Table Maintenance - Control

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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 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.

1.2 What's New

This section introduces the new features and improvements for **Table Maintenance - Control** for release Version 22.01. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22.01 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact the **Client Services** Support.

Physicians Table - Report Option -- FA-13391

DESCRIPTION: A new Physicians Master Table Report is now available to help identify all the records in the Physician table. The report generates in a CSV format, and it is available both from the Report Dashboard and via a new **Report** option on the Physicians list screen.

DOCUMENTATION: See Physicians 114

Chapter 2 Overview

This User Guide describes the Control Tables that are maintained via Table Maintenance.

Select **Web Client** > **Tables** > **Control**

Table Maintenance - Control

NOTE: *Facilities outside of the United States may utilize a different address format to display in select tables. The address may display the Province and Postal Code instead of the State and Zip Code when the Country Code field is set to a country code other than "US." To display the foreign fields for your facility, contact a TruBridge Representative.*

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 the Control tables. 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 tables. To change the date format for your facility, contact a TruBridge Representative.*

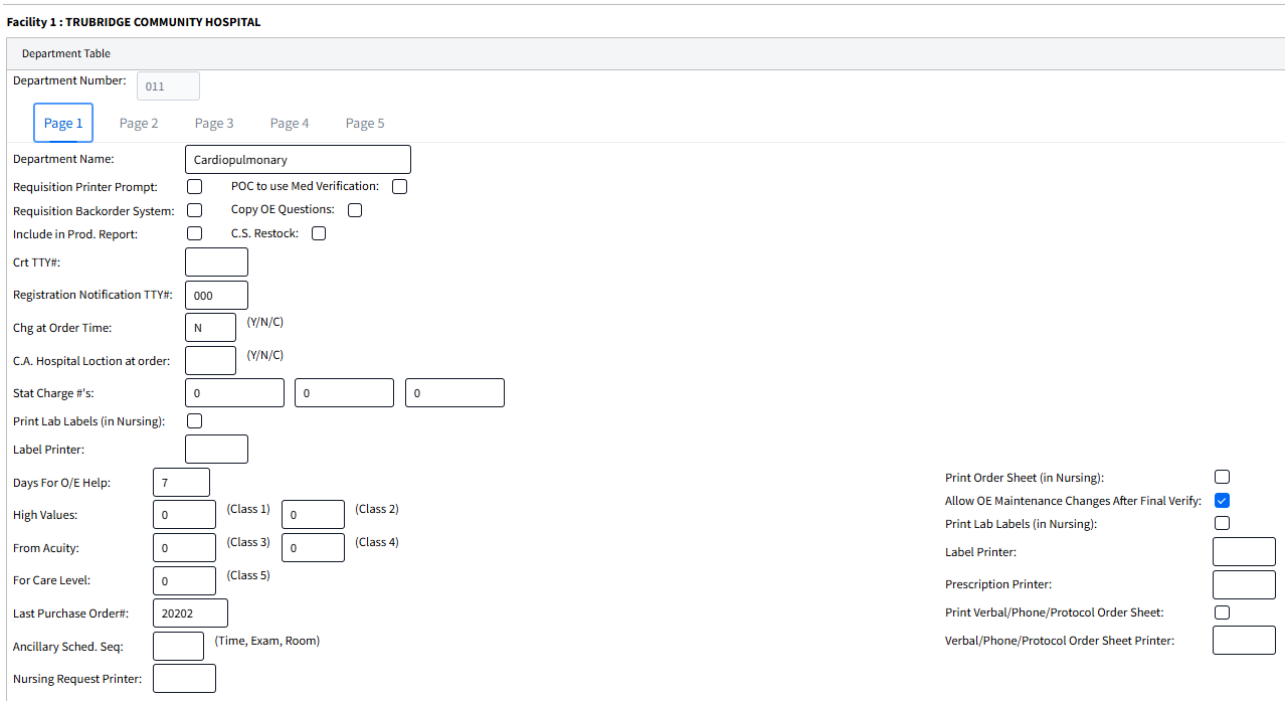
Chapter 3 Department Table

The Department Table contains fields that affect different parts of the system. A table is set up for each department in the facility to store specific information relating to the different departments.

Select **New** to enter a new department, or select an existing department from the list and select **Edit**.

3.1 Department Table, Page 1

Select **Web Client** > **Tables** > **Control** > **Departments** > **Select a Department** > **Page 1**



Department Maintenance, Page 1

- **Department Number -** Load the 3-digit code in this field.
- **Department Name -** Enter the Department Name, up to 30 characters in length. This name displays on various screens and pulls to any reports that pull the department number.
- **Requisition Printer Prompt -** If selected, there will be a printer number prompt when **P** is selected to print Incoming Orders.
- **POC to use Med Verification -** Selecting this field will give access to Med Verification via Pharmacy category in POC.
- **Requisition Backorder System? -** When selected, this allows a Department to not be included when the Backorder System is activated in the requisition control record.

- **Copy OE Questions? -** When selected, Order Entry questions will copy forward when multiple orders are placed on a patient and the same question is used in the previous order.

- **Include in Prod. Report?**
  - If selected, this will add this department to the Productivity Report in Executive Information.
  - If **N** is entered, the department will not be on the report.

- **C.S. Restock -** When the C/S Restocking Report (Hospital Base Menu > Inventory (pg 1) > C/S Restocking Rpt) is run, the information will generate for all departments with this field is selected.

- **CRT TTY# -** This field regulates which terminal receives electronic mail. This includes Employee and Department mail, Transfer/Discharge notices, Failed Fax notices and New Employee or Terminated Employee Notification mail. For ancillary departments, this includes orders sent from other departments. For nursing, this designates the terminal for incoming reports from laboratory.

- **Registration Notification TTY# -** The TTY listed in this field will receive notification when a patient is registered if selected from the Miscellaneous tab in the Registration and ADT screen. The message "INC-PAT" will flash at the bottom of this terminal's screen.

- **Chg at Order Time -** An entry is necessary only for clinical ancillary departments. Individual items may be set for a different charge point (Chg at Order, Item Order entry information) and will over-ride the setting placed here.
  - A **Y** in this field will produce a charge at order time regardless if a nursing or ancillary department places the order.
  - An **N** in this field will produce a charge when the order is completed.
  - A **C** will issue a charge when either a nursing or ancillary department enters collection information in field 10 of the order.

- **C.A. Hosp. LOC at order: (Y/N/C) -** This field will determine at what time an order will have a level of care assigned to the charge. If the field is blank then it will default to the "Charge at Order" field and assign the level of care at the same time that the order charges.

- **Stat Charge #'s -** Item(s) entered in these lines will automatically be charged to the patient's account when an order is made with STAT status. "STAT" items with no charge amount may be created and placed here if the goal is to gather STAT statistics without charging the patient.

- **Days for O/E Help -** Order Entry Instructions has a **notification** function that prompts to select **HELP** when placing an order. The **HELP** selection displays information and/or instructions for the selected item. This field regulates the number of days the prompt will display for this department after a change or addition has been made. The default for this field is 07.

- **High Values From Acuity For Care level -** This field is a function of the TruBridge Acuity Application. Acuity Class levels rank each patient according to the level of required nursing care. To complete this field, the highest numeric value for the class level is entered into each class level field.

- **Last Purchase Order# -** When creating POs, if a separate automatic numbering scheme is needed by department, the last Purchase Order number can be loaded in this field. This field will override AHIS page 1, field L for those departments with a number loaded.

- **Ancillary Sched.Seq. -** Enter **T**-Time, **E**-Exam, or **R**-Room to determine the sort for the Radiology exam schedule.

- **Nursing Request Printer -** This field determines where order verification sheets and Specimen Collection sheets print for nursing departments. If this field is blank, the sheets will print to the terminal's workstation printer.

- **Print Order Sheet (in Nursing) -** When selected, this Nursing Station will be able to print order sheets in place of order verification sheets. The order sheet will allow all orders that are verified together to print on one piece of paper, with information consistent with the order verification slips. This should be selected for the Specimen Collection sheet to print at the selected Nursing Request Printer.

- **Allow OE Maintenance Changes After Final Verify -** When selected this field allows changes to the Order Entry Maintenance Screen after the final verification of an order.

- **Print Lab Labels (in Nursing) -** If selected is entered, Lab Labels will print in Nursing.

- **Label Printer -** If the previous field is selected enter printer number to print labels.

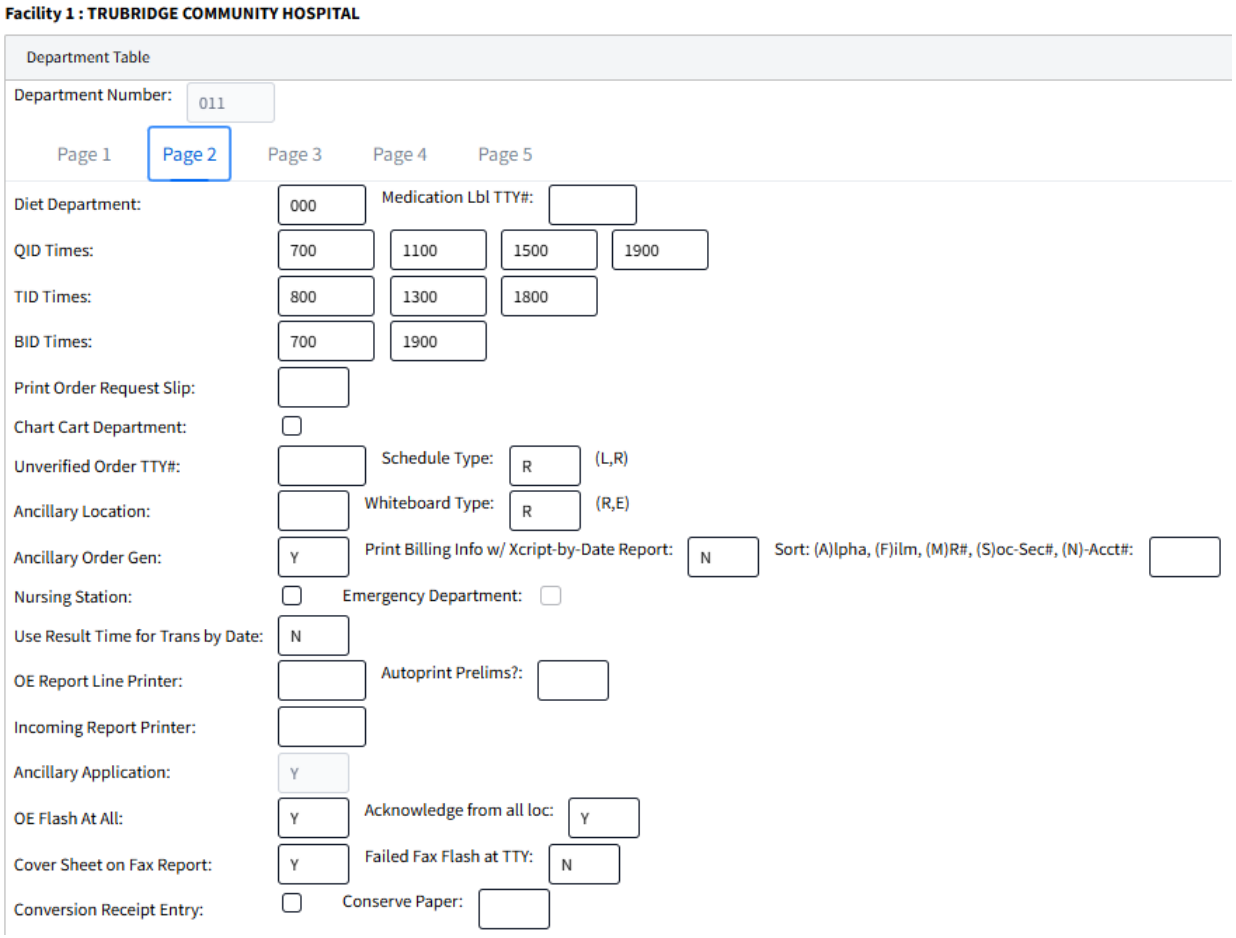
- **Prescription Printer** - This field creates a way to load a default printer for the department when prescriptions are printed from (that department) in Prescription Entry.

- **Print Verbal/Phone/Protocol Order Sheet** - This switch controls the autoprinting of the Verbal/Phone/Protocol Order sheet that will print after the entry of any Verbal, Protocol, or Phone orders via Updated Order Entry.

- **Verbal/Phone/Protocol Order Sheet Printer** - A valid department printer number may be entered in this field to indicate where the Verbal/Phone/Protocol Order sheet will print. If an invalid printer number is entered in this field, the prompt "INVALID PRINTER" will appear.

3.2 Department Table, Page 2

Select **Web Client** > **Tables** > **Control** > **Departments** > **Select a Department** > **Page 2**



Department Maintenance, Page 2

- **Diet Department -** Allows a facility to direct diet orders to two different Dietary departments. The department number of the second Dietary department is entered in this field for each nursing department sending orders to it. If the field is left blank, dietary orders will go to the Dietary department listed in AHIS, page 3, field 6.

- **Medication Table TTY# -** Designates the zebra printer to be used for pharmacy labels.

- **QID, TID, and BID Times -** Controls default schedule time for ancillary items with frequencies.

- **Print Order Request Slip**
  - If answered **N**, will disable the request print out for ancillary or nursing departments that do not want to receive request forms when orders are placed.
  - If answered **Y**, will allow order requests to print. This should be selected for the Specimen Collection sheet to print at the selected Nursing Request Printer.

- **Chart Cart Department -** Select this field for Point of Care departments.

- **Unverified Order TTY# -** Used in the POC application to regulate which terminal receives an electronic MEDS notice when medication orders are placed by Pharmacy. Orders placed by Pharmacy are unverified until nursing staff verifies in the system that the order is correct. Also used to regulate which terminal receives an electronic MEDORD notice when non-licensed staff enter medical orders. Orders placed by non-licensed staff remain unverified until a licensed nurse verifies them.

- **Schedule Type: (L,R)**
  - Enter **L** for Laboratory. This option will display schedule with Turn Around Times.
  - Enter **R** for Respiratory only. This option displays the schedule, allowing a department to schedule and assign treatments.
  - This field defaults to **L**.

- **Ancillary Location -** Used to identify this department as a patient location for Community Report distribution. “Location” is field E on an ancillary Patient Functions screen.

- **Whiteboard Type: (R,E) -** The choices for the Whiteboard are **R** for Inpatients and **E** for Outpatients.

- **Ancillary Order Gen -** Items setup as multiple orders can be automatically generated each day for Ancillary departments that utilize this option. When these items are ordered, they must have a frequency entered in field 5 of order entry maintenance. Each day when orders are generated, the system will generate orders for departments that have a **Y**es in this field.

- **Print Billing Info W/Xcript-by-Date Report? -** Departments that produce transcriptions have the ability to print a copy for the physician who provides a related service that is billed separately (radiology, cardiology or pathology service).
  - If answered **Y**, the Transcription by date report will print patient billing information (Physician Services Log) with each transcription.
  - If answered **N**, only a copy of the transcription will print. In the sort field, select one of the listed options to sort the Transcription by Date report.

- **Nursing Station -** Selecting the check box allows the department to be available for selection when creating a hospital tracking board and designates that the nursing department be listed as a nursing station for the **S**end option, “Another Nursing Station”.

- **Emergency Department -** When this field is selected, the department will be considered an Emergency Department. The Emergency Department Application is a purchased application. Please contact a TruBridge Representative for more information.

- **Use Result Time for Trans by Date? -** Used by radiology departments to build a file for the Transcription by Date report. This allows radiology to prevent duplicate reports from printing based on either result or completion times.
  - If answered **Y**, the system will use the result time (transcription time) to pull transcriptions to the Transcription by Date Report.
  - If answered **N**, the system will use the complete time (radiology completes from schedule) to pull transcriptions.

- **OE Report Line Printer# -** If laboratory cumulative reports are to print at this nursing station, enter the 3-digit line printer number in this field. Leave this field blank for reports to print in laboratory at the printer designated in field 14, page 3 of the Laboratory Control Table.

- **Incoming Report Printer -** Controls what type of printer preliminary reports are printed to at a given nursing department.
  - For the "Autoprint Prelims?" prompt, entering a **Y** causes reports to automatically print to the line printer defined in the first line of this field.
  - An **N** will suppress the auto-print option.

- **Ancillary Application -** Designates if this department is running a purchased Clinical Ancillary application. Access to this field requires a password; please contact the TruBridge Clinical Ancillary Department.

- **OE Flash at All**
  - If answered **Y**, all terminals in the department will display the appropriate Incoming "ORDER" or "REPORT" flash.
  - If answered **N**, only the "mail" terminal will display the flash.

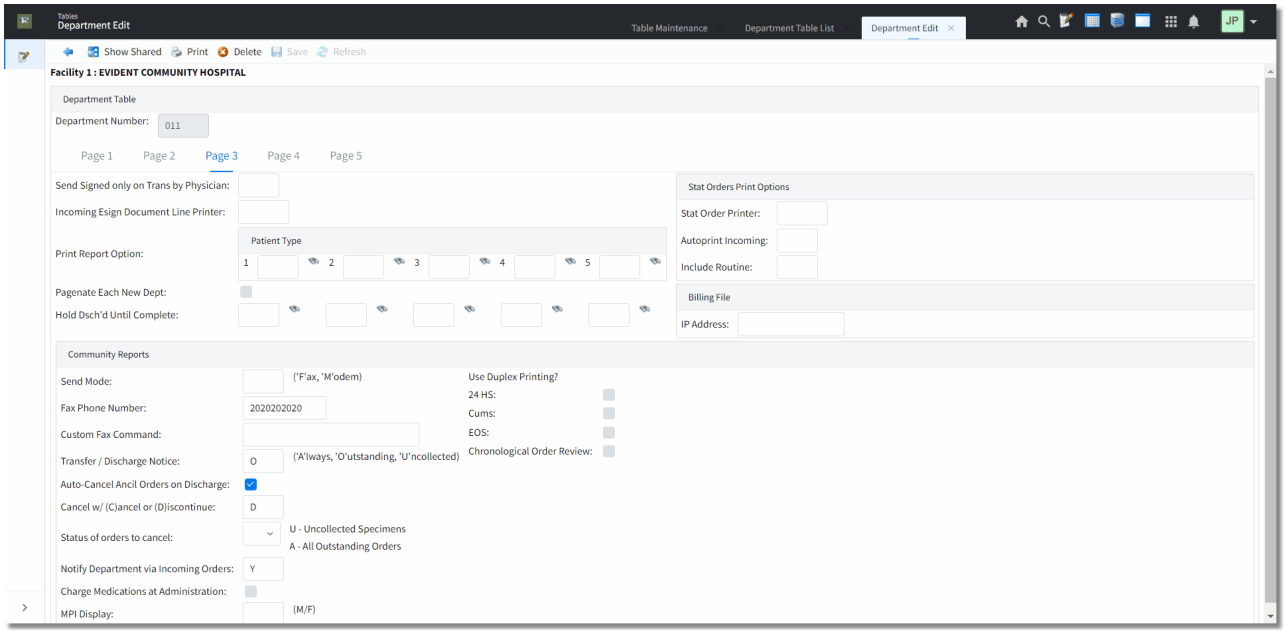
- **Cover Sheet on Fax Report? -** If answered **Y**, then a fax cover sheet is generated with each out-going fax from this department.

- **Conversion Receipt Entry -** If selected, Insurance Conversion Receipt Entry will be accessible in receipting. If blank this option will not be displayed.

- **Conserve Paper**
  - If answered **Y** all lab results for a particular patient will print on the same sheet.
  - If answered **N** each lab result will print to a separate sheet.

3.3 Department Table, Page 3

Select **Web Client** > **Tables** > **Control** > **Departments** > **Select a Department** > **Page 3**



Department Maintenance, Page 3

- **Send Signed only on Trans by Physician?**
  - If this field is set to **Y**, only signed transcriptions will appear on the Transcription by Physician report for that department.
  - If this field is set to **N**, all transcriptions will appear on the Transcription by Physician report.

- **Incoming Esign Document Line Printer -** Enter the line printer number to print incoming Esign Documents.

- **Print Report Option -** This field controls which cumulative report is printed at runtime of Community Report Distribution. There is a single character field for each of the five patient types. Options for each field are:
  - **S**-Single account cumulative vertical (which is the default)
  - **M**-Multi-account cumulative vertical, **V**-Single account cumulative by Sub-Department
  - **C**-Multi-account cumulative by Sub-Department
  - @-Lab Results by Physician with Pending
  - **N**-Non-cumulative vertical
  - **R**-Lab Results by Physician
  - **X**-Do NOT send a report

- **Paginate Each New Dept -** If selected, each sub-department on the Laboratory Cumulative report will print on separate pages for the following report options:
  - **S**-Single account
  - **M**-Multi-account
  - **N**-Non-cumulative vertical

- **Hold Disch'd Until Complete -** Controls whether cumulative reports will be held for discharged patients until all orders are complete. An entry is available for each of the five patient types.
  - If answered **Y**, then no reports will be sent to this location for that patient type until the patient has been discharged AND all orders have been completed.
  - This option should not be used if **N**-Non-cumulative vertical is designated in field 7.

- **Send Mode: ("F"ax, "M"odem) -** Enter **F** or "M" to designate how Community Reports are to be sent.

- **Fax phone Number -** The Dept fax number should be loaded in this field. Enter the number without spaces or dashes. Only enter the area code if long distance.

- **Custom Fax Command -** This is a 30-character field that may accommodate any special fax number needed. It may include the 1 for long distance, area code, extension, etc. When there is no entry in the Hold Disch'd Until Complete field, the system will dial the number found in this custom command field.

- **Transfer/Discharge Notice -** When Inpatients are transferred or discharged from a nursing station, a "NOTICE" flash may be sent to any valid department. The message is sent to the tty# loaded in field 6 – CRT TTY#.
  - Enter an **A** – Always to always notify this department regardless if there are any existing orders.
  - Enter an **O** – Outstanding to notify this department only if there are outstanding orders.
  - Enter a **U** – Uncollected to notify this department only if the order does not have collection information entered in field 10 of Order Entry Maintenance.

- **Auto-Cancel Ancil Orders on Discharge -** Allows Ancillary departments (defined in AHIS) to designate whether orders will automatically be canceled at the time the patient is discharged.
  - **Cancel w/ (C)ancel or (D)iscontinue**: (C)ancel is the default. Upon discharge, orders will be updated to a canceled or discontinued status depending on the Ancillary department involved. (e.g., frequency orders will need to be discontinued, whereas all other orders will need to be canceled)
  - **Status of orders to cancel**: **U** - Uncollected Specimens or **A** - All Outstanding Orders. Uncollected is defined as not having information entered in the "Collect" field of the order's Order Entry Maintenance screen and have not been completed or canceled. Outstanding is defined as not having information entered in the "Complete" field of the order's Order Entry Maintenance screen. Discharging the patient will only automatically cancel the orders with the status defined. Lab orders will not be automatically canceled if the "NS Cancel Uncollected" field in the Laboratory Control Table 26 is set to N (no), nursing services will need to place an order for **<=CANCEL LAB ORDER=>** indicating which tests need to be canceled and why.
  - **Notify Department via Incoming Orders**: **Y** (yes) or **N** (no). Designates whether the Ancillary department receives a notification of cancellation in their Incoming Orders and Reports screen when a patient is discharged. "Canceled" will print on any media that is printed regarding a cancellation notice.

- **Charge Medications at Administration -** Allows individual nursing departments the ability to charge Pharmacy medications at the time of administration. A separate switch located on each item must also be set to **Y**es. Utilizing this feature, medications are no longer charged via Pharmacy. Medications are charged once End-of-Shift procedures are performed via the nursing department.

- **MPI display -** This field determines whether MR Number or film number is shown on the MPI display. The default for this field is **M** for MR Number.

- **Stat Order Printer -** Allows the designation of a 3-digit line printer or workstation printer to which to auto-print STAT orders. This field may also be left blank.

- **Autoprint Incoming -** Designates whether all, STAT, or no orders will autoprint through incoming orders. The options are
  - **A**-All
  - **S**-STAT orders
  - **N**-None

- **Include Routine -** Designates whether routine orders with the same schedule time will print when STAT orders are printed.

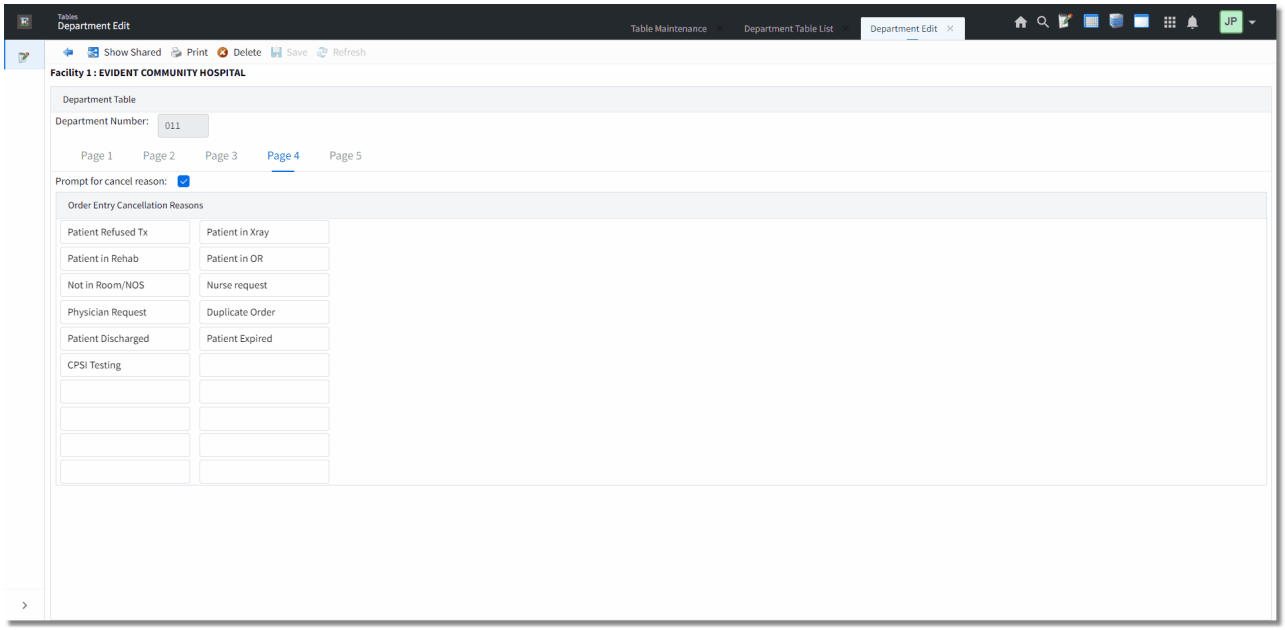
- **IP Address -** This field enables the file generated from running the Physicians Service Log Report to be sent to a specific IP Address. If the field is left blank, the file will be sent to the NTServer.

- **Use duplex prt? 24HS Cums EOS -** Setting these fields to **Y** will allow the department to duplex print reports from Point of Care. The options are 24 Hour Reports, Cumulative Reports, and End of Shift Reports.

- **Chronological Order Review**
  - Default: Y (yes)
  - Options: Y (yes) or N (no)
  - Usage: Designates whether orders in order review will display in chronological order or reverse chronological order.
    - Y (yes): Orders will display in chronological order in order review.
    - N (no): Orders will display in reverse chronological order in order review.

3.4 Department Table, Page 4

Select **Web Client** > **Tables** > **Control** > **Departments** > **Select a Department** > **Page 4**

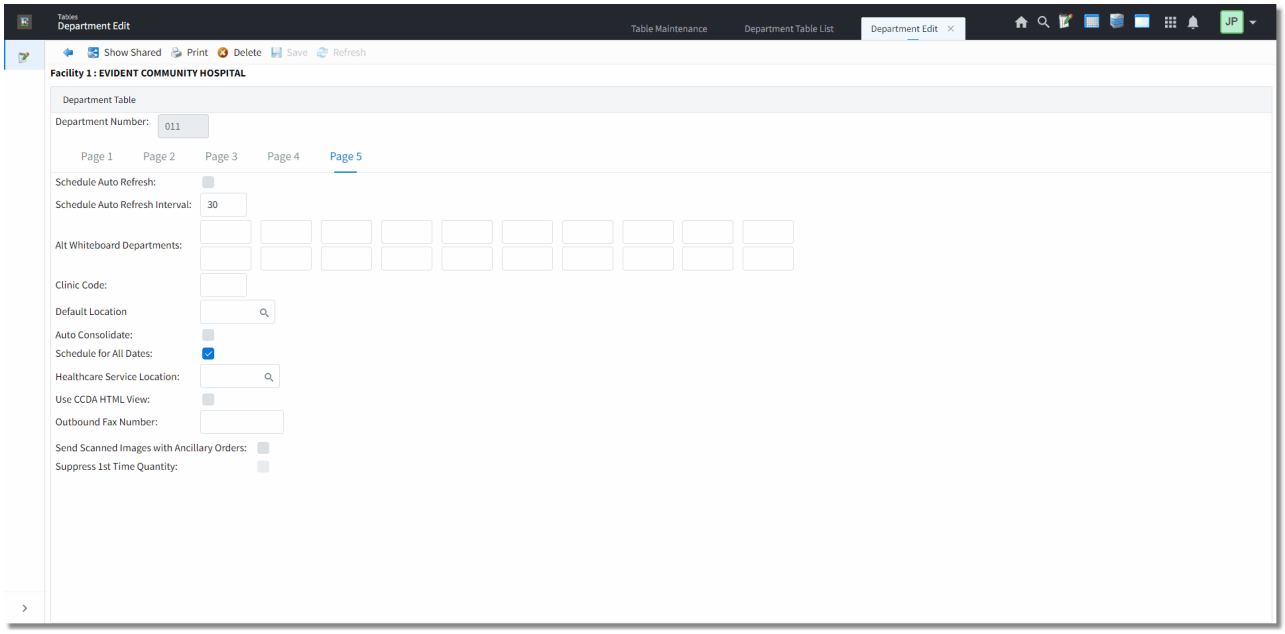


Department Maintenance, Page4

A total of up to 20 order cancellation reasons can be defined for each department. Define a new cancellation reason (up to 20 characters) in the space provided. Select Prompt for cancel reason box to have the system prompt for a reason at order cancellation. Refer to the Clinical Order Entry User Guide for more information.

