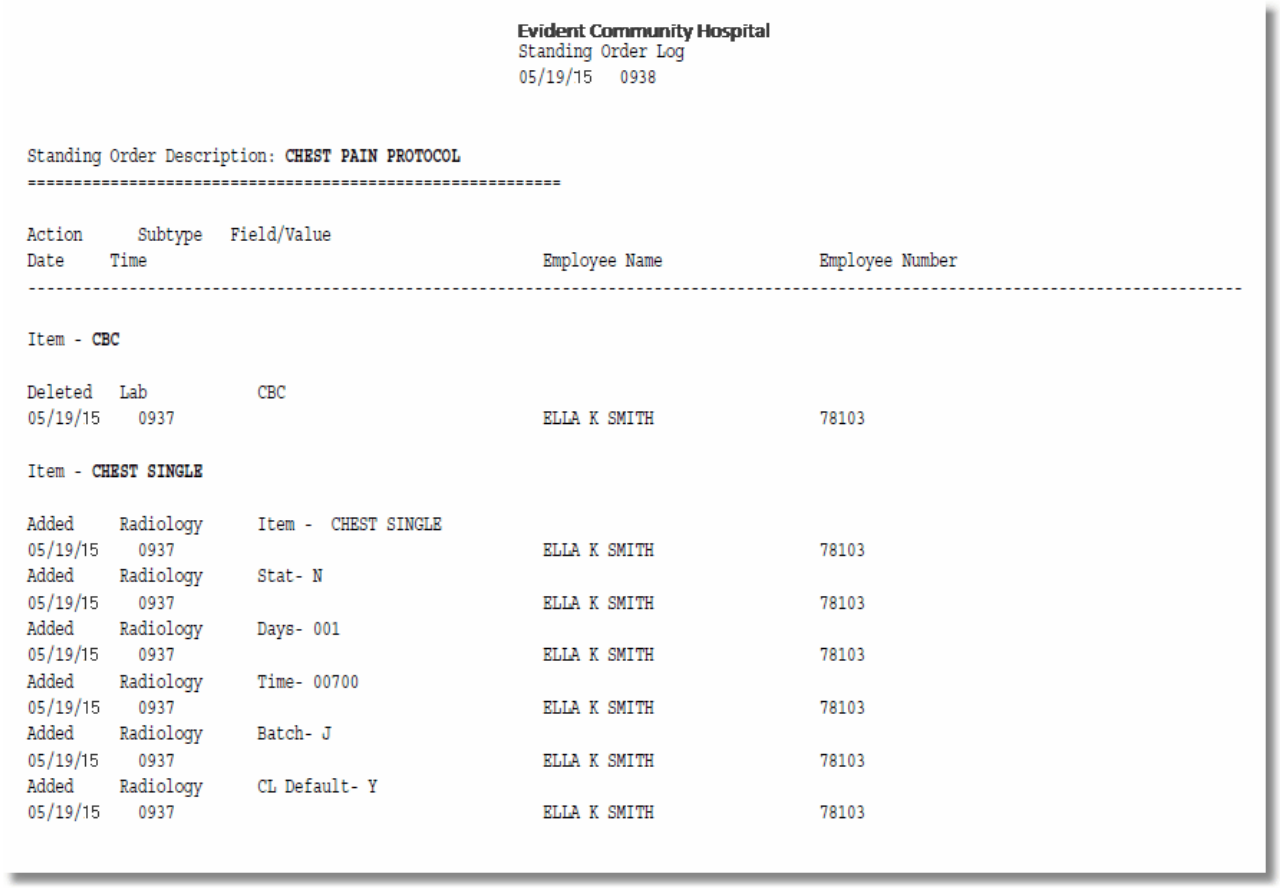
Printing the Standing Order Log

1. Go to **Web Client > System Menu**.
2. From the **Hospital Base Menu**, select **Master Selection** > **Print Reports** > **Tables** > **Standing Order Audit Log**.
3. The Magnifying Glass  provides a lookup of all Group Standing Orders. Either select Group Standing Orders individually or leave the **GSO** field blank to include all Group Standing Orders with maintenance changes falling within the date range you select.
4. In the **From** and **To** fields, enter the date range to include. The system defaults to the current date.
5. Select **OK** or **Cancel** to exit.

Description and Usage

The Standing Order Audit Log report captures any changes made to a Group Standing Order setup, including changes made by Point of Care, Ancillary, or CPOE. The report will include the date the change occurred, the activity performed on the item, and the employee identification that performed the alteration.

Standing Order Audit Log



Evident Community Hospital
Standing Order Log
05/19/15 0938

Standing Order Description: **CHEST PAIN PROTOCOL**

Action Date	Subtype Time	Field/Value	Employee Name	Employee Number
Item - **CBC**				
Deleted 05/19/15	Lab 0937	CBC	ELLA K SMITH	78103
Item - **CHEST SINGLE**				
Added 05/19/15	Radiology 0937	Item - CHEST SINGLE	ELLA K SMITH	78103
Added 05/19/15	Radiology 0937	Stat- N	ELLA K SMITH	78103
Added 05/19/15	Radiology 0937	Days- 001	ELLA K SMITH	78103
Added 05/19/15	Radiology 0937	Time- 00700	ELLA K SMITH	78103
Added 05/19/15	Radiology 0937	Batch- J	ELLA K SMITH	78103
Added 05/19/15	Radiology 0937	CL Default- Y	ELLA K SMITH	78103

The following information is provided on the report:

- **Standing Order Description:** The description of the Group Standing Order. This appears in bold.
- **Item:** The description of the item added, deleted, or changed. This also appears in bold.
- **Action:** The action taken on the Item (i.e, whether it was deleted, added, or changed).
- **Subtype:** The item's issuing department.
- **Field/Value:** The field description within the Group Standing Order and the information entered.
- **Date:** Date the alteration was made.
- **Time:** Time the alteration was made.
- **Employee Name:** Name of the employee who made the alteration.
- **Employee Number:** Employee number of the employee who made the alteration.

Chapter 9 Ancillary Exam Type

9.1 Overview

Please refer to Exam Types in the Table Maintenance-Patient Intake User Guide for more information on this topic.

Chapter 10 Ancillary Exam Rooms

10.1 Overview

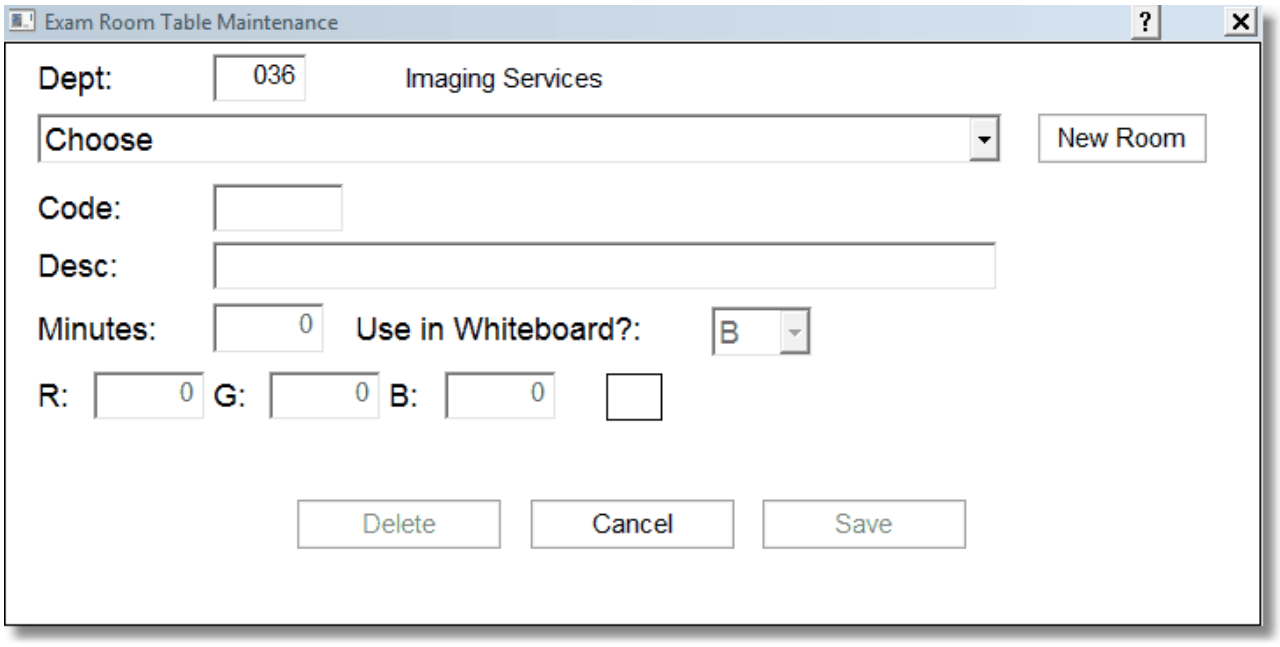
The system may use Ancillary Exam Rooms for the Radiology Schedule to display the procedure room for the scheduled exam. This also allows the schedule to be printed or sorted by exam room.

NOTE: *Access to the Business Office and Charge/Inventory Tables is necessary to define Ancillary Exam Types. Notify the site contact or TruBridge for additions or changes to this option.*

10.2 Exam Room Setup

NOTE: *Exam Rooms may be assigned to specific TTY#s, enabling the Radiology schedule to display* ***My Outstanding Orders*** *and* ***My Completed Orders****. Please see Port Descriptions in the Device Control User Guide for more information on this topic.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Exam Rooms**



Ancillary Exam Room Maintenance

- In the **Dept** field, enter the three-digit department number for Radiology and press **Enter**.
- To view existing rooms for the selected department, select from the **Choose** drop-down.
- To create a new room, select **New Room**; then complete the fields as follows:
  - **Code:** Enter the exam room code. This field is limited to five characters, using upper or lower case letters *(Examples: MAMMO for Mammography room, XRAY1 for X-Ray Procedure Room 1, DIAG for Diagnostic Procedure Room).*

- **Desc:** Enter a room description.
- **Minutes**, **Use in Whiteboard**, **R**, **G**, and **B:** These fields do not need to be addressed unless Radiology chooses to use the whiteboard as their patient list screen. The Patient Documentation software will be set up to reflect your own Radiology Rooms, minutes, and colors.

- Select **Save** to save the exam room, **Delete** to remove the exam room, or **Cancel** to abort the exam room creation process.

- Check the box next to the **Scheduled Room** field on Page 3 in Order Entry Information. A room entry may also be required by selecting the check-box for the **Scheduled Room Required** field in Order Entry Information.

- **Default Room:** A predefined list of Exam Rooms will display if a **?** is typed in that field. Enter an Exam Room code if the procedure is to automatically pull to **My Outstanding Orders** or **My Completed Orders** on the Radiology Schedule.

Chapter 11 Report Location Table Maintenance

11.1 Overview

The Location Table Maintenance is used to define patient report locations. These typically include home health agencies, nursing homes, and clinics. Locations are defined to provide report options in Community Report Distribution, Transcriptions by Physician, and report distribution during esign. Defined locations may be assigned to a patient account via the Patient Functions screen and patient Registration, either full or temporary.

When an ancillary department **Send** option is selected, the system offers a menu that includes patient location or another location. The system finds the location in the Report Location Table Maintenance and sends the report, transcription, or document based on the defined settings.

Please refer to Report Locations in the Table Maintenance-HIM User Guide for more information on this topic.

Chapter 12 Laboratory Control Information Table

12.1 Overview

The Laboratory Control Information defines how many of the processes within the lab application will function. Access to the laboratory control information is based on department and employee security. Contact TruBridge Support about changes to this table if access is not available.

Please refer to Lab Control Information in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 13 Radiology Control Information Table

13.1 Overview

The Radiology Control Information table is divided into three separate pages. Please refer to Radiology Control Information, Page 1, Radiology Control Information, Page 2, and Radiology Control Information, Page 3 in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 14 Custom Forms (User Defined)

14.1 Overview

Custom labels, cards, and/or forms may be created for individual ancillary departments for the following six programs:

- Specimen Collection Labels
- Receiving Department Requisitions
- Lab Labels from Incoming Orders
- Lab Labels from orders placed from within the department
- Radiology Jacket Labels
- Lab Labels from Non-Lab department orders
- Dietary Labels

The contents of the forms are defined in the Business Office table, Udef Labels. The form is constructed by defining the field names and field content using mnemonics that will capture system demographic information. Forms may also include free text information.

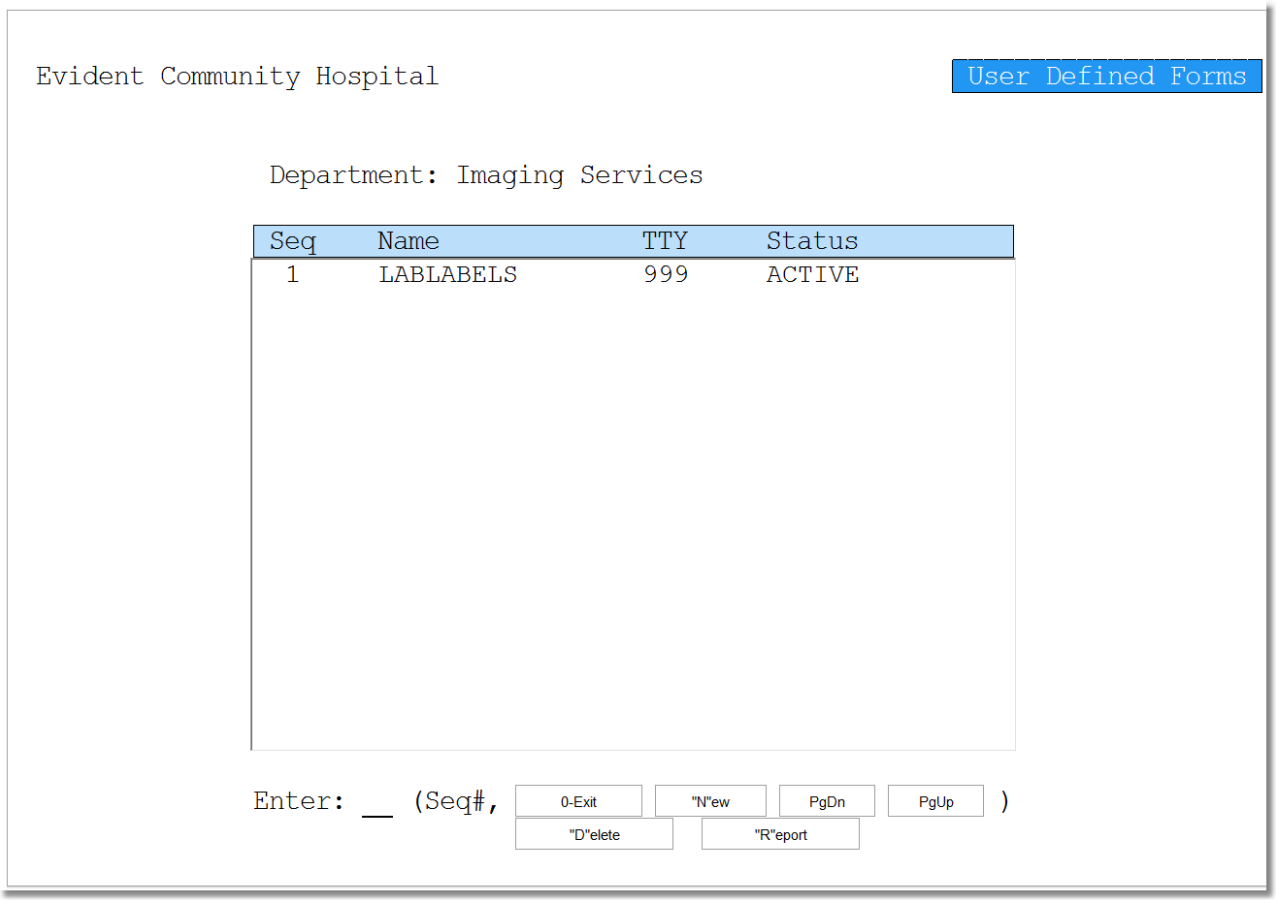
Custom forms may print in standard or landscape orientation and will print to the printer defined in the Laboratory Control Table, the Radiology Control Table when appropriate, to the printer defined for the item, the printer entered upon printer prompt where applicable.

Field names may be customized with:

- Specific font
- Number of characters per inch
- Bold
- Italics
- Regular text (default)

14.2 Accessing Custom Forms Tables

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Udef Labels**



User Defined Forms

The User Defined Forms screen will be displayed. This screen includes existing forms (labels and requisitions), the TTY number (of the terminal that generates the form) and the status (active or inactive) of each. Active forms are currently in use. Inactive forms are under construction or are not being used at the current time. The following options may be selected:

- **Enter:** Enter the sequence number listed to the left of the existing form
- **0-Exit:** To return to the previous menu
- **N-New:** To create a new form
- **PgDn:** To advance to the next page of existing forms
- **PgUp:** To return to the previous page of existing forms
- **D-Delete:** To delete an existing form
- **R-Report:** To view or print custom label setup

14.3 Creating a New Form

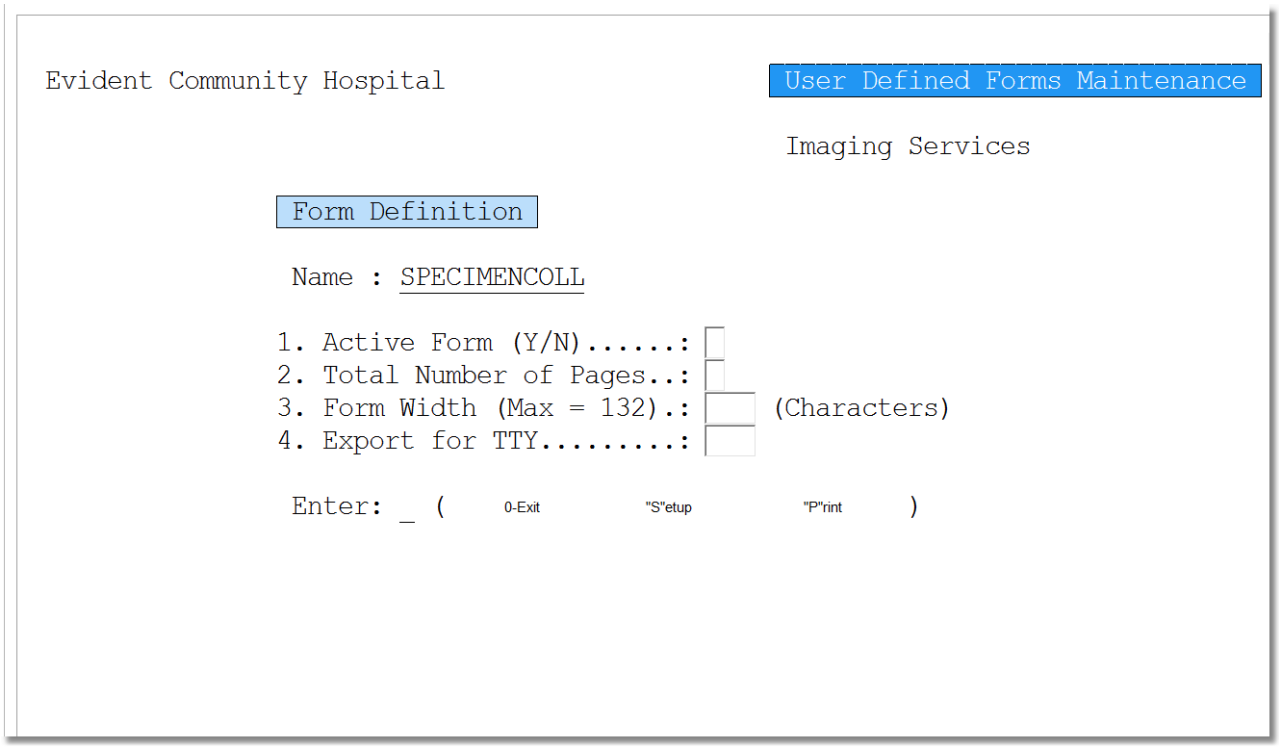
NOTE: *When creating a custom form, the user must be logged into the specific ancillary department for which the form will be used.*

- From the User Defined Forms screen, select **N-New** and press **Enter.**
- The User Defined forms Setup menu will be displayed. Select the appropriate type of form.

Defining the Basic Format of the Form

Once the appropriate application has been selected, the User Defined Forms Maintenance table will be displayed. The basic format of the form is defined in this table. The name displayed is a result of the application selected.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Udef Labels** > **New**



User Defined Forms Maintenance

1. Active Form (Y/N):

- Default: N
- Options: Y (yes) or N (no)
- Usage: Controls whether the form is currently in use. If there are two forms defined for the same tty in which one is active and the other inactive, in order to activate the inactive form, the

prompt “Selecting “Y” will OVERWRITE the Existing ACTIVE Form. ARE YOU SURE (Y/N)?” will be displayed. If answered Y (yes), the system will copy the format over the active form and that form will no longer exist. The existing active form may be saved by changing the tty number to a bogus number. Contact Information Services for an available bogus tty number.
  - Y: Currently in use.
  - N: Under construction or not in use.

2. Total Number of Pages:
- Default: 1
- Options: 1-9
- Usage: Defines the total number of pages defined for the form. Each label or card is considered one page. For example, in radiology, if a flash card, a request card, and an ER card is needed, the total number of pages in this form would be three.

3. Form Width (Max = 132):
- Default: 80
- Options: 01-132
- Usage: Defines the width of the form. The average page of paper accommodates 80 characters at 12PI. The page will accommodate 132 characters at 16PI. A standard lab label will accommodate 44 characters at 12PI.

4. Export for TTY#:
- Default: Blank
- Options: The TTY number of the terminal that will generate the form.
- Usage: Defines the terminal that will generate the form. Exports entered in Order Entry Information will override custom-defined forms.

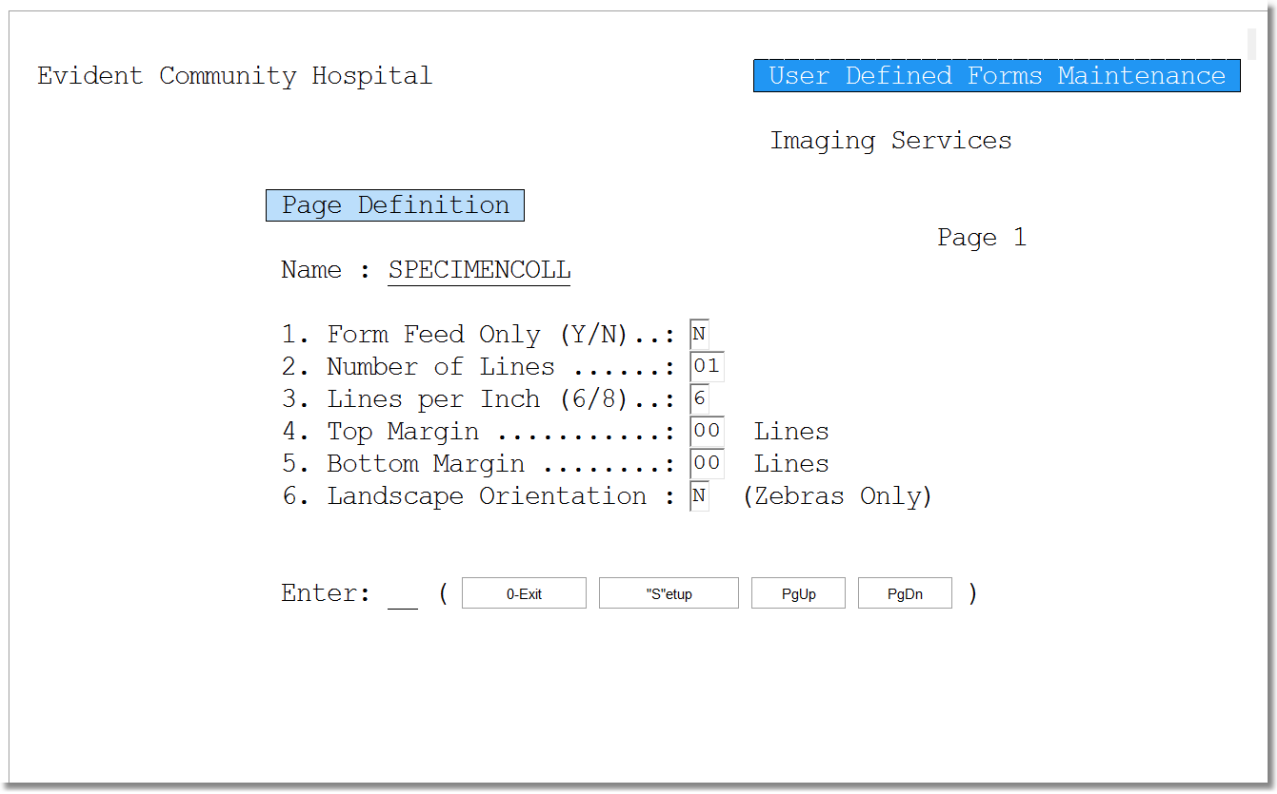
At the bottom of the screen, the following options may be selected:

- **Enter (Seq#):** Accesses the selected sequence number.
- **0-Exit:** Returns to the previous menu.
- **Setup:** Advances to the Page Definition screen where the format of each page of the form is defined.
- **Print:** Allows the form to be printed/previewed.