3.5 Department Table, Page 5

Select **Web Client > Tables > Control > Department Table > Select a Department > Page 5**



Department Maintenance, Page 5

- **Schedule Auto Refresh -** If the facility would like the Whiteboard, the Laboratory/Respiratory/ and Radiology exam schedules to automatically update/refresh, this field needs to be selected**.** This works in conjunction with the next field.

- **Schedule Auto Refresh Interval -** If using Auto Refresh, the system with Auto Refresh the Whiteboard, Laboratory,Respiratory and Radiology exam schedules according to the number of intervals loaded in this field. This may be up to 99 intervals. Intervals are cycles on each individual PC.

- **Alt Whiteboard Departments -** Enter the departments the Whiteboard census should display all patients within or associated with.

- **Clinic Code -** This 2-digit code is set up in the Clinic Code table. A code entered here will pull the place of service associated with this clinic code to the 1500 billing form when charging from this department. This will override the place of service code in the Summary Code table.

- **Default Location -** This field allows a default room to be set for a department Tracking Board. When a patient is checked into the department, the patient will display on the Tracking Board in the default location entered.

  NOTE: *Both the* ***Clinic Code*** *and* ***Default Location*** *must be entered for this department to be available in the look-up menu from TruBridge Provider EHR Patient Location Maintenance.*

- **Auto Consolidate -** This field is used for ancillary transcription. If this field is selected any orders that have been charged within 3 minutes of each other will automatically combine together when

selected via the Transcribed Orders option from the patient functions screen or Transcribe Orders via the Medical Records application. If this field is set to **N** orders will have to be combined manually by selecting the orders that are to be consolidated individually.

- **Schedule for All Dates -** Select this field to default the Filter Date field in Department Procedure Schedule to All Dates. Leave blank to default it to Through Today.

- **Healthcare Service Location** - Enter the National Healthcare Safety Network (NHSN) Location Code for this department. This code will be used for Healthcare Survey, Antimicrobial, and Cancer Registry reporting. The NHSN Location Codes displayed in the look-up are maintained by TruBridge.

- **Use CCDA HTML View** - Select this field to default the Patients Medical Summary (CCDA) to display in the HTML view instead of displaying it in the Viewer. All export options will remain the same whether the Summary is displayed in the Viewer or the HTML view.

- **Send Scanned Images with Ancillary Orders -** This field controls a department's ability for images scanned against an order to send when a report is sent with ancillary report distribution. The default setting is unchecked.

- **Suppress 1st Time Quantity -** Not functional at this time.

The following options are available on the action bar at the top of the screen:

- **Show Shared -** If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print -** Displays the table settings in Adobe Reader.

- **Delete -** Deletes the table settings.

- **Save -** Saves changes made to the table settings.

- **Refresh -** Allows changes to show immediately in the Department Table list.

Select the  **Back Arrow** to return to the previous screen.

3.6 Most Common

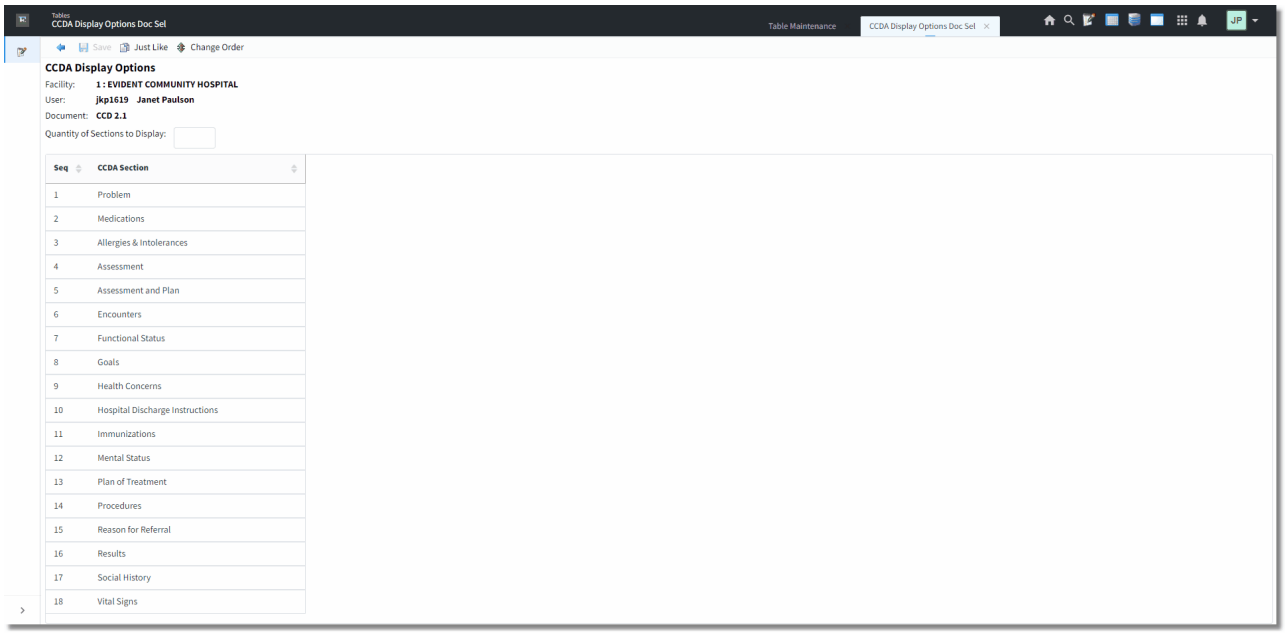
To create the 22 Most Common orders for a department, select the department from the Department List, then select **Most Common** from the action bar.

Chapter 4 CCDA Display Options

The CCDA Display Options table allows the order and number of sections that display within CCDA documents to be customized per login.

To begin, enter the User login. A magnifying glass is available to search for a specific login. Next, highlight the CCDA document that will be customized for the user, then choose **Select**.

Select **Web Client** > **Tables** > **Control** > **CCDA Display Options** > **Select CCDA Document**



CCDA Display Options - Maintenance

Enter the Quantity of Sections to Display, the number entered here will indicate the number of sections to be displayed based on the order that has been setup. If this field is left blank, all sections will display for the login. To customize the order in which the sections display, select the **Change Order** option on the action bar. Select a CCDA Section from the list, then use the directional tools on the action bar to customize the section order for the login. Select **Save** to keep any changes.

A **Just-Like** option is also available. This option will allow the Quantity of Sections to Display and Section order to be copied from another user. After **Just-Like** is selected, a list of logins will display. Highlight the user login to copy from and then choose **Select.** Select **Save** to keep any changes.

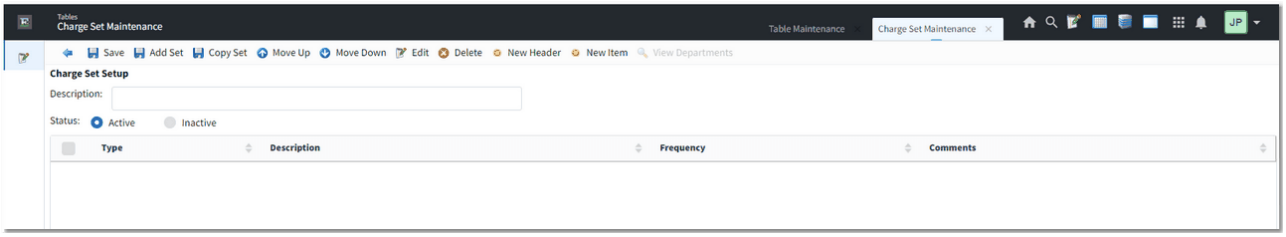
Select the  **Back Arrow** to return to the previous screen.

Chapter 5 Charge Templates

The ability to add Charge Sets/Charge Templates is available to Systems Maintenance users. Once charge sets are created, they provide a way to quickly charge a group of procedures/supplies. Select the **Charge Templates** option to display a default list of Active and Inactive Charge Sets.

To create a new charge set, select the **Department** drop-down and select the department for which the charge set will be used and select **New**.

Select **Web Client** > **Tables** > **Control** > **Charge Templates** > **Select Department** > **New**



Charge Set Setup

Type in the Description of the new Charge Set. There are several options available for adding items:

- The **Status** radio buttons allow the charge set to be in an **Inactive** status which hides it from usage or an **Active** status which allows the usage.
- **New Item** allows the addition of charge items to the Charge Set. The list provides all items that have an issuing department for which the Charge Set belongs. Only one item may be selected at a time.
- **New Header** allows the addition of a header within a Charge Set so that charge items may be organized.
- **Delete** allows any entry in the Charge Set to be deleted by selecting the item, then selecting Delete.
- **Edit** allows changes to the Header Description for any additional Headers that were added.
- **Move Down and Move Up** allows the items to be moved down or up one position on the list.
- **Add Set** allows an existing charge set to be linked to the current list. It will display on the list as a Header with the verbiage Link. When used during charge entry, it will pull in the charge items that exists as part of that set. This linked charge set will always reflect any additions or changes to the set from which it was added.
- **Copy Set** allows an existing charge set to copy all charge items as well as the Header from the selected set into the current set being maintained. The copied set will remain as is even though the set it was copied from may be changed in the future.

When either **Add Set** or **Copy Set** is selected, the Charge Set list will appear. Select the applicable list and select **Insert**.

Select **Save** to save all functions performed on this screen.

Select the **back arrow** to display the new charge set created along with existing charge sets.

Chapter 6 Collection Units

The Collection Units List provides a database of all UCUM codes (Unified code for Units of Measure) with their long descriptions. This database is accessed via a lookup icon thoughout the TruBridge EHR whenever a UCUM needs to be linked to information within TruBridge.

Chapter 7 Clinical Note Classification Reporting

The Clinical Note Classification Reporting (CNCR) table allows facilities to cross-reference custom-named clinical documents to standardized LOINC codes. This table is an integral part of how the TruBridge EHR shares patient data and ensures interoperability across other platforms, including Communication Center, the CCDA, MyCareCorner, and Get Real Health's certified Application Programming Interface (API), used by application developers. Completing this crosswalk is an important step in ensuring your facility does not violate the Information Blocking terms of the Cures Act.

The Clinical Note Classification screen will display a listing of Clinical Note Classifications. The following options are available:

- **Search**: Allows the classification codes to be filtered by the characters entered within the search field.
- **Description/Code**: Allows the user to choose if the search parameters use the Classification Code or Description.

The Clinical Note Classification will display a list with the following columns:

- **Classification Code**: Displays the LOINC Code that is attached to the record.
- **Description**: Displays the LOINC Code description.
- **Application**: Displays the application the LOINC code is associated with.

To create a new Clinical Note Classification, select **New** from the action bar. For additional information see Create a New Clinical Note Classification 19.

To edit an existing Clinical Note Classification, select **Edit** from the action bar. For additional information see Existing Clinical Note Classification 20.

Selecting **Refresh** will display the most current listing of Clinical Note Classifications.

To return to the Control Table, select the **Back Arrow** or select **X** from the Clinical Note Classification Reporting Tab at the top of the screen.

7.1 Clinical Note Classification Edit

The Clinical Note Classification Edit screen will display when **New** or **Edit** has been selected within the Clinical Note Classification Reporting screen.

Create a New Clinical Note Classification

To Create a New Clinical Note Classification:

- Select the **Application** to associate the document to a LOINC code. The selection made within this field will determine what Application screen displays when Continue is selected from the action bar.
- Select the  **Magnifying Lens** icon to select the Classification code. Once selected, the Classification Code Lookup will display. Use the Search field to look up codes by code or description. Then select the needed code from the list and choose **Select** from the action bar to attach the code. To exit without saving, select the  **Back Arrow**.
- **Exclude From: CCDA**: If selected, allows the classification code to not pull to the CCDA.
- **Exclude From: EHI**: If selected, allows a document to be excluded from the EHI export queue.
- **Exclude from Portal Until Released**: Allows clinical notes to be excluded from the portal until the provider releases them from the chart. This check box is only available when the following application types are selected: Electronic Forms, Clinical History Reports, Clinical Documentation, Documentation Reports and Physician Documentation.
- Once the **Application Type** and **Classification** code have been selected, select **Continue** from the action bar. The selection made within the Application Type will determine what Application screen displays when **Continue** is selected from the action bar.
  - **Image Titles** application will display the Image Titles from within Business Office Tables. Select an image title and choose **Select** to attach it to the classification code.
  - **Medical Records Header** application will display the HIM Physician Headers screen that will display a list HIM header titles. Select the header title and choose **Select** to attach it to the classification code.
  - **Electronic Forms** application will display the live Patient Category Eforms within the Electronic Forms Library. The Electronic Form list may be searched by a free text search field and the Eform subcategory. Select an Eform and choose **Select** to attach it to the classification code.
  - **Physician Documentation** displays a list of active PhysDoc Titles. The PhsyDoc list may be searched by a free text search field. Select a PhysDoc Title and choose **Select** to attach it to the classification code.
  - **Clinical Documentation** application will display the document list for Patient Documentation Documents. The document list will display only active documents. The document list may be filtered by Document Type, by Title or Description and by a free text search. Select a document and choose **Select** to attach it to the classification code.
  - **Documentation Reports** application will display a listing of active Documentation Reports. The documentation report list may be filtered by report Type or by a free text search. Select a documentation report and choose **Select** to attach it to the classification code.

- **Order Entry Transcription** application will display Order Entry Transcriptions. The list may be searched by a free text search field. Select an Order Entry Transcription and choose **Select** to attach it to the classification code.

  NOTE: *Once an item from an application screen listing has been assigned to a classification code, the attached item will no longer display within the application screen listing.*

- Select **Save** to save the classification code.

Crosswalking Documents for Interoperability Purposes

Note that the selections listed above (Image Titles, Medical Records Header, Electronic Forms, Clinical History Reports, etc.) are basic document types found in any given patient's electronic health record. The names or titles of documents within these document types are custom-defined at each facility. For interoperability purposes, the documents used at your facility that could be classified as any of the 8 LOINC codes below must be crosswalked accordingly. The documents from the TruBridge EHR that correspond to these LOINC codes will be shared via interoperability means (such as the CCDA, MyCareCorner, and API).

Document Classification/Description	LOINC Code
Consultation Note	11488-4
Discharge Summary	18842-5
History & Physical Note	34117-2
Procedure Note	28570-0
Progress Note	11506-3
Imaging Narrative	18748-4
Laboratory Report Narrative	11502-2
Pathology Report Narrative	11526-1

Edit an Existing Clinical Note Classification

To Edit an Existing Clinical Note Classification Code:

- Select the Clinical Note Classification that needs to be edited.
- The Application is not available to be edited and will display disabled.
- Select the  **Magnifying Lens** icon to change the Classification code. Once selected, the Classification Code Lookup will display. Use the Search field to look up codes by code or description. Then select the needed code from the list and choose **Select** from the action bar to attach the code. To exit without saving, select the  **Back Arrow**.
- Select if the classification code should be excluded from the CCDA.

- Select **Continue** from the action bar. The selection made within the Application Type will determine what Application screen displays when Continue is selected from the action bar. See Create a New Clinical Note Classification 19 for additional information on the application screen.

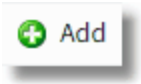
- Select **Save** to save the classification code.

Chapter 8 Facility Reporting Populations

The Facility Reporting Populations table is used with the Healthcare Surveys and Antimicrobial Reporting applications. It will allow the National Healthcare Safety Network (NHSN) Location Code to be assigned to a specific Patient Population for reporting purposes.

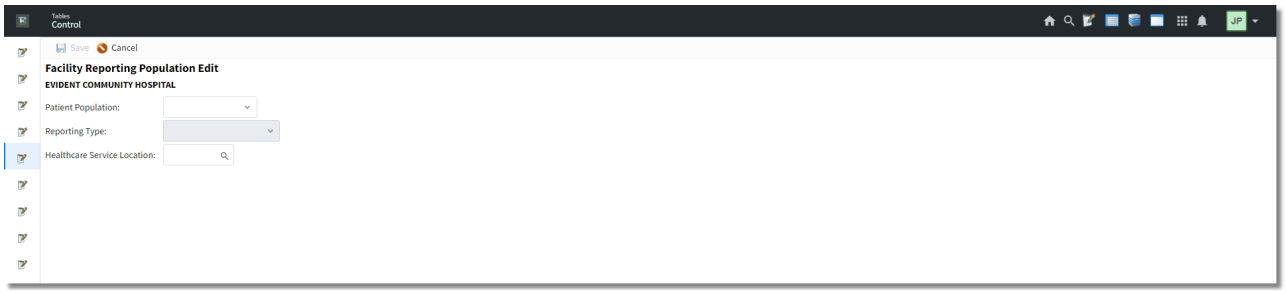
***NOTE**: The Healthcare Surveys and Antimicrobial Reporting applications are still under development.*

The filter option allows information to be delimited by Patient Population and/or Reporting Type.

Select 

Add to create a new Patient Population or select an existing entry from the list.

Select **Web Client** > **Tables** > **Control** > **Facility Reporting Populations** > **Add**



Facility Reporting Populations

- **Patient Population**: Select the appropriate Patient Population. The following options are available.

  Inpatient
  Outpatient
  Observation
  Emergency
  Ambulatory
  Critical Care

- **Reporting Type**: Select the appropriate Reporting Type. The Reporting Types will vary depending on the Patient Population chosen. The following list identifies the Reporting Types available for each Patient Population.

  Inpatient: Blank, Antimicrobial or Healthcare Surveys
  Outpatient: Blank
  Emergency: Blank, Antimicrobial or Healthcare Surveys
  Ambulatory: Blank or Healthcare Surveys
  Critical Care: Blank

- **Healthcare Service Location**: Select the Healthcare Service Location that applies to this Patient Population. The Healthcare Service Locations are based on the National Healthcare Safety Network (NHSN) location code system.

The following options are available on the action bar:

- **Save**: Saves changes made to the table settings
- **Cancel**: Returns the user to the Facility Reporting Populations List without saving any changes

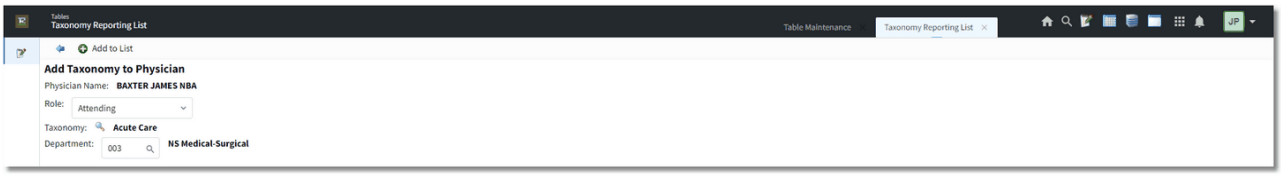
Chapter 9 Taxonomy Reporting

The Taxonomy Reporting table is used to associate multiple taxonomy codes to providers and employees for healthcare surveys.

The search option allows providers to be searched by physician number or by name, or employees may be searched by login or employee name.

To add taxonomy information to a provider or employee, select a name from the list and then click **Select**.

Select **Web Client** > **Tables** > **Control** > **Taxonomy Reporting** > **Select Provider or Employee**



Physician Taxonomy List

- To add a default taxonomy code for the physician, select the **magnifying glass** next to the Default Taxonomy field to display the Taxonomy List. Select the appropriate code and then select **OK** to add the code to the provider or employee.
- To add additional taxonomy codes, select **Add Taxonomy** on the action bar. For providers, this will allow a role to be selected, further defining the type of provider they are (Anesthesiologist, Hospitalist, Attending, etc.). For providers and employees, select the **magnifying glass** next to the Taxonomy field to search for the appropriate taxonomy code and then select the **magnifying glass** next to the Department field to search for the department the provider or employee works in.
- Once all information has been populated, select **Add to List** from the action bar. This will save the information and return to the Provider/Employee Taxonomy List.

NOTE: *A default taxonomy code must be added in order for the* ***Add Taxonomy*** *option to become available.*

The following options are available on the action bar:

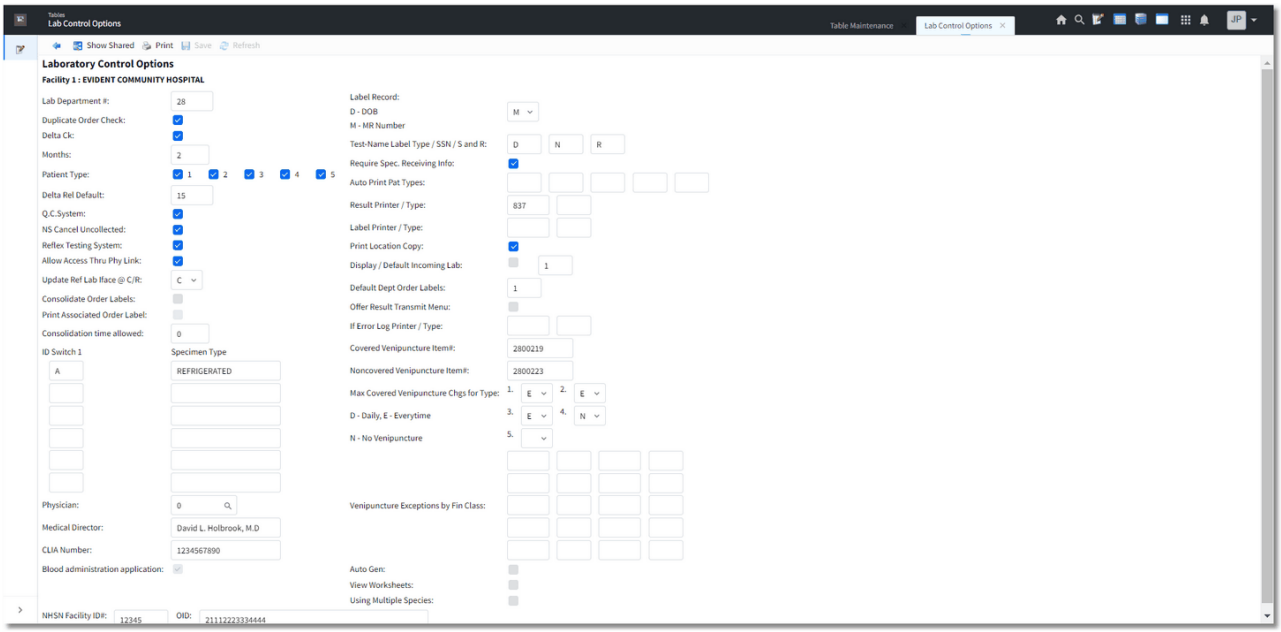
- **Save**: Saves changes made to the table settings
- **Add Taxonomy**: Select this option to add additional taxonomy codes
- **Remove Taxonomy**: Select this option to remove a taxonomy code
- **Just Like**: Select this option to copy the taxonomy codes from another provider/employee.

Select the  **Back Arrow** to return to the previous screen.

Chapter 10 Lab Control Information

10.1 Lab Control Options

Select **Web Client** > **Tables** > **Control** > **Lab Control Options**



Laboratory Control Record

- **Lab Department #**
  - Options: Three-digit department number assigned to laboratory in Department Maintenance and page 3 of AHIS Control.
  - Usage: Controls department wide generation of venipuncture charges.

- **Duplicate Order Check**
  - Default: Blank (No)
  - Usage: Controls the use of duplicate order check for all clinical ancillary applications.
    - Checked (Yes): Activates the use of duplicate order check for all ancillary departments.
    - Unchecked (No): Suppresses duplicate order checking.

  NOTE: *To suppress the duplicate order check feature for an individual department's items, delete the entry in the field for-Dup Order CK. #Days on page 3 of Item Order Entry Information. This will prompt the system to go back zero days to see if the item has been previously ordered.*

- **Delta Check Mths PtTyp**
  - Default: Unchecked (No)
  - Usage: Controls the use of Delta Check feature for all departments with entries in the Reference Range Table. Pharmacy departments also utilize the delta check option to capture creatinine results for the Creatinine Clearance calculation.
    - Checked (Yes): Activates the use of Delta Check for ALL departments.
    - Unchecked (No): Suppresses Delta check for ALL departments.

- **Mths:** Defines the number of months the system will look back for results.
- **PtTyp:** Defines the patient stay types the system will look at for results.

NOTE: *To suppress the Delta check feature for a department's specific reference range entries, enter an "X" in the Delta Check field on page one of the reference range entry.*

- **Delta Relative Default**
  - Options: Any number from 1-100(**-99** will remove an entry)
  - Usage: The value entered here is a default percent value that will be applied to all Reference Range entries with **N** in the Delta Check field of the Reference Range Table.

- **Q.C. System**
  - Default: Unchecked (No)
  - Usage: Controls access to Quality Control test definition in the Reference Range table.
  - Checked (Yes): Activates access to the **Quality Control Define Test** option in the Reference Range table.
  - Unchecked (No): Suppresses access to Quality control test definition in the Reference Range table.

- **NS Cancel Uncollected**
  - Default: Unchecked (No)
  - Usage: Determines whether nursing departments may cancel an uncollected order. Provides laboratory with a notification when an uncollected specimen is canceled by nursing services.
    - Checked (Yes): Allows nursing to cancel an uncollected order if necessary. A nursing canceled order label may be set to print with incoming orders.
    - Unchecked (No): Nursing will not be allowed to cancel uncollected orders that have been charged.

NOTE: *If nursing is not allowed to cancel uncollected orders that have been charged, a generic =>Cancel Order<= must be sent to the laboratory.*

- **Reflex Testing System**
  - Default: Unchecked (No)
  - Usage: Controls access to reflex test criteria definition in the Reference Range table.
    - Checked (Yes): Activates access to option for **Reflex Test Criteria** in the Reference Range table.
    - Unchecked (No): Suppresses access to reflex test criteria in the Reference Range table.

- **Allow Access Thru Phy Link**
  - Default: Unchecked (No)
  - Usage: Provides Physician Link customers access to view or print ancillary results or reports.
    - Checked (Yes): Allows access to Physician Link Patient Functions Screen options: Display/Print Ancillary Orders, Display/Print Results by Test, Display/Comparative Report, Print Comparative Report--This Stay, Display Comparative Report--All Stays, Print Comparative Report--All Stays, Multi Facility Comparative Report (where applicable), and Print Summary Detail Report.
    - Unchecked (No): Disallows access to the above options.

- **Updt Ref Lab Iface @ C/R**
  - Options: C (Collect) or R(Receive)

- Usage: Allows the reference lab batch to be created either at Collect time or Receive time of a Reference Lab order. This field is used by the TruBridge Interface Department.

- **Consolidate Order Labels**
  - Default: Unchecked (No)
  - Usage: Allows lab labels to consolidate when orders are placed on the same account #, with the same scheduled date and time and the items are run on the same analyzer (Control Switch 8).
    - Checked (Yes)**:** Lab labels will consolidate. The label for the first item will print with an asterisk, indicating that more than one test was ordered.
    - Unchecked (No): Lab labels will not consolidate. All Labels will print.

- **Consolidate Time Allowed**
  - Default: 1 minute if blank
  - Options: 1-5 minutes
  - Usage: Defines the time limit that the system uses to consolidate orders, of the same account, that are run on the same analyzer. A time limit from 1 to 5 minutes (default is one minute). When the table setting is '0', the consolidation logic works using the default of one minute (i.e. when collected within the same minute, consolidation occurs).

NOTE: *When Consolidate Lab Labels field = Y, Consolidate Time should = 0.*

Referring Facility Information

These fields define specimen types for the ASTM Bi-directional Interface application.

- Control Switch 1 in the **Control Switches** field of the Item Master is used for order consolidation and to indicate specimen type. The entry in switch 1 must match one of the corresponding entries in this field.

Examples:

(Control Switch 1)	Specimen Type:
R	Refrigerate
F	Frozen
A	Ambient

- **Physician**
  - Usage: Enter the Medical Director's Physician number as listed in the Physician Tables or select the magnifying glass to initiate a search. The physician number will allow the system to pull necessary information from the physician table for all results sent to third-parties, the state and federal agencies. The following fields from the physician's table will pull:
    - Physician number
    - UPIN
    - NPI Number
    - Last, First and Middle Names
    - Phone Number
    - Group Name
    - Group Address 1 and 2
    - Group City
    - Group State

  - Group Zip Code

- **Medical Director**
  - Usage: Blood Administration Electronic Forms will pull the Medical Director name in this field when a database code of *MEDDIR is used in the setup of a control within the form.

- **CLIA Number**
  - Usage:
    - Blood Administration Electronic Forms will pull the CLIA number listed in this field when a database code of *CLIANUM is used in the setup of a control within the form.
    - Lab CLIA information from this field will update a result file for tests performed in-house and will be available via the Patient List report which is housed in the Report Dashboard feature.

- **Label Record "M"/R# OR "D"OB**
  - Default: M = Medical Record number
  - Options:
    - M = Medical Record number
    - D = Date of Birth
  - Usage: The entry in this field determines whether the Medical Record number or Date of Birth will print on type A, B or C collection labels. Type D labels include both DOB and Medical Record number. See the Laboratory User Guide for examples of Laboratory order labels

- **Test-Name Label Type**
  - Test Label Type Default: A
  - Options: A, B, C, D , E, or J
  - Usage: Controls the type of laboratory labels printed with each laboratory order.
    - **A** – Procedure label includes patient name, account number, room number or location, age, sex, ordering physician, test name, order number, scheduled date and time, and either medical record number, date of birth or admit date.
    - **B** – Procedure label prints patient name, account number, order number, scheduled date and time, and test name. Collection label has spaces for writing collection information.
    - **C** – Procedure label prints a barcode and includes the patient name, account number, test name, order number and scheduled date/time. Collection label has spaces for writing collection information.**D** – This variation includes an aliquot label. Procedure label includes: patient name, account number, room number or location, age, date of birth, ordering physician, medical record number, test name (bold print), order number (bold print), scheduled date and time, and specimen requirement. Aliquot label includes the patient name, account number, test name, order number and scheduled date/time. Collection label includes social security number and spaces for writing collection information.
    - **E** – Barcode label includes: patient name, account number, test description, barcode of order number, and schedule date and time/priority. This label is placed on the specimen tube prior to processing through the instrument.
    - **J** – Barcode label which includes aliquot labels. Procedure label includes: patient full name, account number, date of birth, location, patient type, test description, barcode of order number, and schedule date and time/priority. Aliquot Label includes: Patient name, account number, date of birth, order number, and test name.

NOTE: *See the Laboratory User Guide for examples of Laboratory order labels.*

- **Social Security Number(SSN)**
  - Default: Y
  - Options: Y (yes) or N (no)
  - Usage: Yes will allow the patients' social security number to print on type D and E labels only. No will prevent the patients' social security number from printing on D and E labels.

- **Specimen Collection/Request Labels(S&R)**
  - Default: B
  - Options: N(none, B(both), S(specimen collection), or R(request label or procedure label)
  - Usage: This option controls the printing of Specimen collection and Request labels. This field works in conjunction with the **Display/Default Incoming Lab** field with respect to nursing incoming orders
    - o **N:** User does not get the prompt for # of Labels, nor does the Specimen collection label print
    - o **B:** Both the Specimen Collection and Request(procedure) label will print. Orders placed in lab will prompt for # of Labels.
    - o **S:** Both the Specimen Collection and Request(procedure) label will print. Orders placed in lab will prompt for # of labels.
    - o **R:** Only the Request Label will print. Orders placed in lab will **NOT** prompt for # of specimen coll. labels.

Scenario	Spec Collec/Request Labels (S & R)	Display/Default Incoming Lab	Default Dept Order Labels
Incoming: No Prompt,No Specimen Collection Label **Lab Ordering:** Prompt for # of Labels for Spec Collection label	**B**	N, 0	1
Incoming: No Prompt, No Specimen Collection Label **Lab Ordering:** Prompt for # of Labels for Spec Collection label	**S**	N,0	1
Incoming: No Prompt, No Specimen Collection Label **Lab Ordering:** No Prompt for # of labels for Spec Coll label	**R**	N,0	1
Incoming: Prompt for # of Labels for Spec Collection label **Lab Ordering:** Prompt for # of Labels for Spec Collection label	**B**	Y, 1	1
Incoming: Prompt for # of Labels for Spec Collection label **Lab Ordering:** Prompt for # of Labels for Spec Collection label	**S**	Y, 1	1
Incoming: No Prompt,No Specimen Collection Label **Lab Ordering:** No Prompt for # of labels for Spec Coll label	**R**	Y, 1	1

Incoming: No Prompt,No Specimen Collection Label **Lab Ordering:** No Prompt for # of labels for Spec Coll label	**N**	Y, 1 or N, 0	1

- **Require Spec. Receiving info**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls whether order entry maintenance, **Received** field, must have an entry prior to result entry.
    - Y**:** System will require entry of received information in addition to collection information for each order prior to result entry.
    - N: System will allow result entry regardless if received information has been entered.

- **Auto Print Pat Types**
  - Default: Blank, no entry
  - Options: Blank, Patient types: 1, 2, 3, 4, 5
  - Usage: Controls printing of preliminary reports in laboratory for designated patient types. Reports will print to printer defined in field **Result Printer/Type**. Up to five patient types may be entered.

- **Result Printer/Type**
  - Default: Blank, no entry
  - Line 1-printer designation options:
    - S – Workstation
    - Three-digit line printer number defined in device control table
  - Line 2-printer type:
    - Lexmark Laser printers, and TI Microlaser = P
    - Okidata model 192, 292, or 320 = M
    - Okidata model 393, and Seikosha SBA 10AI = E
  - Usage: Identifies the printer used for automatically printing the preliminary reports in the laboratory, used in conjunction with **Auto Print Pat Types**. If this field is left blank, preliminary results will not print to the designated printer in laboratory.

  NOTE: *When the printer type is changed in the* ***Type Printer*** *field of port maintenance in the device control table, this field will update accordingly.*

- **Label Printer/Type**
  - Default: S-WorkstationLine 1 -printer designation options:
    - S = Workstation
    - Three-digit line printer number defined in device control table
  - Line 2-printer type:
    - Okidata model 320 = M
    - Zebra label printer = Z
  - Usage: Identifies the laboratory label printer.

  NOTE: *Exports defined in the device control table for department PC's or CRT's will override the entry made in this field. When the printer type is changed in the* ***Type Printer*** *field of port maintenance in the Device Control Table, this field will update accordingly.*

- **Print Location Copy**

- Default: N (no)
- Options: Y (yes) or N (no)
- Usage: Controls Report Location prompt when printing Lab Results by Physician and Physicians with Pending.
  - Y: Will present the optional sort for Lab Results By Physician and Lab Results By Physician With Pending for the Report Location indicated on the patient functions screen.
  - N: Will not prompt for Report Location when printing the above reports.

- **Display/Default Incoming Lab**
  - Default: Line 1-Display "Label" prompt: N (no)
  - Line 2-Default number of labels displayed: 0-zero
  - Options: Line 1 Y (yes) or N (no) and Line 2 Number from 0-9
  - Usage: Entries in this field control whether the "HOW MANY LABELS" prompt appears when printing Incoming Orders, for Collection Labels. The second line defines the default number of Collection Labels that will print.
    - The first space determines if prompt for specimen collection labels will be displayed from Incoming Orders.
    - The second space is for the default number of labels displayed.

  NOTE: *If extra collection labels are needed, the default may be overridden when printing Incoming orders*

- **Default Dept Order Labels**
  - Default: 0-zero
  - Options: Number from 0-9
  - Usage: For orders placed within laboratory, this field determines the default number of labels displayed in the prompt at order verification.

- **Offer Result Transmit Menu**
  - This field is under development.

- **If Error Log Printer/Type**
  - Default: S-Workstation
  - Line 1-printer designation options:
    - S – Workstation
    - Three-digit line printer number defined in device control table
  - Line 2-printer type:
    - Lexmark Laser printers, and TI Microlaser = P
    - Okidata model 192, 292, or 320 = M
    - Okidata model 393, and Seikosha SBA 10AI = E
  - Usage: If the hospital has an ASTM Reference Lab Interface error messages, exceptions and transmission reports will automatically print to the printer designated here.

NOTE: *When the printer type is changed in the* ***Type Printer*** *field of port maintenance in the device control table, this field will update accordingly.*

The Venipuncture Charge program provides a mechanism to charge patient accounts for laboratory venipuncture collections. Charges may be generated for an account on a daily basis, every time a specimen is collected or not at all. The system may apply covered and non-covered venipuncture charges based on patient type. Exceptions may also be made by financial class.

Features include:

- Allows venipuncture charge to be generated for each sample collected. Orders having the same collect time will be considered one sample.
- Allows no charges to be generated unless otherwise specified by financial class.
- Generates charges once a day.
- Provides different ways of charging venipuncture by patient type.
- Prevents venipuncture charges from occurring on courier specimens. Specimens collected offsite may be designated as such by a **.** (period) in the first space of the collector's initials (field 10-Collect on OE Maintenance screen).
- Provides financial class exceptions that will override patient type venipuncture charge mechanism.
- If the financial class exception receives fewer charges than the same type patient with a different financial class, a non-covered venipuncture charge is applied to maintain workload units. Non-covered venipuncture charges will print under the Non-covered chgs column on the bill.

Requirement: Each laboratory item that is eligible for a venipuncture charge must have the **Lab Venipuncture** field of Item Order Entry Information selected.

Defining the Venipuncture Charge Program:

- **Covered Venipuncture Item**
  - Default: Blank, no entry
  - Options: Eight-digit item number. Leading zeroes must be entered if item number is less than eight digits.
  - Usage: Defines the covered venipuncture item that will be applied to a patient's account. The venipuncture item must have the Order Entry Information, venipuncture field unchecked so as to not charge a venipuncture charge on itself.
- **Noncovered Venipuncture Item**
  - Default: Blank, no entry
  - Options: Eight-digit item number. Leading zeroes must be entered if item number is less than eight digits.
  - Usage: Defines the non-covered venipuncture item that will be applied to patient accounts based on the criteria specified.
    - Item number must be eight digits, include leading zeroes if less that eight.
    - Must have a non-covered insurance summary code in the **Ins. Summary Code** field on page 1 of the Item Master.
    - Requirement: A non-covered venipuncture item must be used. This allows use of the Maximum Covered Venipuncture Charges by Patient Type and Exceptions by Financial Class. If WLUs are being tracked, this item must have appropriate units added. **Note**: The Non-covered venipuncture charge will print under the **Non-covered charges** column on the bill.
- **Max Covered Venipuncture Chgs for Types**
  - Default: Blank, no entries

- Options:
  - **E**- generate a venipuncture charge for every different sample collection time.
  - **D-** generate a venipuncture charge once a day.
  - **N**- no venipuncture should be generated unless otherwise specified under financial class exceptions.
- Usage: Defines the maximum number of venipuncture charges for each patient type.

- **Venipuncture Exceptions by Fin Class**
  - Options:
    - Line 1 (financial class) Three-character financial class, may include use of "*" to wild card
    - Line 2 (charge mechanism):
      - **E-** generate a venipuncture charge for every different sample collection time
      - **D-** generate a venipuncture charge once a day
      - **N-** no venipuncture should be generated unless otherwise specified under financial class exceptions.
  - Usage: Defines the financial class exceptions for generating venipuncture charges but only bill those insurance companies that will accept a charge.

- **Auto Gen**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls if system will auto-generate covered and non-covered venipuncture charges through CRON.
    - **Y:** System will automatically generate venipuncture charges for the previous calendar day.
    - **N:** Charges may be generated manually in laboratory via Print reports -Generate Venipuncture Charges option.

- **View Worksheets**
  - Default: N(no)
  - Options: **Y**(Yes) or **N**(no)
  - Usage: Governs access to result worksheets under patient clinical history. Will determine whether or not departments other than laboratory will be able to view and/or print worksheet documentation.

- **Using Multiple Species**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Creates option for multiple species in the Reference Range table. System will refer to field for **Species** on the patient functions screen to use species-specific reference ranges.
    - Y: Activates species-specific reference ranges. The **Species** field on the Patient Functions menu must have the appropriate species entered prior to result entry.
    - N: Will not prompt for species-specific reference ranges.

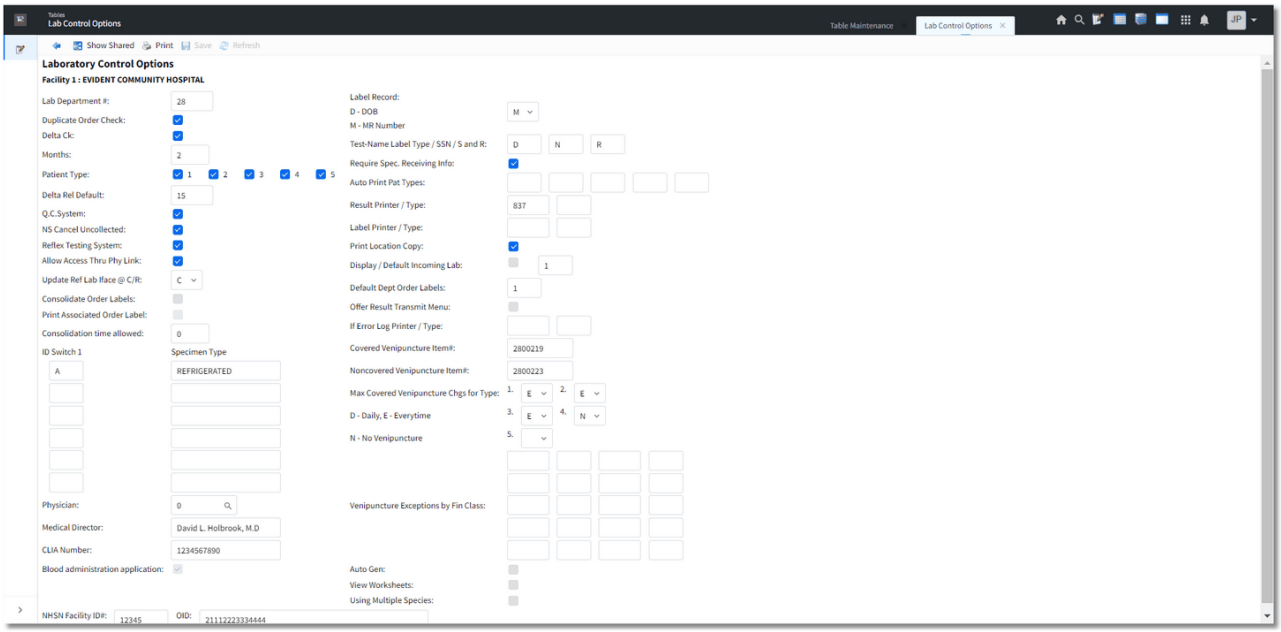
NOTE: *Species choices are Human, Equine, Feline, Canine, and Bovine. The system will default to Human if no entry is made in the 'Species field on the Patient Functions screen.*

- **NHSN Facility ID#**
  - Usage: Enter the facility's NHSN number to be used in Health Care Surveys.

- **OID**
  - Usage: Enter the OID to be used in Health Care Surveys.

10.2 Comparative Report Control

Select **Web Client** > **Tables** > **Control** > **Comparative Report Options**



Comparative Report Control

Comparative Print Control - Printing Options:

These fields deal with Comparative report options for discharged patients. The Medical Records department usually charts these reports.

- These options are designed to facilitate charting by Medical Records:
  - Providing a print sort options for each patient type.
  - Ability to hold printing Comparative reports, depending on patient type, until all results are complete.
  - Suppress printing Comparative reports on non-patients (e.g.: Home health, physician offices and veterinary patients).
  - Ability to have reports print in the Medical Records department if appropriate.

- **Sort Discharged By**
  - Default: N – sort by patient account number
  - Options:
    - **A-** sort by alpha: print the report sorted by patient name.
    - **M-** sort by Medical Record # if the patient account does not have a MR#, then sort by alpha.
    - **N-** sort by patient account number
  - Usage: Controls how discharged patients comparative reports are sorted. An entry may be made for each patient type. Be sure to populate all five fields regardless of whether they are using that type or not. The Result Patient Type field will control which patient types will print in Medical Records.

- **Hold Discharged until Complete**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines if discharged patients' Comparative reports will be suppressed from printing until all outstanding orders are complete. An entry may be made for each patient type.
    - **Y:** The system will look for all orders that were:
    - Completed in the selected interval, OR
    - Resulted in the selected interval and are also complete, OR
    - Patients were discharged in the selected interval and have no outstanding orders.
    - **N:** The system will print all patient Comparative reports for the selected interval regardless if there are outstanding orders. The Comparative will print for each interval if an outstanding order has been completed.

- **Suppress Print For Locations**
  - Default: Blank, no entry
  - Options: Up to five, two-digit location codes defined in the Location Table
  - Usage: Suppresses printing of specific Comparative Reports by location code. When the report program is generated, the system will check accounts for report location codes entered in the Report Location field of the Patient Function Screen. If the location code matches an entry in this field, the report will not print to Medical Records.

- **Medical Records Printer Number**
  - Default: Blank, none
  - Options: Three-digit line printer number defined in device control table Blank, will print to line printer defined in the**CRON Printer #** field or to printer keyed at run time (manual generation).
  - Usage: Defines the printer where comparative reports for discharged patients are printed. Allows reports to print in the Medical Records Department if a printer number is indicated.

NOTE: *When the printer type is changed in the* ***Type Printer*** *field of port maintenance in the device control table, this field will update accordingly.*

CRON Options:

- **Last Run Time**
  - Default: 0001
  - Options: Any four-digit time designation.
  - Usage: Designates the last run time to be used for auto-printing the comparative Report. The time indicated is the result cutoff time from the previous day. Example: If 0001 is entered in this field, when the system generates Comparative reports at the time defined in CRON, results completed from 0001 the previous day to the generation time will be added to the Comparative report.

- **Results Patient Type**
  - Options:
  - Patient types 1, 2, 3, 4, or 5 to print all reports for each patient type. All fields must be populated.
    - **A-** to print type 1 patients only those with room numbers
    - **B-** to print type 2 patients only those with room numbers
    - **C-** to print type 3 patients only those with room numbers
    - **D-** to print type 4 patients only those with room numbers

  - o **E-** to print type 5 patients only those with room numbers
- Usage: Controls patient types to be auto-printed through CRON. Up to five types may be entered, but an entry must be made in each field.
- Example: 1 2 2 3 3 or 1 B 3 4 E any other combinations

- **CRON Printer #**
  - Options: Three-digit line printer number defined in the Device Control table.
  - Usage: Determines which printer the comparative Reports are printed when they are not printed to a nursing station or to medical records.

NOTE: *When the printer type is changed in the* ***Type Printer*** *field of port maintenance in the device control table, this field will update accordingly.*

Split Report Options:

The Split Report feature of the comparative report prevents large reports printing on patients who have lengthy admissions (SNF, long term care). It will print "permanent" versions of the report for blocks of time as the patient record expands. The Comparative report will "start over" the day after the last permanent report.

- **Print Split Report**
  - Default: N (no)
  - Options: **Y** (yes) or **N** (no)
  - Usage: Activates the split reports option for the comparative Report.

- **PT. Type1 - Split After**
  - Default: 60 days
  - Options: 1-999
  - Usage: Indicates how many days after admission to split the comparative Report for patient type 1. The Report will split at this number and multiples thereof. This field requires entering a password; call TruBridge Ancillary support to make changes to this field.

- **Nonpt. Type1 - Split After**
  - Default: 120 days
  - Options: 1-999
  - Usage: Indicates how many days after admission to split the comparative Report for patient types 2, 3, 4 and 5. Report will split at this number and multiples thereof. This field requires entering a password; call TruBridge Ancillary support to make changes to this field.

Multiple Account Report Options:

The Comparative Report may be printed for multiple accounts per patient. This allows nursing, laboratory, respiratory and physician link departments to print a comparative report, for a patient that includes results for all account numbers over a specified amount of time.

- **Multiple Rpt History Limit**
  - Default: Blank, no entry
  - Options: If Blank, the system will look back for all previous results. Field holds 1-99 months.

- Usage: Designates how far back the system will gather information to print on the comparative report. The Comparative report will print with results from multiple accounts. Only the most current account number will print in the header of the report.

- **Include IP W/Mult Cumvert**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls if inpatient results are included on the multiple account comparative report.
    - **Y:** System will include inpatient results when auto-printing the multiple account comparative Report.
    - **N:** System will not include inpatient results.

Comparative Report Format Options:

- **Chronological Order**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls whether results print in chronological or reverse chronological order on the comparative report. Results print by collection date and time.
    - **Y:** Results will print from the least current to most current.
    - **N:** Results will print from the most current to lease current.

- **Paginate Each New Dept**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls if the comparative report will page-break after each laboratory sub-department. Sub-departments are entered in Control Switch 5 field of the **Control Switches** field in the Item Master.
    - **Y:** The comparative report will page-break after each sub-department.
    - **N:** The comparative report will not page-break after each sub-department.

- **Print Pending Status**
  - Default: N (no)
  - Options: **Y** (yes) or **N** (no)
  - Usage: Determines if **Pending** status will print on the comparative report in the result column of any order (test) that is:
    - Collected, but not completed or cancelled.
    - Resulted, but not completed.
    - Cancelled, resulted but not completed.

  NOTE: *The verbiage:* ***Pending Orders*** *or* ***No Pending Orders*** *will print in the header of the report regardless of the entry made in this field.*

- **Print All Patient Types:** This field is currently inactive.

- **Print View Unverified**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines if unverified laboratory results print on the comparative report or may be viewed by nursing, physicians and a department other than the resulting department when:

  - The order has unverified results
  - Item has a **Y** in Item OE Information, **View Unverified Order** field and OE Information **Cumulative Detail Seq**. field is not 999.

- **Print Cumvert at NS**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Indicates if comparative report is to print at nursing stations or departments.
    - **Y**: Indicates the Comparative report will print at the nursing stations or departments.
    - **N:** Comparative report will not print at nursing stations but will print in laboratory at the line printer designated in the **CRON Printer** field.
  - Requirement: Nursing stations or departments must have a **Y** in Department Maintenance table **Nursing Station** field and a line printer number entered in the **OE Report Line Printer #** field.

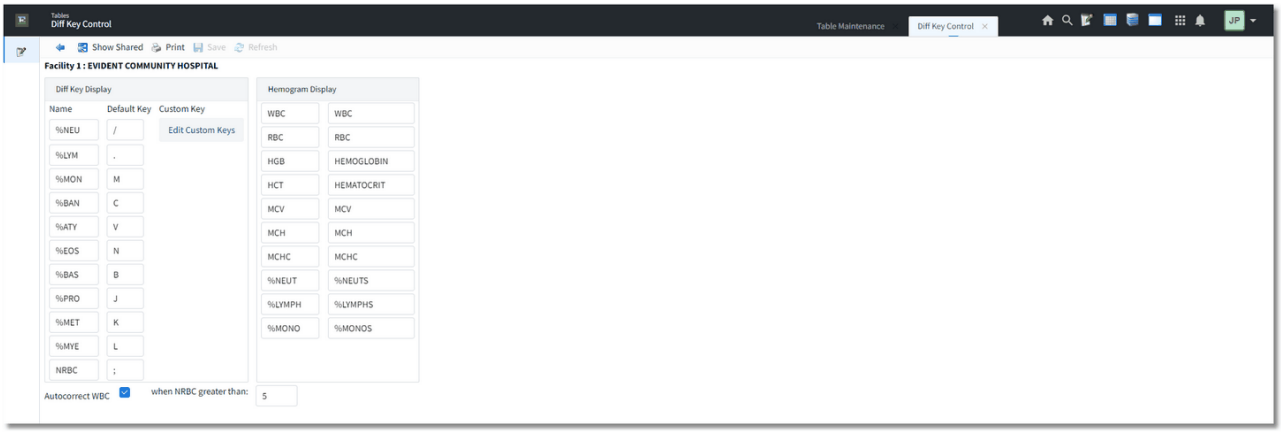
- **Department Print Order**
  - Default: None
  - Options: comparative sub-department designations (see Item Master chapter)
  - Usage: Regulates the print order of sub-departments on the comparative Report, as determined by field **-Control Switches**, Control Switch 5 of the Item Master. Items without an entry in Control switch 5 will print at the end of the Comparative report without a sub-department heading.

- **Display "Copy To"**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines if a **Copy To:** section will be added to Community Report.
    - Y: Copy To section will be added to the Community Report. This section includes Physicians and Locations receiving the Community Report as well as the method of distribution based on table settings.
    - N: Copy To section will not be included on the Community Report.

- **Print Report Date/Time**
  - Default: N
  - Options: Y
  - Usage: Determines if the Report(Completed) Date/Time appear on the Comparative Reports.
    - **Y:** The Report Date/Time that the order was completed will appear under the Collect/Date on the Comparative Reports.
    - **N:** The Comparative Report will not contain the Report Date/Time of the order.

10.3 Diff Counter Options

Select **Web Client** > **Tables** > **Control** > **Diff Counter Options**



Diff Key Control

Diff Key Display:

Diff Key Display area contains three parts: Name, Default Key, and Custom Key.

- **Name -** The cell name to appear on the differential counter display grid.
  - Abbreviation may be up to four characters in length.
  - The system will match the first four letters of the abbreviation with the corresponding reference range table.
  - Example: %NEUT would be defined in this table and would match the reference range table, %NEUTROPHIL. %NEUTROPHIL will appear on the comparative report.
  - The cell type NRBC, which does not enumerate into the TOTAL block, is a fixed spelling and cannot be changed. NRBC is defined in the Reference Range table, but the calculation does not need to be defined. The system will auto-calculate.

- **Default Key -** The keyboard symbol that will be used when the Custom Key feature is not used.

- **Custom Key -** Defines which keyboard symbol will be used to count the cell type when the Custom Key feature is used.

NOTE: *Diff Name Display may be defined to replace automated differential. The Diff Name Display must match the first 4 characters of the cell type to be replaced on the auto-diff display. Please contact a TruBridge Ancillary Support Representative for assistance.*

Hemogram Display:

The test parameters fields will display in the on- line differential counter. This portion of the table acts as a cross-reference table for the differential counter display and the reference range entry. Each field has two parts: NAME and REFERENCE

- **Name -** The abbreviated test name to appear on the differential counter display. Name may be up to six characters long.

- **Reference -** This is the test name as defined in the reference range table. It must match the reference range format. This name may be up to 13 characters long and will default to the hard coded reference range names. Hemogram Name Display(defaults): WBC, RBC, HGB, HCT, MCV, MCH, MCHC, RDW, PLT, MPV

Set Custom Keys Tab:

Usage: Allows the user to be able to customize the keyboard settings by technician.

Enter the employee number and enter corresponding characters in the custom key column. Once the user has signed on and accessed the on-line differential counter, the custom keys will appear for that employee. If the custom keys are not set up for an employee, then the default keys that are set up will display.

Existing Custom KeysTab:

Displays the existing employee number and name along with the custom keys chosen.

NOTE: *For audible to sound once the Diff Counter count reaches 100, the following clientware settings must be setup for any device utilizing the diff counter: Tools > Options > Sounds > Set Event at Notification and Play a system defined sounds: System asterisk. Next select Misc tab under Options > Under Mail check 'Make a Sound' and under Other, do NOT check Bell. PC must have a sound card and some sort of speakers, either as part of PC or as an accessory. Make sure the volume is turned up to hear the audible.*

- **Autocorrect WBC**
  - Default: Blank = N (no)
  - Options: Checked = Y or Unchecked = N
  - Usage: Allows laboratory to designate whether the system automatically corrects the WBC when the number of NRBC's manually counted exceeds a designated limit. The Diff Counter must be used for this feature to function.
    - **N:** WBC's will not automatically be corrected when NRBC's are manually counted.
    - **Y:** WBC's are automatically corrected when the number of NRBC's counted is greater than the number entered in the corresponding field.

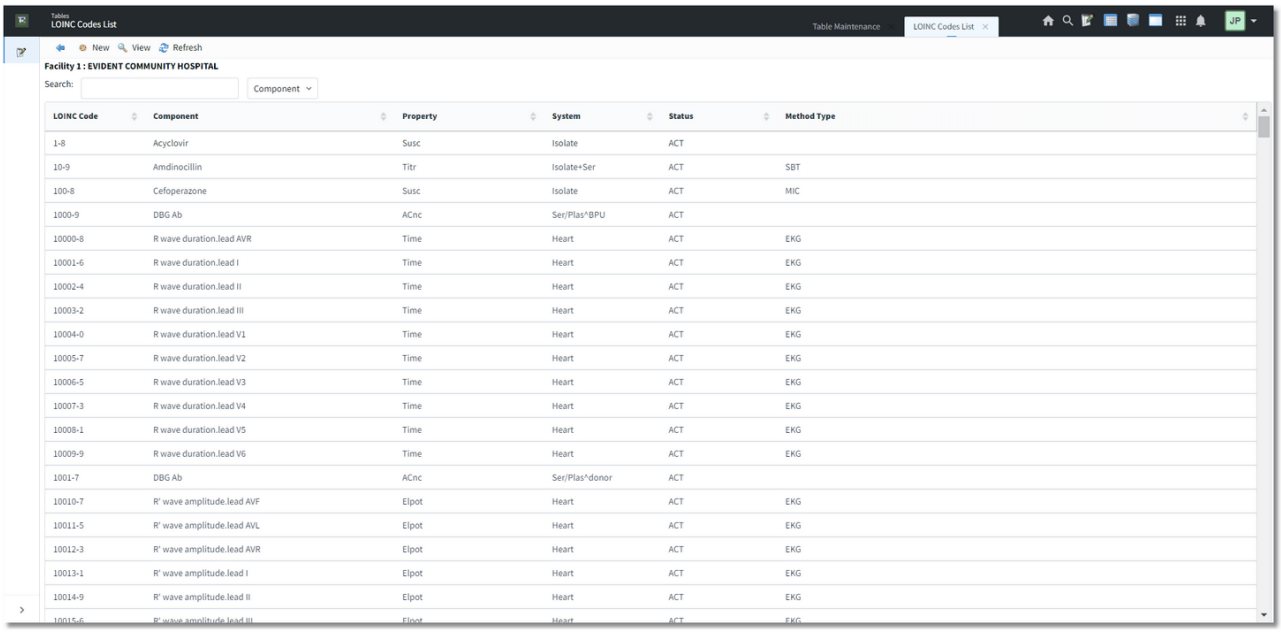
- **when NRBC greater than:**
  - Options: 1-99
  - Usage: Designates the number of NRBC counted manually, which must be exceeded before the WBC is automatically corrected.

- **Blood Administration Application:**
  - Default: Blank=N
  - Options: Blank or Checked(Y)
  - Usage: If site has purchased Blood Administration Application, this field should be checked. Will not allow the use of the application if not checked.

10.4 LOINC Code Table

The TruBridge EHR has the ability to use LOINC codes (Logical Observation Identifiers Names & Codes) in the Laboratory application. A LOINC database, which currently contains 41,000 entries, is available for download at no charge. In addition, users may define and store their own codes for use in the system. From this table, existing codes may be displayed and new ones may be created.

Select **Web Client** > **Tables** > **Control** > **LOINC Codes**



LOINC Code Table

The default search is Component, but may be changed to Code by using the drop-down search topic to the right of the search window.

Select **New** on the action bar to create new LOINC code fields.

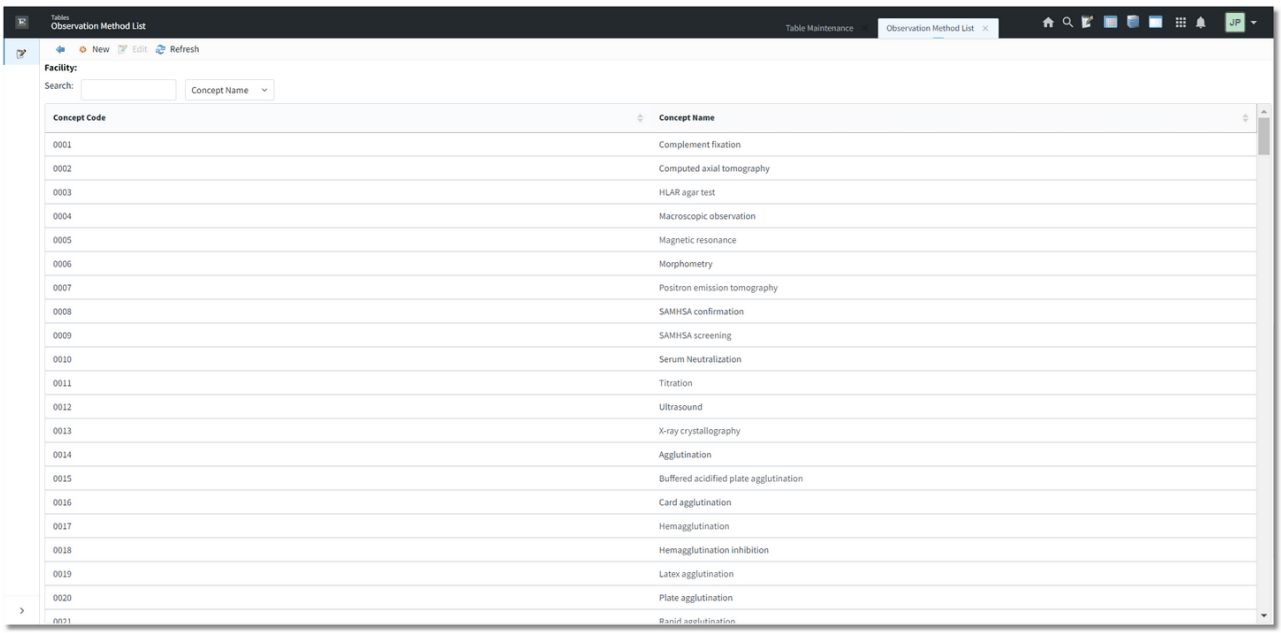
Select **View** on the action bar to view the LOINC information as well as delete any user-defined LOINC codes.