Defining the Basic Format of Each Page

Once the basic format of the form has been defined, select **S-Setup** to define the basic format of each page of the form. The Page Definition screen for the first page will be displayed.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > New > "S"etup**



Page Definition

1. Form Feed Only:

- Default: N
- Options: Y (yes) or N (no)
- Usage: Allows a blank page (or label) to feed between each page. This could also be used to skip a page (or label) between each patient. This would be considered one page.

2. Number of Lines:

- Default: 01
- Options: 01-99
- Usage: Defines the number of lines the form will contain.

3. Lines per Inch (6/8):

- Default: 6
- Options: 6 or 8
- Usage: Defines the number of lines that will appear per inch.

4. Top Margin

- Default: 00
- Options: 01-98
- Usage: Defines the top margin. The system will insert a 3-character margin for the top, bottom

and sides of the page even when the top margin is set to zero when printing to a post-script printer.

5. Bottom Margin:

- Default: 00
- Options: 01-98
- Usage: Defines the bottom margin. The system will insert a 3-character margin for the top, bottom, and sides of the page even when the top margin is set to zero when printing to a post-script printer.

6. Landscape Orientation:

- Default: N
- Options: Y (yes) or N (no)
- Usage: Allows the form to be printed in Landscape Orientation (rotates the text 90 degrees). This option is only available for Zebra printers.

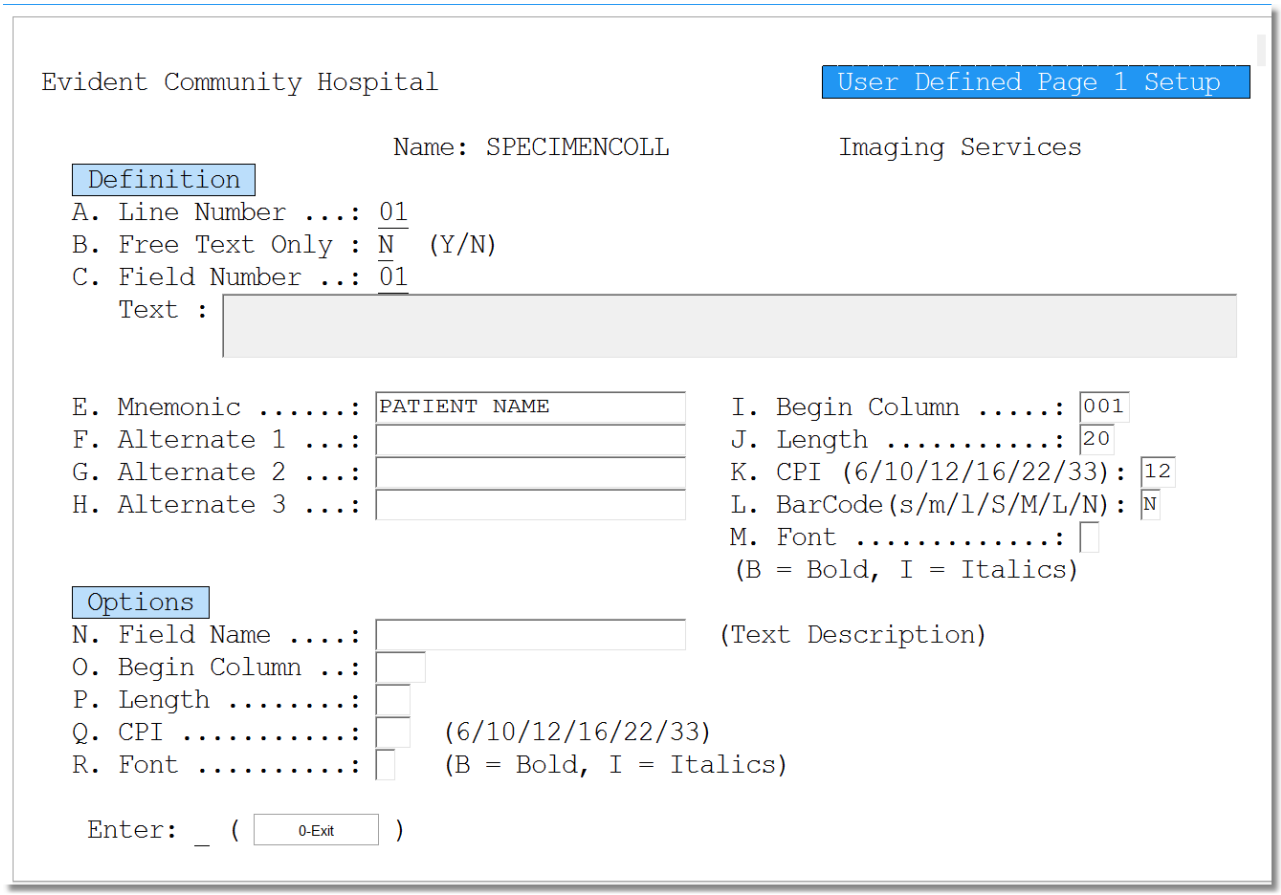
At the bottom of the screen, the following options may be selected:

- **Enter (Seq#):** Accesses the selected sequence number.
- **0-Exit:** Returns to the previous menu.
- **Setup:** Advances to User Defined Page 1 Setup where each field of each line of the form is defined.
- **PgDn:** Advances to the following page of the form as defined in the form definition table.
- **PgUp:** Returns to the previous page of the form as defined in the form definition table.

Defining Each Field of Each Line of the Form

Once the basic format of each page has been defined, select **S-Setup** to define each field of each line. The contents of each line are constructed by defining field names and field contents using mnemonics for system demographics. Each line may have up to 30 fields. The system will automatically skip a space between fields and/or field names. Each field is defined in a separate table like the one below. For example, the screen below defines field 1 of the first line, on page one. It indicates that the patient name should print in the first field on line one, page one.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > New > "S"etup > "S"etup**



User Defined Page 1 Setup

Definitions

A. Line Number: The line currently being created.

B. Free Text Only (Y/N): Defines whether the information on this line is free-text only. When set to Y (yes), allows access to the Text field to enter free text information.

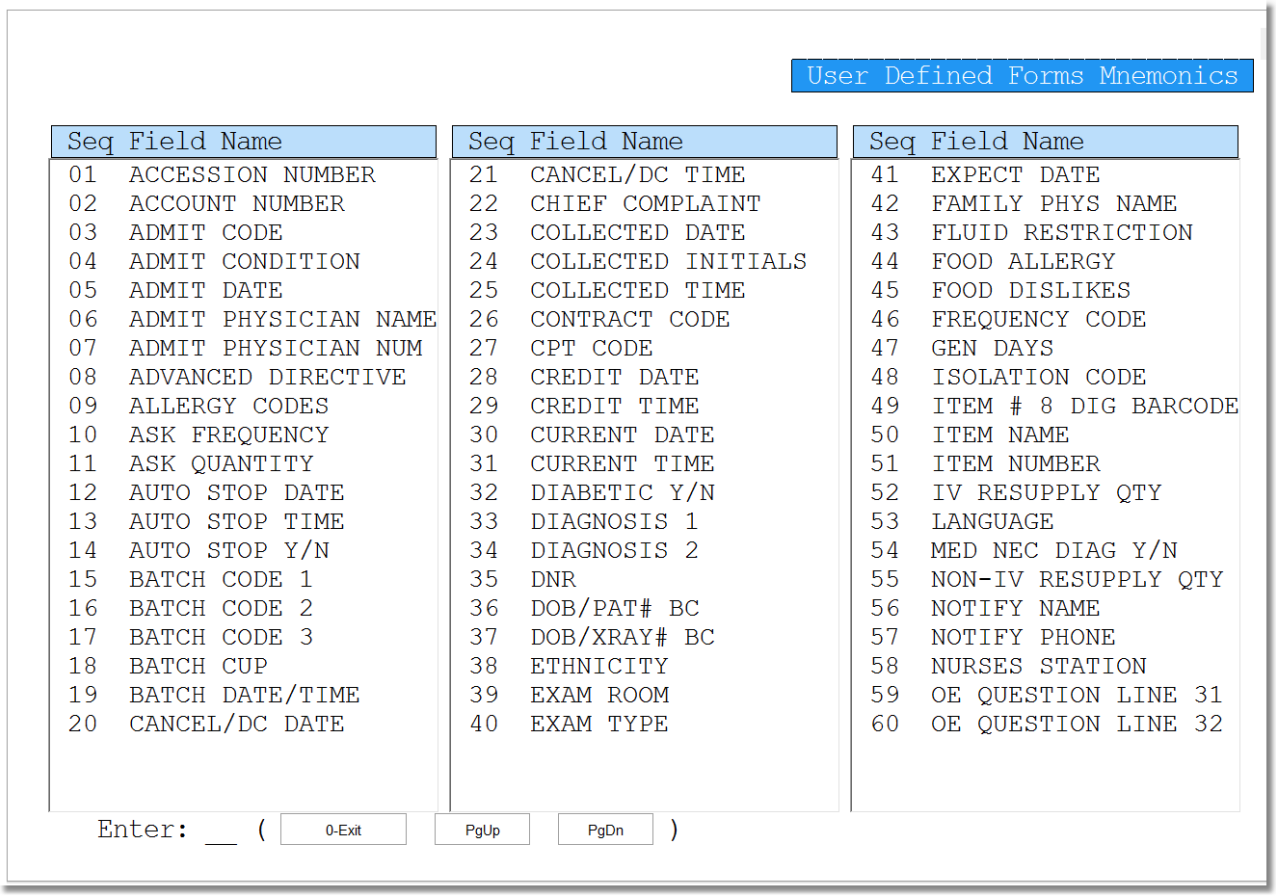
C. Field Number: The field number currently being defined. Depending on the characters per inch selected, as many as 30 fields per line may be entered. Each field may be a defined number of characters. Text greater than the field will be truncated.

D. Text: Defines the free-text information. (The system will not indicate when the end of the line has been reached. This will need to be checked by manually viewing or printing the form.)

E. Mnemonic: The mnemonic that corresponds to the patient information to be included on this line may be selected from a list by entering a question mark (?) or entering it exactly. When selected, the system will display the maximum numbers of characters for that field. This may be adjusted manually if necessary. When working across one line, one field at a time, the system will calculate where the next column may begin. The space needed for the entered information will

also be displayed.

NOTE: *If Accession number is used as part of the user defined form, this information will update the ImageLink (PACS) work list.*



User Defined Forms Mnemonics

F. Alternate 1: The first choice of alternate information to be included when the requested patient information as indicated by the mnemonic is not available.

G. Alternate 2: The second choice or alternate information to be included when the requested patient information as indicated by the mnemonic is not available.

H. Alternate 3: The third choice or alternate information to be included when the requested patient information as indicated by the mnemonic is not available.

I. Begin Column: Defines where each new field begins.

J. Length: The length of this particular field. The system calculates the minimum amount of space required for each mnemonic. This field may be greater than or less than the suggested number. If the field is smaller than the suggested number, information will be truncated.

K. CPI (10/12/16): Defines the size of print.

L. Bar Code (Y/N): Defines whether a bar code will print. This will always start in position 1 on the line.

M. Font: (B–Bold, I–Italics) Defines whether the text is to be printed in bold or italics. The default is regular font.

Options

N. Field Name (Text Descriptions): This field is used to add a description to the mnemonic selected. For example, if the mnemonic for patient name is selected, the description "Patient Name:" could also be included with the patient's name. The system will automatically calculate the necessary space needed and apply the description before the mnemonic.

O. Begin Column: Defines the column where the above description will begin printing.

P. Length: Defines the length of the text description.

Q. CPI (10/12/16): Defines the size of font of the text description.

R. Font (B – Bold, I – Italics): Defines whether the text description will print in bold or italics.

Chapter 15 Reports Table

15.1 Overview

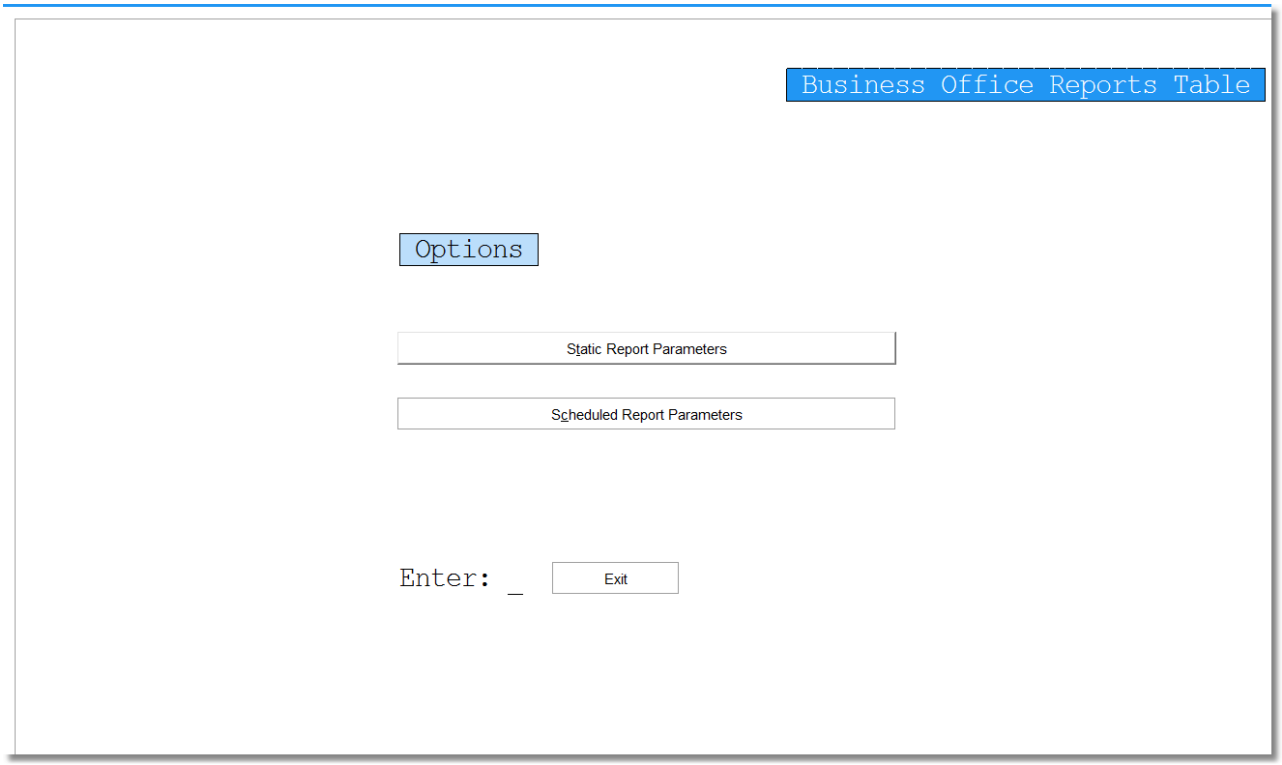
The Reports Table controls the scheduled auto-printing of certain ancillary reports. The following reports may be set up to auto print:

- Nursing Station Census (Mini)
- Patient Diets By Room (only those with orders)
- Patient Diets By Room (list all rooms)
- Lab/Cardio/Rehab Daily Procedure Log
- Lab/Cardio/Rehab Outstanding Orders
- Print Specimen Collection Report (with or without Labels)
- Lab/Cardio/Rehab Physician Service Log
- Lab Daily Results Patient Name Seq (Results By Patient)
- Alternate Lab Physician Report (Community Report)
- Radiology Daily Procedure Charged Log
- Results Log By Date (Transcription By Date Report)
- Transcription By Physician
- Radiology Outstanding (Incomplete) Orders

The Reports Table resides in the Business Office tables and proper security is necessary to access the table. Notify your facility contact or TruBridge Support to enter or change if access is not available.

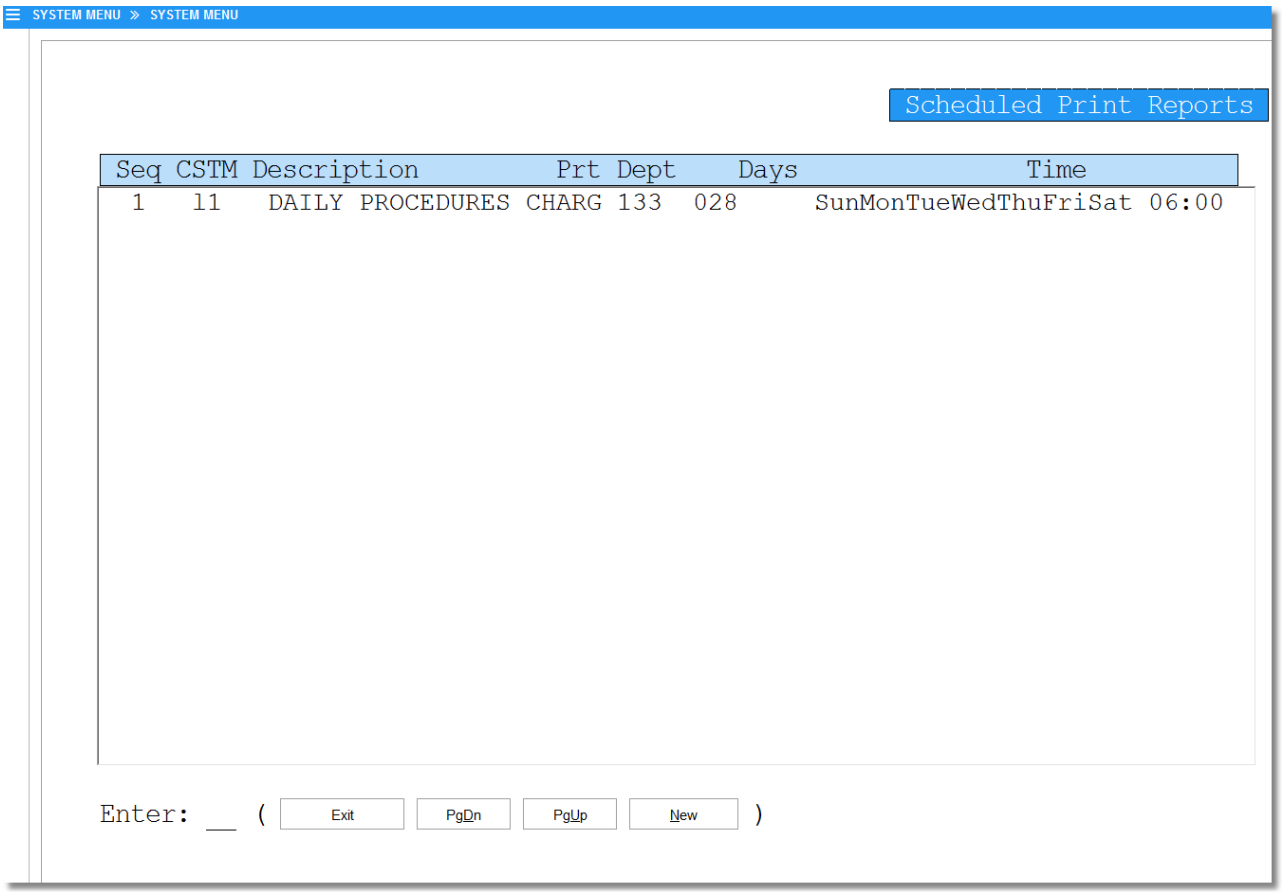
15.2 Accessing the Reports Table

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Reports Table**



Business Office Reports Table

From the Business Office Reports Table screen, select **Scheduled Report Parameters**. The Scheduled Print Reports screen is displayed.



Scheduled Print Reports

The Scheduled Print Reports screen lists the reports that are already scheduled to automatically print. The following information is displayed:

- Sequence
- CSTM
- Description
- Print Number
- Department Number
- Specified Print Days
- Specified Print Time

15.3 Modifying Existing Reports

To modify an existing scheduled report, type the sequence number (listed to the left of the report name) in the **Enter** field and press <**Enter>**. The Scheduled Report Maintenance menu will display.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Reports Table > Scheduled Report Parameters > Enter Sequence # > press Enter**

Scheduled Reports Maintenance

The following information appears on the Scheduled Reports Maintenance screen.

- **CSTM:** Defines the selected report (determined by TruBridge EHR).
- **Last Run:** The last time the system ran the scheduled report.
- **Description:** The name of the selected report (the report to be modified).
- **Printer:** The printer number where the report will print. To change the number, enter **1** and press **<Enter>**; then type the new number.

- **Dept:** The department number for which the report is auto-printing. To change the number, enter **2** and press **<Enter>**; then type the new number.

- **Day of the Week:** The days on which the report will print.
  - To select days, enter **3** and the corresponding letter (A through G) when cursor is on the command line, or click on the desired day of the week.
  - To deselect days, enter **3** and the corresponding letter (A through G) when cursor is on the command line, or click on the desired day of the week.

- **Time (Military):** Time at which the report should print. To change the time, enter **4** and press **<Enter>**; then type the new time. This must be a 15-minute interval.

At the bottom of the screen, the following options are available.

- **0-Exit:** To exit this screen.

- **"D"elete:** To delete this setup.

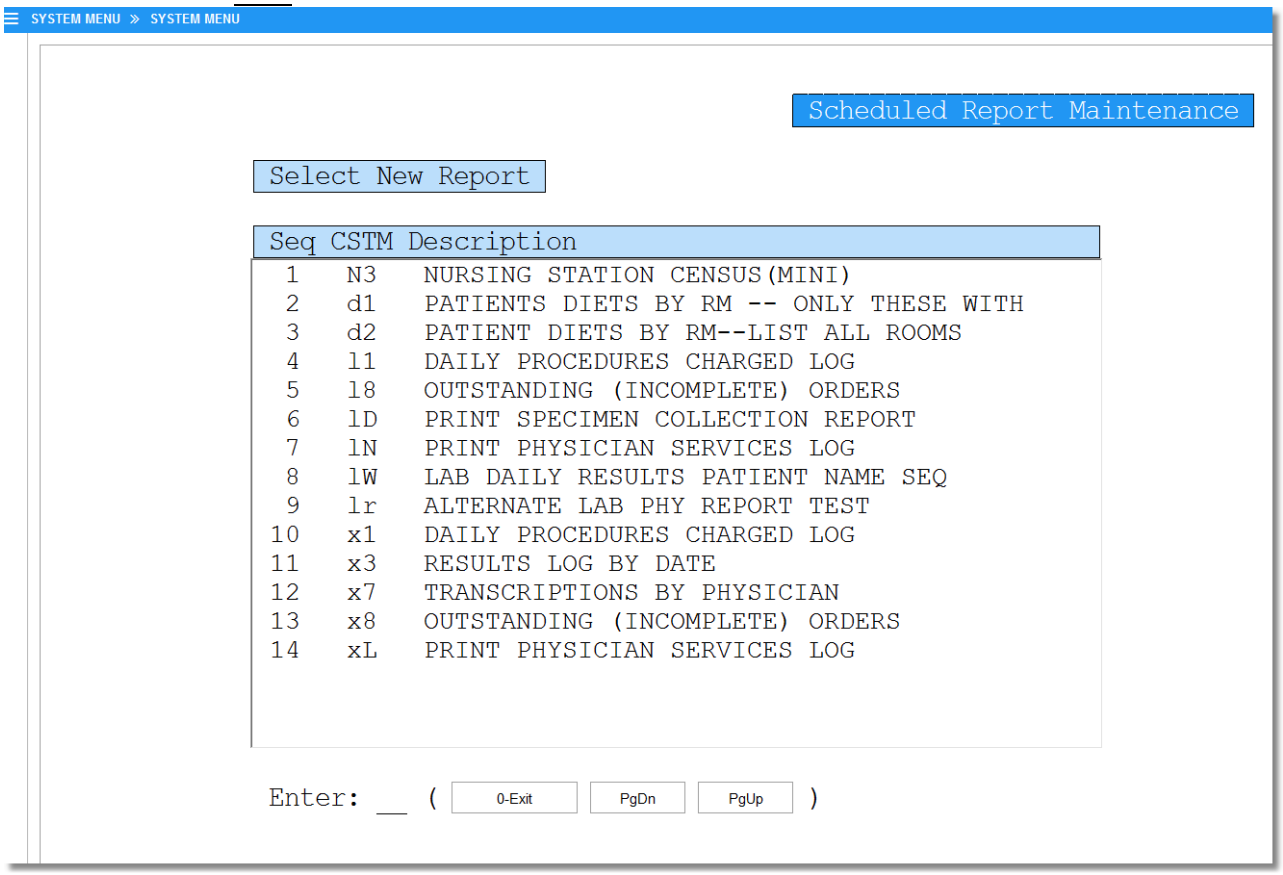
- **"R"eport Parameters:** To display the report parameters required for printing a specific report.

15.4 Creating New Reports

Follow these steps to define parameters for auto-printing a new report.

1. From the Scheduled Print Reports screen, select **New**:

   Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **Reports Table** > **Scheduled Report Parameters** > **New**.



Scheduled Report Maintenance - New

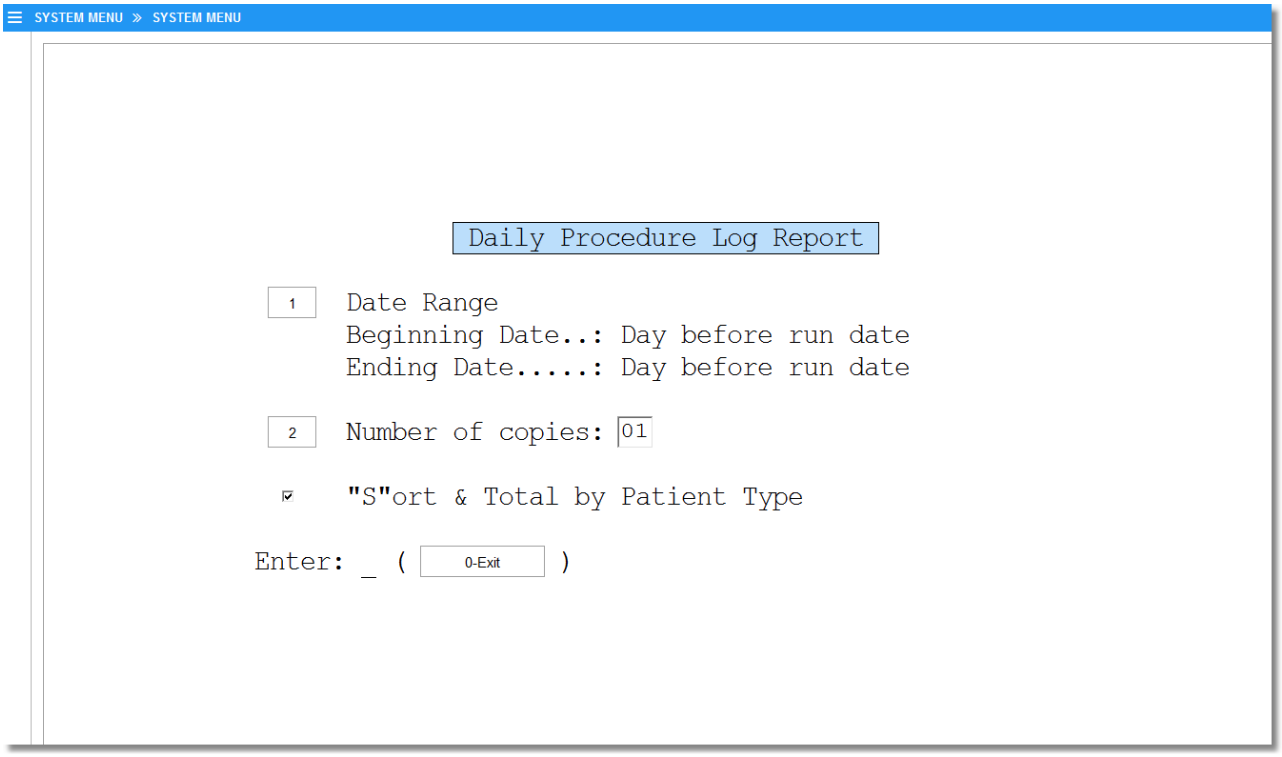
2. Type the sequence number of the report you want to schedule for auto-printing and press **<Enter>**. The Scheduled Report Maintenance screen is displayed.

3. Complete fields 1 through 4 to set up the Printer, Department, Days of the Week, and Time the report should auto-print.

4. Select **Report Parameters** and define the appropriate parameters for this report. The options on this screen vary depending on the report selected.

15.5 Examples of Report Parameters

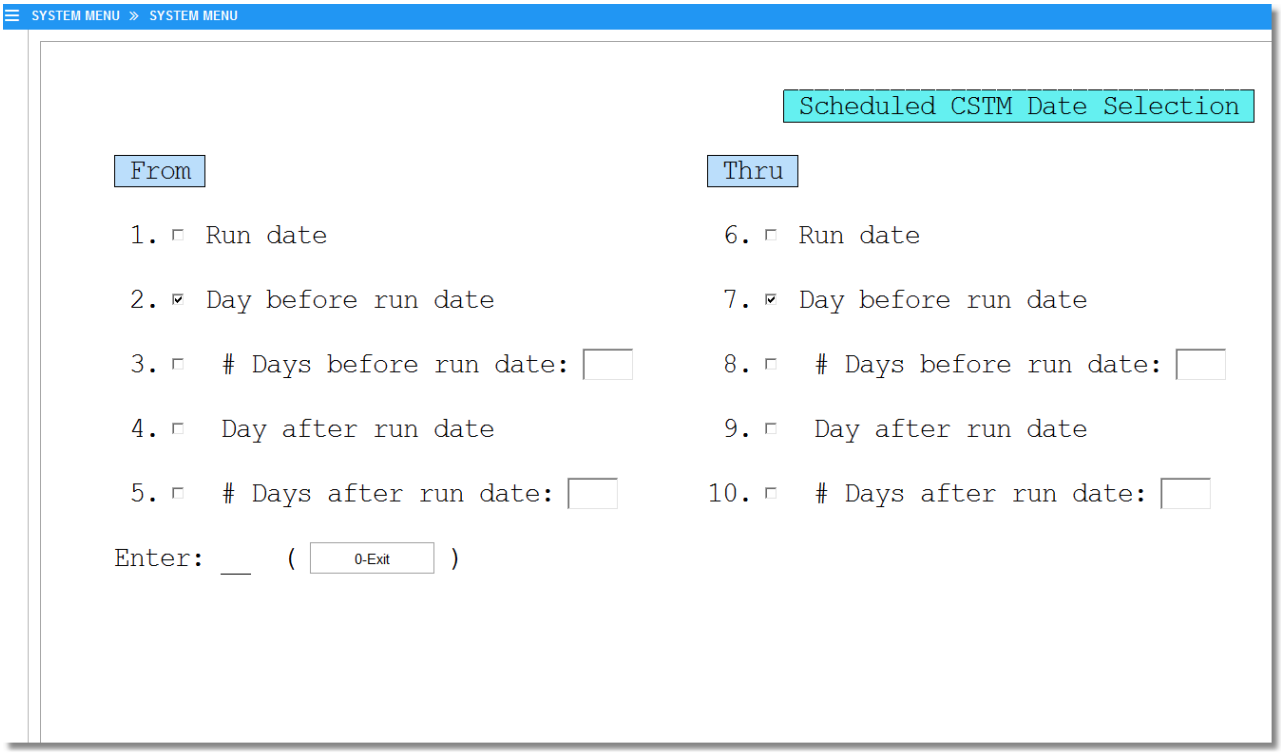
Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Reports Table > Scheduled Report Parameters > Sequence # > Report Parameters**



Report Parameters

- **Date Range:** Displays Scheduled CSTM Date Selection screen.
- **Number of Copies:** Default is 01, but may change to value up to 10.
- **Sort & Total by Patient Types:**
  - Default: No (unchecked)
  - Options: No (unchecked) or Yes (checked)
  - Usage: Provides the ability to sort by patient type and gives totals for each patient type.
    - **Y:** Report will sort by patient type, will alphabetize the patients within each type, and provide totals for each patient type.
    - **N:** Report will not sort by patient type but will print in alphabetical order by patient name. Patient totals will not break out by patient type.

After selecting **Date Range**, the following screen will display:



Range Selection of a Scheduled Report

Select the appropriate day range options that will apply each time a report is to be generated.

- **From:** Select the appropriate day from which the report will begin.
- **Thru:** Select the appropriate day on which the report will complete.

Chapter 16 Specimen Tables

Please refer to Specimen Tables in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 17 Item Master

17.1 Overview

Please refer to Item Master in the Materials Management chapter in the Table Maintenance-Control User Guide for more information on this topic.

Chapter 18 Order Entry Information

18.1 Overview

Order entry information provides item-specific controls for many order entry processes when a new item is set up using the **Just-Like** function (see Item Master 42).

Please refer to Order Entry Information in the Materials Management chapter of the Table Maintenance-Control User Guide for more information on this topic.

Chapter 19 Order Entry Instructions

19.1 Overview

Order Entry Instructions (Help information) is designed to provide online information about clinical procedures, tests, and patient preparation. This information is available to ancillary departments and Outreach Client Access clients. Help information includes department specific information. The online information is available at order entry and is displayed by selecting **Help** from the order entry maintenance screen.

The following are some application-specific examples.

Laboratory:

- Synonyms for the test: Sedimentation rate, ESR, Sed Rate
- Specimen requirements: type of collection tube
- Patient preparation: fasting, non-fasting
- Reporting time: available STAT, same shift, or sent to State Reference lab (2-4 weeks)

Radiology:

- Patient preparation: NPO, enema prior to exam
- Explanation of procedure
- Post-procedure instructions

Cardiopulmonary:

- Patient preparation: no smoking prior to procedure
- Explanation of procedure
- Instructions for at home treatments

Physical/Occupational Therapy:

- Patient preparation: wear comfortable clothes, non-skid shoes
- Explanation of procedure
- Instructions for at home exercises

Dietary:

- Explanation of special diets (diabetic, cardiac, surgical)

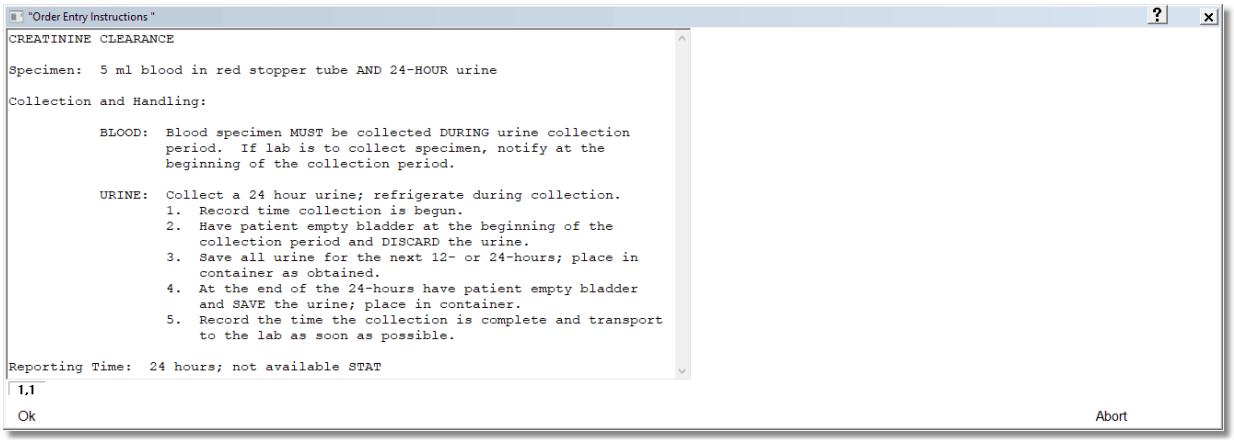
- Diet instructions
- Sample menu

19.2 Defining Order Entry Instructions

To define Order Entry Instructions, these areas must be addressed:

- Thrive (TruBridge EHR) Word Processing or the edit box feature may be used for defining Order Entry Instructions. Edit boxes act like most traditional word processing software.
- Proper security is necessary to access the Charge/Inventory Tables. Notify your site contact if access is not available.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Item #** > **Order Entry Instructions**



Order Entry Instructions, ClientWare Edit box

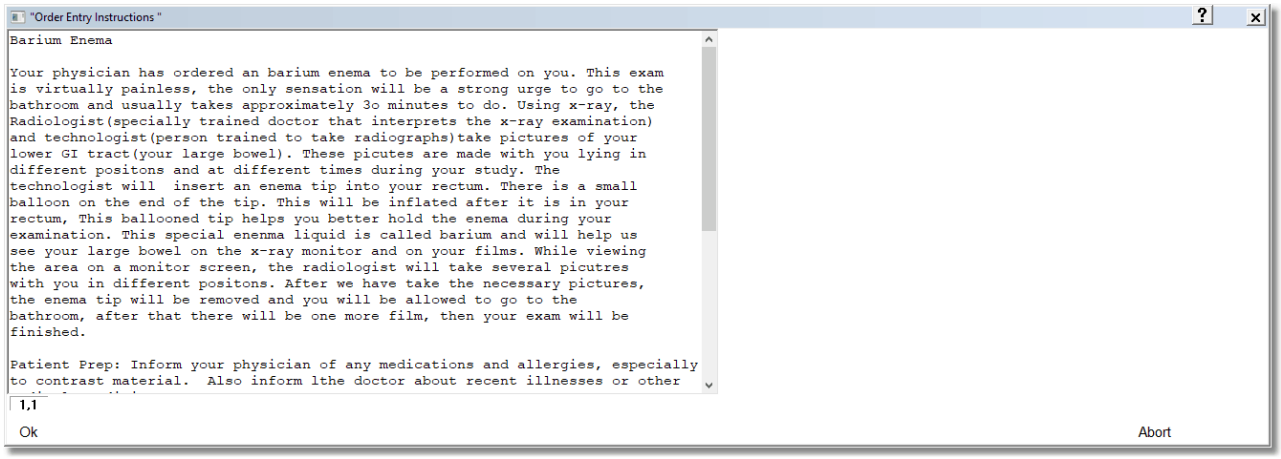
- The system will display a CPWriter document if not using the edit box feature. If using CPWriter, at the bottom of the screen of the document, the directory and document name will be displayed.
- All Help documents are in the directory /usr3/oehelp followed by the item number.
- TruBridge EHR default Help documents reside in /usr2/lab.
- If edit boxes are being used to create these documents, the system will open an edit box to enter or change the help information.
  - Edit boxes do not support Thrive (TruBridge EHR) word processing commands.
  - After entering information, select **OK** to save the document or **Abort** to exit without saving the changes.
- Upon exiting the document, the system will display, **DO YOU WISH TO NOTIFY USERS OF ANY CHANGES? _ (Y/N)**

- **Y:** System will flash **H-HELP** at the bottom of the order entry maintenance screen when item is selected for order entry. Prompt will flash for the item based on the number of days specified in the field -**Days for O/E Help** on page 1 of Department maintenance.
- **N:** System will not prompt at order entry that the Help screen information for this item has changed.

- Order Entry instructions may be printed from the appropriate department via the Order Instructions Report. This report is available for all clinical ancillary departments that have installed the application.

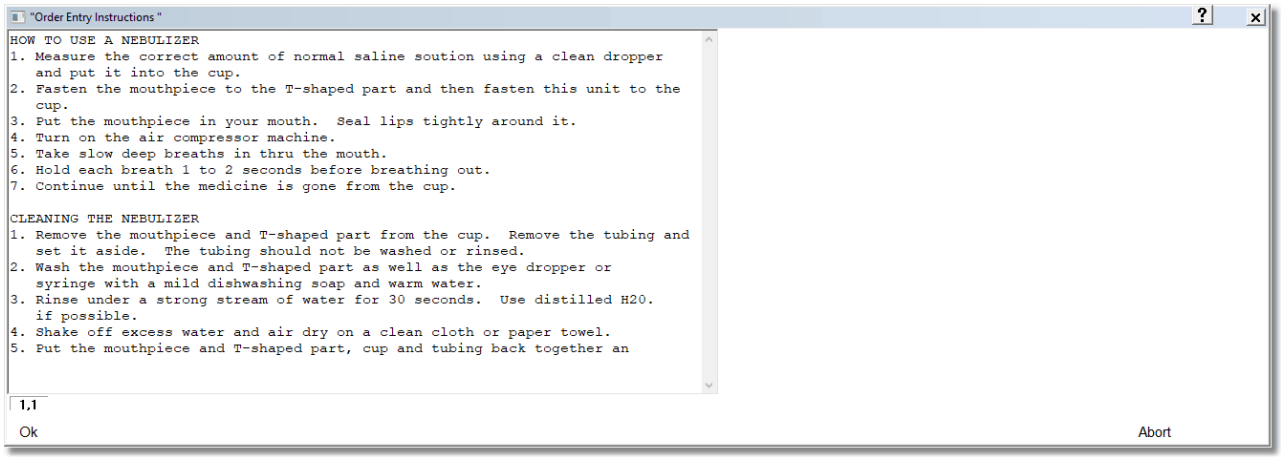
Ancillary departments and Outreach Client Access clients may display, print, or send information. See specific ancillary user guides for instructions on the use of the Help Information.

Radiology Order Entry Instructions, Radiology example



Order Entry Instructions Radiology

Cardiopulmonary Order Entry Instructions, Nebulizer example



Order Entry Instructions Cardiopulmonary

Chapter 20 Order Entry Results Format

20.1 Overview

Order Entry Results Format is an item specific option for creating report formats. Result formats allow result fields to be defined based on the type of result reported (numeric, alphabetic, interfaced result, or non-columnated).

- Results that print in columns on the Comparative Report are defined in the Reference Range table (RRT). The format is a link between Item Function information and the Reference Range Table.

- Free-form formats may be defined for items where test results are not defined in the RRT. These items must be printed in detail (not-columns) on the Comparative Report.

- A single item number may have several test results reported (URINALYSIS, CBC, MANUAL DIFF). Not all of the constituents of the result format are orderable, but each may be defined in the Reference Range Table.

- There are several types of result formats. Most pull information about the test from the Reference Range table.
  - o Numeric and alphabetic results that will print in columns on the Comparative report.
  - o Numeric and alphabetic results that will not print in columns (will print in detail) on the Comparative report.
  - o Free-form formats for tests that are not defined in the Reference Range table and will print in detail on the Comparative report.

- The format for each test will print on the Order Instructions Report. See the Print Reports chapter of the Laboratory User Guide.

20.2 Defining Result Formats

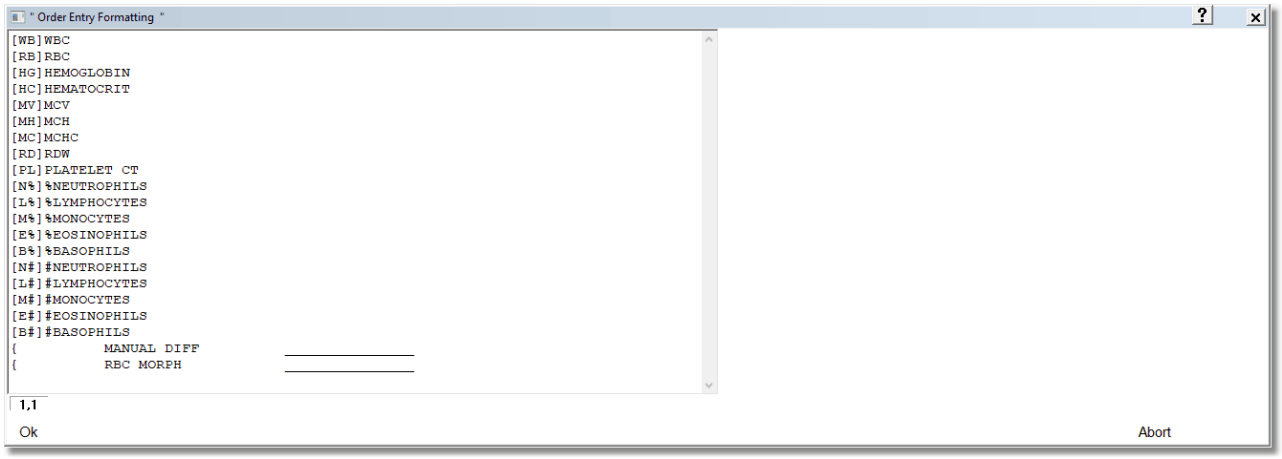
To define Order Entry Results Format, these areas must be addressed:

- It is recommended that Thrive (TruBridge EHR) Word processing be used, but edit boxes may be used for simple formatting.

- Proper security is necessary to access the Charge/Inventory Tables. Notify your site contact or TruBridge to enter or change formats if access is not available.

- Always test new or altered formats on one or more test patients of the appropriate age and sex. The site contact can provide a test patient account example for testing. When testing is complete, it is recommended to delete results and cancel/credit any charges to a zero balance.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Item #** > **Order Entry Results Format**



Order Entry Formatting - Numeric Format with Clientware Edit Box

- The system will display a CPWriter document with the cursor in the upper-left corner. Using Thrive (TruBridge EHR) word processing commands, enter the appropriate information. At the bottom of the screen, the directory and document name will be displayed. If using edit boxes, enter the appropriate information and select the **Okay** button at the bottom of the screen and the directory and document name will **not** be displayed.

- The format document will reside in /usr_/oeformat followed by the item number, where the '_' represents the directory code found in the Company Specific Directory Codes set up by TruBridge Technical Support.

- If using the edit box feature, the system will open an edit box to enter or change questions. Note that edit boxes do not support Thrive (TruBridge EHR) word processing commands.

Numeric Reference Range Formats

There are two types of numeric result formats that will pull information from the Reference Range Table. These are results that print in columns on the Comparative Report and results that will print in detail on either the Comparative Report or the Cumulative Detail Report.

Numeric Results Printing in Columns on the Comparative Report:

- Define a Reference Range entry for each test/analyte of the item to be reported or used in a calculation. This should be done prior to entering result formats.

- Place a **[** (bracket) in column 1, immediately followed by the IDENTICAL description used in the Reference Range Table. **There may be only one result per line (row)**.

- If the test is performed on an interfaced instrument and a numeric result is reported, the following format is used. Interface codes are defined in the Interface Table of the Business Office Tables. Call TruBridge Clinical Interface Support for further assistance.

- Place a **[** in column 1, immediately followed by the two-character interface code.
- Place a **]** in column 4, followed by the IDENTICAL description used in the Reference Range Table. **Example**: [NA]SODIUM

- For panels or profiles, repeat this step for each reported test of the item.
  - The order that tests are listed should be the same order that the technologist will be entering results.
  - The name of the profile may be entered on line 1 without a format code. Example: The title ELECTROLYTES is not defined in the Reference Range Table; this would only appear on the preliminary report and on Order Review. It does not appear on the Comparative Report.
  - The item ELECTROLYTES would have the appropriate laboratory sub-department code in the **Control Switch** field, Control switch 5 of the Item Master. This will place all of the result fields in the correct sub-department of the Comparative report.

- Save the result format document and return to the Item Functions screen.

Numeric Print in Detail Formats:

NOTE: *Results that print in detail do not print in columns on the Comparative Report.*

- Place a **Y** in Control switch 7 of the **Control Switch** field of the Item Master. This indicates that the results for the item need to print in detail rather than columns on the Comparative report.

- Define a Reference Range entry for each constituent of the item to be reported or used in a calculation.
  - The description is not limited to 13 characters and may contain up to 20 characters.
  - Units may be 10 characters or less.
  - Interpretive information may be added to the format and will print on the preliminary report.

- Format results in the same manner as numeric results that print in columns on the Comparative Report.

- When finished formatting, save the document and return to the Item Functions screen.

Age and Race from Registration Copy to Format

The system has the ability to automatically pull the patients' age and race entered during registration to the results format. This will occur only if the Order Entry Results format is keyed as **AGE** and **RACE**. If these result fields are required in a calculation, they must also be set up in the reference range table. The predefined answers in the reference range table for **RACE** will need to match the choices that appear in during registration.

Clinical Information-Height and Weight-To Copy to Format

If **HEIGHT** and **WEIGHT** (in capital letters) are set up in the reference range table and added to the item's Order Entry Format, the values will pull automatically to the resulted document provided the patient's clinical information has been populated prior to resulting. The WEIGHT will pull from the current weight field. If no weight has been entered in the weight field, it will pull from the admit

weight. HEIGHT and WEIGHT in Order Entry Questions may also pull to the result format—refer to Order Entry Questions Instructions 61 in this Guide for proper setup. The clinical information HEIGHT and WEIGHT will override, if different from Order Entry Questions values.

Alpha Reference Range Table Formats

Alpha Results Printing in Columns on the Comparative Report

- Define a Reference Range entry for each constituent of the item to be reported or used in a calculation. This should be done prior to entering result formats.

- Place a **{** (brace) in column 1 of the document.

- If the test is performed on an interfaced instrument and an alphabetic result is reported, the following format is used. Interface codes are defined in the Interface Table of the Business Office Tables. Call TruBridge Clinical Interface Customer Support for further assistance.
  - Place a **{** in column 1, immediately followed by the two-character interface code.
  - Place a **}** in column 4

- Description must begin in column 12 (sometimes in column 13), after the **{** and be IDENTICAL to the Reference Range Table description. Limit is 13 characters to print in columns on the Comparative Report.

- Formatting rules for resulting with Predefined Alpha Answers:
  - If alpha answers are **not** interfaced and flags are **not** used:
    - Enter 15 result underlines. This MUST begin in column 33 and end in column 47. Result areas are made using the _ underscore bar. The answer line may be no longer than 15.
    - Answers greater than thirteen characters will be footnoted with a **SEE BELOW**.
  - If H, L, A, or AC flags are defined in the Alpha Answer definitions of the Reference Range tables, the number of underlines included in the format must be decreased.
  - If a one or two character flag is defined, alpha result lines must be ten underlines or less. Predefined alpha answers cannot exceed eight characters.
  - If alpha results are interfaced (with or without flags), alpha result lines must be ten underlines or less.
  - If alpha result formats contain pre-defined units of measure, they must start in position 48 or 56-78.