Select the  **back arrow** on the action bar to exit to the previous screen.

10.5 Observation Method

The Observation Method table stores a list of Observation Method Codes (Concept Codes) and Method Descriptions (Concept Names). The laboratory often refers to these as the Methodology of a procedure/test. This table operates in conjunction with the Reference Range Table. See the chapter for Reference Range Tables for the instructions on adding the code to the Reference Range Table entries.

Select **Web Client** > **Tables** > **Control** > **Observation Method**



Control Table -Observation Method

The user may search by Concept Name or Concept Code by using the drop-down search topic to the right of the search window.

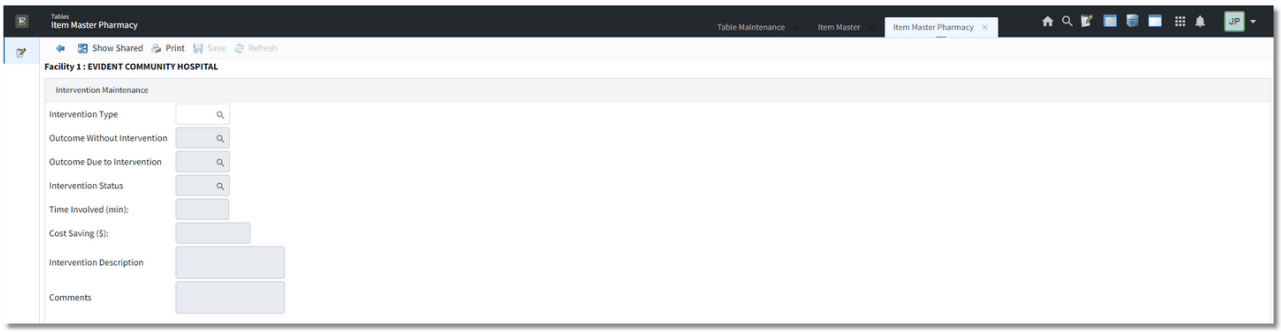
To add a new Observation Concept Name and Code, select **New** in the action bar.

To change an existing entry, select the entry and then select **Edit** in the action bar.

Intervention

Select **Intervention** on the action bar to access the Intervention Maintenance screen.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Intervention**



Predefined Intervention Setup

- **Intervention Type**
  - Default: Blank
  - Options: Select intervention type from look up menu.
  - Usage: There can be as many as 36 different Intervention types. elect 99-Other to use an Intervention Type that is not setup or to use an unlisted Intervention Type.

- **Outcome Without Intervention**
  - Default: Blank
  - Options: Select suspected outcome from look up menu.
  - Usage: There can be as many as 12 selections to choose from. Enter a ? (Question mark) to display a lookup. Select 99-Other to use an unlisted Outcome Without Intervention.

- **Outcome Due to Intervention**
  - Default: Blank
  - Options: Select outcome due to intervention from look up menu. Select by sequence number.
  - Usage: Enter a ? (Question mark) to display a lookup. Select 99-Other to use an unlisted Outcome Due to Intervention. There can be as many as 12 selections to choose from.

- **Intervention Status**
  - Default: Blank
  - Options: Select Intervention Status from look up menu. Select by sequence number.
  - Usage: Enter a ? (Question mark) to display a lookup. Select 99-Other to use an unlisted Intervention Status. There can be as many as 12 selections to choose from.

- **Time Involved (min)**
  - Default: Blank
  - Options: 0 – 999.9 minutes
  - Usage: Enter the number of minutes spent by the pharmacist on the intervention. (See Pharmacy Reference Manual Chapter 8 for further information).

- **Cost Savings ($)**
  - Default: Blank

- Options: 0 – 9999999.99
- Usage: If a dollar figure is applicable to the intervention performed, enter the amount. (See Pharmacy Reference Manual Chapter 8 for further information). If not applicable, type <-1> and press <Enter>. This enters $0.00 in the Cost Savings field.

- **Intervention Description**
  - Default: Blank
  - Options: Allows four lines of text describing intervention performed.
  - Usage: Description is especially important if using the 99-Other option for Intervention Type.

- **Comments**
  - Default: Blank
  - Options: Up to four lines of free text
  - Usage: Allows up to four lines of additional information to be entered. The Comments field is free text.

NOTE: *A report listing all predefined interventions can be generated by selecting* ***Department Specific*** *from the Hospital Base Menu and then selecting* ***Predefined Interventions****.*

10.6 Performing Labs

The Performing Labs table will be set up by the user to house any third party that is currently performing tests for the site. The table provides fields to contain the third party's CLIA#, Code, Name, Address 1 and 2, City, County, State, Zip, Country, Medical Director, Medical Director NPI, and the Lab Director. Contact Interface Support for any questions regarding the Performing Labs table.

NOTE: *For facilities outside of the United States, the address fields will display Province and Postal Code instead of State and Zip code respectively if the Country Code field is set to another country other than "US." A TruBridge representative will need to be contacted in order for these address fields to be activated.*

Select **Web Client** > **Tables** > **Control** > **Performing Labs**

Performing Labs

To add a new Performing Lab, select **New** in the action bar on the bottom of the screen.

To change an existing entry, select the entry and then select **Edit** in the action bar on the bottom of the screen.

10.7 Reference Range Table

The Reference Range table is a three-page table used to define results fields for both numeric and alphabetic test. Entries may be made for any ancillary department that utilizes result entry for patient reports. Panel names are not defined in this table nor are results with free-form formats.

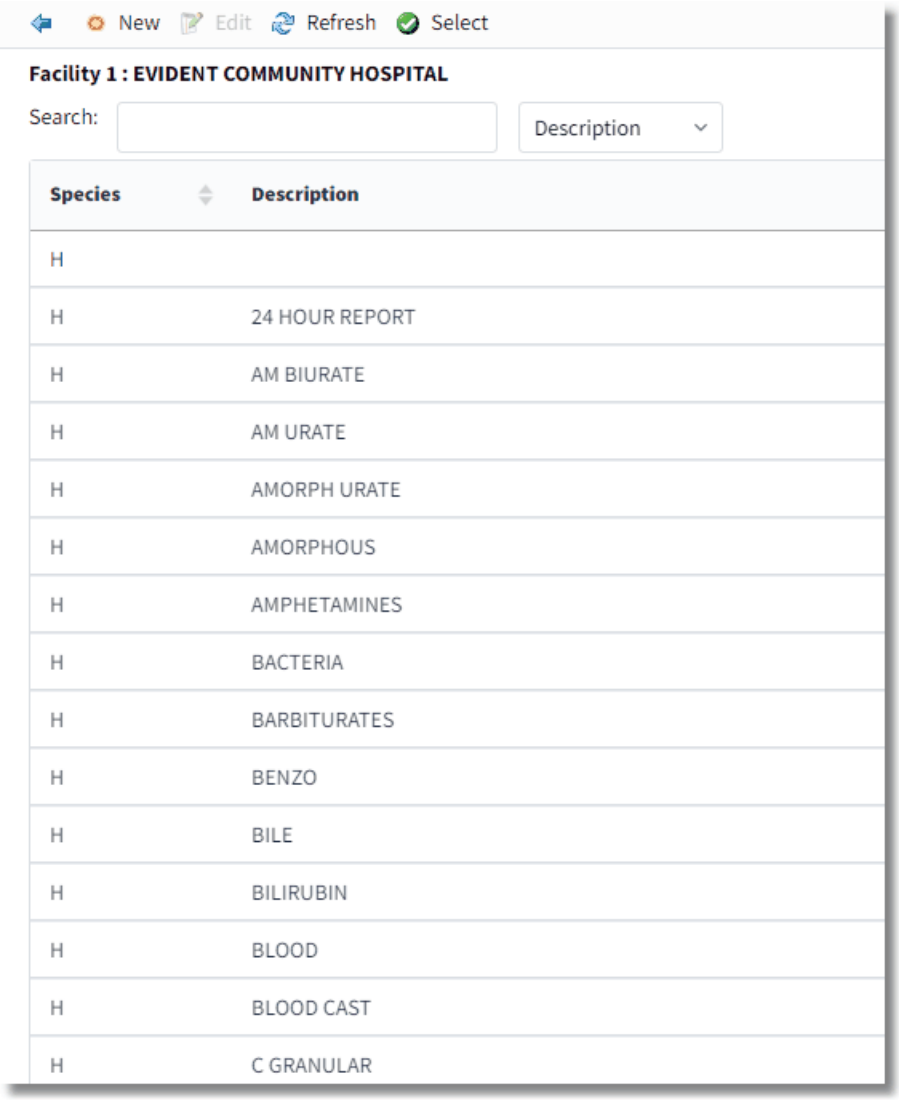
Access to this table is based on department or employee security and may be located via the following path: **Web Client** > **Tables** > **Control** > **Reference Range Table**.

Features of the Reference Range table include the following:

- Define human, feline, canine, bovine, and equine reference ranges
- Reference ranges may be set up for 15 different age groups for each sex. The system will compare the results to the appropriate reference values and flag patient as H (High), L (Low), HC (High Critical) or LC (Low Critical).
- Ability to add SNOMED codes to H,L, HC or LC ranges and the ability to add SNOMED codes to flagged alpha answers.
- Any changes made to the reference ranges for numeric or alpha answers will be reflected by an Effective Date field. Upon receipt of v19 release, that date will be reflected in the Effective Date field until change are made.
- Ability to define numeric and alphabetic results to print in columns on the comparative report
- Indicate method units.
- Up to four decimal points may be used. The system will “line up” decimal points on the comparative report.
- Sequence results on the Comparative Report.
- Define age and sex specific reference (normal) ranges.
- Define extreme result limits that prompt the user to acknowledge if correct. The system will prompt if result value exceeds defined extreme limits.
- Define pre-defined alpha answers for alpha answered tests.
- Attach an interpretive document that will print once on the comparative report.
- Define calculations, reflexive testing and quality control for each reference range entry.

Build a Reference Range Table entry for each procedure that will refer to this table for patient results.

Select **Web Client** > **Tables** > **Control** > **Reference Range Table**



Lab Reference Range Master

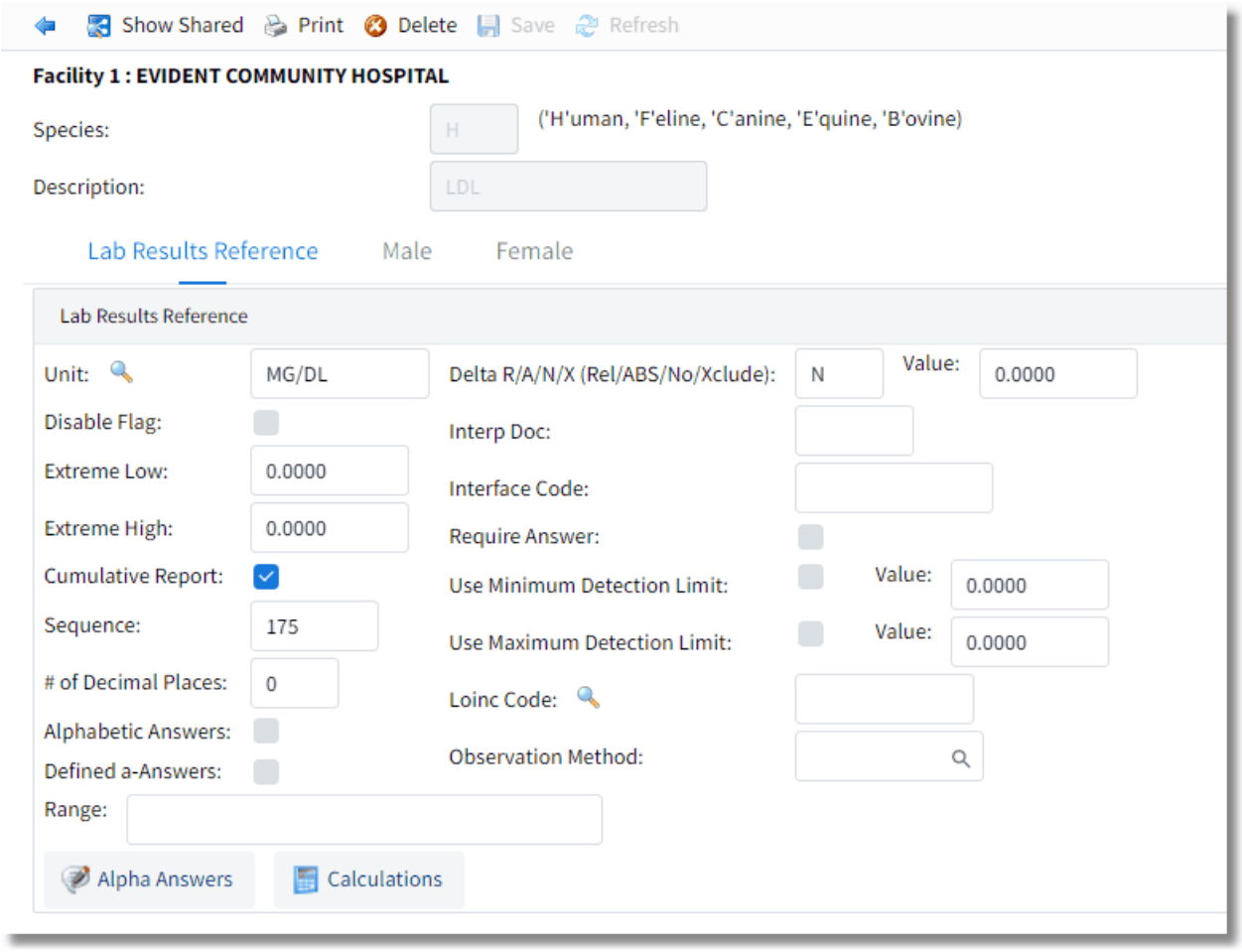
The Species will appear in the left column and the test entries will appear in alphabetical order. The screen provides a **Search:** window and a drop-down search choice option of Species or Description.

To create a new entry, select the **New** option located in the action bar at the bottom.

To edit an existing entry, select the desired test, select the **Edit** option located in the action bar at the bottom or double-click the desired test.

Defining Numeric Results

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Select Test**



Lab Results Reference

Define each test requiring a result entry format, using the following criteria for each field:

- **Species -** Options: 'H'uman, 'F'eline, 'C'anine, 'E'quine, or 'B'ovine

- **Description**
  - Default: None
  - Options: Columnated results: thirteen characters or less. Non-columnated, detail results: twenty characters or less.
  - Usage: Enter the test description (name), to appear on the resulting report.
    - o Numbers, spaces and punctuation may be included in the description.
    - o Description limits must include spaces and punctuation.

  EXAMPLES: AMYLASE 24 HR URINE rather than 24 HR URINE AMYLASE. Adding a space in front of a test name is frequently used for urine analytes when there is an existing entry. (space) GLUCOSE

- **Unit**
  - Options: Columnated results: Five characters or less. Non-columnated, detail results: ten characters or less.
  - Usage: Select the lookup icon to choose from the appropriate unit from the UCUM table or manually enter the units reported for this test if not using the UCUM table. Every effort should be made to be consistent with upper and lower case letters in the units to avoid confusion to the clinical staff.

- **Disable Flag**
  - Default: Unchecked(No)
  - Usage: Controls the abnormal high, low and/or critical flags for this test.
    - Checked (Yes): Will disable the reference ranges from printing on the Comparative and preliminary reports. Results will not be flagged as H, L or critical. Typically used for tests that do not have reference range values (e.g.: INR, Height, Weight) otherwise system will display and print L=0, H=0.
    - Unchecked (No): Reference range flags are enabled.

- **Extreme Low**
  - Options: Eight-digit number.
  - Usage: Controls a low value warning flag to prompt at result entry that is independent of critical result flag.
    - Enter a low value to alert the technologist with an extreme value warning.
    - This field is useful to aid in acknowledging established, reportable range or linearity limits, and resulting errors.

- **Extreme High**
  - Options: Eight-digit number.
  - Usage: Controls a high value warning flag to prompt at result entry that is independent of critical result flag.
    - Enter a high value to alert the technologist with an extreme value warning.
    - This field is useful to aid in acknowledging established, reportable range or linearity limits, and resulting errors.

- **Cumulative Report**
  - Default: Unchecked (No)
  - Usage: Controls if entry is to print to Comparative Reports.
    - Checked (Yes): Designates this test to appear on the comparative and cumulative summary comparative reports.
    - Unchecked (N): Will suppress this test from printing to the Comparative Reports. If a reference range entry is defined for a calculation (e.g.: HEIGHT, WEIGHT, # OF SQUARES, etc.), it may be appropriate to enter an **N** in this field.

- **Cumulative Sequence**
  - Default: 0 (zero)
  - Options: Number from 1-999. Enter **-01** to remove entry
  - Usage: Controls the sub-department sequence for this test on Comparative Reports
    - This entry is used to assign the sequence in which this test is to appear on the comparative or cumulative summary comparative reports. Is also used to sequence custom called-in comments.
    - Each laboratory sub-department that prints on the comparative has a sequence range from 1-999.

- Sequence numbers should be assigned in increments of 5 or 10 so additional tests may be inserted without having to renumber the entire department. Tests without a sequence number will appear alphabetically on the comparative report after sequenced tests.

- **# of Decimal Places**
  - Default: 0 (zero)
  - Options: 0, 1, 2, 3 or 4
  - Usage: Defines the number of decimal places reported for numeric test results. System will round up or down any result entered with more that the defined number of significant digits.

- **Alphabetic Answers**
  - Default: Unchecked (No)
  - Usage: This field designates whether the test result is alphabetic or numeric. If numeric, leave blank**,** if alphabetic enter a check in this field.

- **Defined Alpha Answers**
  - Default: N (no)
  - Usage: When Alphabetic answers is checked, this field is used to indicate if pre-defined answers are being used for result entry. This field will default to unchecked if field 8 is unchecked.
    - Checked (Yes): Pre-defined alpha answers are defined for this entry. See section for **Alpha Answers Definitions**.
    - Unchecked (No): Pre-defined alpha answers are not defined for this entry. System will allow entry of a numeric or alphabetic result.

- **Range**
  - Options: Up to forty characters or numbers
  - Usage: Enter information pertaining to this table entry. This information does not pull to result formats.

  EXAMPLES: *Date the test was placed in use, date reference ranges were established. Entry is for Respiratory care, Dietary, or QC use. This is helpful when similar tests are defined for multiple departments (pH, height, or weight).*

  NOTE: *This field will change to the word* ***RANGE*** *when the Alphabetic Answers field is checked and will allow the user to enter what the Normal range would be for that particular alpha test. The information in this field will pull to the patient comparative report.*

- **Delta**
  - Default: N
  - Options:
    - R: Designate a relative value to check the selected test, enter the % in the second field.
    - A: Perform delta check by an absolute value based on the units defined in field 1, enter the value in the second field. *Example: MCV 3 fL, RDW 2, or HGB 2 g/dL*
    - N: Performs check using a default percentage. Default is defined in **Delta Rel Default %** field on page 1 of the Laboratory Control Table.
    - X: Excludes this test from Delta Check.
  - Usage: The Delta Check option is used to notify the technologist at result entry if the current test result is different from the last result, based on the above options.
  - Requirement: A **Y** must be entered in **Delta check:** field on page 1 of the Laboratory control table to use delta-checking feature.

- **Interp Doc**
  - Options: Up to four-character document name
  - Usage: Controls the placement of an Interpretive Document on the comparative report for this entry.
    - o There are occasions when a test does not have an established reference range or interpretive data is used for diagnostic purposes.
    - o Examples are INR, cardiac risk index, etc.
    - o An interpretive document is created in the /usr3/f/lab1 directory. A document name of up to four characters is entered in this field.
    - o The interpretive document will print only once at the bottom of the designated sub-department section for the comparative report. It will print when the first order has a completed result.

- **Interface Code -** This option is used for a customized Reference Lab interface.

- **Require Answer**
  - Default: Unchecked (no)
  - Usage: This field designates if an answer is required in the result or comment field. A check mark in this field will require a result or comment to be entered in the result field before exiting off the result screen.

- **Use Minimum Detection Limit**
  - Default: Unchecked (No)
  - Value: The numeric value determined to be the lower linearity of the interfaced instrument.
  - Usage: A check mark (Yes) in this field will allow interfaced results that are less than the value field to be reported with a **<** -less than sign and the limit defined. When autoverify is in use, these results will be sequestered based on the settings in the analyzer autoverify table.

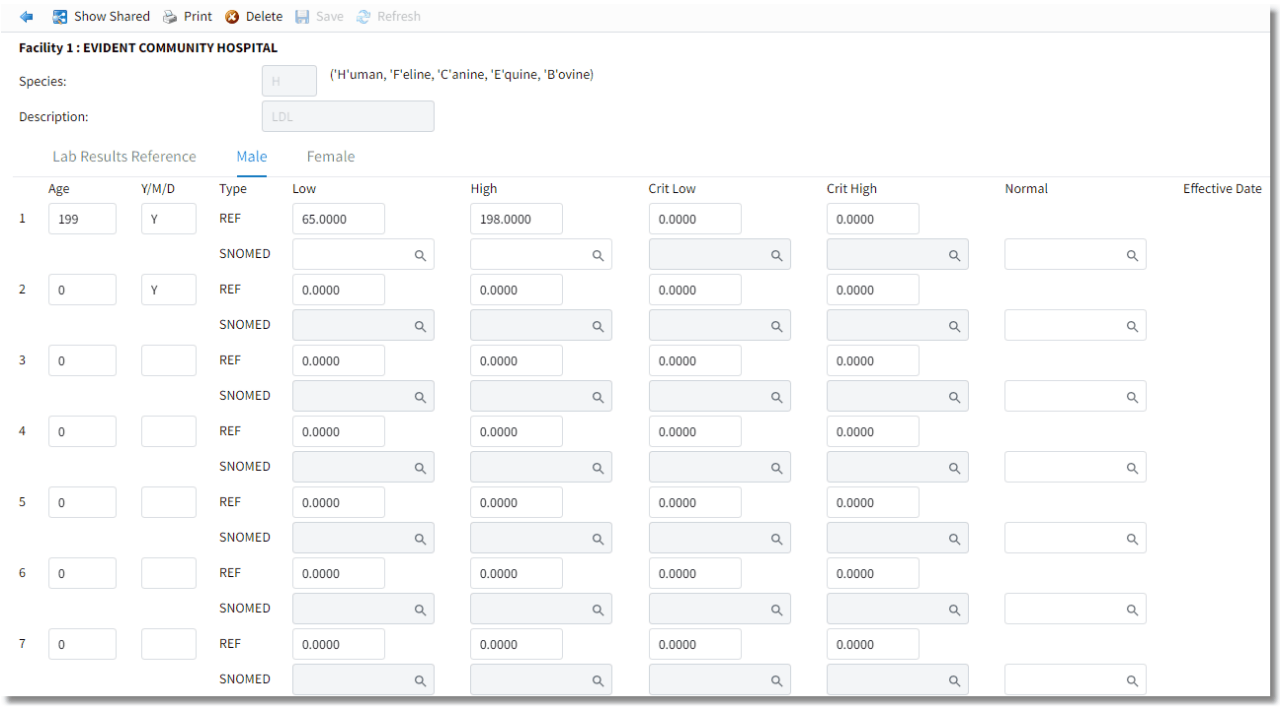
- **Use Maximum Detection Limit**
  - Default: N
  - Value: The numeric value determined to be the upper linearity of the interfaced instrument.
  - Usage: A check mark (Yes) in this field will allow interfaced results that are greater than the value field to be reported with a **>** -greater than sign and the limit defined. When autoverify is in use, these results will be sequestered based on the settings in the analyzer autoverify table.

- **LOINC Code:**
  - Options: Entry of LOINC code by user or by typing a **?** will initiate a look-up function.
  - Usage: The LOINC laboratory terms set provides a standard set of universal names and codes for identifying individual laboratory and clinical results. LOINC codes applied to a result, may be displayed via the **Look w/Audit** option under Order Review. The LOINC codes may be available via the Ad Hoc Reporting system.

- **Observation Method -** Entry of an Observation Method(Concept Codes) or descriptions may be entered via the Lookup Icon to the right of the field. Many users refer to these as the 'Methodology' of a procedure.
  - Default: Empty
  - Usage: Once an Observation Method is selected from the Lookup Icon, the user must select Save to apply the method to the test. This information will be captured during the resulting process in Lab and becomes part of the information sent out via an interface to third-party vendors, State and Federal agencies.

Male and Female Reference Range Maintenance

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Select Test** > **Select Male Tab**



Male Reference Range

Male reference ranges are defined on the Male tab. Fifteen different age ranges may be defined for each sex. Female ranges are entered on the Female tab. Features of the table include:

- The system defaults to a beginning age of **0** (zero, birth) and will then look at the age in line 1 to determine the first age range.
- Entries in the female table are not necessary if reference ranges are not sex specific. The system will read up.
- Reference Range values printing to comparative reports are limited to four digits including a decimal point.
- Numeric entries that are designated to print in detail are limited to no more than five numbers to the left of the decimal place and no more than two numbers to the right of the decimal.
- Entries made to the table may be used in reflexive testing criteria and age/sex specific calculations.

To build the table, enter the ending age for the first range in column 1 of line 1. To apply a range to all age groups, we recommend the use of age **199** to cover all possible age ranges. For multiple age entries, lower age ranges must be entered before higher age ranges. Ages are **less than** entries, i.e., for an age range of **up to** (and including) 10 years, the entry must be 11. If the patient age is higher than any range found in the table, the system will use high and low values of zero (0).

In the second field, enter **Y** for years, **M** for months or **D** for days to indicate specific ranges. Pressing **Enter** will automatically apply **Y** (years).

Under the appropriate heading, enter the low and high values of the reference range. These ranges are inclusive. Example: SODIUM L=132 and H=145, 132 would not flag as **L** but 131 would flag **L**.

If critical ranges have been established, enter the low and high critical limits. These values are also inclusive. Values must be entered in both critical ranges even if only one critical flag is used. Example: APTT high critical >100 seconds, enter **1** in low critical field.

Continue to enter reference range values for each subsequent age range. To exit from table entry, enter a **0** (zero) in the Y/M/D column and the cursor will move to the command line.

To add appropriate SNOMED codes to H,L, HC or LC ranges, select the SNOMED list icon to the right of the field and select from the list or enter the SNOMED code manually.

Any changes made to the reference ranges for numeric will be reflected by the Effective Date field.

Select the **Female tab** to access the female reference range table. Enter female reference range values for each age range in the same manner as male ranges. To apply a range to both Males and Females, it is only necessary to fill in the section for Male reference ranges.

NOTE: *To remove an numeric value entry, type a zero (0) on the field. To remove an alpha character like, D, M or Y, highlight the field and select the Delete key.*

The following icons listed in the action bar are:

- **Print:** Will open the reference range table entry in adobe reader 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 'Refresh and Lose Unsaved Changes', Yes or No.

Possible flags:

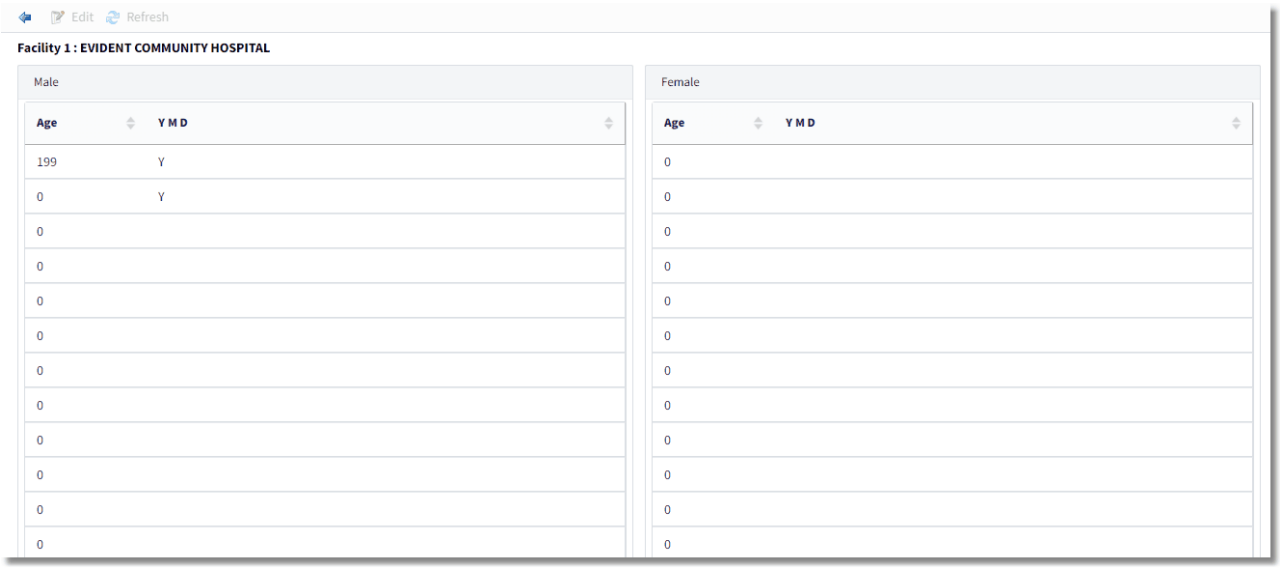
- **LC**: Result is lower than low critical limit
- **L**: Result is lower than low limit but higher than low critical limit
- **H**: Result is higher than high limit but lower than high critical limit
- **HC**: Result is higher than high critical limit

Calculations

Result calculations may be defined for each age and sex entry in Results Reference Master Index. Fifteen reference range entries are possible for males and females, allowing a total of thirty calculations to be defined. Features of the calculation table include:

- If only one calculation is necessary the system **will read up** and use the first entry.
- Tests defined for different species are also able to utilize this option.
- All fields used in the calculation must be included in the result format, be formatted in the correct sequence to perform the calculation, and must reside in the Reference Range Tables.
- If a calculation requires another calculated field and the user doesn't necessarily want it to appear on the result screen and report, that calculation must be set up in the Reference Range table but **not** in the result format. For example, a BSA used in calculating a Creatinine Clearance doesn't necessarily have to appear on the lab report if the user so desires.
- The ability to change a numeric result to an alpha by typing @ followed by an alpha result code will remain an option for numeric calculated results that may be amended.