- For reference range values to appear on Order Review and Preliminary Reports, place **(** (open parentheses) in column 56 followed by any normal or reference information. Enter a **)** (closed parentheses) in column 78. Example: (NORMAL: Negative)

- For panels or profiles, repeat this step for each reported test of the item.
  - The order that tests are listed should be the same order that the technologist will be entering results.
  - The name of the test may be entered on line 1 without a format code. Example: The title URINALYSIS is not defined in the Reference Range Table; this would only appear on the preliminary report and in Order Review. It does not appear on the comparative report.
  - The item URINALYSIS would have the appropriate laboratory sub-department code in Control switch 5 of the **Control Switch** field of the Item Master. This will place all of the result fields in

the correct sub-department of the comparative report.

- Save the document and return to the Item Functions screen.

NOTE: *There must be an underscore before and after the result. If a defined answer is 8 characters (POSITIVE, for example), then 10 underscores are needed on the result format. 8 spaces are needed for the result, plus 1 underscore at the beginning and end to capture the entire defined answer on the result format. The first and last underscores do not accept result characters.*

Alphabetic Print in Detail Formats:

- Place a **Y** in Control switch 7 of the **Control Switch** field of the Item Master. This indicates that the results for the item need to print in detail rather than in columns on the Comparative Report.
- Define a Reference Range entry for each constituent of the item to be reported or used in a calculation. This should be done prior to entering result formats.
  - o The description is not limited to 13 characters and may contain up to 20 characters.
  - o Pre-defined alpha answers are not limited to thirteen characters.
  - o Interpretive information may be added to the format and will print on the preliminary report.
- Format results in the same manner as alphabetic results that print in columns on the Comparative Report. Print in detail formats may be set with an Interface code if needed.
- When finished formatting, save document and return to the Item Functions screen.

Free-Form / Free-Text Formats

A free-form / free-text format is necessary when a test does **not** use the Reference Range Table.

- Place a **Y** in Control switch 7 of the **Control Switches** field of the Item Master. This indicates that the results for the item need to print in detail rather than columns on the Comparative Report.
- **Always leave at least four blank spaces in the left margin of each line. If free-text is entered closer than column 5, the test will not print on the Comparative Report.**
- Any type of character may be used in the result field.
- Result fields may be of any length (that will fit on one line).
- Normal values may be broken down into as many populations as necessary.
- Tests are not defined in the Reference Range Table.
- If a test is defined in the Reference Range Table, the format for that result line must contain a **[** for numeric or a **{** for alpha.
- Create the format with only one result field per line.

- Whenever possible, use the following guidelines for free form format components.
  - o Reference Lab result areas are made using the underline _ (underscore) bar.
  - o There must be an underscore bar before the result and after the result (e.g., if up to 10 spaces are needed for the result, 12 underscores must be in the format). The first and last underscores do not accept result characters.
  - o If a test typically has a common result (such as NEGATIVE), this result may be placed in the format. The result will need to be preceded and followed with an underscore. At result entry, the default result may be accepted (by skipping over it) or may be changed to another result.

Example: _NEGATIVE_ or _NON-REACTIVE_

Combined Detail Formats

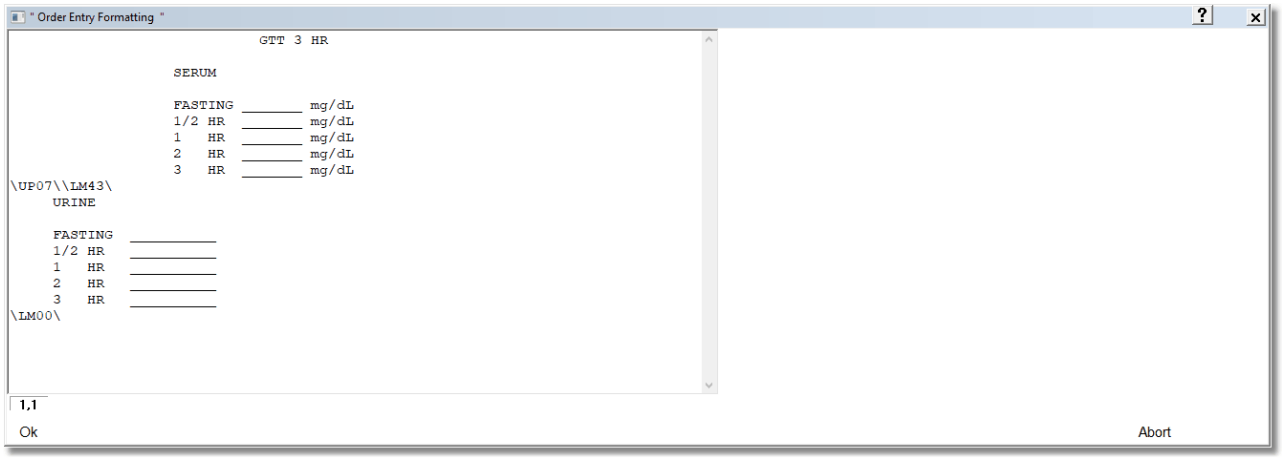
There is no special procedure to follow to mix report format methods; use one format-type per line, following the instructions above for each. Combined formats may also use special printer commands that allow multiple results to print on a single line.

Example: *GLUCOSE TOLERANCE TEST*

- Place a **Y** in Control switch 7 of the **Control Switches** field of the Item Master. This indicates that the results for the item need to print in detail rather than columns on the Comparative Report
- Alpha reference range formats may be entered so the Urine test constituents allow use of predefined answers from the Reference Range Table.
- Free-form result lines may be added for the numeric results with an **UP** print command so that two results will print on one line. The **UP** command must be before the **LM** command.
- Interpretive information may be added at the bottom of the format if needed.

The example below shows a combined detail format using the **UP** and **LM** commands.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Item #** > **Order Entry Results Format**



Combined Format to print in detail

- Format the SERUM GLUCOSE result fields first. Be sure not to start any closer than 5 from the left margin. The units may be added at the end of the result fields if not using the Reference Range Tables for results.

- On the last line of the SERUM GLUCOSE result fields, add the print command **\UP08\\LM43**.
  - The number of lines following the **UP** command will vary depending on how many result lines are in the tolerance.
  - The **LM** (left margin) print command tells the printer how far over the second column needs to be.

- Enter the URINE result fields as free form formats.

- Put a **\LM00** print command at the bottom of the format to return test results to the default left margin.

HL7 Interface Format

Special interface codes must be used for test results sent from a reference laboratory or laboratory instrument via an HL7 Interface. Call TruBridge Clinical Interface Support for instructions or questions about this type of interface.

- Place a **Y** in Control switch 7 of the **Control Switch** field of the Item Master. This indicates that the results for the item need to print in detail rather than columns on the Comparative Report.

- Tests are **not** defined in the Reference Range Table.

- Create the format using the available reference laboratory interface codes.

- In column 5, enter a _ and type the test description. Include a _ behind the description also. This allows */(slash)* to be used at result entry to pull a custom called-in comment such as **See Separate Reference Lab Report**.

- On the second line, column 1, enter **^$** which is used to send the order to the reference lab.
- On the third line, column 1, enter **^^** followed by the mnemonic code (also known as battery or profile code). A description is not necessary.
- On each subsequent line, enter **$$** followed by an individual test code. A description is not necessary.

Example: ***Underscore in column 5, name of test, and underscore afterward.***

AMITRIPTYLINE
^$
^^423SB
$$80047000
$$80047100
$$80047200

- HL7 interface items have a site code loaded in Order Entry Information that causes a flash on the OE Maintenance screen when ordering.

Printer Port Interface Format

Special interface codes must be used for test results sent from a reference laboratory or laboratory instrument via a Printer Port Interface. Call TruBridge Clinical Interface Support for instructions or questions about this type of interface.

- Place a **Y** in Control switch 7 of the **Control Switch** field of the Item Master. This indicates that the results for the item need to print in detail rather than columns on the Comparative Report.
- Tests are **not** defined in the Reference Range Table.
- Create the format using the available reference laboratory interface codes.
- In column 5, enter a _ and type the test description. Include a _ behind the description also. This allows *I(slash)* to be used at result entry to pull a custom called-in comment such as **See Separate Reference Lab Report**.
- In column 1 of line 2, enter **++**, in column 1 of line 3, press **Enter**, and repeat on next line.

Example: Underline in column 5, name of test, and underline following. ++, ++ follow on the next two lines

*_ALPHA-FETOPROTEIN TUMOR_*
++
++

Chapter 21 Order Entry Questions

21.1 Overview

The Order Entry Maintenance display contains four Order Entry Question lines. Each of these lines will accept entries of up to 75 characters. These lines allow the placement of item specific information, questions, or comments during Order Entry.

- Required questions will be presented at order entry.
- Questions and information entered in these fields will print to the request form in the ancillary department and on the nursing order verification slip.
- In Radiology, information may be set to pull to the Radiology Touch Schedule and the transcription if desired.
- Predefined answers may be defined in the Reference Range Table and provide a lookup window.
- Results may be entered at order entry on a comment/questions line that will pull to the result format for verification by qualified laboratory personnel.
  - The system will capture the initials of the person answering the question as the person resulting the result field.
  - This is effective for recording bedside glucose results by nursing staff and having laboratory staff verify the result so that it will print on the Comparative Report. A separate item would be necessary.
- The software has the ability for any question created on an item to be viewed when orders are being resulted. If no answer is provided on the question, the Order Entry Question will be the only thing that appears. The user will need to enter '**OE**' from the command line on the result screen and the Order Entry Question(s) and answers will appear.
- Separate Physician Chartlink Questions are available for the Physician application. Any question lines used must match the Order Entry Questions exactly.
- Order Entry Questions and Physician Chartlink Questions may be set to copy over from the first order placed to the following orders. This is done in the Department Maintenance Table, page 1, **Copy OE Questions?**

21.2 Defining Order Entry Questions

To define Order Entry Questions, these areas must be addressed:

- Thrive (TruBridge EHR) Word Processing or the edit box feature may be used for defining Order Entry Questions. Edit boxes act like most traditional word processing software.
- Proper security is necessary to access the Charge/Inventory Tables. Notify your site contact or TruBridge to enter or change questions if access is not available.

- The system will display a CPWriter document with the cursor in the upper-left corner. Using Thrive (TruBridge EHR) word processing commands, enter appropriate information. At the bottom of the screen, the directory and document name will be displayed. If edit boxes are used, enter the appropriate information and select the **Okay** at the bottom of the screen. The directory and document name will **not** be displayed.

- All question documents are in the directory /usr3/oeques followed by the item number.

- Information can be entered using any characters. Only information placed into the first 75 spaces of each of the first four lines will appear on the Order Entry Maintenance screen.

- Questions must also follow the same space restrictions indicated above. It is recommended that the questions be set up in lower case letters to stand out. When setting up the questions, use the following guidelines:
  - o Each line may have multiple question fields.
  - o Result areas are made using the underscore _.
  - o There must be two extra underscores for each answer area. The first and last underlines do not accept answer characters.
  - o Always leave a space between the question and the first underline.

- An answer field may be made to require a response by using one of the following formats:
  - o **N** in second position with underscores before and after Y or N answer only and cannot be skipped. *Example: Patient fasting? _**N**_*
  - o **R** in second position with underscore before and longer line after requires an answer and field cannot be skipped. *Example: Date and time of last dose: _**R**_____*

- Blank underline allows field to be skipped; user may answer if indicated. *Example: Current meds: _____*

- Questions needing the user to choose from a list of predefined answers will be preceded by a brace as follow:
  - o {Start Meal: _R_____
  - o The question after the brace must be built in the Reference Range Table ensuring the alpha answers and predefined alpha answers fields are checked.
  - o Any predefined question must appear at the beginning of the Order Entry Question line and only one predefined question is available per line.

- Display attributes may be used to prevent a statement from being overlooked. These attributes will not be displayed if the user does not select the **Edit** option from the Order Entry screen.

  Red Background behind statement: Either command in CPWriter will yield this look.
  - Option 1:
    - o Hold **Ctrl** and press **V**, then Hold **Ctrl** and press **[**, type **G2**
    - o Type the question or statement.
    - o At the end of the line, Hold **Ctrl** and press **V**, then Hold **Ctrl** and press **[**, type **G0** (this last character is a zero).
    - o Example: **^[G2 Call laboratory to schedule before ordering!^[G0**
  - Option 2:
    - o Hold **Ctrl** and press **V**, then Hold **Ctrl** and press **[**, type **G6**

- Type the question or statement.
- At the end of the line, Hold **Ctrl** and press **V**, then Hold **Ctrl** and press **[,** type **G0** (this last character is a zero).
- Example: **^[G6 Review Help for proper collection procedure.^[G0**

Radiology Item Questions

It is important for the reading radiologist and the radiology staff to know the reason imaging procedures are ordered. The **Reason for Procedure** question pulls from the second line of Order Entry Questions to the BODYTEXT mnemonic located on the OEWORD header. This becomes a permanent part of the results in Clinical History.

The Radiology department also needs specified information for transporting patients to the department. This may be accomplished by defining transportation questions required during the Order Entry process.

The following Order Entry Questions formatting is used for Radiology Items.

In order for the Transportation and/or IV and/or O2 information to print on the Radiology Composite Requisition, fields must be placed into specific locations of the Order Entry Questions of the items. These fields must be created EXACTLY as follows:

- **Transportation:** (Spelling must be exact) The word must begin in position 1 (position 2 if predefined answers are created); the underline that follows must extend from positions 17 thru 38 (18 thru 38 if predefined answers are created), inclusive.

- **IV?** (Spelling must be exact) Must begin in position 42; the underline that follows must extend from positions 46 thru 48, inclusive.

- **O2?** (Spelling must be exact) Must begin in position 52; the underline that follows must extend from positions 56 thru 58, inclusive.

There are two different formats for this function:

- First option:
  - Line 1 CHEST PA & LAT (name of test)
  - Line 2 Reason for Procedure: _R_____
  - Line 3 {Transportation: _R_____ IV? _N_ O2? _N_
    - The item description on Line 1 pulls to the Radiology Schedule **Procedure** description.
    - This option provides one Order Entry Question line for additional comments that may be needed.

- Second option:
  - Line 1 {Transportation: _R_____ IV? _N_ O2? _N_
  - Line 2 Reason for Procedure: _R_____
    - The **Procedure** description on the Radiology Schedule pulls from the Item Master description.
    - This option provides two Order Entry Question lines for additional comments that may be needed.

Pulling Additional OE Questions to the Radiology Schedule and/or Transcription

At times there may be a need to pull additional **Reason for Procedure** or patient history to the Radiology Schedule and the transcription.

The second line of the question format is hard coded to pull to the Radiology schedule and the transcription. If additional lines are needed to pull to these areas, the third and fourth lines may be set to pull by placing a **greater than symbol >** at the beginning of the line. If this is done, the information in these lines will pull to the **REASON** section of the Radiology Schedule as well as in the **<BODYTEXT>** mnemonic in the transcription header.

If the additional information is only needed to pull to the transcription, an @ **symbol** is placed at the beginning of the line. This will allow the information to pull to the transcription only.

If the third line is designated to pull additional information, it will become necessary to move the transportation information that is normally in this field to line 1. Line 1 has been modified so that the information in this line will pull to the composite requisition. If line 3 is not designated to pull additional information with either the **> or** @, then it is not necessary to move the transportation information to line 1.

NOTE: *If the item description is not in line 1 on Order Entry Questions, it pulls based on the item description in the item master.*

Below is an example of pulling additional information. In this example:

- Line 1: has transportation information loaded and will pull to the composite requisition.
  - **Transportation** must begin in position1. The line that follows must extend from position 17-38.
  - **IV?** must begin in position 42. The underline that follows must extend from position 46-48.
  - **O2?** must begin in position 52. The underline that follows must extend from position 56-58.

- Line 2: has Reason for Procedure information and will pull to the Radiology Schedule, the composite requisition, and the transcription.

- Line 3: has additional Reason for Procedure Information and will pull to the Radiology Schedule and transcription due to the **> symbol**.
  - The **> symbol** must start in the first position of the line to pull information to the schedule and transcription.

- Line 4: has additional patient history information that will pull to the transcription only due to the @ **symbol**.
  - The @ **symbol** must start in the first position of the line to pull information to the transcription.

Predefined Order Entry Questions

Order Entry Questions may be formatted to include a drop-down of predefined answers for quick entry.

To Create a Drop-Down of Pre-Defined Answers:

1. Place a **{** (brace) before the question.

   Example:

   {Transportation:
   {Reason for Procedure:

2. The exact Order Entry Question must be created in the **Description** field of the Reference Range Table. The Description field is limited to 13 characters. Numbers, spaces, and punctuation may be included in the description, but the beginning brace is not entered.

3. The **Alphabetic Answers** and **Defined a-Answers** should be selected. No other fields on the Reference Range Table are needed.

4. Select **Alpha Answers**.

5. After selecting **Alpha Answers**, the Alpha Answer Definitions screen will display. Up to 30 answers (15 per page) may be defined. Select **ALL** to advance through all fields. Enter the first predefined answer in the first line under the first column, **Answer**.

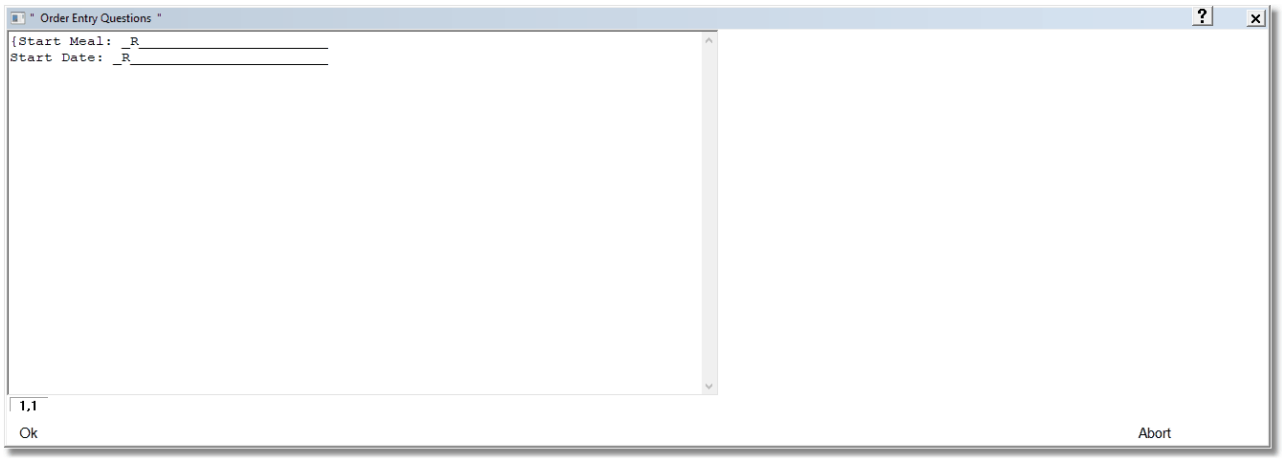
NOTE: *Any changes made to the reference ranges for alpha answers will be reflected by the Effective Date field.*

The following icons are listed in the action bar at the bottom of the screen:

- **Print:** Will open the reference range table entry in a PDF document to allow printing.
- **Delete:** Will delete the reference range table entry.
- **Save:** Will save any new information added to the screens.
- **Refresh:** Will not save information immediately; takes you to a prompt asking, "Refresh and Lose Unsaved Changes?" Select Yes or No.

Dietary Item Questions

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Item #** > **Order Entry Questions**



Order Entry Questions

Specific Diet Questions

The description of the specific diet pulls to Clinical Information via the Item Master Name, provided the **Diet Item** field is checked in the Order Entry Information, page 5, for the item.

Generic Diet Questions

When using generic diet orders, the Diet Order question will pull to Clinical Information, provided the question is set up on the first line of the Order Entry Questions and starts in the second position when the item's department number is set in the OE prefix for the Dietary Department.

Phys App Questions

Physician Chartlink Questions are available for the Physician application to use during the Order Entry process for physicians. These may include all of the Order Entry Questions or only specified lines. Any question lines used must match the Order Entry Question exactly.

Ancillary Order Entry Questions that are not duplicated in Physician Chartlink Questions will not be required for the physician to answer. When these orders are verified in Patient Documentation, nursing will be prompted to answer these unanswered Order Entry Questions. If the Chartlink Control Table is set to send orders directly to ancillary, the Order Entry Questions will not be offered to answer.

The general requirements for Physician Chartlink Questions are the same as Order Entry Questions. The same standards for Radiology and Dietary Questions should be followed.

When creating questions with predefined answers, the question is limited to 20 characters in the Reference Range Table. This does not include the alpha command brace {. The spelling and spacing must be exactly the same as the Order Entry Question line.

The underscore for the answer response is limited to 40 characters including the '**R**' when the question is required.

Order Entry Questions in Result Documents

Order Entry questions may also be set up to allow answers and/or results to pull into the result document. Using a formatting process similar to that of item setup, the questions will look to the reference range tables for a matching entry. If a match is found, and an Order Entry Result Format has been defined, the system will pull information entered in the question to the result format. For example, predefined alpha answers will display the same lookup window as is seen through resulting.

- Numeric answers will only accept the number of decimal places that are defined in the reference range tables.
- All reflex criteria, interpretive text, and calculations will remain the same.
- This feature will allow other departments, such as nursing, to enter results for tests that they have performed. Bedside glucose monitoring is one example.
- The date and time and the initials of the person placing the order will pull to the result field audit trail, unless the results are changed. If the results are changed, they will then show the date and time and the initials of the person entering the results.
- Clinical Information **HEIGHT** and **WEIGHT**, if different from what is entered via Order Entry Questions, will pull from Clinical Information, override the Order Entry Questions for **HEIGHT** and **WEIGHT**, and copy to the result format. This is the only exception to the Order Entry questions ability to copy over to the results.
- A numeric response question requires the bracket, **[** in column 1, followed by the test name (as defined in the reference range table), a **Space,** an **Underline followed by an R**, and **then a minimum of 11 (eleven) underlines**.
- An alpha response question requires the brace, **{** in column 1, followed by the test name (as defined in the reference range table) and up to 45 underlines. Limited to, however, 15 underlines in order to print columnated on the comparative report.
- The corresponding format must be placed be in **Order Entry Results Format**.

NOTE: *For multiple questions on the same line, only the first question is eligible to pull to the result format.*

21.3 Printing Order Entry/Chartlink Questions

Order Entry/Chartlink Questions may be printed via the Print Reports option in the Laboratory, Radiology, Cardiopulmonary, and Physical Therapy software applications. See those user guides for instructions on printing this report.

Chapter 22 Order Entry Worksheets

22.1 Overview

The worksheet option provides an online area where notes, preliminary results, Internal QC, specimen information, and other information may be recorded without noting in the report format. This is especially useful in Microbiology, Manual Hematology (body fluids), and Pathology areas of the Laboratory. Dietary may also find this option useful for Nutritional Assessments. Features include the following:

- Worksheets are item specific and may be customized based on what type of information needs to be noted.
- Access to the worksheet is available from Order Entry Maintenance > Select Test > Wksht.
- Worksheet information may be formatted to copy results to the Order Result screen provided the worksheet format is set up to match the Order Entry Result Format.
- When resulting a worksheet, the system records the date, time, and initials of each person that enters information. If the worksheet is accessed for review only, no updates occur.
- The system removes the sequence number from resulted lines, which prevents changes at subsequent entries.
- Worksheets may be deleted when an order is incomplete and the results are deleted. The user will receive a prompt asking, "*Are you sure you want to delete? Yes/No*." When answering "Yes,", the user will receive a second prompt, stating, "*Results DELETED! Do you want to delete the Worksheet Also? Yes/No*."
- Reflex testing, calculations, results index, custom called-in documents and predefined alpha answers may be used with worksheets.
- Worksheets can be used when certain results or notes are needed but should not appear on Preliminary or Comparative Reports.
- Worksheets may be resulted individually or by batch. This feature is based on a worksheet batch code defined in the item Order Entry Maintenance. See the Laboratory User Guide for result entry instructions.
- Entries are moved to Clinical History with the patient's results.

22.2 Defining Order Entry Worksheets

To define Order Entry Worksheets, the following criteria must be met:

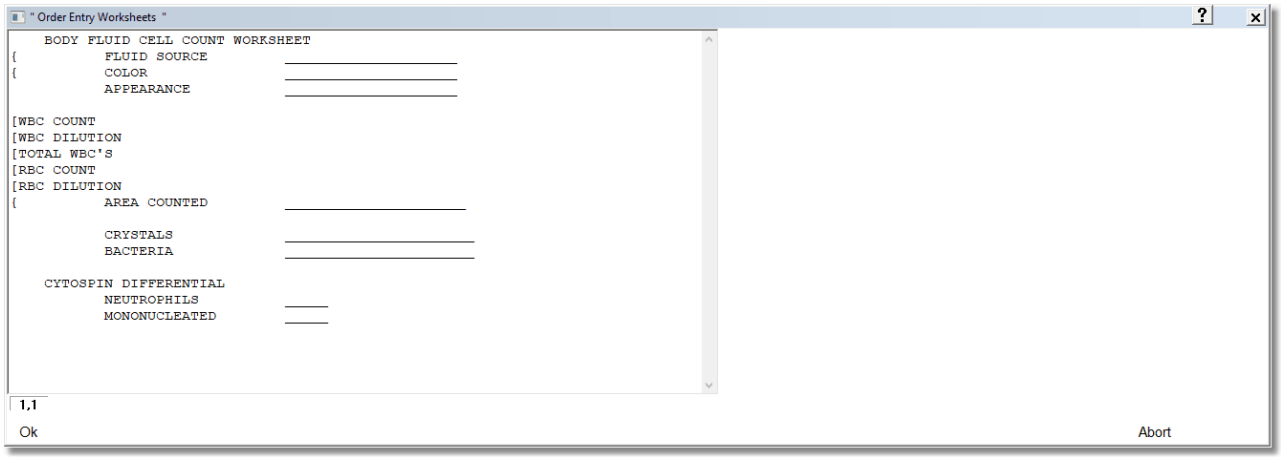
- The use of Thrive (TruBridge EHR) Word Processing or the use of edit boxes. Edit boxes do not support Thrive word-processing commands.