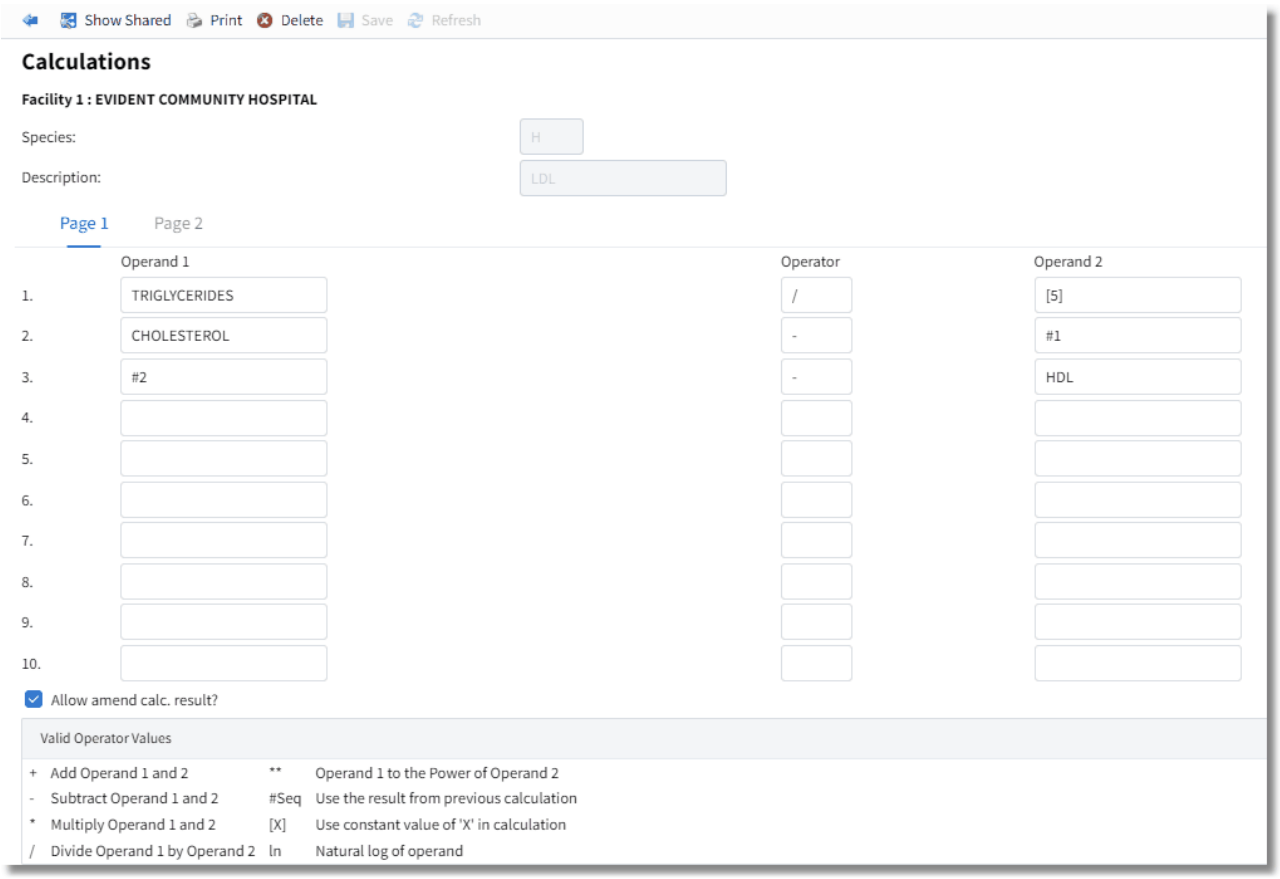
Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Edit** > **Calculations**



Calculation Criteria

- The Calculation Criteria table of defined reference ranges will display and indicate the age, sex, and whether a calculation has been defined. Select the desired age entry to define a calculation.

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Edit** > **Calculations** > **Select Age** > **Edit**



Completed Result Calculation

- This table has ten lines, allowing up to ten different operations. Use one of the operation values listed at the bottom of the screen in the 'Valid Operator Values' area to define each line of the calculation.

  NOTE: *The order that calculations are listed must follow basic arithmetic rules of operation.*

  EXAMPLE: *LDL=(CHOLESTEROL–HDL)– (TRIGLYERIDE / 5)*

  NOTE: *When setting up the calculation of the natural logarithm, it may be necessary to multiply the log value by 1 in order to fit the format of the calculation screen.*

- Define the first operation of the calculation by entering the test name or constant in Operand 1. This is followed by the operation symbol and then the test or constant performing the operation.
  - In our example for calculating LDL, line 1 defines the first part of the calculation.
  - Line 2 defines the second operation of the calculation.
  - Line 3 uses the results of the previous two lines to calculate LDL

- Allow amend calc. results? checkbox field is used to indicate if at result entry, the calculated result may be changed.
  - The default is **Unchecked** (no).

- A calculated result field may only be changed if this option is set to **Checked** (yes).

- Select **Save** to save the calculation

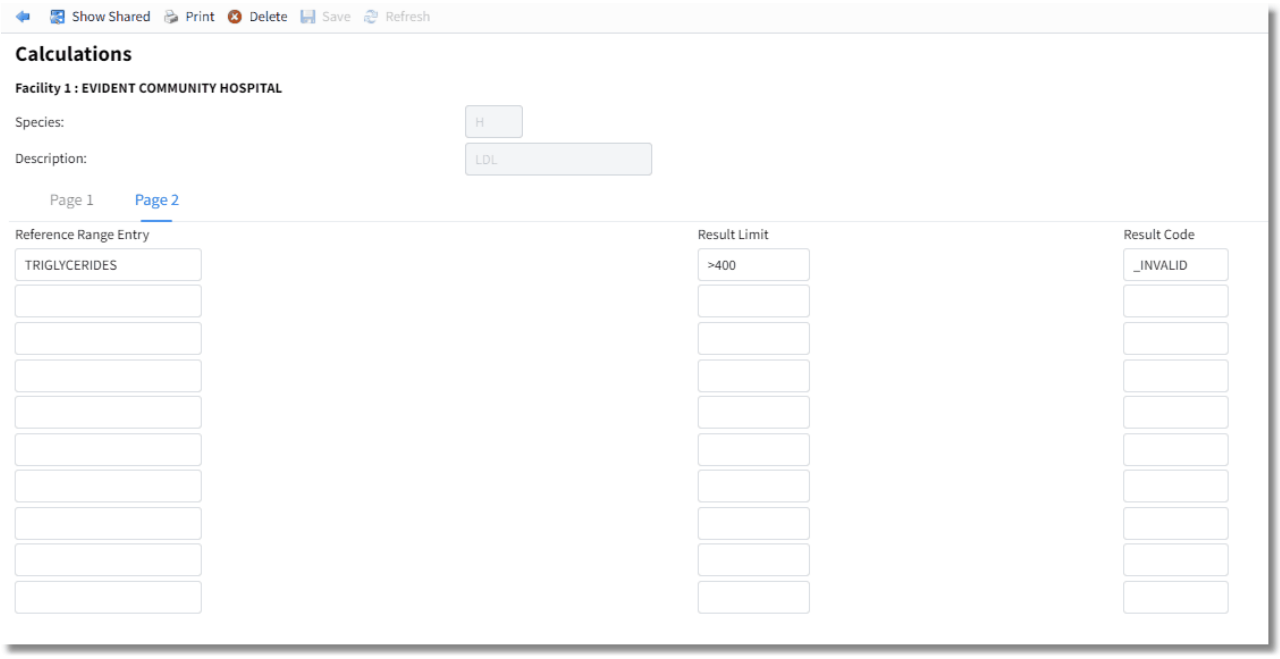
- Once a calculation has been defined a **Y** will display under **Computed Result Calculation** column in the **Calculation Criteria** screen.

Defining Calculation Limits

Currently the Calculation Limit defining must be performed by accessing the Reference Range Tables via Department Specific of the Laboratory Hospital Base Menu screens. Result codes may be defined for calculated values when parameters exceed defined limits.

A typical example is LDL values that cannot be calculated when a TRIGLYCERIDE value is greater than 400 mg/dL. When the defined Result Limit is exceeded, the system automatically inserts the corresponding Result Code into the calculated result field.

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Edit** > **Calculations** > **Select Age** > **Edit** > **Page 2**



Calculation Limits

- The Calculation Limits table allows up to ten Reference Range Entry definitions for components used in the calculations.

- The Result Limit column defines greater than **>** or less than **<** values for the corresponding Reference Range Entry. When the Result Limit is exceeded, the calculation does not occur.

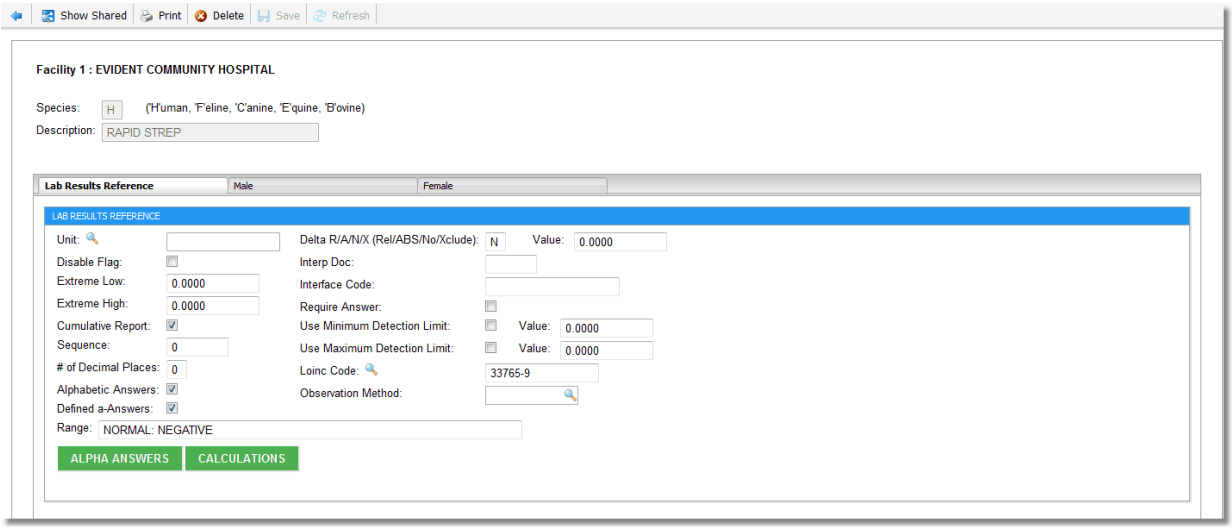
- The Result Code allows up to eight characters to define the answer which will be applied to the calculated result field when the Result Limit is exceeded.

EXAMPLE: NOT CALC, NOT APPL, INVALID, or REPEAT.

Defining Alphabetic Results

Alphabetic (alpha) answers are defined differently from numeric results in the Reference range tables. Alpha answers may be either free-text entry or pre-defined. Pre-defined answers allow all possible reportable results to be specified in the system. During result entry, only one of the pre-defined answers may be selected. Entry of @ in a result field allows a free-text entry of an alpha result as opposed to selecting from the pre-defined answers. Pre-defined answers are extremely useful to build consistency and prevent spelling errors. Free-text alpha answers will allow any alphabetic or numeric answer to be entered.

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Select Test**



Lab Results Reference

- **Species -** Options: 'H'uman, 'F'eline, 'C'anine, 'E'quine, or 'B'ovine

- **Description**
  - Default: None
  - Options: Columnated results: thirteen characters or less. Non-columnated, detail results: twenty characters or less.
  - Usage: Enter the test description (name), to appear on the resulting report.
    - o Numbers, spaces and punctuation may be included in the description.
    - o Description limits must include spaces and punctuation.

- **Unit**
  - Options: Columnated results: six characters or less. Non-columnated, detail results: ten characters or less.
  - Usage: In general alpha tests do not have units, leave this field blank if applicable.

- **Disable Flag -** This field is not utilized for alpha results.

- **Extreme Low -** This field is not utilized for alpha results.

- **Extreme High -** This field is not utilized for alpha results.

- **Cumulative Report**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls if entry is to print to Comparative Reports.
    - Y: Designates this test to appear on the Comparative Report and cumulative summary comparative reports.
    - N: Will suppress this test from printing to the Comparative Report.

- **Cumulative Sequence**
  - Default: 0, zero
  - Options: Number from 1-999. Enter **-01** to remove entry.
  - Usage: Controls the sub-department sequence for this test on Comparative Reports.
    - This entry is used to assign the sequence in which this test is to appear on the comparative or cumulative summary comparative reports. Is also used to sequence custom called-in comments.
    - Each laboratory sub-department that prints on the comparative has a sequence range from 1 – 999.
    - Sequence numbers should be assigned in increments of 5 or 10 so additional tests may be inserted without having to renumber the entire department.
    - Tests without a sequence number appear alphabetically after the sequenced tests.

  NOTE: *Reflexed Comments that are defined in the Reference Range tables and should footnote with the tests name to which they apply, should NOT be assigned a Cumulative Sequence number. If a Cumulative Sequence number is assigned to these comments, the comment will footnote without the tests name to which it applies.*

- **# of Decimal Places -** This field is not utilized for alpha results. A default of **0**(zero) will display.

- **Alphabetic Answers**
  - Default: Unchecked (no)
  - Options: Checked(yes) or Unchecked(no)
  - Usage: When checked, this field will allow this test to be resulted with an alphabetic answer.

- **Defined Alpha Answers**
  - Default: Unchecked (no)
  - Options: Checked(yes) or Unchecked(no)
  - Usage: When field 8 (Alphabetic answers) is checked, this field is used to indicate if pre-defined answers are being used for result entry. This field will default to unchecked when field 8 is is unchecked.
    - Y: Pre-defined alpha answers <u>are</u> defined for this entry. Option **Alpha Answsers Def** will appear at the bottom of the display. See **Alpha Answer Definitions section** to define answers.
    - N: Pre-defined alpha answers <u>are not</u> defined for this entry. Will allow entry of a numeric or free-text alphabetic result.

- **Range**
  - Options: Up to eighteen characters or numbers.
  - Usage: If field **8-Alphabetic Answers** is checked(Y), **COMMENT** field changes to **RANGE**. Normal or expected results for alphabetic answers are entered in this field and will print on the

comparative report. Result formats for alphabetic results must include the normal/expected result to print on preliminary reports. See Order Entry Results Format section in this user guide.

Examples: *Negative, None seen, Non-reactive*

- **Delta -** This field is not utilized for alpha results.

- **Interp Doc**
  - Options: Up to four-character document name
  - Usage: Controls the placement of an Interpretive Document on the comparative report for this entry.
    - There are occasions when a test does not have an established reference range or interpretive data is used for diagnostic purposes.
    - Examples are INR, cardiac risk index, etc.
    - An interpretive document is created in the /usr3/f/lab1 directory. A document name of up to four characters is entered in this field.
    - The interpretive document will print only once at the bottom of the designated sub-department section for the comparative report.
    - This is regardless of the number of times the test was ordered.

- **Interface Code -** This option is used for a customized Reference Lab interface.

- **Require Answer**
  - Default: Unchecked (no)
  - Options: Checked(yes) or Unchecked(no)
  - Usage: When selected, this field designates if an answer is required in the result or comment field.

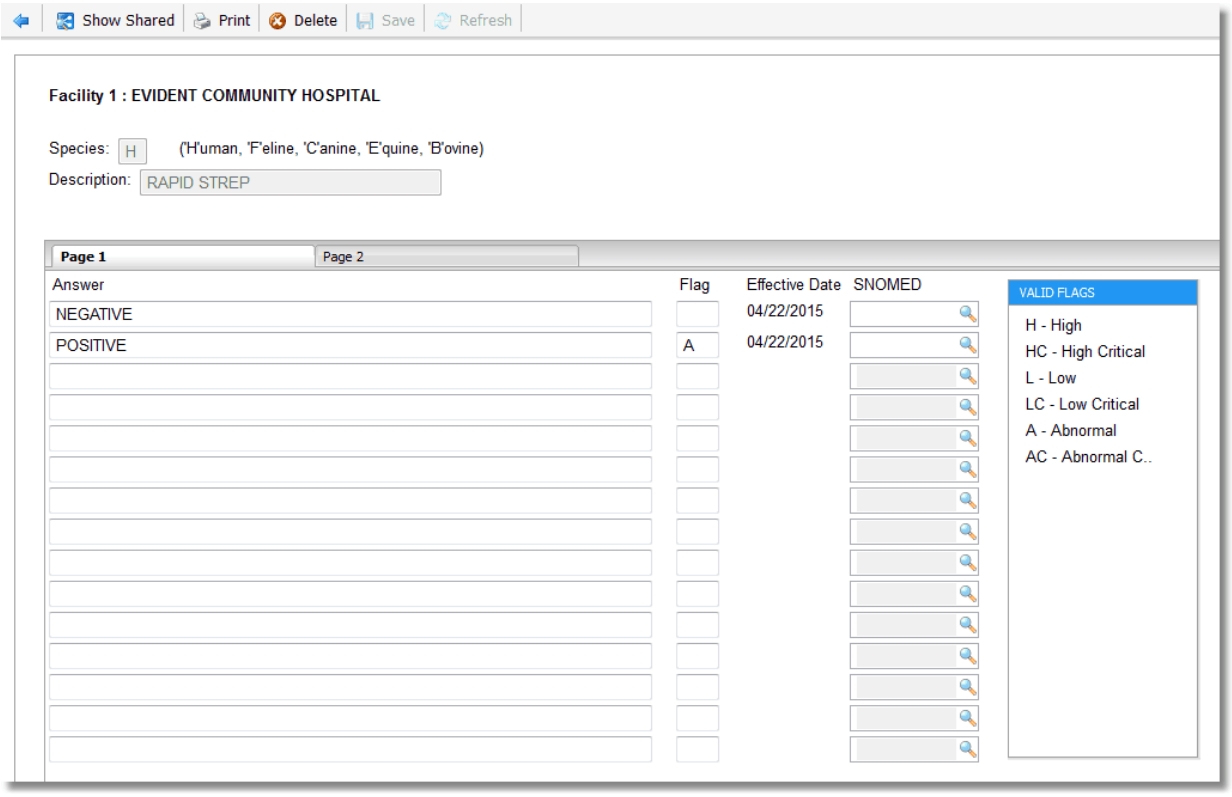
- **Use Minimum Detection Limit -** This field is not utilized for alpha results.

- **Use Maximum Detection Limit -** This field is not utilized for alpha results.

- **LOINC Code**
  - Options: Entry of LOINC code by user or by typing a **?** will initiate a look-up function.
  - Usage: The LOINC laboratory terms set provides a standard set of universal names and codes for identifying individual laboratory and clinical results. LOINC codes applied to a result, may be displayed via the **Look w/Audit** option under Order Review. The LOINC codes may be available via the Ad Hoc Reporting system.

- **Observation Method -** Entry of an Observation Method(Concept Codes) or descriptions may be entered via the Lookup Icon to the right of the field. Many users refer to these as the 'Methodology' of a procedure.
  - Default: Empty
  - Usage: Once an Observation Method is selected from the Lookup Icon, the user must select Save to apply the method to the test. This information will be captured during the resulting process in Lab and becomes part of the information sent out via an interface to third-party vendors, State and Federal agencies.

Select **Web Client** > **Tables** > **Control** > **Reference Range Table** > **Select Test** > **Alpha Answers**



Alpha Answers

- After selecting the **Alpha Answers** option, the Alpha Answer Definitions screen will display. Up to thirty answers (fifteen per page) may be defined.

- Enter the first pre-defined answer in the first line under the first column, **Answer**. If the test is to print in columns on the comparative report, limit the entry to thirteen characters. If the test is designated to print in detail (not in columns), the limit is forty characters.

  NOTE: *If graded results (1+, 2+, 3+, etc.) are reported, enter each choice in a separate line.*

- When the answer has been defined, press **Enter** to advance to the second column, **Flag**. A list of possible flags is displayed on the menu.
  - If H, L, A, LC, HC, or AC flags are defined in Alpha Answer definitions, of the Reference Range tables, the number of underlines included in the format must be decreased. This will also result in a decrease in the pre-defined answer length.
    - o If a one or two character flag is defined, alpha result lines must be ten underlines or less. Pre-defined alpha answers cannot exceed eight characters.
    - o If alpha results are interfaced (with or without flags), alpha result lines must be ten underlines or less.
    - o If alpha result formats contain pre-defined units of measure, they must start in position 48 or 56-78.

- To add SNOMED codes to flagged alpha answers, select the List Icon to the right of the SNOMED field and select from the list or enter the value in manually.

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

***CAUTION**: The use of flags for alphabetic answers requires modification of the result format. Flags will print on both the preliminary and Comparative Reports. See Order Entry Results Format in the Ancillary Reference user guide.*

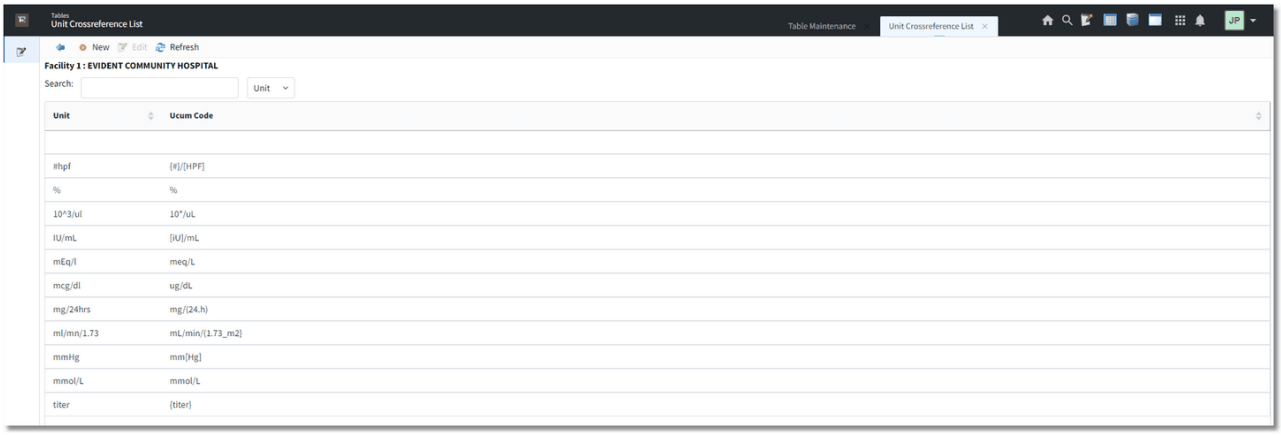
The following icons listed in the action bar are:

- **Print:** Will open the reference range table entry in adobe reader 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**.

10.8 Unit Crossreference (UCUM) Table

When reportable lab tests are transmitted, it is required that the units be transmitted in standard UCUM values (Unified code for Units of Measure). A Unit Crossreference (UCUM) table is available in Table Maintenance to provide a crossreference between the units entered in the Reference Range Table and the defined UCUM value for reporting results.

Select **Web Client** > **Tables** > **Control** > **Unit Crossreference (UCUM) Table**



Unit Crossreference Table

The user may search by Unit or UCUM values by using the drop-down search topic to the right of the search window.

To add a new Unit Crossreference, select **New** in the action bar.

To change an existing entry, select the entry and then select **Edit** in the action bar.

Chapter 11 Materials Management

11.1 Item Master

The Item Master contains the tables in which the charge items are stored and later retrieved during Charge Entry.

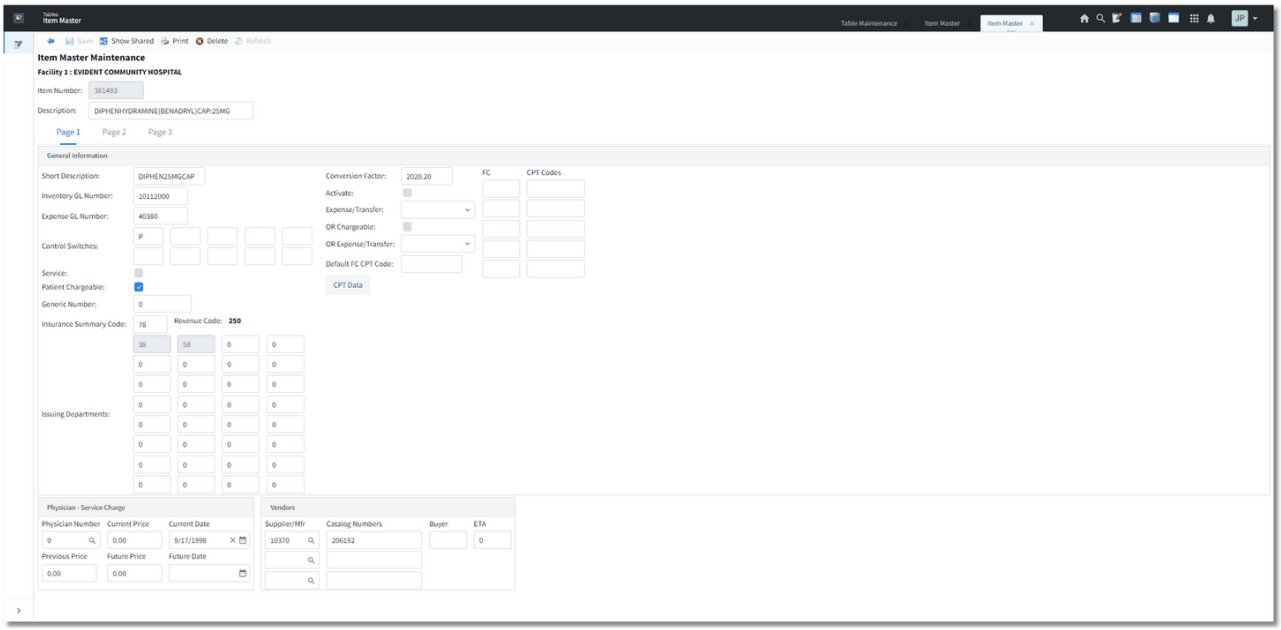
Before an item can be charged to a patient's account, it needs to be set up correctly. There are several aspects to consider when creating items. The items will need correct General Ledger accounts loaded, prices and summary charge codes to ensure the correct Revenue Code pulls for billing purposes. The following sections detail how to set up an item so that it can be used for patient charging.

Select 

New to enter a new item. To edit an existing item, select the item from the list.

Item Master, Page 1

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Page 1**



Item Master, Page 1

- **Item -** The Item Number that will be assigned to this item is entered.
- **Description -** The item description may contain up to 40 characters. It is important to be consistent with the descriptions. For example, all catheters should begin with “CATH” followed by a more detailed description of the item.
  - Sample item descriptions are:
    - AIRWAY 80 MM ADULT SM
    - AIRWAY CHILD

- BANDAGE KERLIX 2”
- BANDAGE KERLIX 3”
- BATTERIES 1.5V AA
- BATTERIES 1.5V C
- CATH TROCAR 16 FR J&J 645852
- ACETAMINOPHEN (TYLENOL) 325MG TABLET

  - Included in the description are the item name, type and size. Maintain consistency in the item description when using abbreviations or any other special characters. Do not use numeric characters at the beginning of the description or any other special characters. The system will search for items in alphabetic order. It is recommended that punctuation such as commas, periods, slashes and dashes not be used as part of the description, with the exception of generic items whose description is typically enclosed with =><=.
  - Before building the item file, consider that other departments will be using item descriptions also. For example, nursing will read the piggyback labels; insurance will be examining the patient account detail; and numerous departments may order goods from the Materials Management department. Therefore, it is important that each department be able to understand the item descriptions.

- **Short Description -** The short description of the item should be as complete as possible, up to 13 characters in length. This field will default to the first 13 characters of the long description; however, the short description may be over-keyed. The short description is used for charge entry, barcode piggyback labels, Med-Verify Med List, insurance and certain inventory reports.

- **Inventory GL Number -** The General Ledger inventory asset account number should be entered in this field for all inventory items (chargeable and non-chargeable). An inventory item is one that will be counted at physical inventory time and is the responsibility of purchasing to track and reorder. It is also an item that is used by several departments. If the item is a direct expense item, then the expense General Ledger number for the appropriate department is entered. Only a valid GL number that is set up in the General Ledger module will be accepted in this field.

- **Expense GL Number -** For most items, key in the first five digits of the supply expense number in this field. There may be multiple expense codes depending on the amount of division used in the General Ledger application. For example, if office supplies need to be categorized separately from general departmental supplies, then a different 5-digit number would be used. If an item is always charged to a specific department, an 8-digit expense General Ledger number may be entered. For direct expenses, leave this field blank. Only a valid GL number that is set up in the General Ledger module will be accepted in this field. This field is utilized with the Materials Management application.

- **Control Switches -** For non-Ancillary departments, the Control Switches are user-defined codes that may be used to distinguish groups or categories of goods to be pulled on inventory database reports. There are 10 spaces available and any letter or number may be used. For Ancillary departments each of the switches has the following functions:

  - **Control Switch 1:** (multiple functions)
    - Used for consolidation of orders for bidirectional lab interfaces and used for storage conditions for bidirectional HL7 Reference Lab interfaces. For interfaced Reference Lab items, it must match what is setup in the Lab Control Table in regards to the Referring Facility Information section.
    - When the item (test) is not performed on an interfaced instrument, switch 1 may be used to designate a batch work list. A Batch Code (upper or lower case letter) is entered in this field that corresponds to a designated batch work-list and will appear in the Batch Code field of order entry maintenance.

  - Used to consolidate modalities for the Radiology Composite Requisition and transcription auto-consolidation. A letter code corresponding to the appropriate modality (i.e. c = CT Modality) may be loaded. This will allow exams with the same modality code that are ordered and verified at the same time to print on the same requisition. Up to 4 exams may print on one requisition. In addition, if a department is using the transcription auto-consolidation feature, the system will automatically combine transcriptions with the same modality code that are charged out at the same time or within 3 minutes of each other.
- **Control Switch 2:** Used for Workload Statistics. When controls are analyzed everyday regardless of the number of patient tests/procedures, the total number of controls is entered in Control switch 2. For example, if two levels of controls are assayed three times a day for Glucose, “6” will be entered in Control switch 2 of the Glucose Item Master. When the patient's first order for Glucose is charged, the system will calculate the workload value by multiplying the Glucose item's workload unit by six and document that value on the Daily Procedure Log.
- **Control Switch 3:** Used for Workload Statistics. When controls are analyzed with every test/procedure, the total number of controls assayed is entered in Control switch 3. For example, if two levels of controls are assayed for each Gentamicin order, “2” will be entered in Control switch 3 of the Gentamicin Item Master. Each time a patient order for Gentamicin is charged, the system will calculate the workload value by multiplying the Gentamicin item's workload unit by two and document that value on the Daily Procedure Log.
- **Control Switch 4:** Used for breaking out Workload by Charge code for sub-departments. Enter a letter that coincides with a laboratory sub-department (see Control Switch 5 below) or for radiology modalities/sub-departments (e.g., *C=CT, M=Mammo, P=Pathology, B=Blood Bank).*
- **Control Switch 5:** Used to categorize and sort tests for the Comparative, Cumulative Detail, Cumulative Summary, Outstanding Orders reports and to View Previous Results. The codes and their functions are built into the program and cannot be modified; they are as listed below:
  - A: Chemistry
  - B: Protein Electrophoresis
  - C: Urine Chemistry
  - D: TDM & Toxicology
  - E: Hematology
  - F: Manual Hematology
  - G: Coagulation
  - H: Body Fluids
  - I: Microbiology
  - J: Parasitology
  - K: Urinalysis
  - L: Immunology
  - M: Cytogenetics
  - N: Cytology
  - O: Histology
  - P: Blood Bank
  - Q: Chemistry Profile
  - R: Reference Laboratory
  - S: User defined in AHIS Control Record Maintenance, Page 5, Reference Lab Names fields
  - T: User defined in AHIS Control Record Maintenance, Page 5, Reference Lab Names fields
  - X: Respiratory Care
- **Control switch 6:** (dual functions)
  - Used to categorize and sort tests by sub-department when printing the Lab Results by Patient report.
  - Used to categorize and sort tests by sub-department when reviewing results by On-Line Supervisor Review.

- **Control switch 7:** Used for designating tests that must print in a non-columnated format (i.e., in detail) on the Comparative Report. Enter a **Y** for non-columnated laboratory results. The default when blank is **N** for columnated results that are limited to 13 characters in length. Columnated results that exceed the 13 character limit will be footnoted at the bottom of the relevant sub-department section on the Comparative Report.
- **Control switch 8:** Used to designate the instrument on which the test is performed if consolidation of labels is used by way of the **Consolidate Order Labels** field (must be checked) in the Laboratory Control Information table. The TruBridge EHR will consolidate orders with the same schedule date/time and print on one label. Consolidation is denoted on the label by an asterisk (*). If this switch is not being used for consolidation of labels, it may be used similar to Control Switch 4 (see above) for designating a letter code to define a modality or sub-department to allow the Workload by Charge Code report to be sorted by this control switch.
- **Control switch 9:** Used to designate items to a specific batch work-list. Upper or lower case letters may be used. This switch has the same batch function as Control switch 1. This allows a test to be included on more than one batch work-list. If the item has component tests done in more than one work area of the lab, it may be placed on additional batch work-lists designated in either or both of these switches.
- **Control switch 10:** (multiple functions)
  - When an Item (test) is performed on a bi-directional instrument, enter the code that corresponds with the download code defined in the Interface Control Table.
  - When the item (test) is not performed on an interfaced instrument, this may be used to designate a batch work list. A batch code (upper or lower case letter) may be entered in this field that corresponds to a designated batch work-list.
  - Used by the lab schedule when using the filter by sub-department.
  - When the Specimen Information Required switch in Order Entry Information is checked, the following will apply:
    - When R is loaded, the exception prompt for Specimen Information will not be evoked.
    - When M is loaded, the following Specimen Information fields must be populated or an exception prompt will appear displaying the missing fields:
      - Item Master LOINC
      - Specimen Type
      - Specimen Source Site
      - Collection Method
      - Collection Amount
      - Collection Units
      - Organism SNOMED
      - Drug LOINC
    - When any letter other than R or M is loaded, the following Specimen Information fields must be populated or an exception prompt will appear displaying the missing fields:
      - Item Master LOINC
      - Specimen Type
      - Specimen Source Site
      - Collection Method
      - Collection Amount
      - Collection Units
      - Reference Range
      - UCUM
      - SNOMED(for Results)

- **Service -** Service items are used by the system to distinguish between procedure-type charges and item charges. Service items, when selected, do not appear on the Physical Count Sheets, the

Inventory Cost Report, the C/S Restocking Report, or the Monthly Activity Report (within the Materials Management application). Examples of items that are considered services would be procedure charges for casting, rentals, or reusable or sterilized instruments. When this field is unchecked, the system will default to **No**. Within the inventory system, a **Yes** or **No** response is necessary.

- **Patient Chargeable -** This field indicates if this item is chargeable or non-chargeable. When this field is checked, it identifies the item as being chargeable and if unchecked it designates non-chargeable. This field is linked to options Item Expense and Item Transfer Requisitions in the Charge Tables Inventory Control screen. This field does not affect patient charging in any way; it is used by Materials Management only.

- **Generic Number -** If a generic number is loaded, it will pull to the charging screen when the item is charged. This is not used by Pharmacy.

- **Insurance Summary Code -** When setting up a new item, a Summary Code should be used that follows the current scheme. For example, if setting up a central supply item, the Summary Code should be 43. To determine the appropriate code, a Summary Charge Code List may be printed. The Summary Charge Code is important because of its effect on Insurance Billing. Without the correct code, an inaccurate Revenue Code may pull to the billing forms. Only a valid Summary Codes that is set up in the Charge Summary Code table will be accepted in this field.

- **Issuing Departments -** The Materials Management department number should be loaded on any item that will be placed on a purchase order and/or issued (expensed/transferred) to departments. Also, this field determines which departments may issue a charge for an item. There is a maximum of 32 departments that may issue an item to a patient. Any item may be expensed to any department; however, only departments that will actually charge an item to a patient need to be entered. An issuing department may only be deleted from an item before the item has been charged. To delete the department, access Item Department Master. Enter the department to be deleted at the prompt "Department" and then select **Delete.** If the item has statistical information, the message "Deletion Not Possible - Statistical Information Would Be Lost" will appear. Only valid department numbers that are set up in the Department Table will be accepted in this field.

- **Physician - Service Charge -** These fields contain Physician Charge information that may be associated with the item. This information will pull during Charge Entry if entered. If left blank, no Physician information will pull during charging.
  - **Physician Number:** This field works in conjunction with the Physician Service Charge field if there is a physician component to the charge. Only a valid Physician number that is set up in the Physician table will be accepted in this field. To choose from a list of existing Physicians access the lookup by selecting the **magnifying glass.**
  - Refer to the following information when setting up a physician charge
    - The Physician Charge is a part of the item charge and is not an addition to the item price listed. For instance, if the item price listed is $50.00, and the Physician Charge is $15.00, the total amount that will be charged to the patient's account is $50.00. The following are ways that these fields may be loaded and the effects:
    - If a dollar amount is loaded in the Physician Service Charge Current Price field, and the Physician Number field left blank, a physician will be required to be entered during Charge Entry for Inpatients. For Outpatients, the Attending Physician will pull from registration.
    - If a dollar amount is loaded in the Physician Service Charge Current Price field, and a valid physician number is loaded into the Physician Number field, it will pull to Charge Entry.

  - If a dollar amount is loaded in the Physician Service Charge Current Price field, and **999999** is loaded into the Physician Number field, it will pull to Charge Entry. The cursor will stop at the "999999", allowing it to be over-keyed.
  - If **99999.99** is loaded into the Physician Service Charge Current Price field, the full price of the item will pull as the Physician Charge.
  - If no dollar amount is loaded in the Physician Service Charge Current Price field, the cursor will skip the physician information.
- Please refer to Charging User Guide for additional information about Physician Charges in Charge Entry.

- **Vendors**
  - **Supplier 1/Catalog Number:** Enter the 5-digit Accounts Payable vendor code assigned to the primary supplier of this item. To display the vendor index, select the magnifying glass**.** Once selected, the vendor name will appear to the right of the number. The cursor will then access the Catalog Numbers field. A maximum of 20 characters may be entered as the primary supplier's catalog number.
  - **Supplier 2/Catalog Number:** Enter the 5-digit Accounts Payable vendor code assigned to the secondary supplier of this item. To display the vendor index, select the magnifying glass. Once selected, the vendor name will appear to the right of the number. The cursor will then access the Catalog Numbers field. A maximum of 20 characters may be entered as the secondary supplier's catalog number.
  - **Manufacturer/Catalog Number**: Enter the 5-digit Accounts Payable vendor number assigned to the manufacturer of this item. To display the vendor index, select the magnifying glass. Once selected, the vendor name will appear to the right of the number. The cursor will then access the Catalog Numbers field. A maximum of 20 characters may be entered as the manufacturer's catalog number.
  - **Buyer:** Buyer codes are used in conjunction with Purchase Order Entry by Item Number for non-stock items requested via electronic requisitions. Buyers are created in the Buyer Code Table, found in the Restock Requisition system.
  - **ETA:** Enter the number of days it takes to receive the item when ordered from a vendor. The ETA field is used to calculate the Expected Date of Arrival or the EDA. Please refer to chapter 7 for additional information on ETA and EDA.

- **Conversion Factor -** This field will allow Pharmacy to charge the actual number of primary units dispensed to the patient. The system will apply the conversion unit to the CPT code to determine the correct number of CPT codes to charge.

- **Activate -** If unchecked, the item will be excluded from the Charge Master Report, the Item Price List Report and the Inventory Description Index Report. If checked, the Item is not excluded from any reports.

- **Expense/Transfer -** If the item is a non-chargeable item, select **Expense** from the drop-down menu, indicating an expense requisition should be created. If the item is patient chargeable, then a transfer requisition will need to be created and **Transfer** should be selected for this field. A transfer requisition will transfer the item from one department to another. If chargeable goods are not tracked, select **Expense** from the drop-down menu. If an item is considered a non-stock item, **Non-Stock** would be placed in this field.

- **OR Chargeable -** If items assigned to OR Preference Cards are charged to patients, this field should be checked. This field does not affect charging, it is used by Materials Management to determine how the item should be issued.

- **OR Expense/Transfer -** If Materials Management is expensing an item to the OR Department, select **Expense** from the drop-down menu. If the item is being transferred from Materials Management to OR, select **Transfer** from the drop-down menu. Non-stock items should be designated by **Non-Stock**.

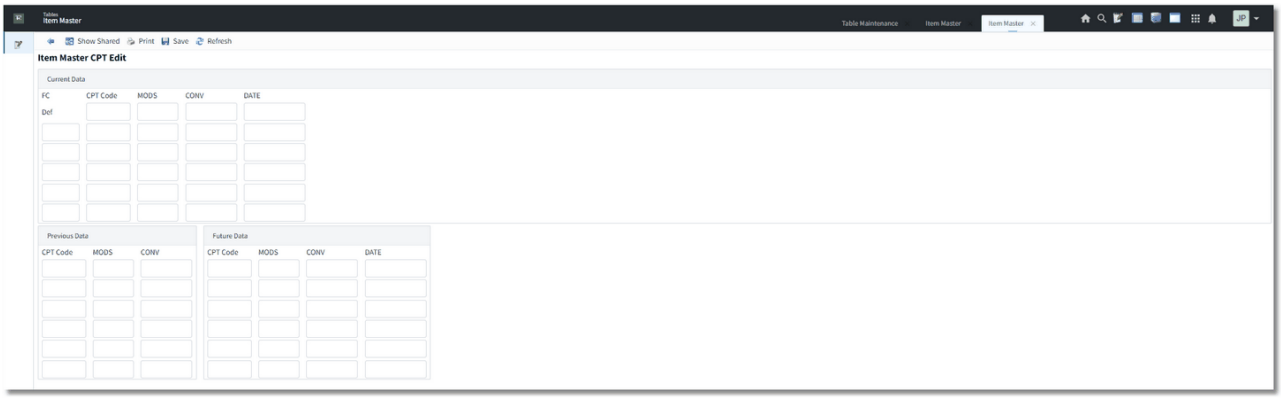
***NOTE**: When the Inventory GL Number begins with a "1" a code of "E" or "T" may be selected from the Expense/Transfer and OR Expense/Transfer drop-down menus. If the Inventory GL Number begins with a "4" the system will allow an "N" to be selected from the the Expense/Transfer and OR Expense/Transfer drop-down menus.*

- **Default FC CPT -** CPT Codes are 5-digit numbers that are significant for insurance billing. Not all items have CPT codes, such as Central Supply items. For those that do, the code should be entered in this field. Up to two 2-digit modifiers may be attached to the CPT code to pull to the insurance billing forms. Only valid CPT codes that are loaded in the CPT table will be accepted in this field.

- **FC CPT Code -** If a CPT code other than the one loaded in the default field should pull for a specific Financial Class, enter the Financial Class Code in the first field and the CPT code in the second field. Up to five additional Financial Class codes may be entered and wild-carding, using **"*"**, is available. Only valid CPT codes that are loaded in the CPT table will be accepted in this table. Only valid Financial Classes that are set up in the Insurance Companies table will be accepted in this table.

- **CPT Data -** When selected, this option will display the Item Master Financial Class CPT & MOD Maintenance screen. This screen allows Current, Future and Previous data to be stored for CPTs, Modifiers and APC-Conversion. This is used for the default and five financial class specific CPT Codes associated with the item. Any changes to a CPT code should be updated in these fields.

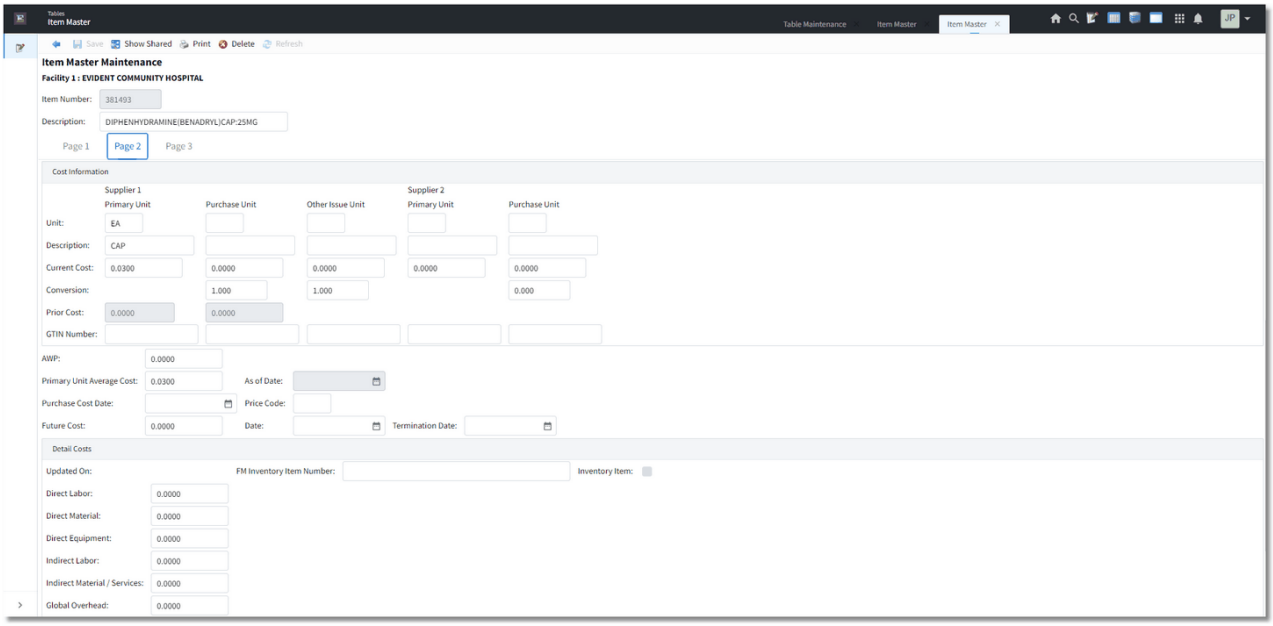
Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an Item** > **CPT Data**



Item Master Maintenance, CPT Data

Item Master, Page 2

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Page 2**



Item Master, Page 2

An item may be set up with two suppliers. Supplier 1 should always be the primary supplier. Supplier 2 should only be used if the item is ordered from more than one supplier. See the **Note** area for information on the unit.

- **Unit:**
  - **Supplier 1/Supplier 2 Primary Unit:** This should be the most common dispensing unit for this item. It also represents the charge unit for this item. It is important to be consistent in choosing the 2-digit codes. Enter the 2-digit code that represents the smallest unit of issue (i.e., how it is dispensed to the units or floors). Some examples are **EA** – each, **PR** - pair, **BX** - box, **DZ** - dozen and **RL** - roll.
  - **Supplier 1/Supplier 2 Purchase Unit:** Enter the 2-digit unit in which the item is purchased. For example, Admit Kits are bought by the case, so **CS** may be entered.
  - **Supplier 1 Other Issue Unit:** The Other unit is another dispensing unit.

  NOTE: *Each 2-digit unit may be used as an ordering or issuing unit. For example, if the purchase unit is case for both Supplier 1 and Supplier 2, use different codes: CA and CS. Other examples: BO and BX for box, and PK and PG for package.*

- **Description:** Enter a 15-character maximum description of the Primary, Purchase, and Other units. This description should be as brief as possible. For example, if EA was the primary unit for a catheter, a description of “1 CATH” may be used.

- **Current Cost:** Enter the current cost for the Primary, Purchase, and Other units. When the current cost for the Primary unit is changed, after exiting and re-entering the screen, the previous cost pulls to the Prior Cost field.

- **GTIN Number:** The Global Trade Identification Number may be entered for each unit of measure for the item. This will allow GS1 barcodes to be scanned with the use of a PDA. The following may be accomplished when scanning GS1 barcodes:
  - Receive an item into inventory using PO Receiving
  - Restocking purposes
  - Adjustments to item balances
  - Update item costs
  - Charging items through Floor Stock Entry, Patient Charging, and Charging

- **Conversion:** The conversion factor represents the number of Primary units contained in the Purchase unit. For example, if the Purchase unit of Admit Kits is a **CA**se of 12 kits, and the Primary unit is **EA**ch, the conversion factor is 12. The next field represents the number of Primary units contained in the Other unit. For example, if the Other Unit is a **BO**x that contains 10 items and the Primary unit is **EA**ch, the conversion factor is 10.

- **AWP:** Enter the Average Wholesale Price of the item. This represents the average price for a purchase unit from a wholesaler.

- **Primary Unit Average Cost:** This field is used by the inventory system as an average of the cost of the item. Each time an item is received, the system calculates a new average cost by taking the quantity on hand in the MM department multiplied by the current average cost, adding this to the total value of goods received, and dividing this sum by the quantity on hand in the MM department after receiving. Contact TruBridge support for instructions to change this field.

- **Purchase Cost Date:** The current cost date is entered in this field. This field displays the last date the purchase cost was updated due to the future cost date being met.

- **Price Code:** The Price Code assigned to this item. Price Codes are set up in the Pricing Table.

- **Future Cost:** Enter the Future Purchase cost for this item.

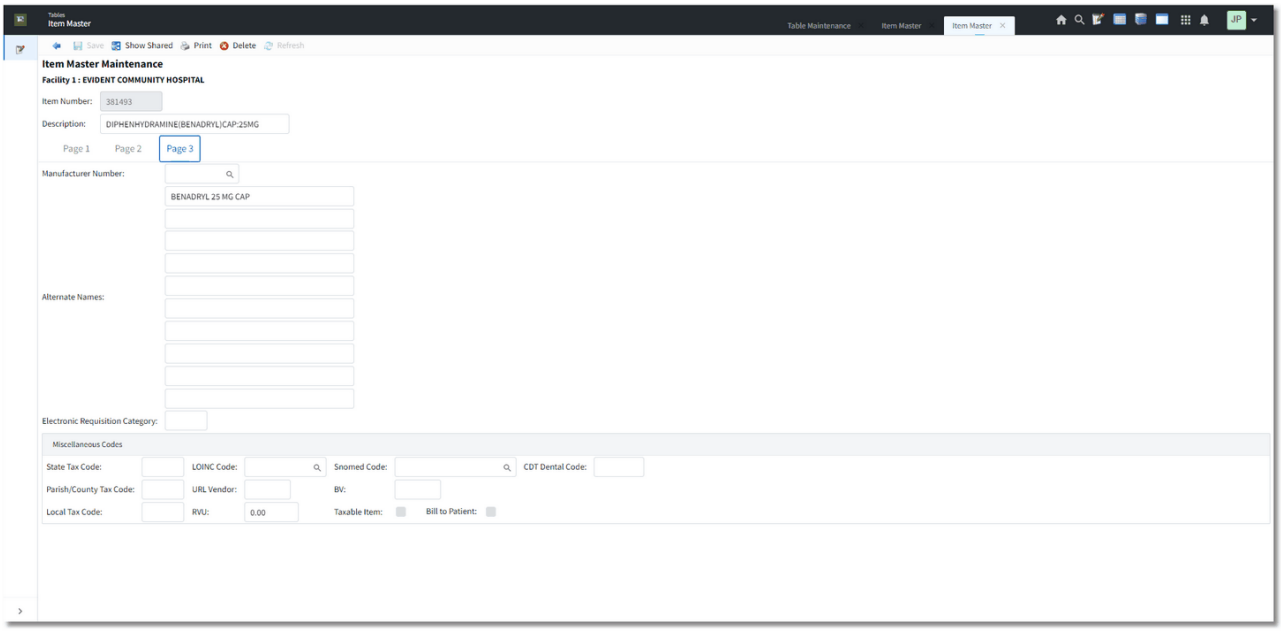
- **Date:** Enter the Future Purchase Cost effective date for this item.

- **Termination Date:** This field should be used for inventory items that are going to be discontinued. Enter the effective date that the item should no longer be used. If the A/R Date is greater than the Termination Date, the message “Item has been discontinued” will appear during Charge Entry.

- **Detail Costs:** The Detail Costs fields are used in several ways, one of which is in the cost calculation in the Contract Management system. Detail Costs may be a useful tool in contract negotiations and may be pulled to an Ad Hoc report. Another use is in conjunction with the Kramer Interface. This interface uploads detail costs from a diskette. It will move the existing costs into the Prior Costs fields. Information may also be manually loaded in the Detail Costs fields.
  - **Direct Labor:** Enter the direct cost of labor for this item.
  - **Direct Material:** Enter the direct cost of material for this item.
  - **Direct Equipment:** Enter the direct cost of equipment for this item.
  - **Indirect Labor:** Enter the indirect cost of labor for this item.
  - **Indirect Material/Services:** Enter the indirect cost of material/services for this item.
  - **Global Overhead:** Enter the cost of global overhead.

Item Master, Page 3

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Page 3**



Item Master, Page 3

- **Manufacturer Number -** Enter up to an 8-digit Manufacturer Number for the item. This field is linked to the Manufacturer Table. A lookup window may be accessed by selecting the **magnifying glass**.

- **Alternate Names -** Up to 10 alternate names may be entered into the description index for this item. Upon selecting description, this item number will be pulled to Patient Charging.

- **Electronic Requisition Category -** A category code may be entered at this time. The categories are set up in the Categories Table (Hospital Base Menu-Charge Tables and Inventory-Restock Requisition System-Categories). When items are forwarded from ordering departments, they will go to the appropriate tty # in the receiving department based on the category code. The tty # will receive the flashing "request" message that appears when requisitions are submitted.

- **Misc Codes -** Tax percentages may be entered for State, Parish/County and Local taxes. These percentages are set up in the Restock Requisition System (Hospital Base Menu-Charge Tables and Inventory-Restock Requisition System-Tax Table). When this item is ordered on a Purchase Order or requisitioned, the correct tax figure will be included.
  - **State Tax Code:** This field corresponds to the State Tax field in the Tax Table.
  - **Parish/County Tax Code:** This field corresponds to the Parish/County Tax field in the Tax Table.
  - **Local Tax Code:** This field corresponds to the Local Tax field in the Tax Table.
  - **LOINC Code -** Enter the Logical Observation Identifier Names & Codes number. The LOINC code may be manually keyed or may be selected from the lookup by selecting the **magnifying glass**. This may be required for Lab tests.
  - **URL Vendor:** Enter the four-character code that is used to identify the item with the appropriate interface.

- **RVU:** The Relative Value Unit for the specific CPT code for clinic procedures may be loaded in this field.
- **Snomed Code**: Enter the SNOMED code associated with the item, or select the correct SNOMED from the lookup by selecting the **magnifying glass**.
- **BV:** The Basic Value is used in conjunction with anesthesia charging. If a basic value is loaded, the system will know that the item is used for anesthesia charging. See Anesthesia Charging for more information regarding the Basic Value.
- **Taxable Item**: Select this field if the item is taxable. Selecting this field will cause tax to be applied to the patient's visit. This field only applies to facilities outside of the United States. For more information on applying tax, please refer to the Patient Tax Table found in the Table Maintenance- Business Office User Guide.
- **Bill to Patient**: This field is for future development.

NOTE: *The State Tax Code, Parish/County Tax Code, Local Tax Code, and Electronic Requisition Category fields relate to the Materials Management application. Please contact a TruBridge Materials Management Representative for more information.*

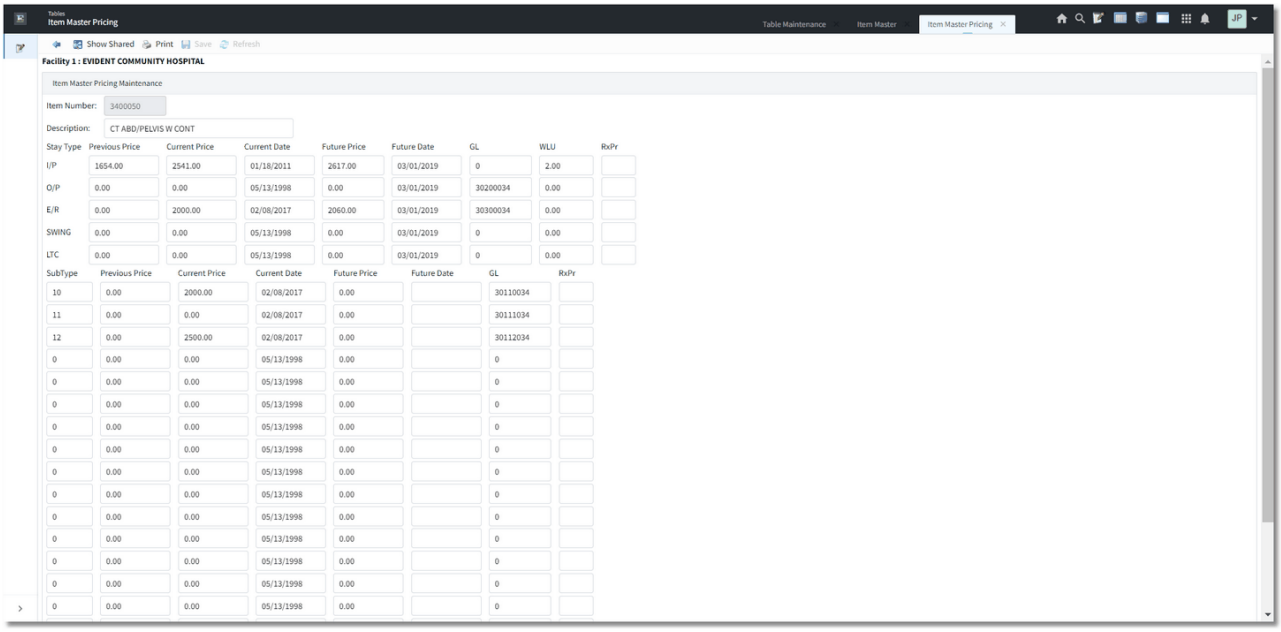
The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Delete**: Deletes the table settings
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Item Master list

Select the **Back Arrow** to return to the previous screen.

Item Pricing Information

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Item Pricing Information**



Item Master, Item Pricing Information

- **Pricing** - first five fields contain price information fields based on the Stay Types. The price charged to the patient and the General Ledger revenue numbers are contained here. Different prices may be assigned for each Stay Type, but typically the same price is charged.
  - **Previous Price:** Once a Future Price is moved by the system into the Current Price field, the existing price is moved into the Previous Price field.
  - **Current Price:** This price is the amount that the patient's account will be charged. Typically, one price is loaded in the Inpatient Current Price field, and the price fields for the remaining Stay Types are left blank. This will cause all patients, regardless of Stay Type, to be charged the same price. The system will read up to find the price to use if the price field is blank.
  - **Current Date:** This is the date the Current Price became effective.
  - **Future Price:** This is the price that should be charged at a future date.
  - **Future Date:** This is the date when the Future Price should become effective and be moved into the Current Price field by the system.
  - **GL:** Enter the General Ledger revenue number the amount charged should be posted. As with the Current Price, if the General Ledger field is left blank, the system will read up to find a number to post. Most facilities typically have a separate General Ledger revenue number for each Stay Type.
    - The General Ledger number loaded may be either five or eight digits. If a 5-digit number is loaded, the system will attach the issuing department entered during Charge Entry to the General Ledger Number to create the 8-digit number. For example, Stay Type 2 may only have 30100 loaded. If department 045 is the issuing department entered during Charge Entry, then the General Ledger Number affected will be 30100045.
    - ***NOTE**: When using an 8-digit General Ledger Number, only a valid General Ledger Number that is set up in the General Ledger module will be accepted in this field.*

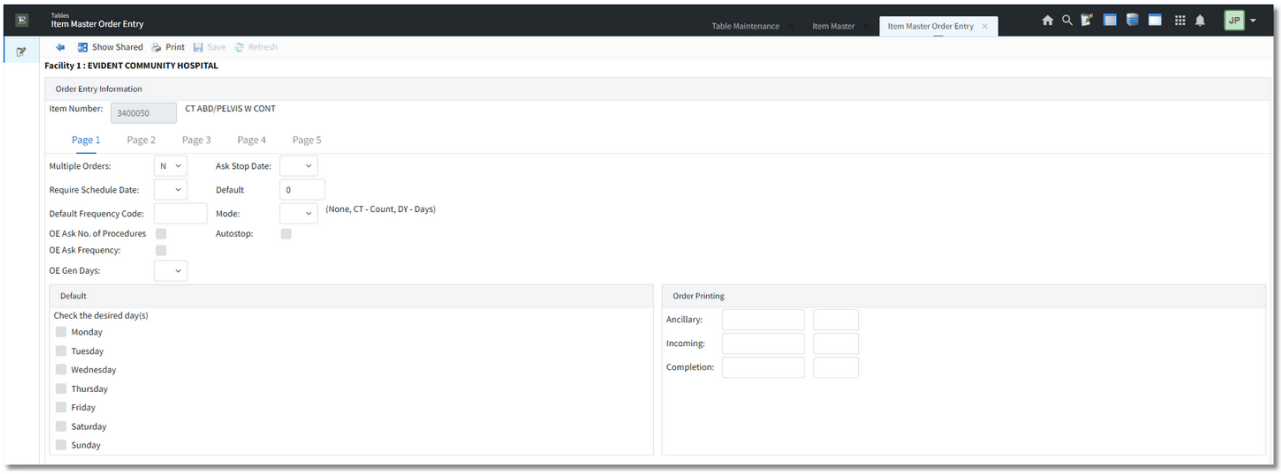
- **WLU:** This field is used for Workload Recording, which is a weighted value that reflects time spent performing this procedure. Laboratory, Respiratory, Radiology and Physical Therapy are typical clinical departments that utilize some type of workload units to determine productivity. As with the price and General Ledger Number fields, when the system finds a blank field it reads up and uses the first value it encounters in a WLU field.
- **RxPr:** A valid Price Code from the Pharmacy application should be loaded if applicable. This will allow price updates to be run for specific groups of items based on the Price Code.