- Proper security is necessary to access the Charge Tables and Inventory. Notify your site contact or TruBridge Support if additional assistance is needed.

- If resulting worksheets by batch, create a unique two-character worksheet batch code for each type of worksheet. Enter the worksheet batch code in the **Result Worksheet Type** field of Item Order Entry Information page 3, for each item that will have worksheets resulted by batch.

Standard Numeric Formats

Select **Web Client > System Menu > Hospital Base Menu > Charge Tables and Inventory > Enter Item # (or use Item or Service Search to look up the item by description) > Order Entry Worksheet**



Order Entry Worksheet With Edit Box

- List the Item Description on the first line starting on space 5 (1,5)

- Start numeric formatting on line 2. Create a worksheet format by typing a **[** in column 1 followed by the reference range table description. If you want the worksheet information to copy over to the Order Entry Results Format, make sure the numeric Worksheet Format line matches the numeric Results Format line. *EXAMPLE: **[COLONY COUNT** entered in both locations.*

- Create a Reference Range Table entry for numeric results. Follow the recommendations for numeric reference range format outlined in the Order Entry Results Format section.

- Define calculations and reflex testing if needed.

- Continue format of worksheet for any additional lines.

Standard Alpha Formats with Predefined Answers

- List the Item Description on the first line starting on space 5 (1,5).

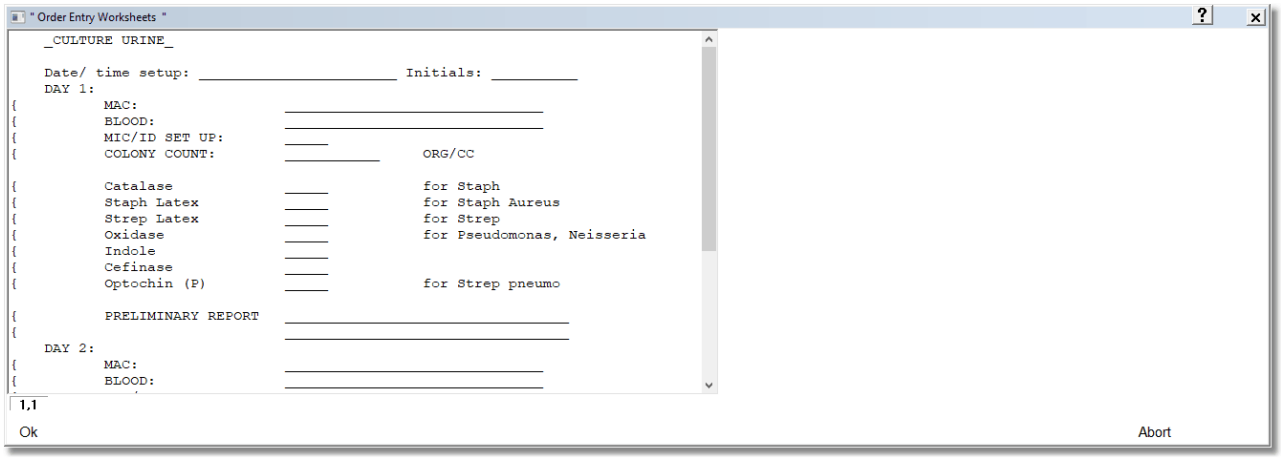
- Start alpha formatting on line 2. Create a worksheet format by typing a **{** in column 1, enter the test description (as defined in the reference range table) in column 12, and enter the result lines

using _ (underlines) starting in column 33.

- Create a reference range entry for an alphabetic result. Create predefined alpha answers following the recommendations for alphabetic reference range format outlined in the Order Entry Results Format section.
- Define reflex testing if appropriate.
- Continue format of worksheet for any additional lines.
- If predefined answers are not used, refer to Standard Free Text Formats 51.

Standard Free-Text Formats

Select **Web Client > System Menu > Hospital Base Menu > Charge Tables and Inventory > Enter Item # (or use Item or Service Search to look up the item by description) > Order Entry Worksheet**



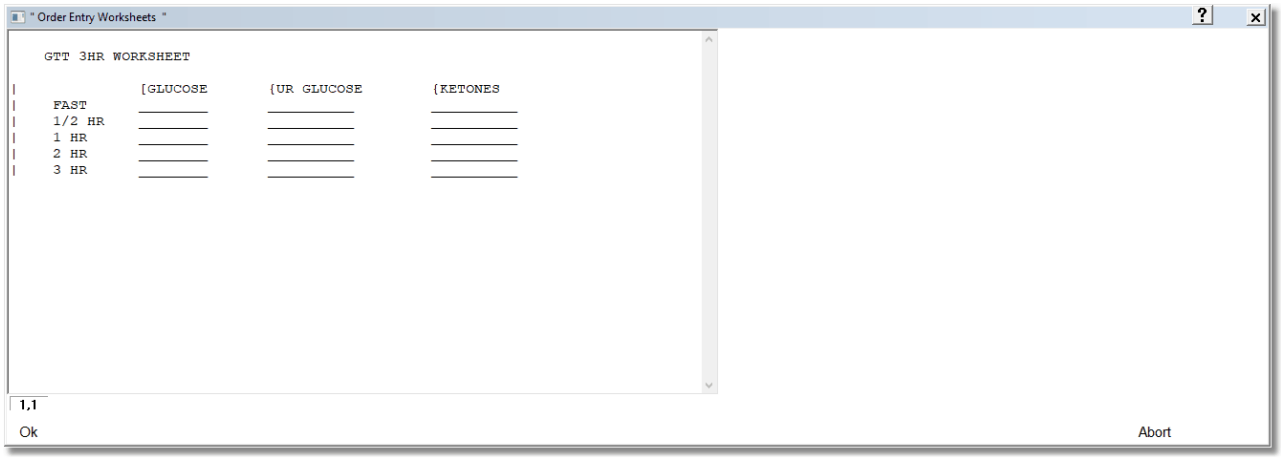
Urine Culture Example of Order Entry Worksheets

- List the Item Description on the first line starting on space 5 (1,5).
- Start the field name in column 5 or greater to keep the sequence number from displaying within the field name.
- Be consistent with formatting. Alpha descriptions should start in column 12.

Vertical Formats

Vertical formats are used when the test names are located at the top of the result column with multiple answer fields situated below each test name. The most typical use is for GLUCOSE TOLERANCE TESTS. This allows each technologist's initials and the date/time the result was entered to be captured on the worksheet and the final results entered at one time in the result format.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Enter Item # (or use Item and Service Search to look up the item by description)** > **Order Entry Worksheet**



Example 3 HR GTT Order Entry Worksheet

- Leave the first line blank. Start entries on line 2.

- Create a worksheet format as follows:
  - Type a **|** (pipe) in the first column. This lets the system know that it should refer to the reference range entry. It may be omitted if the format is entirely free text.
  - The first test name should be in column 6 or greater. If a numeric reference range has been defined, type a left bracket **[** before the test name.
  - If an alpha reference range has been defined, type a brace **{** before the test name.
  - Below the test names, enter a pipe in the first column and the description starting in column 6.
  - Numeric result fields have 8 underlines beginning in the same column as the **[** or **{** that precedes the corresponding test name. The system does not create these fields, therefore units or ranges must also be entered in the format.
  - If units are included in the format, skip four spaces to allow enough room for flags: L, H, LC, HC.
  - Alpha result field must be long enough to accommodate predefined answers plus two additional underlines.

- Create a reference range entry for numeric and alphabetic test names. Create predefined alpha answers. Follow the recommendations for numeric and alphabetic reference range format outlined in the Order Entry Results Format section.

- Define reflex testing if appropriate. Define calculations as needed.

- Multiple result fields may be assigned to each test. 3 HR GTT Example: Test names are listed at the top of the column, description on the left of the result lines.

- Each time a worksheet is accessed during result entry, the system creates a record of the entry including the technologist's initials and the date/time. The sequence number of the previous entry is removed so that entries may not be changed.

Chapter 23 Re-Order Label Information

23.1 Overview

Clinical Ancillary departments can have item-specific orders generated for a defined time period. These items are defined as such in Order Entry Information in the following fields:

- Multiple Orders = Y or B
- OE Ask Frequency = Y
- Ask Stop Date = Y, YR, B, or BR

When these orders are placed, a Stop Date is entered. Both nursing and ancillary departments may print a report or labels for orders that are due to stop within 24 hours. The label information is defined in this option. Features of the Re-order Labels include:

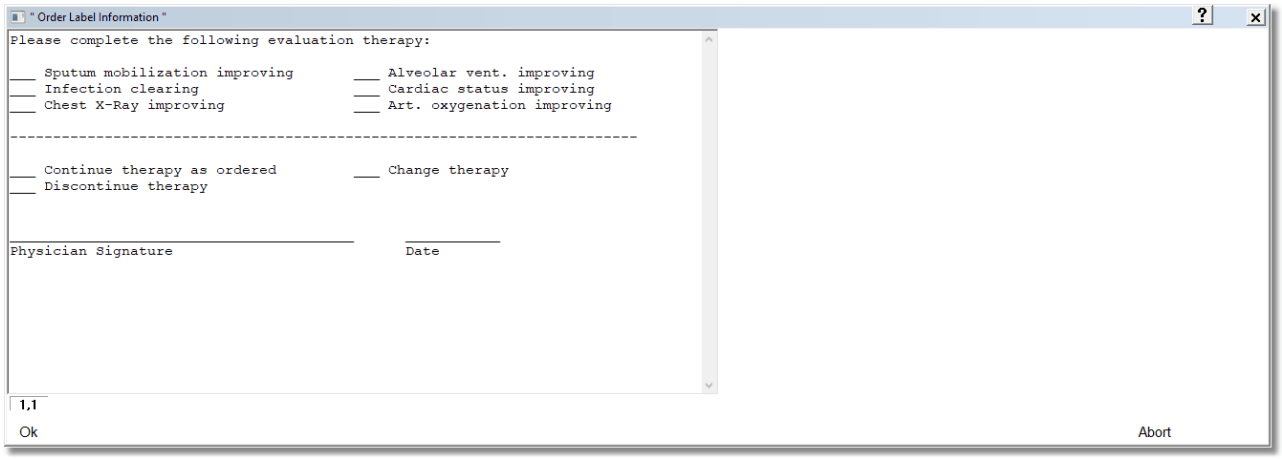
- Labels are placed on the patient's chart to notify the physician that the order is scheduled to stop on the specified date.
- Labels may include text asking if the order is to be discontinued.
- Labels may include text for documenting indications for the order to be restarted.
- Provide lines for the physician's signature and the date.
- Label size is 4 x 1 15/16.

23.2 Defining Re-Order Label Information

To define Re-Order Label Information, these areas must be addressed:

- The use of Thrive (TruBridge EHR) Word Processing or Edit boxes. Edit boxes do not support Thrive Word Processing commands.
- Proper security is necessary to access the Charge Tables and Inventory. Notify your site contact or TruBridge Support if additional assistance is needed.

In UX, select **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Enter Item #** **(or use Item or Service Search to look up the item by description)** > **Re-Order Label Information**



Re-Order Label Information

- The system will display a CPWriter document with the cursor in the upper-left corner. Using Thrive Word Processing commands, enter the appropriate information. At the bottom of the screen, the directory and document name will be displayed. If edit boxes are used, enter the appropriate information and select the **Okay** button at the bottom of the screen and the directory and document name will **not** be displayed.

- The format document will reside in /usr_/oelabel followed by the item number, where the '_' represents the directory code found in the Company Specific Directory Codes set up by TruBridge Technical Support. An **L** will precede the item number and leading zeroes if the item number is less than eight digits.

- Information will print on the label using the following guidelines.
  - Line 1: DEPTNAME RE-ORDER NOTICE prints centered where DEPTNAME is the department description from field 1 of Department Maintenance.
  - Line 2: Patient name in columns 1 – 22.
    - ROOM: XXXXX in columns 27 – 37 where XXXXX is the current patient room.
    - PHYSICIAN: 10-character physician abbreviated name in columns 51 – 62
  - Line 3: ORDER: Item name in column 1 – 49 where item name is item description from Item Master.
  - STOP DATE: MMDDYY HHMM in column 51 – 62, pulls from stop date/time designated at order entry.
  - Line 4 and 5: Print contents of Order Entry Questions lines 1 and 2.
  - All other lines pull from contents of Re-Order Label Information (see example above).

- In order to have text fit on a single label, there is a recommended limit of eight lines of text, and text cannot exceed column 65.

Chapter 24 Reference Range Table

24.1 Overview

Please refer to Reference Range Table in the Table Maintenance-Control User Guide for information on defining numeric and alphabetic results.

24.2 Reflex Test Criteria

Reflex testing is triggered during the resulting process. This feature includes the ability to:

- Add additional documents (result fields or comments) to the result format.

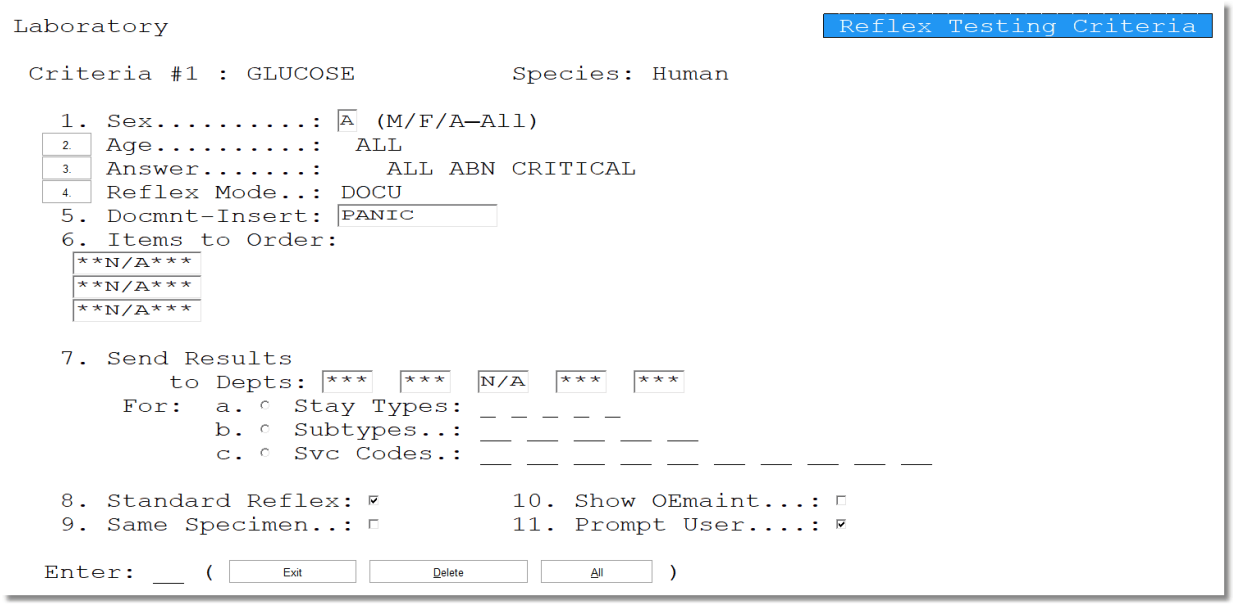
- Generate additional orders.
  - The initials of the resulting technologist are placed in the **Ordered** field in Order Entry Maintenance for the reflexed order and will display an "R" to the right of the "Ordered" date/time stamps.
  - The system will also subject the reflex order to duplicate order checking. If the reflex order qualifies as a duplicate order, the system will prompt whether to order again.
  - The new reflexed order will print labels or an order requisition based on the reflexed items set up in Charge Tables and Inventory.

- Send laboratory results to other departments within the hospital based on the ordering department's Dept Table setup (page 2) for Incoming Report Printer - Auto-Print Prelims or OE Flash at All fields.

Reflexes can either occur automatically (without any tech intervention) or be set up to prompt for a Yes or No response at result entry.

Each test that triggers reflex testing must be defined in the Reference Range Table and included in the Results Format or Worksheet of the item.

Select **Web Client > System Menu > Hospital Base Menu > Charge Tables and Inventory > Enter Item # (or use Item or Service Search to look up the item by description) > Reference Range Table > Alphabetic Index > Select Test > Reflex Testing Criteria**



Reflex Testing Criteria

The screen displays the existing Reflex Testing Criteria. To change or delete an entry, type the sequence number to the left of the desired entry and press **<Enter>**. If no reflexes are set up, the system will proceed directly to the Reflex Testing Criteria screen, **Criteria #1**.

Define the reflex criteria based on the options listed below:

- **1-Sex**
  - o Options: M - Male, F- Female, and A - All
  - o Usage: Enter the sex of the patient that is part of the reflex criteria. If reflexes should be set for both sexes, enter "A" for All.

- **2-Age**
  - o Options: 1 - Less than, 2 - Greater than, and 3 - All
  - o Usage: Define the age of the patient that is part of the reflex criteria. If **less than** or **greater than** are selected, the system will prompt for the appropriate age limit. Enter the age limit, select ENTER, and then designate "Y" for Years, "M" for Months, or "D" for Days.

- **3-Answer**
  - o Options: Low abnormal, high abnormal, all abnormal, low abnormal critical, high abnormal critical, all abnormal critical, or specified value limit.
  - o Usage: Defines the test result that will trigger the reflexive criteria.
    - Numeric results may use any of the listed options, provided that there are entries in the reference range table to meet the criteria. EXAMPLE: If reflex testing criteria is for all abnormal critical Glucose results, the system must detect the critical flags in the reference range tables.
    - **Specified value limit** will prompt for a beginning value and ending value.

- If answers are alphabetic, reflex testing criteria may only be set for predefined alpha answers.
- Select option **8-Specified value limit** and enter the range of the sequence numbers from the alpha answers table to be used as reflex triggers.

*EXAMPLE: For patients under the age of 2, if any positive _URINE GLUCOSE result is selected (TRACE, 1+, 2+, 3+, or 4+), then insert a Reducing Substances DOCUMENT. If the sequence range for these answers is 1 through 5, enter 1 in **beginning** and 5 in **ending** range.*

- **4-Reflex mode**
  - Options: 1 - Order Items, 2 - Insert Document, and 3 - Send Results
  - Usage: Determines what type of reflex will be triggered for a defined result.
    - If **1** - **Order items** is selected, the cursor will move to field **6 - Items to Order**.
    - If **2** - **Insert Document** is selected, the cursor will move to field **5 - Document Insert**.
    - If **3** - **Send Results** is selected, the cursor will go to field **7 - Send Results to Depts.**

- **5-Document Insert**
  - Options: Reflex document name, up to 10 characters.
  - Usage: Defines the document name found in /usr3/f/reflex that is to be pulled into the result format when the reflex is triggered. See instructions for setting up a reflex document at the end of this chapter.

- **6-Items to Order**
  - Options: Up to three item numbers may be entered.
  - Usage: Determines which items will be ordered via reflex testing. The system will assign order numbers and perform duplicate order checking.
  - A lookup is available on any of the three entry lines. Type part of the item description or **?** to look up items starting at the beginning of the alphabet. The system will display the descriptive index. Enter the sequence number of the desired item or double-click the item.
    - When items are ordered via reflex testing, the system will send an incoming ORDER flash to the department's mail terminal. A Reflex Order label can be set to print with the Order number/type of labels. An extra label may be set to print stating that it was a Reflex Test and the name of the item being reflexed.
    - Charge items set to charge at order entry/auto complete may be reflexed to capture charges. The reflex "charge" tests can be set (based on the item setup) so that a label does not print.

EXAMPLE: CKMB, TROPONIN, AND/OR MYOGLOBIN if CK exceeds limit.

EXAMPLE: CBC item charges such as CBC with Automated Differential or Manual Differential.

- **7-Send Results to Depts:** Up to five department numbers can be defined to receive results based on criteria defined in fields 1 through 3.
  - **For**: Select one of the following:
    - a. Stay Types: Up to 5 Patient Stay Types may be defined.
    - b. Subtypes: Up to 5 Patient Subtypes may be defined.
    - c. Svc Codes: Up to 10 Service Codes may be defined.

***NOTE:** Preliminary reports will automatically print when orders are completed. Reports will go to the indicated departments provided the Auto-Print Prelims on page 2 of Department Maintenance is set to **Yes**.*

Reports can be set to show a "result" flash when OE Flash at All is set to "Y" and auto-print prelims is not set up for the department.

- **8-Standard Reflex**
  - o Default: Checked (yes)
  - o Options: Checked (yes) or Unchecked (no)
  - o Usage: Determines if standard reflex criteria will be used
    - Y (yes) allows use of standard reflex mechanism (no information will copy to the reflex order and the Order Entry Maintenance screen will not display).
    - N (no) system will refer to fields 9, 10, or both--may not be unchecked unless fields 9, 19, or both are checked.

- **9-Same Specimen**
  - o Default: Unchecked(no)
  - o Options: Checked (yes) or Unchecked(no)
  - o Usage: Determines if order entry information will copy to the reflexed order
    - Y (yes) allows system to copy collect/receive information, scheduled date/time, ordering physician, and Report Distribution information from the original order to the reflexed order. This option is helpful for those using the same specimen for both the original order and the reflexed order. An example would be a Culture Urine order reflexed from a Urinalysis order.
    - N (no) system will refer to fields 8 or 10.

- **10-Show OE Maintenance**:
  - o Default: N (no)

  NOTE**:** *This option is currently not available for use when resulting multiple reflex tests through Automated Result Entry.*

- **11-Prompt User:**
  - o Default: Y (yes))
  - o Options: Checked (yes) or Unchecked(no)
  - o Usage: Determines if user will be prompted to reflex item, document, and/or result after resulting original item.
    - Y (yes) at result entry, system will display prompt **Do you wish to insert document, and/or create item and/or send results to dept?** based on the criteria defined in fields 1-7 above.
    - N (no) at result entry, system will automatically insert a document, and/or create an item, and/or send results based on the criteria defined in fields 1-7 above.

Defining Reflex Documents

Reflex testing may be used to insert a variety of document types. Use reflex criteria to pull in a comment field for panic values or to pull in additional result fields like a manual differential result document. Either scenario will involve creating a document that columnates on the comparative report.

Reflex testing criteria may be used to automatically prompt at result entry if a value exceeds panic or critical levels. Criteria may be age specific. Reflex comments/documents will print to Preliminary and Comparative Reports and are a part of Clinical History.

Reflexing a comment field or document:

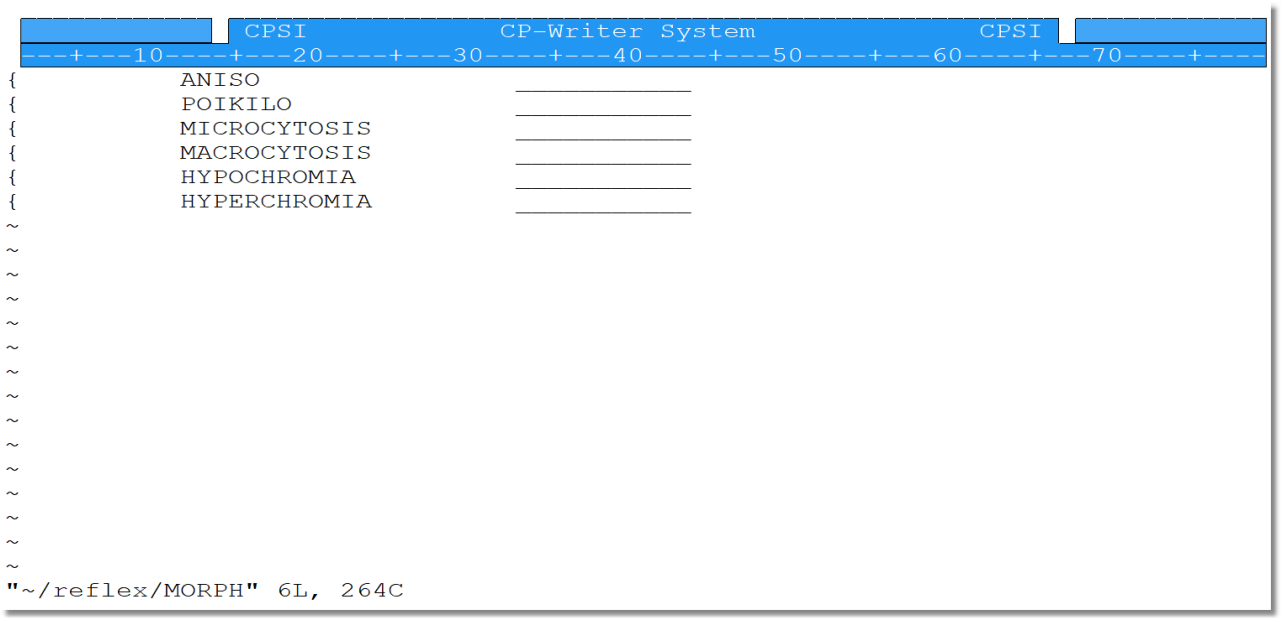
EXAMPLE: *Panic Called, or Critical Called.*

- Create a Reference Range Table entry for "PANIC CALLED" or "CRITICAL CALLED."
  - o Keep description to 13 characters or less.
  - o Cumulative report = Y
  - o Cumulative sequence: It is recommended **NO** sequence number be defined in order for the comment to footnote in the sub-department with the test's name.
  - o Alphabetic answer = Y, Predefined alpha answers = N (for free text answers)

- Create reflex criteria to reflex a document for each test that has a panic or critical level that need to be called.

- Create a document in word processing directory, /usr3/f/reflex, naming it the same name as in the **Reflex Test Criteria** screen. Path: **Hospital base menu > Other Applications and Functions** > **Word Processing** > **Select Library** - **/usr3/f/reflex** > **Select document** > **enter Document Name**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **Enter Library /usr3/f/reflex** > **Select Document** > **Standard Edit**



Example of Manual differential reflex document

- Name the document to indicate what the reflex is pulling in. Limit is 10 characters.

- Alpha format the comment. See the alpha format 50 section of this user guide.
  - o Left brace **{** in the first column.
  - o Reference range entry description beginning in column 12 (e.g., CRITICAL CALLED).

  - o Result underlines beginning in column 33.
    - If more than 15 result-underlines are formatted, an entry of more than 13 characters may be keyed. This will cause the comment to footnote in sub-department on comparative report. An excessive number of footnotes may clutter the report.
    - If 15 result-underlines are formatted, an entry of only 13 characters or less may be keyed and will not footnote on the Comparative Report.

- Numeric result fields must look just like result entry screen:
  - o Left bracket **[** in column 1.
  - o Reference range name beginning in column 12.
  - o Result underlines beginning in column 33, maximum 9 if result is columnated on the Comparative Report.
  - o Units start in column 46, maximum of 6.
  - o Abnormal flags will automatically pull from the Reference Range table entries when resulting.

- Alphabetic result fields must look just like a standard alpha result document. See alpha format 50 section of this user guide.
  - o Left brace <{> in column 1.
  - o Reference range name beginning in column 12.
  - o Result underlines beginning in column 33 with a maximum of 15 if result is columnated on the comparative report.
  - o Normal range in column 56 starting with a "(" and ending with ")" in column 78.

EXAMPLES:

- Insert a document with CKMB, MBINDEX, TROPONIN, or MYOGLOBIN result fields if the CK is elevated.
- Insert a manual differential document if the automated CBC parameters exceed limits.
- Reflex a microscopic document if indicated by urine chemistry results.

Chapter 25 Interpretive Documents

There are instances when a test parameter does not have any reference ranges but has interpretive information that needs to be attached to the result. Interpretive data may accompany INR or HCG. Interpretive documents may be used to make a statement about a test. ALCOHOL may need a statement that **Method does not constitute a legal blood alcohol level**.

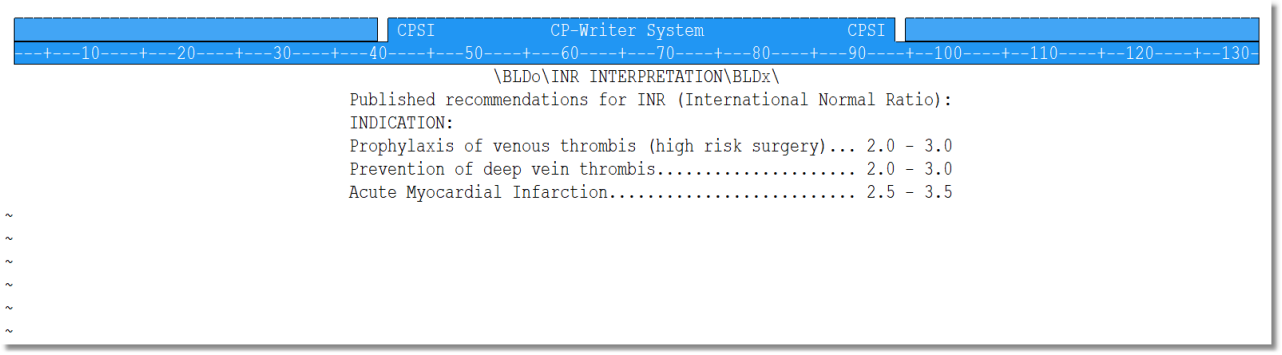
Features of Interpretive documents include:

- Prints to the associated sub-department on the Comparative Report **one** time regardless of how many times the test was resulted.
- Prints at the bottom of the Comparative Report sub-department. Interpretive documents are a good option for frequently ordered items when you don't want the results to display as "Print in Detail" on the Comparative Report. They allow multiple columned results to pull to the Comparative report concisely and include one Interpretative Document at the end of the sub-department section for the test.
- May be included in the result format and appear on preliminary reports.
- Can be used when a test has reference ranges based on criteria not supported by the reference range table. For example, HCG has different female reference ranges for pregnant and non-pregnant women, which are not based solely on AGE or SEX.

25.1 Defining Interpretive Documents

1. Create the Interpretive document in Thrive word processing directory /usr3/f/lab1.

   Select **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing > Enter Library /usr3/f/lab1 > Select Document > Wide Screen Edit**



INR Example of Interpretive Document

2. Name the document to indicate the test it is associated with. The character limit is four. Examples: INR, HCG, or BNP.

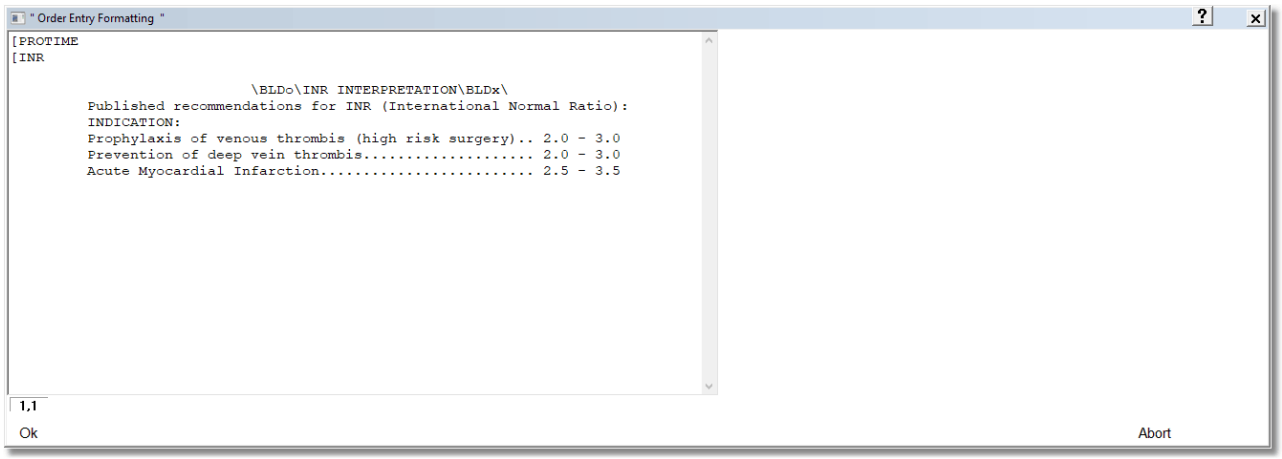
3. From the word processing document options, enter **B-Wide screen edit**. This produces a 132-column document that may be centered on the comparative report.

4. Using Thrive word processing commands, enter the text. The recommendation for the title is to start on position 52. Use the above INR example as a guide.

5. Select the associated test from the reference range table (INR, HCG, or BNP). In field **12-Interp Doc**, enter the document name as created in /usr3/f/lab1. This field will place the information on the Comparative Report.

6. In Order Entry Result Format of the associated test, add the Interpretive document to the format. This will place the interpretive text on the preliminary report.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Enter Item # (or use Item or Service Search to look up the item by description)** > **Order Entry Results Format**



Order Entry Results Format

Chapter 26 Custom Called-In Documents

There are many instances when it is necessary to add a comment or pull in an additional result field. Custom called-in documents allow each site to define comments for specimen appearance, called, or faxed to information. In addition, result fields for unusual results may be created and pulled in only when necessary so that blank result lines do not print to reports. See the Laboratory User Guide for utilizing a custom called-in comment or document.

26.1 Defining a Custom Called-In Document

- Create a Reference Range Table entry for the comment or test. *EXAMPLE: FAXED TO:, CALLED TO:, SPECIMEN NOTE, or WAXY CASTS*.
  - o Keep description to 13 characters or less to print in columns on the Comparative Report.
  - o Cumulative report = Y
  - o Alphabetic answer = Y
  - o Predefined alpha answers = N (for free text answers) or Y (for predefined alpha answers. Predefined answers need to be 13 characters or less to pull correctly to the Comparative report, columnated format.

- Create the called-in document in word processing directory **/usr3/f/lab**.

- Name the document using a two or three-character mnemonic. It is recommended that the document name be in capital letters. The document needs to be formatted just like an alpha answer result format.
  - o Left brace **{** in column 1.
  - o Reference range name beginning in column 12.
  - o Result underlines beginning in column 33 with a maximum of 15 if result is columnated on Comparative Report.
    - If more than 15 result-underlines are formatted, an entry of more than 13 characters may be keyed. This will cause the comment to footnote in sub-department on comparative report. An excessive number of footnotes may clutter the report.
    - If 15 result-underlines are formatted, and an entry of 13 characters or less is keyed, the comment will not footnote on the Comparative Report.
  - o If called-in document is an alphabetic test, enter the normal range in column 56 starting with a **(** and ending with **)** in column 78.

Chapter 27 Corrected Results

Many regulatory agencies require that when completed results are amended there is documentation on the patient's chart listing the amended result, the correct result, and who was notified. The system has the following capabilities:

- System will automatically pull in a comment line for notification documentation.
- Corrected results will automatically be sent to the patient's nursing station.
- The previous (original) and corrected result will both display in order review and print in adjoining columns on the Comparative Report. The original results are not removed from the patient's record.
- An audit trail may be viewed in order review by selecting the **Look w/Audit** option. The original and corrected results will be displayed along with the initials/date and time of each entry.

27.1 Defining Corrected Results

- Requirement: The field **Use Corrected Reports**, in the Item Order Entry Information, page 3 must be checked=yes. If this option is being created for all department items, call TruBridge Support so that a program may be executed to perform this function in mass.
- Create a reference range entry for the amend comment. EXAMPLE: **Amend Called:** Keep description to 13 characters or less to print in column on the Comparative result.
  - o Cumulative report = Y
  - o Cumulative sequence, recommend greater than 900 so it will print after tests in the sub-department.
  - o Alphabetic answer = Y
  - o Predefined alpha answers = N (for free text answers).
- Create the document for corrected reports in the word processing directory /usr3/f/lab.
  - o Document must be named CORRECT.
  - o The document needs to be formatted just like an alpha answer
    - Left brace { in column 1
    - Reference range name beginning in column 12
    - Result underlines beginning in column 33 with a maximum of 15 if result is columnated on the Comparative Report. If more than 15 underlines, the document will footnote in the sub-dept section on the Comparative Report.

Chapter 28 Results Index

28.1 Overview

The Results Index allows the use of predefined results, comments, or additional report formats to be entered into a result by entering a code or **Answer Key**. This allows predefined answers for result formats that are not defined in the Reference Range Table. The purpose of this function is to allow large amounts of information to be added to a report. There is no limit to the number of defined keys. The keys and the information that they represent are easily placed in the Laboratory System and are site specific. Items using this result index feature will need to be set up to print in detail. Please refer to Item Master in the Materials Management chapter in the Table Maintenance-Control User Guide for more information on this topic.

- There are three mechanisms that may be used through the Results Index:
  - o Single line answers that apply to result fields.
  - o Document insertions that replace result fields.
  - o Comments or information statements that are added below results.

- To apply the answer to a result field, see the Laboratory User Guide, Resulting chapter-Answer Insertions.

28.2 Defining Results Index

1. From the Hospital Base Menu, select **Department Specific**.

2. Select **Results Index**.

3. Select **Maintenance**.

4. Enter the answer key name and then type the long answer name.
   - Up to 10 characters may be used for the answer key.
   - Up to 50 characters may be used for the long answer name.

The answer key may be used to apply the answer to a report field whenever the result field is made using the free-form format only or the result field is long enough to accept the number of characters used in the answer.

Defining a Document as a Replacement of an Existing Result Line

This mechanism REPLACES the entire result field line with the document, rather than making an entry on the field. This feature may be used for any result type. The document may be text of any length, an additional report format, or a combination of both.

1. Access the Results Index and select **Maintenance** on the Results Answer File screen.

2. On the Lab Results Answers File Maintenance screen, enter an Answer Key. Codes of up to 10 characters are allowed.

3. On the Answer field, enter **++** (two plus signs) followed by the name of the document that the Key will represent. (The document name must be no longer than 10 characters.)

4. Access the Word Processing directory /usr3/f/lab and create the document. The document name must be the same as the entry in the Answer field of Results Index. The **++** is not used in the document name.

5. Create the document using Thrive Word processing commands. Text, Reference Range result formats, or free-form result formats may be used. Documents must, however, obey the formatting restrictions of the selected results.

28.3 Displaying Results Index

1. From the Hospital Base Menu, select **Department Specific**.

2. Select **Results Index**.

3. Select **Screen Displays** and press **<Enter>**.

4. Select the sequence number to the left of the desired entry. The entry may then be edited or deleted.

Chapter 29 System Security for Outreach Client Access

29.1 Overview

The Outreach Client Access application allows physician practices online, real time access to the TruBridge Hospital Information and Patient Care System. The physician's office has access to the information necessary to treat their patients without having to call to request the data and wait for the response. Patient test results, as well as medical history, demographics, and insurance information, which are current as of the last transaction entered for the patient's account, are available immediately. Also, physicians may enter orders that will distribute automatically to the proper hospital departments.

Additional features include temporary registration and account maintenance, order entry, medical necessity, medication review, access to patient clinical information, and patient education documents. Most options are controlled by switches defined in Outreach Client Access Table Maintenance. Please notify Hospital Site Contact or TruBridge Support to change security switches or table maintenance.

29.2 Table Maintenance

There are five tabs:

- General
- Security Switches
- Physicians
- Enterprise-Wide Scheduling

Select **Outreach Client Access -Main Functions** > **Table Maintenance**

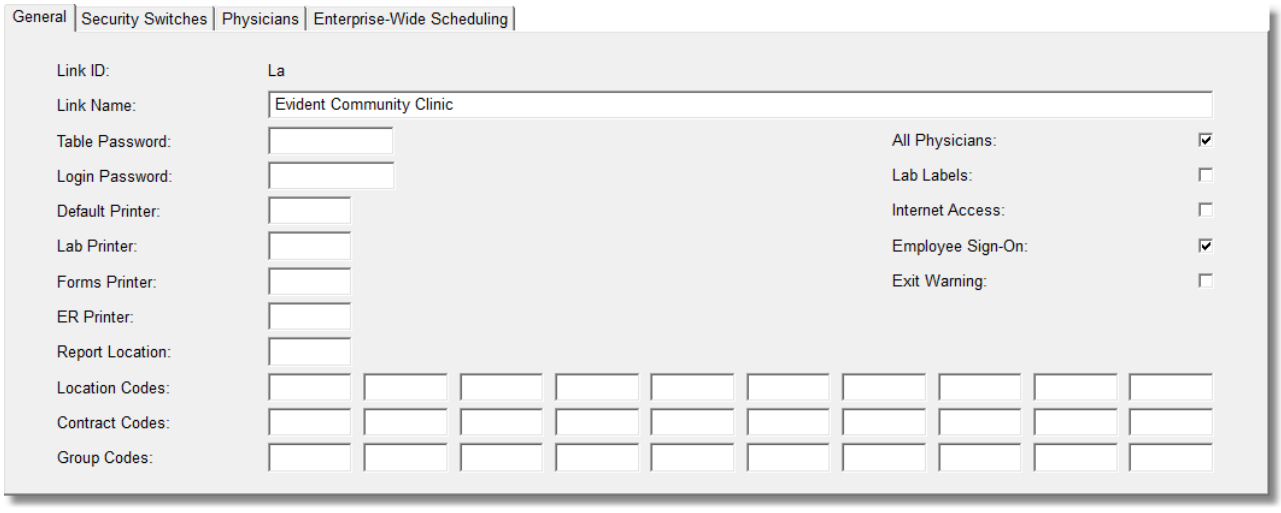


Table Maintenance

After making any edits, select **Save** on the action bar before exiting.

General

- **Link Name:** Enter a valid description. This may be the clinic name, doctor's name, or practice name. Although this field will hold sixty (60) characters, the Link Name entered here should be identical with the Link Name entered in the Company Record, which holds only thirty (30) characters. Therefore, it is preferable to limit the Link Name, wherever it occurs, to thirty (30) characters, or less.

  NOTE: *The* ***Link Name*** *must also be entered in the mail file (/usr/3f/OSMAILRLT) and in the Company Record, and should be identical in all three places. If not, mail and/or other features may not work correctly. Any time the* ***Link Name*** *is changed, it should be changed in all three (3) places.*

- **Table Password:**
  - o Default: Blank
  - o Options: Up to six characters or digits Blank, no password required for table maintenance.
  - o Usage: Provides security to make changes to the control table and security switches.

  NOTE: *Notify the hospital site contact or TruBridge Support if changes need to be made and the Table Maintenance Password is unknown.*

- **Login Password:**
  - o Default: Blank
  - o Options: Up to six characters or digits Blank, no password required for login.
  - o Usage: Provides security for logging into this link. This password is link-wide (i.e., NOT specific to individual user). For user-specific passwords, see Employee Sign-on below.

- **Default Printer:**
  - o Default: Blank
  - o Options:
    - S, workstation printer
    - Three-digit line printer number
  - o Usage: Defines printer for most printing needs, such as reports, Advanced Beneficiary Notices, and Order Sheets.

- **Lab Printer:**
  - o Default: Blank
  - o Options:
    - S, workstation printer
    - Three-digit line printer number
  - o Usage: Defines the printer that will print laboratory labels in the clinic.

- **Forms Printer**
  - o Default: Blank
  - o Options:
    - S, workstation printer
    - Three-digit line printer number
  - o Usage: Defines printer for Admission forms

- **ER Printer**
  - o Default: Blank
  - o Options:
    - S, workstation printer
    - Three-digit line printer number
  - o Usage: Defines printer for ER forms

- **Report Location**
  - o Default: Blank
  - o Options: Three-character report location as defined in the hospital Business Office Tables, Maintenance Menu, Report Locations.
  - o Usage: The Location code in this field will auto-assign to registration field 15 during the registration process. This field is used for report distribution of laboratory results to the Physician or location.

- **Location Code**
  - o Default: Blank
  - o Options: Up to 10 different three-character location codes may be entered.
  - o The Physician Link office will have access to patients with a location code defined in this field, provided the patient has the same code entered in ancillary **Location** field on the patient functions screen.

- **Contract Code**
  - o Default: Blank
  - o Options: Up to 10 different two-character contract codes may be entered.
  - o Usage: The Physician Link office will have access to patients with a contract code defined in this field, provided the patient has the same code entered in **ContractCd** (Contract Code) field, Registration and ADT, Guarantor/Ins, bottom left.

- **Group Codes**
  - o Default: Blank
  - o Options: Up to 10 different three-digit group codes (logins) may be entered, 001 – 010.
  - o Usage: Defines the number of logins for that link ID.

- **All Physicians:**
  - o Default: Blank = No
  - o Options: Checked=Yes or Unchecked =No
  - o Usage: Controls access to patients by physician.
    - Checked: Allows access to patients for all physicians.
    - Unchecked: Limits access to patients only for physicians listed under Table Maintenance, Physicians.

- **Lab Labels:**
  - o Default: Unchecked = No
  - o Options: Checked = Yes or Unchecked = No
  - o Usage:
    - Checked: Allows laboratory labels to be printed with Laboratory Order Entry.
    - The type and quantity of labels printed is controlled by the Laboratory Control Table and the

individual laboratory item (Order Entry Information).
- Labels will print to printer in **Lab Printer** field under Table Maintenance, General.
- Unchecked: Disallows printing laboratory labels.

- **Internet Access**
  - o Default: Unchecked = No
  - o Options: Checked = Yes or Unchecked = No
  - o Usage: Allows access to Internet via Link
    - Checked: Allows Internet access.
    - Unchecked: Disallows Internet access.

- **Employee Sign On**
  - o Default: Unchecked = No
  - o Options: Checked = Yes or Unchecked = No
  - o Usage: Requires Employee Sign on for A/R Audit System tracking.
    - Checked: Requires employee sign on after logging in, using an employee number and password before allowing any Outreach Client Access functions.
    - Unchecked: Employee sign on is not required.

  NOTE: *All employees must be set up through Outreach Client Access System Security before turning this option on. Please refer to the Hospital Information Systems contact for more information.*

- **Exit Warning:**
  - o Default: Unchecked = No
  - o Options: Checked = Yes or Unchecked = No
  - o Usage: Displays exit message when arrow back is selected to exit Base Menu.
    - Checked: Will receive exit message.
    - Unchecked: Will not receive exit message.

Security Switches

Edits to a security switch's status, Y (active) or N (inactive), may be made by simply selecting the security switch. The default is N, therefore selecting the security switch will change its status to Y. To change back to N, simply select the security switch again.

- **Display Admitting Diagnosis:** Determines if the patient's admitting diagnosis is displayed in patient functions screen, Patient Master.

- **Display Admitting Doctor:** Determines if the patient's admitting physician is displayed in patient functions screen, Patient Master.

- **Access to Hospital Order Entry:** Allows access to Hospital Order Entry through patient functions screen, Hospital Order Entry.

- **Access to Hospital Order Entry - Patient Not in Your Practice:** Allows access to Hospital Order Entry for patients where a physician in your practice is ***NOT*** designated as the attending, second, primary care, consulting, or ordering physician. Hospital Order Entry is still accessed via the patient functions screen, Hospital Order Entry.

- **Confidential Patients:** This switch controls access to patients marked as confidential by excluding them from several Census reports and eliminating them from the patient index for employees who do not have access. Confidential patients appear in ClientWare with a **+** to the right of the **Patient Name** field.

- **Post Bulletins:** This switch allows typing, posting, printing, and viewing bulletins from Outreach Client Access Main Functions, Bulletin Board System.

- **Flash Bulletins:** This switch allows displaying a message across all terminals that a bulletin has been posted, using Bulletin Board System, Flash, or Flash Custom.

- **Clinical Access to view Medical Records Transcriptions:** This switch gives the ability to view medical records transcriptions without the ability to edit.

- **Medical Records Transcription Entry:** This switch allows transcriptions to be entered through the Medical Records System.

- **Clinical Information Changes:** This switch provides access and allows changes to Clinical Information.

- **Patient Maint. from Order Entry:** This switch allows access to Patient Maintenance from Hospital Order Entry, Patient Maintenance.

- **Medical Records DRG Grouper screen:** This switch allows access to the Medical Records DRG Grouper Screen (Coding System).

- **Order Entry Use Medical Necessity:** Allows system to check for Medical Necessity, printing an ABN, at order entry. System will use the hospital Medical Necessity Tables for criteria.

- **Allow Insurance Information Edit:** This switch limits changes made to patient insurance information.
  - The default is **No**. This will allow the information to be viewed, but not changed.
  - If set to **Yes**, changes to the insurance information will be allowed.

- **Scanned Image Access:** Allows access to electronic images, whether scanned or electronically attached through patient functions screen, **Image Storage/Retrieval**.

- **Access to MPI:**
  - **Yes:** Allows access to MPI (Master Patient Index) options: DOB, SS#, Clinical Notes, Clinical History, Insurance, and Patient Master information. Prevents access to account detail or balance unless SW 17-Access to Account Detail=Y.
  - **No:** System prompts **Unauthorized for this function** when **Hospital Master Patient Index** option is selected.

- **Access to Account Detail:**
  - **Yes:** Allows access to account detail from MPI if SW 16-Access to MPI=Y.
  - **No:** System prompts **Unauthorized for this function** when AD-Acct Detail is selected from MPI.

- **Census Full Registration:**
  - **Yes:** Allows access to patient registration functions, including admitting, transferring, and discharging, as well as printing admission and ER forms.
  - **No:** System prompts **Unauthorized** when selecting Outreach Client Access Main Functions, **Profile Listing** (Full Registration) or Outreach Client Access patient functions, **Census**.