- **Subtype Pricing -** This section allows prices and General Ledger Numbers to be loaded for specific Sub Types. The Sub Types are two digits in length and are set up in the Patient Subtype System; only valid Subtypes that are set up in the Patient Subtype System will be accepted in the Sub Type field. The system looks to the Patient tab on the Registration and ADT screen to determine if the patient has a Sub Type loaded.

Order Entry Information

Order entry information provides item-specific controls for many order entry processes.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Order Entry Information**



Order Entry Information - Page1

- **Multiple Orders**
  - Default: N (no)
  - Options: N ,Y, B
  - Usage: Entries in this field are used for creating daily orders for any of the clinical ancillary departments.
    - **Y:** The system automatically prompts the ancillary user for entries in the schedule date/time, number of procedures, and frequency fields when placing the order.
    - **B:** The system automatically prompts **BOTH** the ancillary and nursing users for entries in the schedule date/time, number of procedures, and frequency fields when placing the order.
    - **N:** The system will not prompt for entries in the above mentioned fields.
  - Requirements:
    - A **Y** must be in field **OE Ask No. of Procedures** to create a Procedures Prompt field in OE Maintenance and/or

- A **Y** must be in field **OE Ask Frequency** to create a Frequency prompt field in OE Maintenance.

- **Require Schedule Date**
  - Default: N (no)
  - Options: N , Y, B
  - Usage: Entries in this field are used for requiring the user to address the schedule date field in Order Entry Maintenance when an order is placed via Order Entry.
    - **Y:** The system will require the ancillary user to enter a schedule date in the schedule date field when placing the order.
    - **B:** The system will require both the nursing user and the ancillary user to enter a schedule date in the schedule date field when placing the order.
    - **N:** The system will not require the user to address the schedule date field when placing an order via Order Entry.

- **Default Frequency Code**
  - Options: BID, TID, QID, QD=Daily, Q#D, Q#H, 1X, PRN
  - Usage: This field is most useful for setting up daily procedures that are usually scheduled for the same frequency. During order entry, the default frequency may be accepted or changed as needed.
  - Requirements: The default frequency will appear in OE maintenance the Frequency field. Therefore field **OE Ask Frequency must be checked=(yes).**

- **OE Ask No. of Procedures**
  - Options: Checked = (yes) or Unchecked =(no)
  - Usage: Will display the Procedure field on the order entry maintenance screen. This field provides the ability to specify the number of procedures for the ordered item. Items ordered through this mechanism will produce identical multiple orders each with a different order number. Orders will be scheduled for the same date/time and will all require reports (if that item has a report format) and completion.
  - Requirement: **Multiple Orders field must be set to Y or B**

- **OE Ask Frequency**
  - Default: N (no)
  - Options: Checked = (yes) or Unchecked =(no)
  - Usage: This field is used to generate multiple orders based on default or entered frequency. It works in conjunction with field Multiple orders for ancillary items that will generate from day to day. Checked box=(yes):Will produce Frequency field on the Order Entry Maintenance screen when item is ordered. This will create additional orders based on the frequency interval from the schedule date and time of the order.

- **OE Gen Days**
  - Default: N (no)
  - Options: Y, N, B
  - Usage: Ancillary items setup as frequencies, fields: ‘Ask Gen Days:’ and ‘Ask Stop Date:’ of this page, may be also used to define parameters for order generation.
    - **Y**=Only the ancillary department will have the ability to indicate generation days at order entry.
    - **B**=Both nursing and ancillary departments will be prompted indicate order generation days.

- **N**=Neither nursing nor the ancillary department will be prompted for generation days at order entry.

NOTE: *If option **Y** is utilized, when an order is placed from nursing, a Stop Date/Time of 999999 999 will display on the order entry maintenance screen until it is addressed by the ancillary department.*

- **Default**
  - Options: Check the desired day(s)
    - If **Y** or **B** was entered in the previous field, this section defines which days the item will normally generate orders.
    - If this field is left blank, there will be a prompt at order entry to indicate the days of the week the order is to generate after the schedule date and time has been entered.
    - If the item is only scheduled on certain days of the week, check the box next to the default days when this order is generated.
    - If **N** was entered in the previous field, an entry cannot be made in this field.

Example: *Physical therapy performs certain treatments only on Monday, Wednesday and Friday. Check the box next to these days.*

- **Ask Stop Date**
  - Default: N (no)
  - Options:
    - **N**: Do not display **Stop Date** on the order entry maintenance field.
    - **BR**: Display **Stop Date** on order entry maintenance for nursing and ancillary departments and require a response.
    - **B:** Display **Stop Date** on order entry maintenance for nursing and ancillary departments, do not require response.
    - **Y:** Display **Stop Date** on order entry maintenance for ancillary departments only, do not require response.
    - **YR:** Display **Stop Date** on order entry maintenance for ancillary departments and require a response.
  - Usage: Controls when the Stop Date is displayed on the Order Entry Maintenance screen.

- **Default**
  - Default: 0
  - Options: A three-digit numeric field defining the default date when the system will stop orders for this item.
  - Usage: Designates the number of days or orders the system will refer to in determining the stop date. The order will print on the Re-Orders Due report when the order is due to stop within 24 hours. Orders will not generate orders after the specified number of orders or number of days, depending on the Stop Mode.

- **Mode**
  - Default: None, entry required.
  - Options:
    - **CT**: Stop by count. The system will stop generating orders for this item when the total number of orders exceeds the Default. Start date, time, and frequency is used to determine how many orders will generate. This is particularly useful in Physical therapy departments when patient treatments may be reimbursed for a defined number.

- **DY**: Stop by day. The system will generate orders for this item for the specified number of days. The day of the first scheduled treatment is considered day 1.

- Usage: This defines how the **Stop Date** is determined.

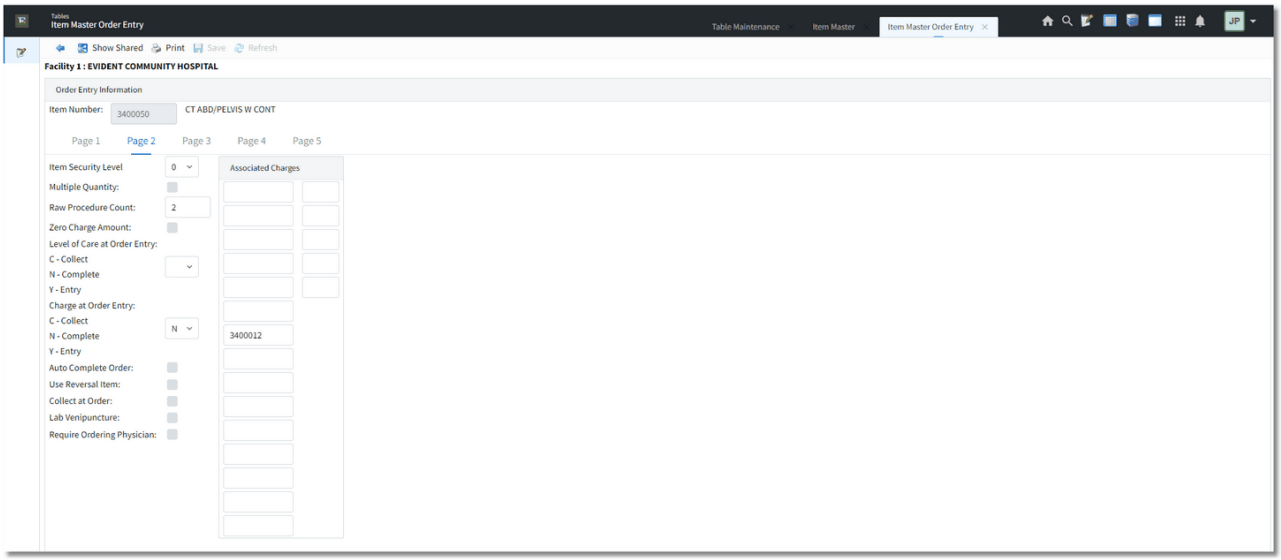
- **Autostop**
  - Default: Unchecked =None, entry required.
  - Options:
    - **Y:** Stop orders automatically from generating beyond the stop date. The system will not produce any additional orders for this item beyond the stop date if at the prompt to RE-start order, "N"o is entered.
    - **N:** Continue to generate orders for this item until discontinued by the user. In order review, the system will keep prompting to RE-start or DC order when stop date is reached. If order is not to be restarted, it must be DC'd to stop generating for subsequent days.
  - Usage: This defines whether or not the user may set the order autostop the order generation beyond the stop date.

- **Order Printing**
  - Options:
    - Ancillary:
      - The first field is reserved for the export that produces the specific label, card or form.
      - The second field is reserved for either a **line printer number** or **S** for workstation.
    - Incoming:
      - The first field is reserved for the export that produces the specific label, card or form.
      - The second field is reserved for either a **line printer number** or **S** for workstation.
    - Completion:
      - The first field is reserved for the export that produces the specific label, card or form.
      - The second field is reserved for either a **line printer number** or **S** for workstation.

    NOTE: *To remove entries, highlight field with mouse, select delete on keyboard.*

  - Usage: These fields provide the ability for ancillary departments to produce item specific labels, cards or forms and define where they will be printed. Labels, cards and forms may be reprinted. When these fields are blank, the system will use the default programs or terminal specific export. If using the **Composite Requisition** application, these fields do **not** have to be defined.
    - ANCILLARY: If the order is placed within the ancillary department the system will print the label, card or form as defined by the program entered in this field.
    - INCOMING: When the order is placed from nursing, the system will print the label, card or form as defined by the program entered in this field.
    - COMPLETION: When items are completed the system will print the label, card or form as defined by the program entered in this field.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Order Entry Information** > **Page 2**



Order Entry Information - Page 2

- **Item Security Level**
  - Default: Blank = 0
  - Options: 0-9
  - Usage: Controls whether the item may be resulted, completed or amended. The security level of the item must be equal to or less than the security level assigned to the employee in order for the employee to be able to enter results, complete and or amend results.

- **Multiple Quantity**
  - Default: Unchecked=N (no)
  - Options: Checked= Y(yes) or Unchecked=N (no)
  - Usage: Determines if an item may be charged for multiple quantities.
    - o Checked box: The system requires the charge quantity to be entered if Charge at Order Entry field = Y or N (order entry or completion).
    - Default charge quantity will be “1”; only quantities of 1 or greater may be entered.
    - This creates multiple charges on a single order, **not** multiple orders.
    - “999” may be entered in the charge quantity field of order entry maintenance and the default charge will be “0” (zero).
    - o Unchecked box: Item will not charge multiple quantities.
  - Recommendations:
    - o If this item is to be ordered by nursing then field **Charge at Order Entry**, should be set to **N** (no).
    - o If the item is for ancillary department use only, then **Charge at Order Entry** may be **Y** (yes) and Ancil Procedure field = **N** (no). System will not charge multiple quantities if Charge at Order Entry = **C** (collection).

- **Raw Procedure Count**
  - Default: 1 (one)
  - Options: Any whole number from 0 (zero) to 999.
  - Usage:

- The raw procedure count field is used to indicate that an item is to be counted as more than one procedure.
- Total raw counts appear on: under the General ledger number on the Daily and Monthly procedure logs for all ancillary departments. They are also included in the Turn-Around-Time report.
- Items may be set to have a raw procedure count of 0 by keying in **-99**.

- **Zero Charge Amount**
  - Default: Unchecked=N (no)
  - Options: Checked=Y(yes) - makes the item zero-charge if no price is designated in the Item Master Unchecked=N(no) - makes the item variable-charge if no price is designated in the Item Master.
  - Usage:
    - This function allows the system to differentiate between zero-charge items and variable charge items, when there is no price designated in the item master.
    - If there is not price in the item master and a "N" is in this field, the system requires a charge amount be entered at charge time (order entry, completion, collection).
    - Variable-charge (non-priced) items that are charge at order entry may not be ordered by nursing departments, they may only be ordered from within the ancillary department.
    - Nursing departments may order variable charge items that are not charge at order entry (collection or completion).

- **Level of Care at Order Entry**
  - Default: Blank if site does not utilize the Critical Access feature. (See the Critical Access User Guide)
  - Options:
    - **Y** - the system will capture the Level of Care when the order is entered.
    - **C** - the system will capture the Level of Care when the order is collected.
    - **N** - the system will capture the Level of Care when the order is completed.

- **Charge at Order Entry**
  - Default: Blank, field defaults to the entry in the Charge at Order Time field in Department Maintenance.
  - Options:
    - **Y** – charge this item at order entry
    - **N** – charge at completion (when information is entered in the **Complete** field of order entry maintenance)
    - **C** – charge at specimen collection, when an entry is made in the **Collect** field of order entry maintenance. Blank, field defaults to the entry in the **Charge at Order Time** field in Department Maintenance.
  - Usage: **Charge at Order Time** field in Department Maintenance regulates the charging mechanism for the department. This field in order entry information may override that mechanism for the individual item. It is recommended that the charging mechanism be as consistent as possible for all items in the department.

- **Auto Complete Order**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage:
    - **Y:** Designates that the item will auto-complete at order entry. Auto-complete items have a status of **complete** at the time they are ordered.

  - Ancillary departments that charge for medications, consumables, or central supply items that do not need reports, often use this.
  - **N:** System will not auto-complete this item, it will be completed based on department procedure.
- Requirement: This function will work ONLY when **Charge at Order Entry** on an item is set to **Y**, **EVEN** when the department table is set to charge at order entry.

- **Use Reversal Item**
  - Default: Unchecked=N (no)
  - Options: Checked =Y (yes) or Unchecked=N (no)
  - Usage: Laboratory: Field is used to indicate that the test is sent to a reference laboratory and the patient is not to be charged by the hospital. System will reverse the charge from the patient account.
    - **Y:** Flags the system to reverse the charge from the patient's account.
    - **N:** Item's charge will not be reversed from patient accounts.
  - Requirements: If the reference lab, used by the hospital, charges for patient's tests, the reverse charge program may be utilized. This program is financial class specific. The insurance financial classes, the reference laboratory is going to bill for, must be listed in AHIS, page 7, **Reverse Charge F/C** field. A reverse charge item, without a price, will also need to be created and loaded in AHIS, page 7, **Reversal Item #** field.

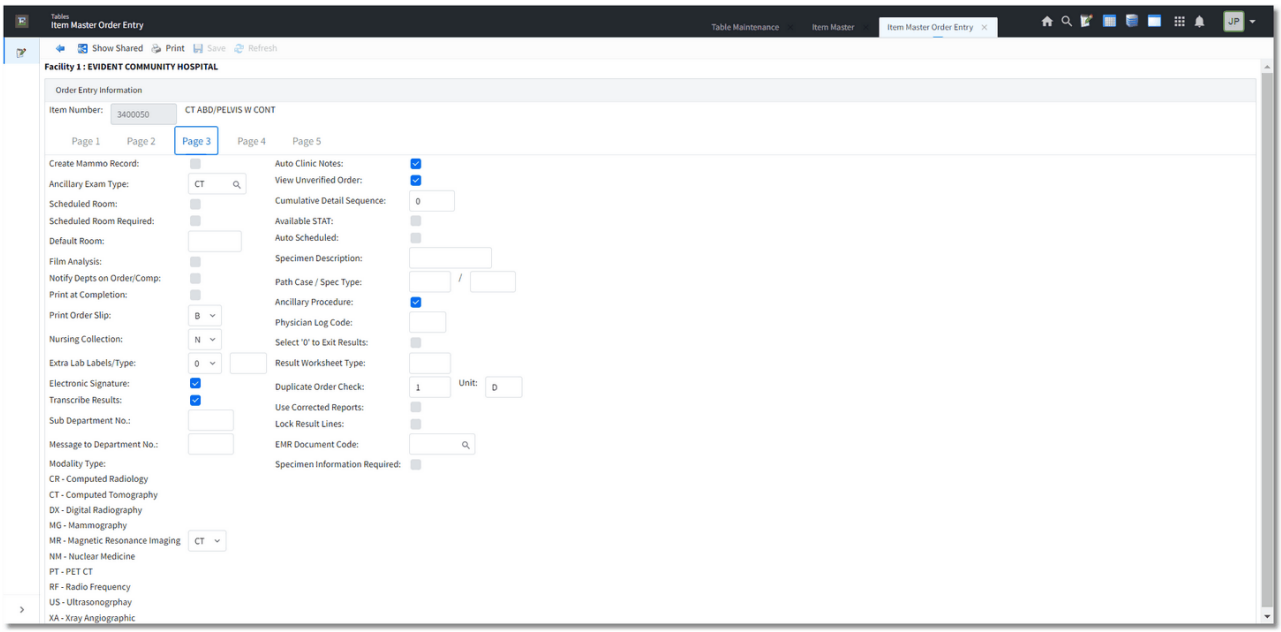
- **Collect At Order**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: This field controls whether or not collection information must be entered in the **Collect** field of order entry maintenance. This is an additional option for nursing collected specimens.
    - **Y:** Collector's initials and date/time of collection must be entered when nursing enters the order. Does not apply when orders are placed from within the laboratory.
    - **N:** Collection information is not required at order entry.

- **Lab Venipuncture**
  - Default: Checked=Y (yes)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: This field is used to indicate that the specimen collected for this procedure is eligible for a venipuncture charge. Entries are used in the Venipuncture charge program outlined in the Laboratory Control Table chapter.
    - **Y:** Specimen for this procedure is collected by venipuncture.
    - **N:** Specimen for this procedure is **not** collected by venipuncture.
  - Requirement:The Venipuncture charge program requires not only appropriate entries in this field, but also in fields the Laboratory Control Table regarding Venipuncture setup. In addition, the report option for **Generate Venipuncture Chgs.** must be set up by a TruBridge representative for the venipuncture program to automatically apply a venipuncture charge based on the setup.

- **Require Ordering Physician**
  - Default: Default: Unchecked=N (no)
  - Options: Checked=Y(yes) or Unchecked=N(no)
  - Usage: This field allows the user to **REQUIRE** ACCESS TO THE ordering Physician field, during nursing order entry. When **Y**, the cursor will automatically stop at the Physician field forcing the user to enter in a physician's name and will not allow this field to be left blank.

- **Associated Charges**
  - Default: Blank, no entry for both fields
  - Options: Up to 15 Items numbers, the first five allowing a disposition code. The last 10 will default to an E-every time charge.
    - 1st position=Item number
    - 2nd position= (disposition code):
    - E - Charge every time the order is completed.
    - D - Charge when the first order of the day is completed, Respiratory use only.
    - S - Charge only once when the first order is completed, Respiratory use only.
    - Blank: Allows entry of one of the above or **Y** (yes), or **N** (no) at **charge** time.
  - Usage: This set of fields allows up to fifteen associated items to be charged with the parent item being ordered. The item number is placed in the first line and the disposition code in the second line. Associated charges are frequently used to charge multiple CPT codes.
  - Notes:
    - Associated Charges do not create orders, therefore if an associated charge needs to be credited to a patient account, the "parent" order must be canceled and credited. Reorder a separate item without the associated charges. Example: If a Gram stain is an every time associated charge for a Urine culture, but for a particular patient one was not done, then the order for the Urine culture must be canceled and credited to reverse the charge for the Gram stain. A Urine culture without an every time associated charge would need to be ordered to charge the patient for just the culture.
    - For variable associated charges, the order entry maintenance screen of the parent item must be accessible when the item is being charged. Example: In departments where results are dispositioned via automated result entry, the order entry maintenance screen does not display. Therefore the technologist may not designate any variable associated charges.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Order Entry Information** > **Page 3**



Order Entry Information - Page 3

- **Create Mammo Record**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage:
    - If the radiology department is using the TruBridge Mammography Recall application, it is necessary to check this field (yes) for all mammography procedures.
    - The default **N** in this field is used for the generic Mammography item and all other Radiology items. Other non-procedure items used in mammography (biopsy needle, additional views, needle localization) should also be set to N.

- **Ancillary Exam Type**
  - Default: Blank, no entry
  - Options: A two-character code previously defined in the Business Office Tables, option Ancillary Exam Types. Characters may be either upper or lower case letters.
  - Usage: This field is designed for use by Radiology.
    - Two character exam codes are assigned to radiology generic and specific items.
    - Only upper case exam types will appear on Radiology schedule.
    - Schedule may be sorted by exam type.
    - may print Schedule by Exam Time report.

- **Scheduled Room**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no).
  - Usage: Ancillary departments have the capability of scheduling procedures by defined exam rooms, as well as defining exam rooms for use with the **My Outstanding Orders** and **My Completed Orders** option of the Radiology schedule. This takes place at order entry and allows departments to view/print schedules by exam room.
    - Checked=Y: Creates **Room** field in order entry maintenance. This field will accept a pre-defined, five-character exam room code.
    - Unchecked=N: Does not create **Room** field in order entry maintenance.
  - Requirement:
    - Exam rooms must be defined in **Ancillary Exam Rooms** option of the Business Office Tables. This field is utilized mostly by the Radiology.

- **Scheduled Room Required**
  - Default: Unchecked= N(no)
  - Options: Checked=Y(yes) or Unchecked=N(no)
  - Usage: Works in conjunction with ‘Scheduled Room’ field checked(yes)
  - Y: Determines if an entry is required in **Room** field.
  - N: **Room** field is prompted at order entry, but an exam room entry is not required.

- **Default Room**
  - Default: Blank
  - Options: Enter the letter/number codes of Exam Room required for this procedures or Leave Blank.
  - Usage: Works in conjunction with Scheduled Room to allow a default exam room to be Assign to a particular procedure.
  - Requirement: Exam Rooms must be defined in **Ancillary Exam Rooms** option of the Business Office Tables. This field is utilized mostly by Radiology.

- **Film Analysis**
  - Default: Checked=Y (yes)
    - Options: Checked=Y (yes) or Unchecked=N (no)
    - Usage: For use with radiology items only. Part of Reject/Repeat Analysis application.
      - **Y:** At charge completion the system will prompt the radiology technologist for film usage. If using this program, this option is indicated for all chargeable radiology procedures.
      - **N:** Item does not prompt for film usage at charge completion.
    - Requirement: To use the Reject/Repeat Film Analysis application, several areas need to be addressed:
      - Item Functions, **Film Analysis** for all items that need documentation of film usage.
      - Film Analysis Table Functions; must be set up by TruBridge for the radiology department.

- **Notify Depts on Order/Comp**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage:
    - **Y:** Once the item is ordered, departments listed in AHIS Page 4-**Notify Dept at Order Time** field will receive a **NOTICE** flash. The department will also receive a **REPORT** flash indicating results for that item.
    - **N**: Departments listed in AHIS will not receive notification.

- **Print at Completion**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: Controls whether charge labels will be printed upon completion when nursing and ancillary departments are placing orders on specific chargeable items.
    - **Y:** Allows charge labels to print upon completion when orders are placed on specific chargeable items. An export and printer number must be loaded in Order Entry Information, Page 1, **Order Printing:, Completion**
    - **N:** Sites placing orders on generic items will continue to complete only lines 1 and 2 in **Order Printing.**

  NOTE: *This field is not used if site is using the Composite Requisition*

- **Print Order Slip**
  - Default: N (no)
  - Options:
    - **Y**: The order will automatically print at the nursing station when it is verified. Ancillaries will not receive the order by incoming orders.
    - **N:** An order record will not print at the nursing station; ancillaries will receive notification through incoming orders. This is the default when left blank.
    - **B:** The order record will print at the nursing station and ancillary department will be notified through incoming orders. Most ancillary items are set with a **B**.
    - **C:** The order record will print at the nursing station. Ancillaries will receive notification when collection information is entered at the nursing station. This option is applicable for nursing collected items (Nursing Collection field) and is frequently used by laboratory for cultures, body fluids, and urinalysis. This option will need to be selected in order to print the nursing Specimen Collection sheet.
  - Usage: This field regulates printing of the order record at the nursing station workstation printer and receiving notification in the ancillary department.

- **Nursing Collection**
  - Default: N (no)
  - Options: N (no), Y (yes) or S (Specimen Collection Copy)
    - **N:** The specimen for this test is not normally collected by nursing, usually collected by laboratory. This is the setting for most laboratory items.
    - **Y:** Identifies that nursing routinely collects the specimen for this item. Orders for this item will appear on Nursing Specimen Collection report and may be collected via Nursing Specimen Collection List. A Specimen Collection Copy is not printed.
    - **S:** Identifies that nursing routinely collects the specimen for this item. Orders for this item will appear on Nursing Specimen Collection report and may be collected via Nursing Specimen Collection List. A Specimen Collection Copy is printed.
  - Usage:
    - If nursing services normally collects the specimen for this test, a Specimen Collection Copy may be generated by the system. This slip should accompany the specimen to the laboratory department after nursing has entered collection information for the order.
    - Orders will appear on the ancillary department's Outstanding Orders Report and will be designated with a **N** for nursing collected specimens.
    - Orders for nursing collected specimens may be included in the Specimen Collection Report.
  - Requirement: This field works in conjunction with field Print Order Slip:= **C.** When Print Order Slip = **C** and Nursing Collection = **S**, then nursing departments will receive a Specimen Collection Copy for this item, and laboratory will not receive an ORDER notice until nursing enters collection information for the order.

- **Extra Lab Labels/Type**
  - Default: First field: Blank, 0 (zero), second field: blank, no entry
  - Options:
    - First field is for the quantity (1-9) of extra labels to print when this item is ordered.
    - Second field is for the type (A, B, C, D, E, and J) of extra label that is needed. See Laboratory Control table section in this user guide for label type examples.
  - Usage: This field has two option lines that deal with printing extra laboratory procedure labels. The system will always print one procedure label of the type specified in the Lab Control Table, page 1, Test Name Label type field. However, there are laboratory analyzers that support bar code and it is necessary to print a procedure label and a barcode label.

  EXAMPLE: *If a barcode label is necessary for a laboratory analyzer, a **1** would be placed in the first option and **J** would be placed in the second. If several procedure labels were needed in Microbiology for cultures, a **4** could be placed in the first option and **D** would be placed in the second.*

- **Electronic Signature**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: To restrict viewing or printing of unsigned transcriptions or reports by other departments.
    - **Y:** Creates a new field -**Signed**- on the order entry maintenance screen for the initials/date/time of the person signing out the report.
    - Electronic Signature application: Order for this item will appear on the "signing physician's" Electronic Signature screen. This will restrict nursing and other ancillary departments from viewing or printing report.

- Non-Electronic Signature application: Option may be used to require employee order entry security switch 55, **Allow Electronic Signature** to release or sign out report.
  - o **N:** Allow report to be viewed/printed when completed or transcribed.

- **Transcribe Results**
  - Default: Checked=Y (yes)
  - Options: Checked=Y (yes) or Unchecked= N (no)
  - Usage:
    - o **Y:** Items will print on the Outstanding Transcriptions report. Items will appear on the transcription results review screen.
    - o **N:** Items will not print on the Outstanding Transcriptions report. Items will not appear on the transcription results review screen.
  - Recommendations:
    - o Radiology: **If site is using Generic Item OE:** Both generic and procedure items should have this field set to **Y**. Central supply items such as IV, catheter sets or medications should be set to **N**. **If site is using Specific Item OE:** Specific items should have this field set to **Y**. Central supply items such as IV, catheter sets or medications should be set to **N**. **If site is using Electronic Signature:** Any item with this field set to **Y** should also have Electronic Signature set to **Y**.
    - o Laboratory: All items that are resulted should be set to **N**. Transcribed items should be set to **Y**.
    - o Respiratory: All items that are resulted should be set to **N**. Transcribed items should be set to **Y**.
    - o Physical Therapy/Occupational Therapy/EKG: If these departments transcribe reports then only transcribed items should be set to **Y**.

- **Sub Department No.**
  - Default: Blank, no entry
  - Options: Any valid, three-digit department number.
  - Usage:
    - o Entering a department number here will allow the Daily Procedure Log to be printed for this sub department. They must however, be logged into the sub department when printing the report.
    - o Charges for this Sub Dept. will not be included in the parent Daily Procedure Log.
    - o Allows sub department to cancel an order if the sub department is the first issuing department listed in the **Issuing Departments** field off the Item Master.

- **Message To Department No.**
  - Default: Blank, no entry
  - Options: Any valid, two-digit department number
  - Usage: This field directs incoming orders for an item to the department number entered in this field.