- **Print Face Sheet:**
  - **Yes:** Allows ability to print a patient's face sheet without access to full registration functions.
  - **No**: Access to (print) Face Sheet is denied. System message is "Unavailable."

- **Retrieve Pt Data by Admit Date:**
  - **Yes:** Allows access to Outreach Client Access Main Functions, Retrieve Patients by Admit Date.
  - **No:** Prevents access to this option. The system displays "**Unauthorized**."

- **Temporary Registration:**
  - **Yes:** Allows access to Outreach Client Access Main Functions, Patient Setup (Temporary Registration).
  - **No:** Prevents access to this option. The system displays "**Unauthorized**."

- **Access to All Results:**
  - **Yes:** Allows access to All results through the MPI (Master Patient Index).
  - **No:** Denies access to All results through the MPI.

- **Access to Imagelink:**
  - **Yes:** Allows access to **PACs** via MPI (Master Patient Index), PACs if the PACs system in use is TruBridge ImageLink Support.
  - **No:** Access to this option is denied. Message "**Unauthorized**" will display.

- **Access to Electronic Forms via Hospital Order Entry:**
  - **Yes:** Allows access to Electronic Forms.
  - **No:** Denies access to Electronic Forms. **Electronic Forms** will be grayed out if this switch is set to No.

Physicians

To Add Physicians for the Practice:

1. Enter their physician number in the upper left field.

2. Select **Add**.

To Remove a Physician from the List:

1. Highlight the physician.

2. Select **Clear**.

Enterprise-Wide Scheduling

- **EWS Screen Security*:*** Controls access to EWS Main Screen Security.

- **EWS Security Level:** Use the drop-down to select levels 1-5.
  - Options: 0-5
    - 0 = Does not allow access to the scheduler.
    - 1 = Allows employee to look up entries only.
    - 2 = Provides employee the ability to schedule tasks.
    - 3 = Allows employee to override defined number of tasks scheduled, if closed, for their department only.
    - 4 = Allows employee to override defined number of tasks scheduled, if closed, for any department. This option may be appropriate for Central Scheduler only.
    - 5 = Allows table maintenance.
  - Usage: Controls the level of access for the Outreach Client Access to the Enterprise Wide Schedule application.

- **EWS Departments:** Displays departments that will allow EWS scheduling.

29.3 A/R Audit and System Security

A/R Audit System may be used to track access to Outreach Client Access screens and functions by Outreach Client Access Employees. Employee tracking will be available ONLY if employees are set up in **System Security** > **Employee Maintenance** and if **Employee Sign-On** is active (**Outreach Client Access Base Menu** > **Table Maintenance** > **Employee Sign-On**).

System Security allows Outreach Client Access employees to be set up so they may use the Employee Sign-On option. Employees who are not set up in **System Security** will **NOT** be recognized.

NOTE: *Please refer to the Hospital's Information Systems contact for further information regarding use these applications.*

Chapter 30 Repeat/Reject Film Analysis

30.1 Overview

The Reject/Repeat Film Analysis feature provides a statistical analysis mechanism to obtain the number of reject and repeat films in radiology. The following features are included:

- Option to enter reject/repeat data upon completion of order or at a later time
- Reason for the reject/repeat films
- Patient positions during reject/repeat films
- User defined criteria for standard number of films and film size for each item
- Option for the user to enter the exam room where the procedure was performed
- Capacity to edit completed records
- Ability to use predefined, non-chargeable film usage entries
- Various statistical reports
- Flexibility for the department manager to turn on/off
- Mammography stats may be combined with entire department or kept separately
- Mammography stats may be turned on for 12 months while the rest of the department is off
- Create Special Usage category for films used in staff education or Quality Control.

TruBridge has given clear definition to the meanings of REJECT and REPEAT:

REJECT: Films taken and then discarded
REPEAT: Extra films that are taken for a specific purpose

The reject/repeat analysis is associated with each item. The film review is triggered by when the item (procedure) is completed from the Radiology Schedule. The following Item Functions will also need to be defined:

- Item Order Entry Information- page 3-Film Analysis = checked(yes)
- Film size and positions need to be defined for each procedure where film usage needs to be documented.

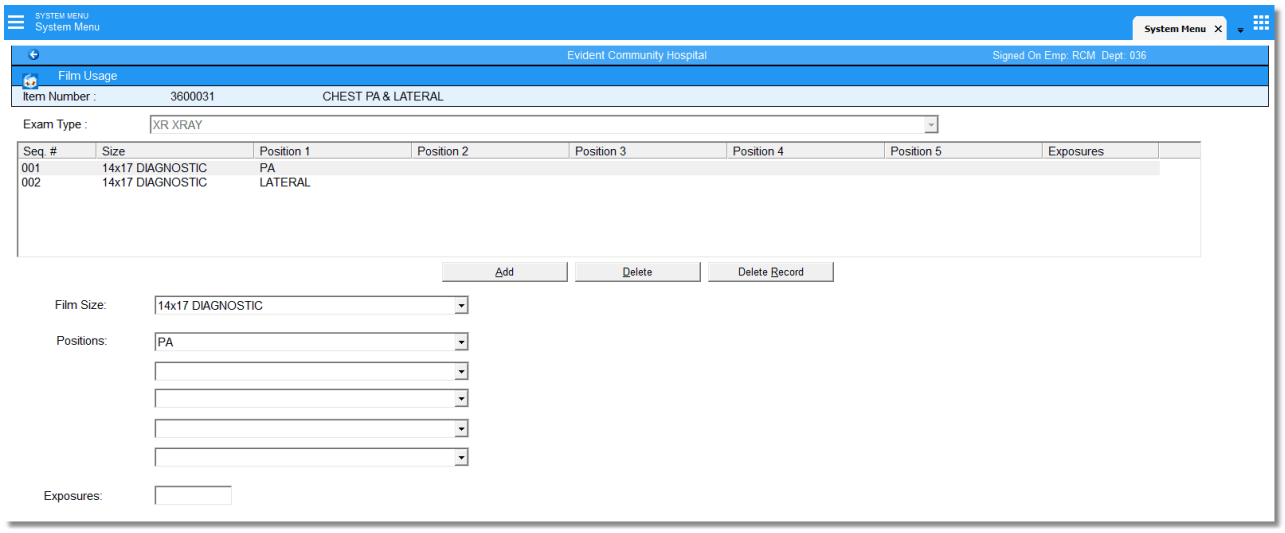
30.2 Item Film Analysis

The Film Analysis option is used only for Radiology Procedure items. It is part of the Reject/Repeat Film Analysis application. This application allows Radiology departments to gather Quality Assurance Statistics on rejected or repeat film studies. The radiology technologist is prompted after order completion to select if the films used were acceptable, rejected, or repeated. It also allows for the reject or repeat reason and which additional film types and positions were used during an exam to be documented.

Film Analysis is where the default film usage (sizes and positions) is defined for an exam and works in conjunction with the item's **Film Analysis** field in Order Entry Information, Page 3, to indicate that the item is part of the Reject/Repeat study.

To define film usage information for Film Analysis, access to the Inventory/Charge Tables is necessary. Notify the site contact or TruBridge Support for changes or additions to this option.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Charge Tables and Inventory** > **Item #** > **Film Analysis**



Film Usage

Enter the appropriate information in the following fields for each specific Radiology item.

- **Exam Type**
  - o Default: None
  - o Options: Two-character Exam Type defined in the **Exam Types** table. There is a look-up box used to select Ancillary Exam Type.
  - o Usage: Designates an exam type for each radiology procedure to be used in statistical reports of the application.

- Select **Add** to add film analysis information:
  - o **Film Size**
    - Default: None

  - Options: Any 17-character film size defined in the Film Size table of Film Table Functions. A look-up box displays with valid entries of the Film Size table for selection.
  - Usage: Defines default Film Size for each film normally used in this procedure. Used in statistical reports of the application.
- **Positions**
  - Default: None
  - Options: **Add** must be chosen before this look-up box will be active. Any 17-character position defined in Position Table of Film Table Functions. A look-up box displays with valid entries from the Position Table for selection. Up to 5 positions may be defined per film size.
  - Usage: Defines default positions for each procedure. Used in statistical reports of the application.

- **Delete:** Allows film sizes to be deleted.

- **Delete Record:** Allows the film usage record to be deleted.

- **Exposures:** Defines the expected number of exposures for each film size.

30.3 Film Analysis Setup

This option allows the Radiology department to gather statistics on repeat/reject films for specific time frames. A standard number of films and film sizes for each item may be entered so that items ordered with this information for repeat/reject require attention by the technologist. Mammography statistics may be kept separately or with the entire department.

Some of the features of this option include the ability to keep repeat/reject statistics for:

- The entire department
- Individual technologists
- Individual items
- Individual positions
- The reason for the repeat/reject

To access the Film Analysis tables:

1. From the Hospital Base Menu, select **Department Specific**.

2. Select **Film Analysis**.

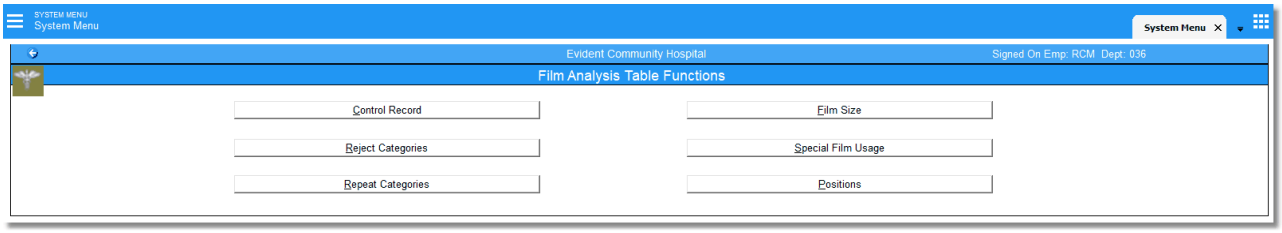
The Film Analysis menu will display:

- **Film Table Functions**
- **Film Record Maintenance**

- **Special Film Record Usage**

For more information regarding Film Record Maintenance and Special Film Record Usage, please see Film Analysis in the Department Specific chapter of the Radiology user guide.

In UX, select **System Menu > Hospital Base Menu > Department Specific > Film Analysis > Film Table Functions**



Film Analysis Table Functions

Film Analysis Table Functions:

- Control Record
- Reject Categories
- Repeat Categories
- Film Size
- Special Film Usage
- Positions

Control Record

- **Use Film Analysis**
  - o Options: Y (checked) or N (unchecked)
  - o Usage: Controls the program prompt whether standard film size and usage was used or not.

- **Include Position for Rejects & Repeats**
  - o Options: Y (checked) or N (unchecked)
  - o Usage: Controls whether the patient position will be a required response when the reject or repeat is being documented.

- **Include Exam Room**
  - o Options: Y (checked) or N (unchecked)
  - o Usage: Controls whether the Exam Room will be used in calculating film usage statistics.
    - This option requires that each eligible item have the **Scheduled Room** and **Scheduled Room Required** both set to **Y (Checked)** in Order Entry Information of item setup.

- The Exam Room is entered in Order Entry Maintenance when an order is placed.
- Exam rooms are selected based on definitions in the Ancillary Room Table of the Business Office Tables.

- **Use Mammography Film Analysis Separate**
  - o Options: Y (checked) or N (unchecked)
  - o Usage: Controls whether film usage statistics for mammography are included with film usage statistics for radiology.

- **Include Exposures**
  - o Options: Y (checked) or N (unchecked)
  - o Usage: Controls whether the number of exposures will be tracked in Radiology. If this feature is used, the Radiology Utilization Log may be used to capture film analysis statistics.

Reject Categories

- **Description:** Reject category descriptions may be up to 25 characters in length.
  - o To add a Reject Category to the table, enter the desired category description and select **Add**.
  - o To delete a Reject Category, select an entry from the display and choose **Delete**.

- **Print All:** Prints a list of the defined reject reason descriptions.

NOTE: *The system is programmed to automatically include "Other Reason" as a category. This option does not need to be defined in the table.*

Repeat Categories

- **Description:** Repeat category descriptions may be up to 25 characters in length.
  - o To add a repeat Category to the table, enter the desired category description and select **Add**.
  - o To delete a repeat Category, select an entry from the display and choose **Delete**.

- **Print All:** Prints a list of the defined repeat reason descriptions.

NOTE: *The system is programmed to automatically include "Other Reason" as a category. This option does not need to be defined in the table.*

Film Size

- **Description:** Film size descriptions may be up to 20 characters in length.
  - o To add a film size to the table, enter the desired category description and select **Add**.
  - o To delete a film size, select an entry from the display and choose **Delete**.

- **Package Units:** This description may be up to 5 characters in length.
  - o An entry in this field is not required.
  - o This entry is used for some statistical reports.

- **Films/Unit:** This description may be up to 5 characters in length.
  - o An entry in this field is not required.

- This entry is used for some statistical reports.

- **Item Number:** A valid item number may be entered in this field. The item description will appear to the right of this field.
  - An entry in this field is not required.

- **Print All:** Prints a list of the defined film size descriptions.

Special Film Usage

This option is used in situations where film usage documentation is necessary for exams that are not related to patient exams. For example, QC, In-Service training, etc.

- **Description:** Special film use descriptions may be up to 25 characters in length.
  - To add a special film usage description to the table, enter the desired category description and select **Add**.
  - To delete a special film usage description, select an entry from the display and choose **Delete**.

- **Print All:** Prints a list of defined special film usage descriptions.

Positions

- **Description:** Position descriptions may be up to 25 characters in length.
  - To add a Position description to the table, enter the desired category description and select **Add**.
  - To delete a Position description, select an entry from the display and choose **Delete**.

- **Print All:** Prints a list of the defined position descriptions.

Chapter 31 Hospital and Report Headers

31.1 Overview

This chapter provides information about the tables and fields from which certain reports receive the hospital name, and instructions for creating different headers necessary for many ancillary reports and transcriptions.

31.2 Fields Containing the Hospital Name

Several different types of report headers must be created by TruBridge Support for printing various reports and documents. Ancillary reports not directly patient related, such as the Daily Procedure Log, will only include the hospital name in the header of the report. Reports that include patient test results will include the hospital address, city, state, and zip code in the header as well. Patient report headers also include the name of the hospital's Medical Director and CLIA number. The hospital name (as it appears on various documents) prints because of the information entered in five different locations within the software.

- **AHIS:**
  - **Page 5, Company Code:** The hospital's two-character company code should be entered in this field. The code entered here is used to interface with the Embosser Card program. This code is assigned by TruBridge prior to installation.
  - **Page 8, Company Name for Clinical Reports:** The hospital name entered in this field will print on the following reports:
    - **POC Reports:** All report headers will pull the name from this field. If blank, reports will pull the description entered in field 1 of the Company Record.
    - **Quality Improvement and Indicator Measurement Reports:** All modules; report headers will pull the name from this field. If blank, reports will pull the description entered in field 1 of the Company Record.
    - **Pharmacy MAR and Patient Drug Information sheets:** Reports will pull the name from this field. If blank, the report will pull the description entered in field 1 of the Company Record.

- **Company Record Maintenance:** Most of the ancillary departments' reports as found in Print Reports include the hospital name in the report header as it appears in Company Record Maintenance, field 1. These reports only print the hospital name (no address) in the header, with the exception of the Comparative reports. These reports include:
  - Daily Procedure Logs
  - Outstanding Transcriptions
  - Schedules by Exams
  - Dietary Reports
  - Specimen Collection Reports
  - Mini-Census
  - Regular Census
  - Lab Comparative Results Vertical and the Vertical Summary from the Patient Functions menu
  - Medication Record (Pharmacy MAR)
  - Ancillary Revenue Report by Issuing Department
  - Point of Care Reports

- **Physician Maintenance Table for Physician 999999:**
  - o Radiology flash cards pull Name, Address, City, State, and Zip
  - o Various Ancillary Reports
  - o Pharmacy Drug Information monographs pull name

- Specific libraries for each ancillary department

31.3 Ancillary Report Headers

MRHEAD

MRHEAD is a document created by TruBridge staff in designated application libraries/directories.

Libraries: Directories in which MRHEAD are created are defined by the technical department in the OE Prefix table, Result Drive # & Directory field. Refer to the chapter for OE Prefix in the System Management User Guide. Examples include /usr/lab1, /usr/xray, /usr/resp, /usr/ekg1, /usr/phyt, /usr/diet.

These directories may be accessed by several different paths:

- **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing >** Enter the appropriate library in the **Currently Selected Library** field

- **Web Client > System Menu > TruBridge Server screen > Word Processing**, and then same as above.

Report headers affected by MRHEAD include:

- Preliminary result reports

- Transcribed reports (transcribed in CPWriter)

NOTE: *Knowledge of CPWriter text editor commands is required to create or change existing report headers. Call TruBridge Support for assistance.*

Print Commands

- MRHEAD contains the following print commands in this order:

```
\TM00\\12PI\\DRAo\\BM09\
\MRHo\
                HOSPITAL NAME
                ADDRESS
                ADDRESS
                CLIA#
```

NOTE: *If printing to a laser printer, change top margin to \TM03\.*

- For Radiology department using CPWriter for transcription: (/usr/xray or /usr#/xray)

\TM00\12PI\\DRAo\\BM09\\PGNo\\MRB2\
\MRHo\

NOTE: *The command MRB2 will cause the second page of transcription to skip two lines following the header before printing. This allows a reasonable space between the header and the remaining transcription.*

- For EKG transcriptions on labels: (/usr/ekg1 or /usr#/ekg1)

\TM00\\LM00\\BM00\\12PI\\LPI8\\DRAo\\FO16\

MRHEAD2

For Laboratory departments using a Microscan interface to report culture and sensitivity information in Microbiology, this document is created in the directory defined in the OE Prefix table, Result Drive # & Directory field, for Laboratory. Refer to the chapter on OE Prefix in the System Management User Guide.

Report headers affected by MRHEAD2 include:

- Laboratory preliminary for Microscan microbiology interfaced results.
- Laboratory comparative microbiology reports using a Microscan interface.

Print Commands

MRHEAD2 contains the following print commands in this order:

\TM00\\LM05\\LPI8\\DRAo\\PAGx\
\MRLo\
HOSPITAL NAME
ADDRESS
ADDRESS

LABORATORY REPORT
(This is optional.)

MRHEAD3

MRHEAD3 is defined to add hospital/laboratory address, medical director, and CLIA # to result report headers. It is created in the appropriate application directory for departments reporting patient results (laboratory and/or respiratory). Create document in Standard Edit (80 character width).

Libraries: Directories in which MRHEAD3 is created are defined by the technical department in the OE Prefix table, field 4, Result Drive # & Directory, for Laboratory or Respiratory departments. Refer to the chapter on OE Prefix in the System Management User Guide

These directories may be accessed by several different paths:

- **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing >** Enter the appropriate library in the **Currently Selected Library** field **> Document Index** (to view a defined document) **> MRHEAD3 > A-Standard Edit**
- **Web Client > System Menu > TruBridge Server screen > Word Processing**, and then same as above

Report headers affected by MRHEAD3 include:

- Cumulative Results-Detail
- Cumulative Detail
- Results by Patient Report
- Community reports that print in detail
- Physician with Pending
- Results by Physician
- Report for M/R file

Print Commands

- MRHEAD3 does not contain print commands. MRHEAD3 does not include the Hospital Name. The hospital name included in the header of these reports prints as a result of the information entered in field 1 of Company Record Maintenance.
- MRHEAD3 includes the hospital address, city, state, and zip code.
- It may also include the name of the laboratory's Medical Director and CLIA number.
- To edit information, use 80-character, standard edit.
- Limited to two lines of information.

MRHEAD4

MRHEAD4 is used to add the hospital/laboratory address, medical director, and CLIA # to 132 column width patient reports.

Libraries: Directories in which MRHEAD4 is created are defined by the technical department in the OE Prefix table, Result Drive # & Directory field. Refer to the chapter on OE Prefix in the System Management User Guide.

These directories may be accessed by several different paths:

- **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing >** Enter the appropriate library in the **Currently Selected Library** field **> Document Index** (to view a defined document) **> MRHEAD4 > B-Wide-Screen Edit**
- **Web Client > System Menu > TruBridge Server screen > Word Processing**, and then same as above

Report headers affected by MRHEAD4 include:

- Comparative Results Vertical and Vertical Summary
- Community Reports (Non-Cumulative Vertical report, Single Account Vertical report, Multi-Account Vertical report, Multi-Account Comparative-by Department, and Single Account Comparative-by Department)

Print Commands

- MRHEAD4 does not contain print commands. MRHEAD4 does not include the Hospital Name. The hospital name included in the header of these reports prints as a result of the information entered in field 1 of Company Record Maintenance.
- MRHEAD4 includes the hospital address, city, state, and zip code.
- It may also include the name of the hospital's Medical Director and CLIA number.
- To edit, use 132-character, wide screen edit.
- Limited to two lines of information.

OEWORD and OEWORDES

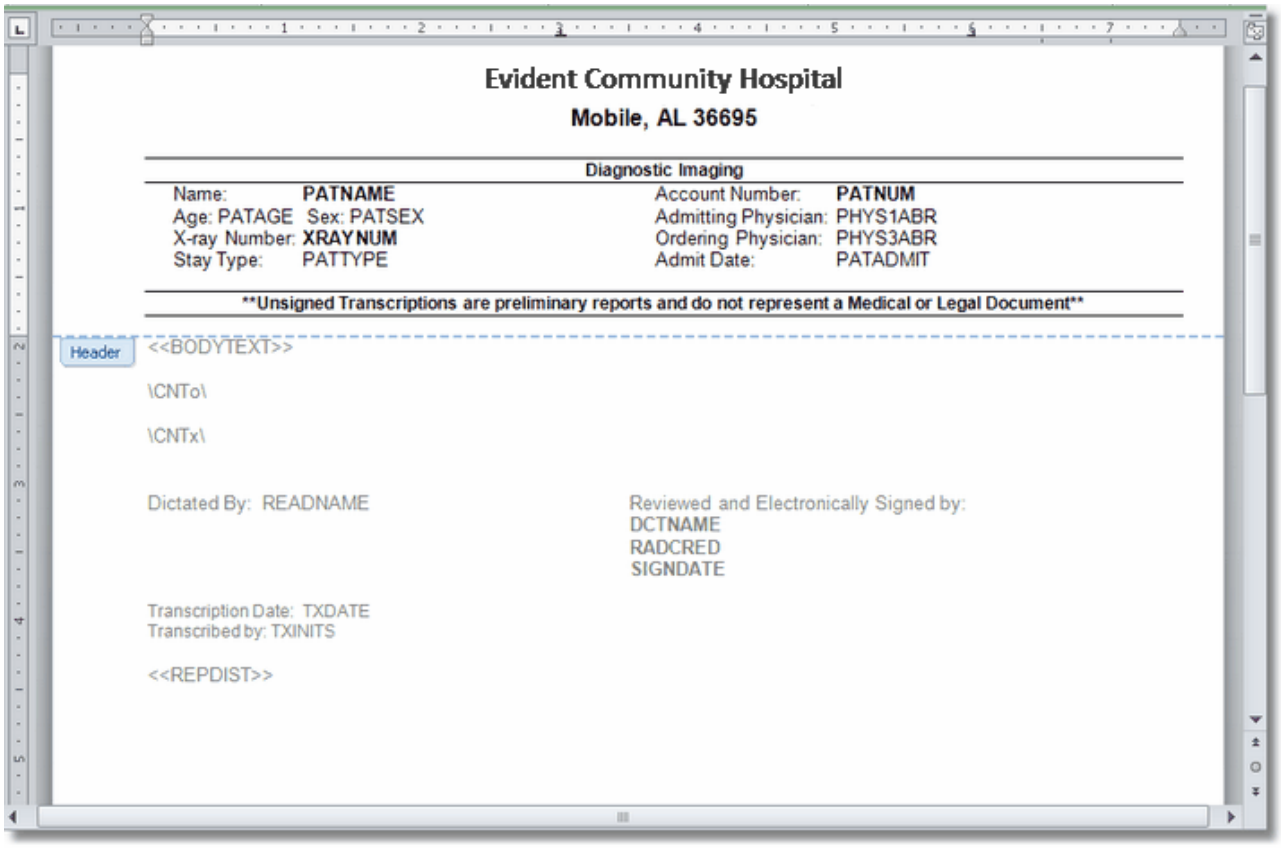
Hospitals using Microsoft Word® to transcribe patient reports against orders must have OEWORD and/or OEWORDES created in each department's result library. Hospital address, patient demographic, exam data, dictation, and transcription information are defined in the document header. Each header is customized to include site-specific information.

The OEWORDES header will be used for transcribing against orders that will be electronically signed within the system, whereas the OEWORD will be used for transcribing against orders that are not set to be electronically signed. If OEWORDES is not created, the system will continue to use the OEWORD header.

NOTE: *The library for the departments'* ***OEWORD*** *and* ***OEWORDES*** *is created and defined by the technical department in the OE Prefix table, Result Drive # & Directory.*

OEWORD and OEWORDES must be created within Microsoft Word. Verify the Microsoft Word application is installed on in the Clientware session. From the Hospital Base Menu, select **Tools** from the toolbar. Select **Options > Programs** tab, and verify **Microsoft Word for Windows** is selected.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **Selected Library** > **/usr/xray** > **Select Document** > **OEWORDES** > **Standard Edit**



OEWORDES

- Create the Transcription header including the hospital name, city, state, and zip code. The OEWORD and OEWORDES headers consist of three parts: demographics, disclaimer (optional), and text placement code.
  - o The header may be arranged and customized in any manner.
  - o Patient demographics are pulled from selected mnemonic codes and must contain the patient

name and account number.
- The field titles, such as Name or Pt Name, are site defined, but are not required.
- When creating columns, always use the Tab functions and not spaces.
- The disclaimer is included in the header below the patient demographics.
- Borders may be used to separate information.

- Below the header, include the command <<BODYTEXT>>. This command inserts the item description from the order and the reason for the procedure (from Order Entry Maintenance, second Question line.) This command also inserts the completed date/time and will insert the CPT code per the Radiology Control Table setup.

  NOTE: *When entering abbreviated mnemonics, use the down arrow key instead of the* ***<Enter>*** *key. The AutoCorrect feature will capitalize the first letter and make the other letters lowercase if* ***<Enter>*** *is used.*

- For hospitals using the Transcription Log, the count command may be used for transcription in Microsoft Word.
  - Enter the begin-count command, **\CNTo**, in the body of the report and press **<Enter>** twice.
  - Enter the end-count command, **\CNTx**, in the body of the report and press **<Enter>** twice.
  - The transcription should begin following the begin-count command and end before the end-count command.

- Transcription is done within Microsoft software, so Microsoft keyboard shortcuts are available. Most transcriptionists need the cursor placed at the same point when beginning a transcription. The placement may be between the count commands or anywhere on the header.
  - First, open the OEWORD or OEWORDES header.
  - Place the cursor where the transcriptionist needs the cursor to begin.
  - Press **<Ctrl> + <F9>**. Two braces with a gray background will show the placement for the cursor.
  - When the transcriptionist opens the document to transcribe, press **<F11>** and the cursor will go to this position.

  NOTE: *The shortcut keys only have to be set up once. They may be set up online or on site from any PC.*

- Electronic Signature mnemonics should be entered on the lower portion of the OEWORDES header when transcriptions against orders are set for Electronic Signature. These mnemonics pull the transcription, signature, and report distribution information.

Miscellaneous Transcription Headers

Interfaced Transcription Headers

Hospitals routinely use outside Radiology transcription/radiologists services that are interfaced with the TruBridge system. When using a Text Transcription interface, the margins can be off, causing the text to be cut off along one side of the page. The following header settings can be used to alleviate those margin issues and are defined in the OE Prefix result drive and directory.

- MRHEAD pulls the patient demographic information.

\TM00\\10PI\\LM03\\RM80\\DRAo\\BM09\
\MRHo\

HOSPITAL NAME
ADDRESS
ADDRESS

- RDHEAD2A separates the patient demographic information in MRHEAD and the body of the report. Information needed between the patient demographic information and the body of the report, such as the disclaimer, may be added here. Used by Text Transcription interfaces and CPWriter transcriptions.

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RADIOLOGY REPORT

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- RDHEAD3A pulls the electronic signature mnemonics. Used by Text Transcription interfaces and CPWriter transcriptions.

Reviewed and Electronically Signed by:
DCTNAME
RADCRED

Signed Date:
SIGNDATE

- RDADDHEAD separates the original text from addended text. Used by Text Transcription interfaces and CPWriter transcriptions.

**********ADDENDUM**********
****

REPORT MNEMONICS

The following is a list of available mnemonics that may be used in a transcription header.

Mnemonic	Description	Abbreviated Mnemonic
PATNAME	Name	
PATNUM	Account Number	
PATROOM	Room	xPTRM
PATTYPE	Stay Type	xPTYPE
PATMRNUM	Medical Record Number	
PATDISCHARGE	Discharge Date	xDCHGD

PATADMIT	Admit Date	xADMD
PATBDAY	Date of Birth	
PATPHONE	Phone Number	
PATFC	Financial Class	xFC
PATAGE	Age	xAGE
PATSEX	Sex	xSEX
XRAYNUM	Xray Number	
ORDERNUM	Order Number	xORD
REPORTLOC	Report Location	
PHYS1NAME	Admitting Physician Name	
PHYS1ABR	Admitting Physician Short Description	
PHYS1NUM	Admitting Physician Number	
PHYS2NAME	Secondary Physician Name	
PHYS2ABR	Secondary Physician Short Description	
PHYS2NUM	Secondary Physician Number	
PHYS3NAME	Ordering Physician from Order Maintenance (full name)	
PHYS3ABR	Ordering Physician from Order Maintenance	
PHYS4ABR	Family Physician	
SUBTYPE	Patient Stay Subtype	
TRANSDATE	Transcription Date	xTXD
TRANSTIME	Transcription Time	xTXT
TRANSIN	Transcription Initials	xTXI

<<BODYTEXT>>	Pulls the name of the procedure, CPT Code, Complete Initials/Time/ Date, Order Number, and the Reason for Procedure from order.

The following mnemonics will be updated after the transcriptionist exit/saves the document and may be used anywhere in the body of the report for electronic signature.

Mnemonic	**Description**
READNAME	Full name and credentials of the original dictating physician
DCTINITS	Dictating initials supplied by the transcriptionist
TXINITS	Transcriptionist's initials
TXDATE	Transcription date/time captured at the transcription prompt
SCHEDATE	Schedule date/time
COLLDATE	Collect date (lab use)
RCVDATE	Received date/time (lab use)
RSLTDATE	Result date/time (lab use)

The following mnemonics will be updated after the physician signs the report and may be used anywhere in the body of the report for electronic signature.

Mnemonic	**Description**
RADCRED	Credentials of signing physician pulled from physician security
DCTNAME	Signature name from physician security
<<COSIGNATURE_PENDING>>	Will pull signature name when the co-signing physician (second signature) signs a document that requires a co-signature. This is typically used when there are mid-level providers that require the co-signature of a supervising physician.
SIGNDATE	Signed date/time

SIGNINITS	Signing physician initials
<<REPDIST>>	"Copy For": Lists physicians and locations receiving a copy of the transcription. Autosend mode will display when defined in the Physician/ Location tables. If a patient has been discharged after a report has been transcribed but before it has been signed, this mnemonic will append "DISCHARGE" on the report.

NOTE: *TruBridge recommends placing the physician's credentials in the Signature field of the Physician Security table page 1. This will allow the credentials to pull with the physician's name when using the DCTNAME mnemonic. An example would be Daniel E Smith, MD. The Credentials field in the Physician Security table page 1 should be reserved for the physician's specialty such as Radiologist, Chief of Staff, etc.*

The following is a list of available mnemonics that may be used anywhere in the body of the pathology report. The mnemonics will be updated upon transcribing.

Mnemonic	**Description**
<<CASENUM>>	Will pull the pathology or cytology case number.
<<QC>> (**QC=Question Code**)	Will pull answer from particular question.
<<PREOP DX>>	Pulls the pre-op diagnosis answer.
<<POSTOP DX>>	Pulls the post-op diagnosis answer.

NOTHEAD

NOTHEAD is the name of the document for the notification letters' header. It is created in the /usr3/f_/notify directory, where the '_' represents the directory code found in the Company Specific Directory Codes set up by Trubridge Technical Support. It contains the hospital name and address that will appear in the header of the patients' mammography notification letter and a nuemonic to pull the current date.

Libraries: Create the document NOTHEAD in the appropriate directory, designated in OE Prefix table for X-Ray, to suppress MRHEAD from printing on the notification letter. The directory may be accessed by several different paths:

- Hospital Base Menu > Other Applications > Word Processing > Select Library > enter library > Document Index (to view a defined document) > NOTHEAD > Standard Edit.
- TruBridge Server screen > Word Processing, then same as above.

NOTE: *Knowledge of CPWriter text editor commands is required to create or change existing report headers. Call TruBridge Ancillary Customer Service for assistance.*

NOTHEAD is user defined and may contain space for letterhead.

Print Commands:

- If the site is using printed letterhead, leave enough space after the \PGNx\ to manipulate where either the letterhead or patient's address will print.

o This command will suppress page numbers from printing on the notification letter.
o Command must be in first line of document.

- Recommend a left justify if entering hospital/department name and address to keep in letter format.
- \DATE\ will pull the current date. It may be placed before or after address.
- If the site is using windowed envelopes, adjustments to the spacing may be made.

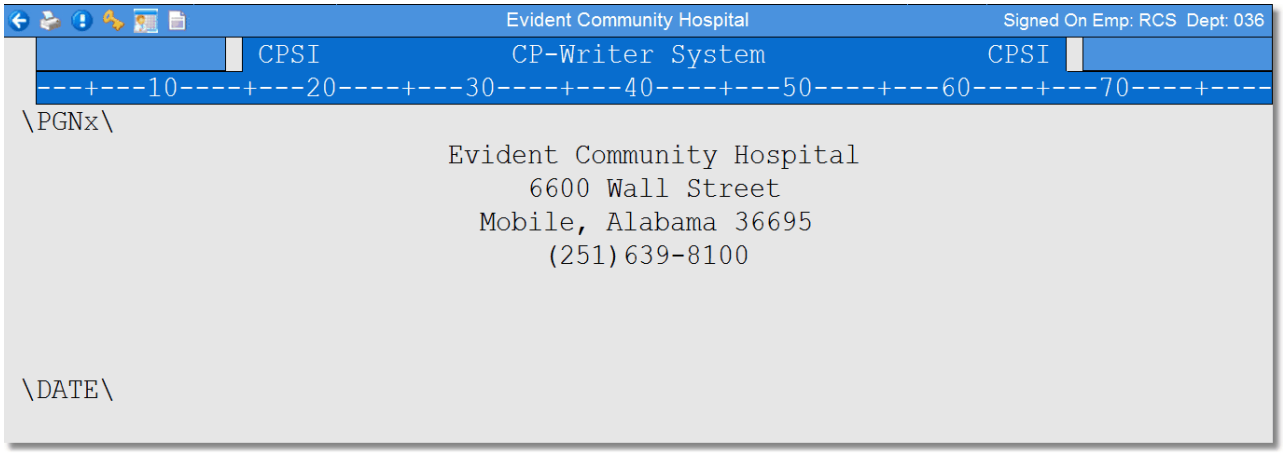
NOTHEAD contains the following print commands and information in this order:

\PGNx\
HOSPITAL/DEPARTMENT NAME
ADDRESS
ADDRESS
PHONE NUMBER

\DATE\

If letterhead is to print with the notification letter, set up NOTHEAD as below.

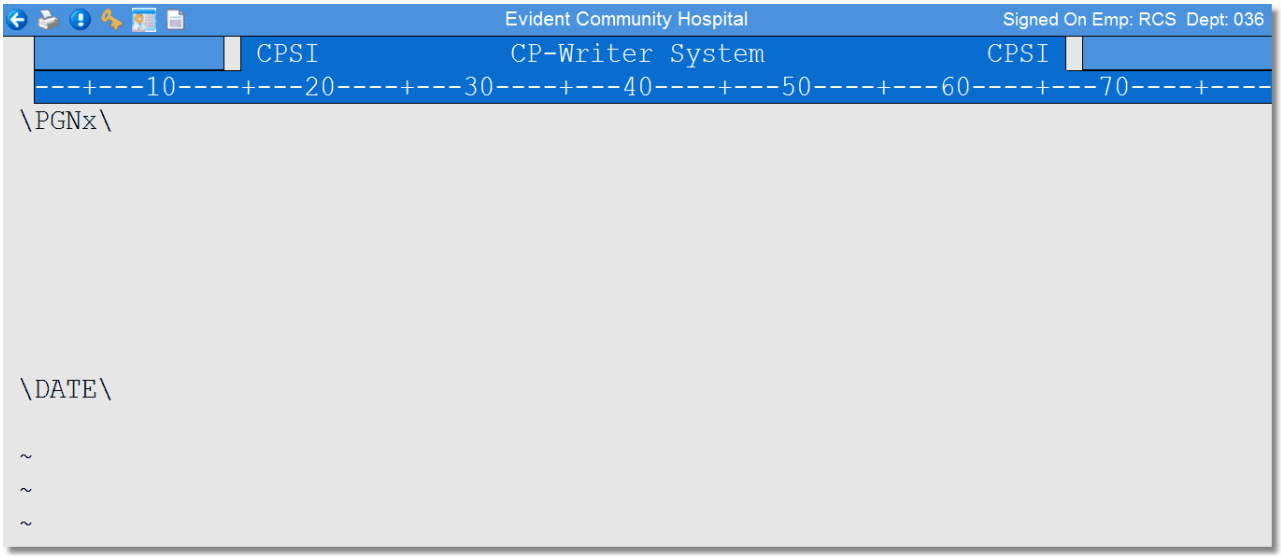
Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/notify** > **Select Document** > **NOTHEAD**



NOTHEAD

If printed letterhead is used, set up NOTHEAD as below:

Select **Web Client** > **System Menu** > **Hospital Base Menu** >**Other Applications and Functions** > **Word Processing** > **/usr3/f/notify** > **Select Document** > **NOTHEAD**



NOTHEAD for Letterhead Paper

Notification Letters

Create Notification letters and physician cover letters in /usr3/f_/notify. Notification letters are defined as separate documents. Letter documents are named with the corresponding notification codes. Each notification letter is user defined:

Notification letter name must match the Notification code in the patient's mammography record.

EXAMPLE: The **Normal** notification letter is named **NORM** in this directory when NORM is the **Normal** notification code.

NOTE: *These notification letter documents will reside in /usr3/f_/notify, where the '_' represents the directory code found in the Company Specific Directory Codes set up by TruBridge Technical Support.*

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/notify** > **Select Document** > **Notification code**

```
          CPSI          CP-Writer System          CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
Dear Patient:

We are pleased to inform you that the results of your recent Mammography
examination is \BLDo\normal/benign\BLDx\.

A report of your results was sent to your referring health care provider.

Your images will become part of your medical file here at Evident Community
Hospital and will be available for our continuing care.  You are responsible for
informing any new health care provider or breast imaging facility of the date
and location of this examination.

Although mammography is the most accurate method for early detection, not all
cancers are found through mammography.  A breast finding of concern should
\BLDo\never be ignored\BLDx\ despite a normal mammogram.  If you notice any new
changes in your breast(s) you should bring them to your health care provider's
attention immediately.

Thank you for allowing us to help in meeting your health care needs.

Sincerely,
```

Normal Notification letter

Physician cover letters may be defined for individual physicians or one standard letter may be sent to all referring physicians:

- Individual physician cover letters are defined with the physician number. As with the notification letters, there are no print commands and the physician's name is included in the salutation.

  EXAMPLE**:** If Dr. John Jones is physician # 123456, his customized cover letter is named 123456.

- If a standard physician notification cover letter is to be sent, define a document PHYNFY.

Select **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing > /usr3/f/notify > Select Document >PHYNFY**

```
          CPSI          CP-Writer System          CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
\DATE\

PHYNAME
PHYADD1
PYSCSZ

Dear DR.

The following is a list of your patients which received letters notifying them
of the results of their mammograms.

Thank you for allowing us to serve your patients health care needs.

~
~
```

Standard Physician Notification Letter

- The following commands may be used anywhere in the letter:
  - o PHYNAME: Pulls physician name from the name line of the ordering physician's table to the letter.
  - o PHYADD1: Pulls information from the Address field of the ordering physician's table to the letter.
  - o PHYADD2: Pulls information from the second address field of the ordering physician's table to the letter.
  - o PHYCSZ: Pulls information from the City, State, and Zip code fields of the ordering physician's table to the letter.

MAMMOHEAD

MAMMOHEAD is the name of the document created in the /usr3/f_/xray directory, where the '_' represents the directory code found in the Company Specific Directory Codes set up by TruBridge Technical Support, that contains the hospital name and address that will appear in the header of the patients' recall letter.

Libraries: Create the document MAMMOHEAD in /usr3_/f/xray. The directory may be accessed by several different paths:

- Hospital Base Menu > Other Applications > Word Processing > Selected Library > enter library > 1-name it MAMMOHEAD or to view a current MAMMOHEAD, select document index > Standard Edit.

- TruBridge Server screen > Word Processing, and then same as above.

NOTE: *Knowledge of CPWriter text editor commands is required to create or change existing*

report headers. Call TruBridge Clinical Customer Support for assistance.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/xray** > **MAMMOHEAD**

```
          CPSI              CP-Writer System                CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
\PAGE\
\BLDo\
\LM12\
Evident Community Hospital
Mammography Department
6600 Wall Street
Mobile, Alabama  36695
251-639-8100
\BLDx\
```

MAMMOHEAD

MAMMOHEAD is user defined and may contain space for letterhead.

- The first line must have \PAGE\ command.
- Add several blank lines as needed for the patient's name and address after the \PAGE\ command so they will appear in the window of a windowed envelope.
- Recommend a left justify if entering hospital/department name and address to keep in letter format.

Print Commands

MAMMOHEAD contains the following print commands and information in this order.

\PAGE\

HOSPITAL/DEPARTMENT NAME
ADDRESS
ADDRESS
PHONE NUMBER
\DATE\

Recall Letters

Libraries: Create Recall, Repeat Recall, and physician cover letters in/usr3/f/xray. Print commands are not used in the letters. Follow standard business letter guidelines. Recall letters are defined as separate documents. Letter documents are named with the corresponding recall codes. Each recall letter is user defined.

NOTE: *The recall letter document will reside in /usr3/f_/xray, where the '_' represents the directory code found in the Company Specific Directory Codes set up by TruBridge Technical Support.*

Recall letter name must match the Recall code.

EXAMPLE: The 1 year letter is named 1YR in this directory when 1YR is a recall code.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/xray** > **1YR**

```
            CPSI            CP-Writer System              CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
Dear Patient,

Our records indicate that it is time for your annual mammogram.  Please contact
your physician's office and have them set up an appointment for you.

Please remember that some cancers (about 8% to 10%) cannot be found by
mammography alone, and that early detection requires a combination of monthly
breast self-examination, yearly physical examination and periodic mammography
examination.

\UNDo\American Cancer Society\UNDx\ recommended guidelines for mammography:
\BLDo\    Age                      Recommendation\BLDx\
        35-40           Baseline \BLDo\(first)\BLDx\ mammogram
      40 and over       Periodic mammogram every year as determined by your own
                        personal history and your physician's recommendation.

\UNDo\Medicare will reimburse for mammography every year\UNDx\

Sincerely,

Mammography Department
```

1YR Recall letter

Repeat recall letters are defined with a patient Recall code followed by -2 or -3 appropriately (-2 being second recall letter and -3 being third recall letter). If a third recall is not sent, then do not define this letter type.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/xray** > **1YR-2**

```
          CPSI            CP-Writer System                CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
Dear Patient,

\CTRM\\BLDo\This is a second reminder.\BLDx\

Our records indicate that it is time for your annual mammogram.  Please contact
your physician's office and have them set up an appointment for you.

Please remember that some cancers (about 8% to 10%) cannot be found by
mammography alone, and that early detection requires a combination of monthly
breast self-examination, yearly physical examination and periodic mammography
examination.

\UNDo\American Cancer Society\UNDx\ recommended guidelines for mammography:
\BLDo\    Age                      Recommendation\BLDx\
        35-40          Baseline \BLDo\(first)\BLDx\ mammogram
      40 and over      Periodic mammogram every year as determined by your own
                       personal history and your physician's recommendation.

\UNDo\Medicare will reimburse for mammography every year\UNDx\

Sincerely,
```

1YR Repeat Recall Letter

Physician cover letters may be also be defined for recall letters. Individual physician letters or one standard letter may be sent to all referring physicians.

Individual physician cover letters are defined with the physician number. As with the recall letters, there are no print commands, and the physician's name is included in the salutation. Repeat recall physician letters are defined with the physician number followed by -2 (the -2 letter is used as second and third recall letter to the physician).

EXAMPLE: If Dr. John Jones is physician # 123456, his customized cover letter is named 123456. Second recall letter is named 123456-2.

If a standard physician recall and repeat recall cover letters are to be sent, define the following documents:

- PHYRC1 (recall cover letter)
- PHYRC2 (second recall cover letter)
- PHYRC3 (third repeat recall)

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Other Applications and Functions** > **Word Processing** > **/usr3/f/xray** > **PHYRC1**

```
          CPSI          CP-Writer System          CPSI
---+---10----+---20----+---30----+---40----+---50----+---60----+---70----+----
\DATE\
PHYNAME
PHYADD1
PHYCSZ

Dear Dr. PHYNAME

Attached you will find a list of your patients who are due for a mammogram next
month.

We have sent them a reminder notice with instructions to contact your office
for a physician order.

Thank you.

Mammography Department
Evident Community Hospital
~
```

Standard Physician Recall Cover Letter

The following commands may be used anywhere in the letter:

- PHYNAME: Pulls physician name from the Name line of the Ordering Physicians table to the letter.
- PHYADD1: Pulls information from the Address field of the Ordering Physicians table to the letter.
- PHYADD2: Pulls information from the Second Address field of the Ordering Physicians table to the letter.
- PHYCSZ: Pulls information from the City, State, and Zip Code fields of the Ordering Physicians table to the letter.

OSHEAD and OSFOOT

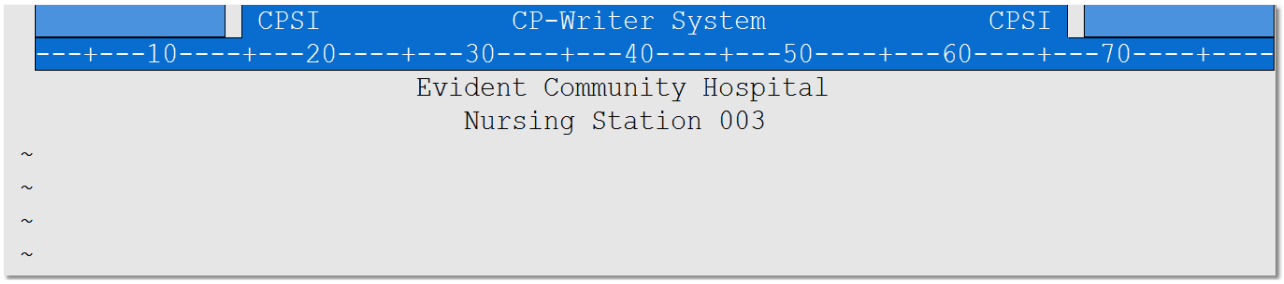
For nursing stations using Order Verification Sheets, Department Table, page 1, Print Order Sheet field = **Y**, the OSHEAD and OSFOOT documents must be set up.

Requirements:

- Header and footer information must be set up in /usr#/wp/d?? directory, with “#” being the number listed in the directory code for the departments and “??” being the nursing department number.
- The header document will need to be named OSHEAD.
- The footer document will need to be named OSFOOT.

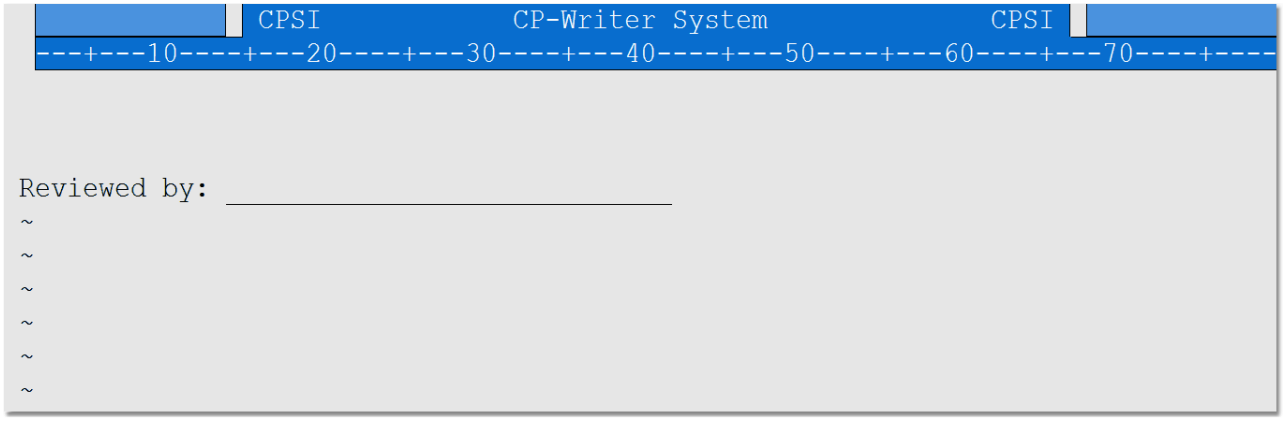
- Both documents must exist (even if blank) if the department does not want to include header or footer information on the order verification sheets.
- Documents must be set up for each department using Order Verification Sheets.

Select **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing > /usr#/wp.d?? (the ? refers to department numbers) > OSHEAD**



OSHEAD

Select **Web Client > System Menu > Hospital Base Menu > Other Applications and Functions > Word Processing > /usr#/wp.d?? (the ? refers to department numbers) > OSFOOT**



OSFOOT