  Example: *If the cardiopulmonary department collects arterial blood gas (ABG) specimens, but laboratory performs the test, a special collection item could be created in the lab charge tables, e.g. Blood Gas Collection, that would have the Cardiopulmonary Department number entered in this field. Lab would receive the order flash for the ABG, but Cardiopulmonary would receive an order flash for the Blood Gas Collection item. To notify sub-department of incoming orders (e.g.: MRI in Radiology--Radiology does not receive the incoming order, but MRI sub-dept would).*

- **Modality Type**

- Default: 'None Selected'
- Options: (These are hard coded in the TruBridge EHR)
  - CR—Computed Radiology
  - CT—Computed Tomography
  - DX—Digital Radiography
  - MG—Mammography
  - MR—Magnetic Resonance Imaging
  - NM—Nuclear Medicine
  - PT—PET CT
  - RF—Radio Frequency
  - US—Ultrasound
  - XA—Xray Angiographic
- Usage: The field works in conjunction with the Image Link Interface set up in AHIS. If items are set with one of these codes, when an order is placed, the system will send the order into the Image Link System. For Meaningful Use statistics, all radiology items that have images, will need to have modality assigned to this field.

- **Auto Clinic Notes**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: A check mark(yes) in this field enables clinical notes to automatically update through order entry at the time the charge is created (at order entry, order completion or collection time) for this item.
  - Requirement:
    - This option is available to all ancillary departments that have one of the available options entered in field **Clinical Notes Grouping** of page 3 in AHIS.

- **View Unverified Order**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: An order has the status of **Unverified** when it has been resulted but not completed.
    - **Y:** Allows a department and MP-EMR Clinical (orders placed from NHO) other than the resulting department to view or print results for such orders.
    - **N:** Does not allow any other departments or MP-EMR Clinical (orders placed from NHO) to view or print unverified results.
  - Requirement: For the laboratory department, this field works in conjunction with the **Print View Unverified** field on page 3 of the Laboratory Control Table to print unverified orders on the Comparative Report and Physician reports.

  Example: *There are instances in the microbiology section of the laboratory department when preliminary culture reports (unverified orders) need to be accessible to nursing departments and print on the Comparative Report and Physician reports.*

- **Cumulative Detail Sequence**
  - Default: Blank, no entry
  - Options: Blank Result prints in department section alphabetically after sequenced items.
    - Sequence number: Whole numbers from 1 to 998
    - **999**: Result does not print on <u>any</u> Comparative Report.
    - To remove an entry in this field, highlight field, select the Delete key.
  - Usage: This field regulates the sequence in which results appear on the Cumulative Detail, Results by Physician, Physicians with Pending and Lab Results by Patient reports.

- An entry in this field is not necessary if using the comparative report.
- Also used to suppress Pathology transcriptions and Blood Bank forms from printing to the above mentioned reports.
- It is recommended that sequence numbers be assigned in increments of 5 or 10 to allow flexibility in assigning the sequence number of new tests.
- When printing the cumulative detail report, the system sorts two ways: First by the department category found in the fifth Control switch of the Control Switch field of page 1 in the item master; tests without a switch 5 indicator are sorted last. Second by the cumulative detail sequence number; items without numbers in this field are sorted last alphabetically.

- **Available STAT**
  - Default: Checked=Y (yes)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: This field is used to control the ability for this item to be ordered STAT by nursing departments.
    - N: Nursing departments will not be able to order such items STAT. System will prompt that the procedure is not available STAT. Ancillary departments are not affected if orders are placed from within the ancillary department.
    - Y: Nursing departments may designate STAT priority.

- **Auto Scheduled**
  - Default: Checked=Y (yes)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage:
    - **Y:** Order for the item is sent to ancillary department scheduled based on schedule and frequency information entered when item is ordered from a nursing department.
    - **N:** Order for this item is sent to the ancillary department unscheduled. Requires the ancillary department to update the schedule and frequency information when ordered by a nursing department. System will not break-out with frequency on multiple orders until scheduled with next frequency time.

- **Specimen Description**
  - Default: Blank, no entry
  - Options: This field will accept more than twelve character but only twelve characters of text (including a space) will print on the Lab Procedure Label.
  - Usage: The contents of this field will print at the bottom of a laboratory procedure label next to **SPECIMEN**:. It is designed to produce user-defined specimen collection information. If this field is blank no specimen information will print on the label.

  EXAMPLES: *1 RED TOP, 1 EDTA, FR PLASMA, URINE CUP, etc.*

- **Path Case/Spec Type**
  - Default: Blank, no entry
  - Options: 1st Position=Pathology Case Type as designated in the Pathology Application. 2nd Position=Specimen Types that are user defined and designated in the Pathology Application. The 2nd position is optional and may be blank.
  - Usage: The user defined pathology category, e.g. S-Surgical, C-Cytology, BM-Bone Marrow, A-Autopsy, may be defined in the 1st position of this field. Items with defined case types create case records and will utilize the appropriate OEWORD header for the case and specimen type(if header is defined as such).

- **Ancillary Procedure**
  - Default: Checked=Y (yes)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: Controls which items are displayed (in the department's descriptive index) for nursing departments.
    - **N:** Item will not display in nursing department for order entry. For items to be used only by the ancillary department. Items waiting to be removed from the item master.
    - **Y:** Item will display in nursing and ancillary descriptive index for order entry.

- **Physician Log Code**
  - Default: Blank, no entry
  - Options: Any single character. **N** is used to designate any items that should be omitted from the Physician Services Log.
  - Usage:
    - This field regulates the item's appearance on the Physician Services Log. Any single character may be used to represent a physician.
    - The Physician Services Log is a report used to provide patient billing information to the physician who provides an item-related service for which he/she will bill the patient (e.g., radiology or pathology services). Patient information prints and lists qualifying items charged to the patient.
    - When the report is printed, a response to print all physician codes will print all except items with a **N** in this field.

  EXAMPLE: *If Dr. Doe reads mammograms, a **D** may be placed in this field for all mammography procedures. The Physician Services Log may be printed for **D** and all billing information for patients who had mammograms would print.*

- **Selecting '0' to Exit Results**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: Controls ability to exit out of multi-page result formats without accessing each page.
    - **Y:** Provides ability to type a "0" (zero) and press <Enter> at the command line during result entry and return to the Order Entry Maintenance Screen. Option available only if subsequent pages of the result format do not contain result fields. If the result format contains result fields on subsequent pages, typing a zero and pressing **Enter** at the command line will move the cursor to the next page in the format to complete the remaining result fields.
    - **N:** The system will display the subsequent pages of results format although there are no other result fields to complete.

  EXAMPLES: *Blood bank product tags, result formats with detailed interpretive comments, etc.*

- **Result Worksheet Type**
  - Default: Blank
  - Options: Two character field lower, or upper case
  - Usage: Defines a worksheet type when using Batch Worksheet result entry. Worksheet formats are defined in Item Functions option X-Order Entry Worksheets.

  EXAMPLE: *UC to designate Urine cultures, BF to designate Body fluids, and BC to designate Blood Cultures.*

See Chapter for **Result Entry** in the Laboratory Application User Guide for further instructions.

- **Duplicate Order Check**
  - Default: 1
  - Options: 0 (zero) to 99

- **Unit**
  - Default: Blank
  - Options: D (days) H (hours)
  - Usage:
    - This first field regulates the number of days or hours that orders will be checked against previous orders for duplication. The second field determines the units (days or hours).The system refers to the schedule time of the order within the time period established in these fields.
    - A **0** (zero) may be entered in the first field for any item that a department does not want to check for duplicate orders.

- **Use Corrected Reports**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: The system has the ability to automatically create a corrected report if a result is changed for any completed order. This option is item specific.
    - **Y**: The system will create an edit trail for the "corrected" and "original" results. A document called CORRECT (in usr3/f/lab) will be pulled into the result format for documentation of corrective action.
    - **N:** The system will not create an edit trail for amended results.
  - Requirement: A document named **CORRECT** must be created in /usr3/f/lab and the particular comment verbage defined in the reference range table. See Reference Range Table Chapter in this user guide.

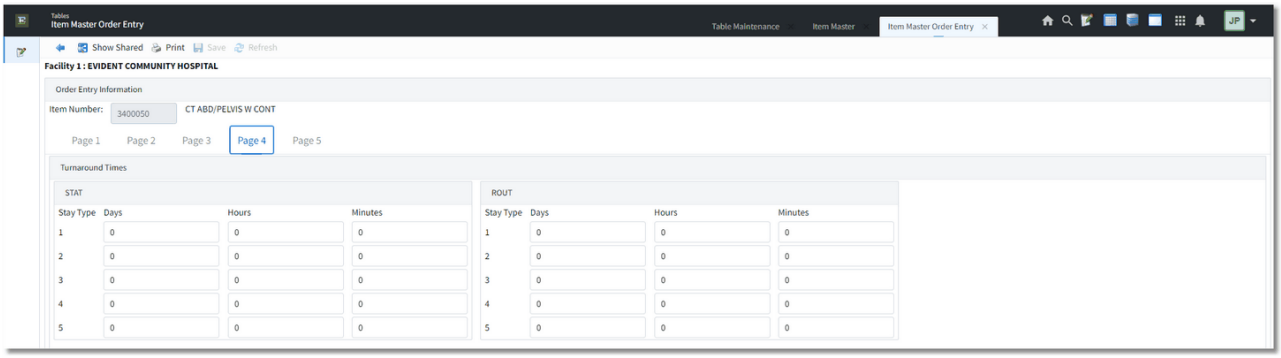
- **Lock Result Lines**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: This field allows the user to choose whether or not an item's result field of a previously resulted order that is not completed, to be accessed without invoking a corrected report. This field is item specific.
    - **Y**: When this field is checked, information previously entered in a result field may be accessed, but the results may not be modified or removed without invoking a corrected report mechanism. If the user re-accesses a resulted line outside of a 1-minute time frame from when first resulted, prompt should appear **'do you wish to make a corrected/amended report?'**
    - **N**: Will allow the result field to be modified or deleted of an incomplete resulted order without invoking a corrected report.

- **EMR Document Code**
  - Usage: This field allows an item to be assigned an EMR document code. The magnifying glass symbol displayed may be used to look up existing EMR codes set up in the Business Office tables, EMR Document Code Table.

- **Specimen Information Required**
  - Default: No

- Usage: This field, when checked (Yes), will allow the system to prompt the user for specimen information at the time of order entry, collection/receiving or completing the orders of the items specified.

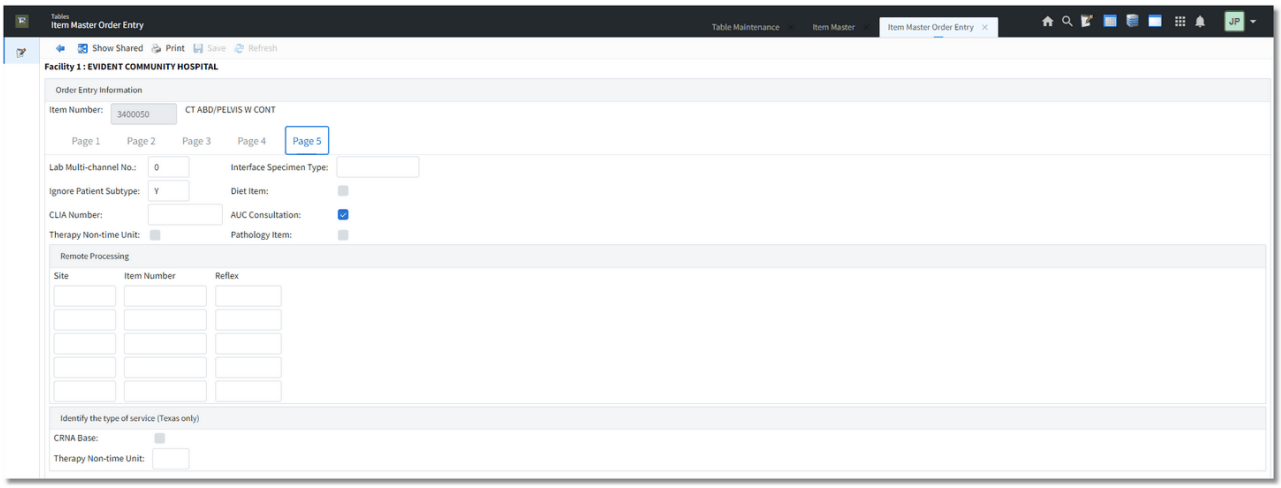
Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Order Entry Information** > **Page 4**



Order Entry Information - Page4

- **Item Specific Turn Around Time**
  - Default: Zeros
  - Options: 'STAT' order and 'ROUT' (routine) order times
    - Days-up to 3 digits
    - Hours-up to 5 digits
    - Minutes-up to 5 digits
    - Clear Stats-removes STAT times
    - Clear Rout-removes Routine times
    - Copies Times—allows user to do an alpha lookup of the Item Descriptive Index and copy the times from a test, already set to the one your are currently setting up.
  - Usage: Users may now designate item specific turn around times for STAT and Routine orders. Times may be designated in minutes, hours, or days. Once the turn around time is exceeded for a specific order, the order will appear on the department schedule under the tab, 'Exceeding Turn Around Time' and will also appear in red under the tab, 'All Orders'. This feature works in conjunction with the 'Turn Around Time Criteria' field 'Time at which TAT clock starts', pg 3-Turn Around Time tab, of the department table.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Order Entry Information** > **Page 5**



Order Entry Information - Page5

- **Lab Multi-channel No.**
  - Default: 00 (double zero)
  - Options: 0-99, **Shift** key and # key will change entry to **00**
  - Usage: This field is used for insurance companies or intermediaries that require bundling of eligible CPT codes.
    - o Designate the number of multi-channel eligible analytes, which should be categorized and coded on insurance claims as Multi-channel Tests. The number represents how many component multi-channel tests are reported for the item. Example: a BUN item would be 1, Electrolytes would be 4.
    - o The use of this feature is based on the minimum number of analytes to be bundled for a designated insurance company. The minimum number is entered on page 2 of the Insurance company tables. Refer to General Support information for the Insurance Company Table.

- **Ignore Patient Subtype**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: When patient sub-types are defined, it may be necessary for the system to ignore any sub-type prices or GL#s loaded in the Item Master when the item is charged. The GL# for subtype in the item will be applied rather than item number GL# unless **Y** is entered in this field.

  EXAMPLE: *An off-site clinic has a laboratory that performs a few basic tests. Sub-types may be setup for the outpatients seen here.*

- **CLIA Number**
  - Default: Blank, no entry
  - Options: 10 Digit CLIA #
  - Usage: This field is used by the Electronic Billing and Medical Office Management applications to submit the CLIA # of the laboratory that performed this individual test when physician services are being billed. The CLIA # will print on the 1500 if a physician charge is being billed through the hospital system.

- **Therapy Non-Time Unit -** Clinical departments at this time do not use this field. This field is used by the Insurance application for reimbursement regulations of Medicare claims. See appropriate documentation for use of this field.

- **Remote Processing -** These fields are used for the bi-directional ASTM Interface to designate which reference laboratory will receive an order through the interface.

- **Identify the type of service (Texas only)**

- **CRNA Base**
  - Checked=Y (yes)
  - Unchecked=N (no)

- **Therapy Non-time Unit**
  - Usage: This field regulates non-clinical functions.

- **Interface Specimen Type: (To be used by Interface Dept only)**
  - Default: Blank, no entry (Will default to serum if no entry provided IF staff has set download format field in IF table for that instrument.
  - Usage: This field is used by the Interface Dept for entering specimen types for use with the Dawning interface. Interface staff will load the abbreviation for each specific specimen type as to what an analyzer expects.

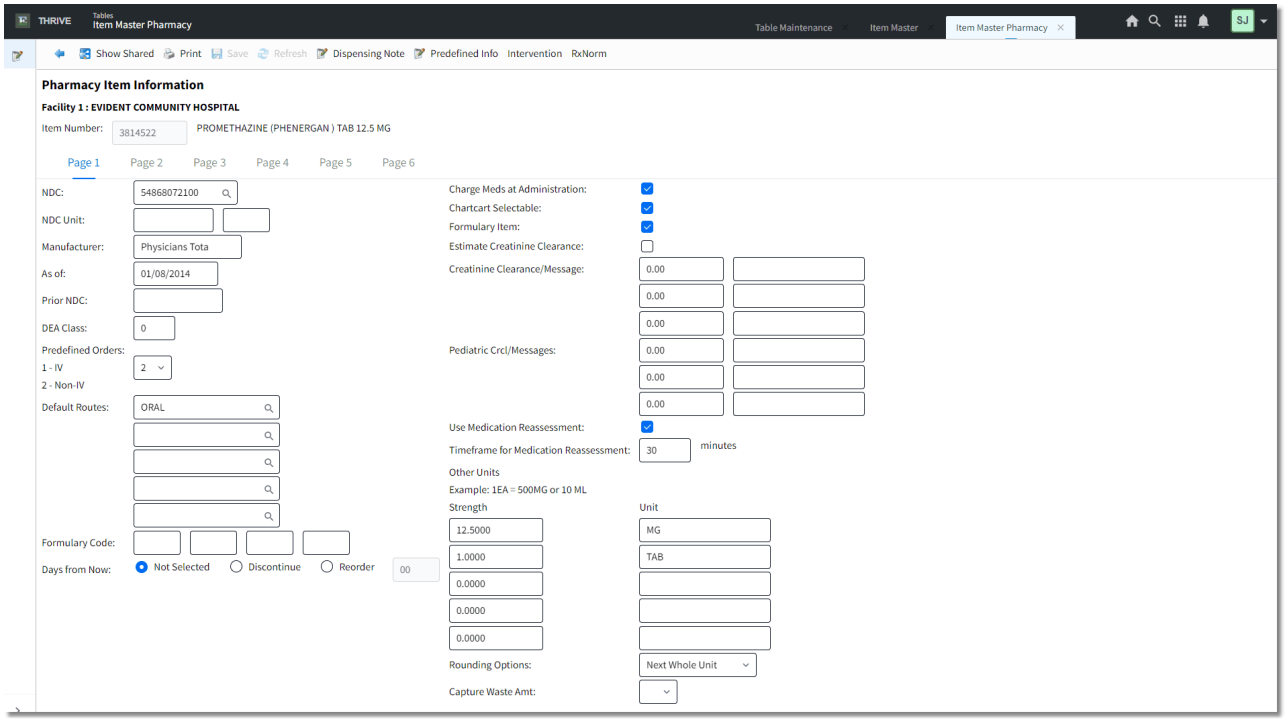
- **Diet Item: (for Dietary items only)**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: This field is only visible when accessing the Item Master from an Order Entry Prefix type D department. When this field is checked (=Yes), and a specific dietary is ordered on a patient, the name of the specific diet (from the Item Master Description field) will update the diet field in Clinical Information, Medact, Diet reports, and Patient Documentation reports.

- **AUC Consultation: (Appropriate Use Criteria)**
  - Default: Unchecked=N (no)
  - Options: Checked=Y (yes) or Unchecked=N (no)
  - Usage: When this field is checked (Yes) then the item will go through the AUC process when ordered.

- **Pathology Item:**
  - Default: No
  - Options: Checked (yes) or Unchecked (no)
  - Usage: When this field is checked (yes), this item will be identified as a pathology item.

Pharmacy Information, Page 1

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 1**



Pharmacy Information, Page 1

- **NDC** (National Drug Code)
  - Default: Blank
  - Options: Use the lookup to access Micromedex to select an NDC number or enter the 11-digit NDC number without hyphens.
  - Usage: All clinical monitoring checking is performed based on this number.

- **NDC Unit**
  - Default: Blank
  - Options: Free text field
  - Usage: Certain states are required to report a unit of measurement in addition to the NDC number. These are two free text fields used to enter the numeric measurement and unit for the medication.

- **Manufacturer**
  - Default: Blank
  - Options: The manufacture name automatically updates from Micromedex when the NDC number is entered.
  - Usage: This field holds the manufacturer of the medication.

- **As of**
  - Default: Blank

- Options: The date will change in this field as the NDC number is changed and the Manufacturer is updated.
- Usage: This field will indicate when a manufacturer changed for the specific medication.

- **Prior NDC**
  - Default: Blank
  - Options: The prior NDC number automatically updates when a new NDC number is entered or an NDC number can be manually entered.
  - Usage: This field holds the number previously entered in the NDC field.

- **DEA Class**
  - Default: Blank
  - Options: Key in the DEA Class or select the lookup to assign a DEA class to the medication.
  - Usage: Schedule medications

- **Predefined Orders**
  - Default: Blank
  - Options: IV, Non-IV
  - Usage: Allows the setup of default information when the correct medication type is selected.

  NOTE: *To remove predefined information from an item, select* ***Predefined Orders****. Open the drop-down menu and select the blank space.*

- **Default Routes**
  - Default: Blank
  - Options: Key in the appropriate routes, or use the lookup to select the appropriate route from the Route Table.
  - Usage: The information in this field determines if the medication order will default to an IV or Non-IV screen during Pharmacy and Physician Order Entry. This field will also be used to verify correct routes of administration during Med-Verify.

- **Formulary Code**
  - Default: Blank
  - Options: Key in the appropriate number that corresponds to the entry in the Formulary Code Table for this information.
  - Usage: Classifies the medication based on American Hospital Formulary System (AHFS) codes. This information is used to generate the Formulary Therapeutic List report.

- **Days from Now**
  - Default: Not Selected
  - Options: Not Selected, Discontinue, or Reorder. If Discontinue or Reorder is selected, a max of 2 characters can be entered in the field to the right.
  - Usage: Allows the system to automatically generate a Hard stop or Auto stop date/time and stop code during order entry.
    - Discontinue: The system will calculate the start date based off of the frequency times selected and will calculate the stop date based on the number of days set up. Will generate Stop Code D.
    - Reorder: The system will use this information during order entry to calculate the auto stop date. The number entered will be added to the start date to calculate the reorder date. Will generate Stop Code A.

NOTE: *The system assigns the shortest reorder day if an IV has multiple components with different reorder days.*

- **Charge Meds at Administration**
  - Default: ✓
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When this field is selected and POC pharmacy is used, charges will be applied to the account when End of Shift is performed in POC. The nursing station must also be set to charge at administration.

- **Chartcart Selectable**
  - Default: ✓
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When selected the medication can be ordered through the Pharmacy application in Point of Care, Physician Order Entry, and Electronic Forms. When this switch is deselected, the medication is not viewable in any of these applications.

- **Formulary Item**
  - Default: ✓
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Flags item as a formulary item when pulled to reports

- **Estimate Creatinine Clearance**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Used to flag the pharmacist during order entry to calculate Creatinine Clearance for drugs that are severely affected by poor renal function.

- **Creatinine Clearance/Message / Pediatric Crcl/Messages**
  - Default: Blank
  - Options: Enter the CrCl value in the first column, enter the dosing message to display in the 2nd column.
  - Usage: When Estimate Creatinine Clearance is selected, this option becomes active. Creatinine Clearance parameters can be set so that the message displays on the Calculate Creatinine Clearance screen during Pharmacy Order Entry. Additional fields to designate pediatric parameters are available.

- **Use Medication Reassessment**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When set to yes, the nurse is required to document a medication assessment via the EMAR. This is the patient's reaction/response to the medication. If this is not done in the time frame set, the medication will display in orange on the EMAR.

  Note: *The notification/alert is determined based on the time frame set on the item (see below). If no time frame is set on the item, the system will refer to the* ***Route Table > Timeframe for Medication Reassessment****. If neither the item nor the route are set up, the system will default to the* ***POC Control Maintenance > Page 6 > Acceptable time before and after scheduled administration times to give medications*** *setup.*

- **Timeframe for Medication Reassessment**
  - Default: Blank

- Options: Key in the appropriate time frame in minutes to require the nurse to document a medication assessment. To access this field, **Use Medication Reassessment** (see above) must be selected.
- Usage: The time frame to require the nurse to have to document a medication assessment after administering a medication.

- **Other Units**
  - Default: Blank
  - Options: Free text field
  - Usage: The default in the system is for one each: the other units field should reflect the strength of the medication. Charging and Medication Verification Administration are dependent on this information.

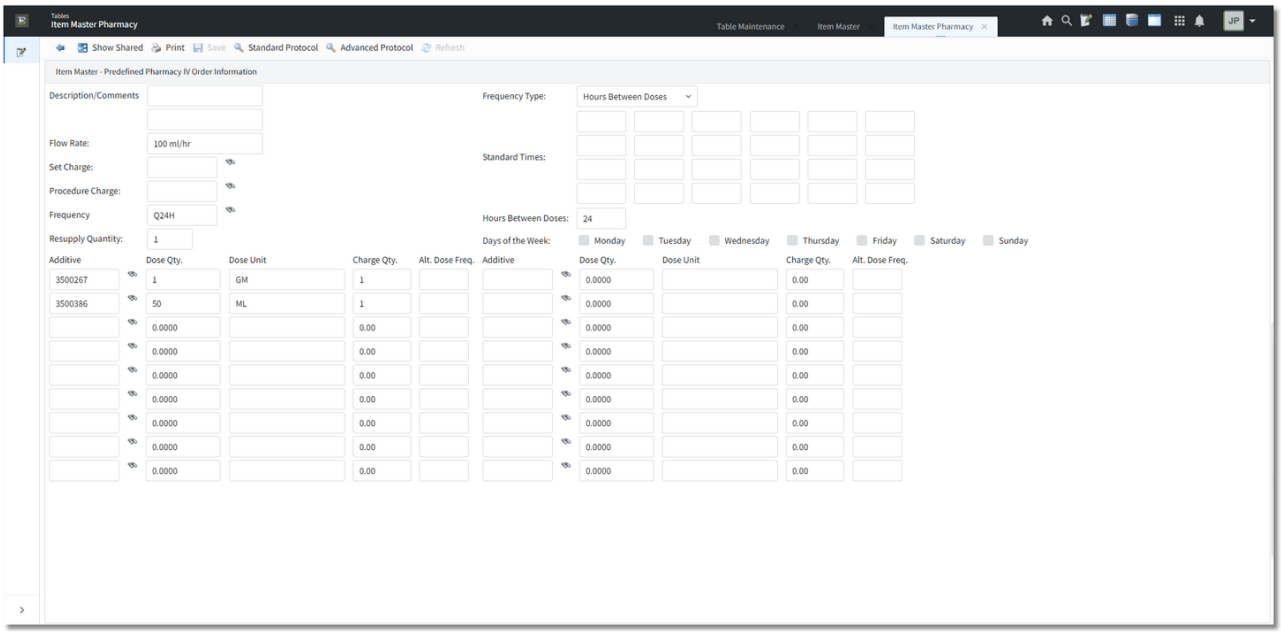
- **Rounding Option**
  - Default: Blank
  - Options: Nearest Unit, Next Whole Unit, or None
  - Usage: The system will charge based upon this field. If set to nearest unit it can charge for 1/4, 1/2, 3/4, or whole. Next Whole Unit will charge for the next whole unit.

- **Capture Waste Amt**
  - Default: Blank
  - Options: Y, Yes, or P, Prompt
  - Usage: The purpose of this field is to allow documentation of discarded drug amounts for submission to CMS for payment.
    - If set to (Y)es, the system will automatically calculate the waste based on Other Units and the dose of the order when the medication is given via the 24-hour eMAR or Medication Verification.
    - If set to (P)rompt, the user will be prompted to enter the waste amount when the medication is given via the 24-hour eMAR or Medication Verification.

- **Dispensing Note (Action Bar)**
  - Default: Blank
  - Options: The **Dispensing Note** option is a free text field for notes relating to the medication. If the dispensing note to be used is identical to another medication, use the lookup to select the item or key in the item number.
  - Usage: This information will be seen in Pharmacy only, nursing will not see this note when ordering medications via the POC Pharmacy application.

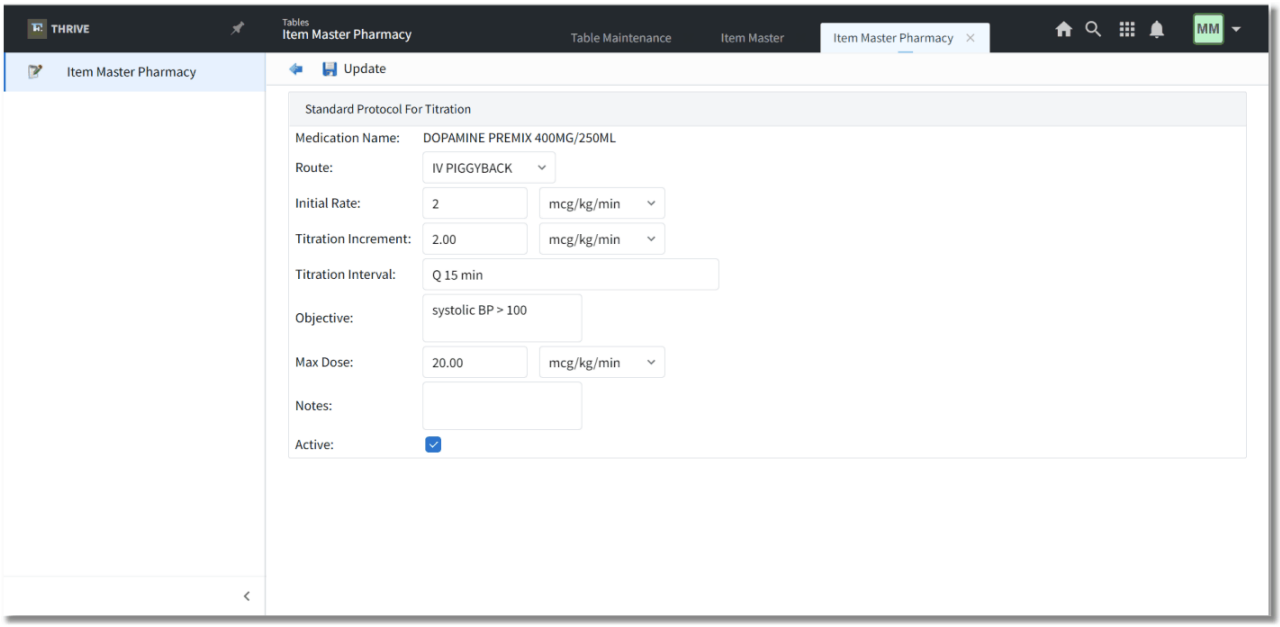
- **Predefined Info (Action Bar)**
  - Default: Blank
  - Options: IV or Non IV
  - Usage: When IV or Non IV is selected in the Predefined Orders field, the **Predefined Info** option becomes active at the top of the screen. Items that are repeatedly ordered by physicians the same way can be preset to generate the information each time the item is selected during Order Entry.
  - To remove predefined information from an item, select the blank option from the **Predefined Order** drop-down menu.

Predefined Info IV Setup

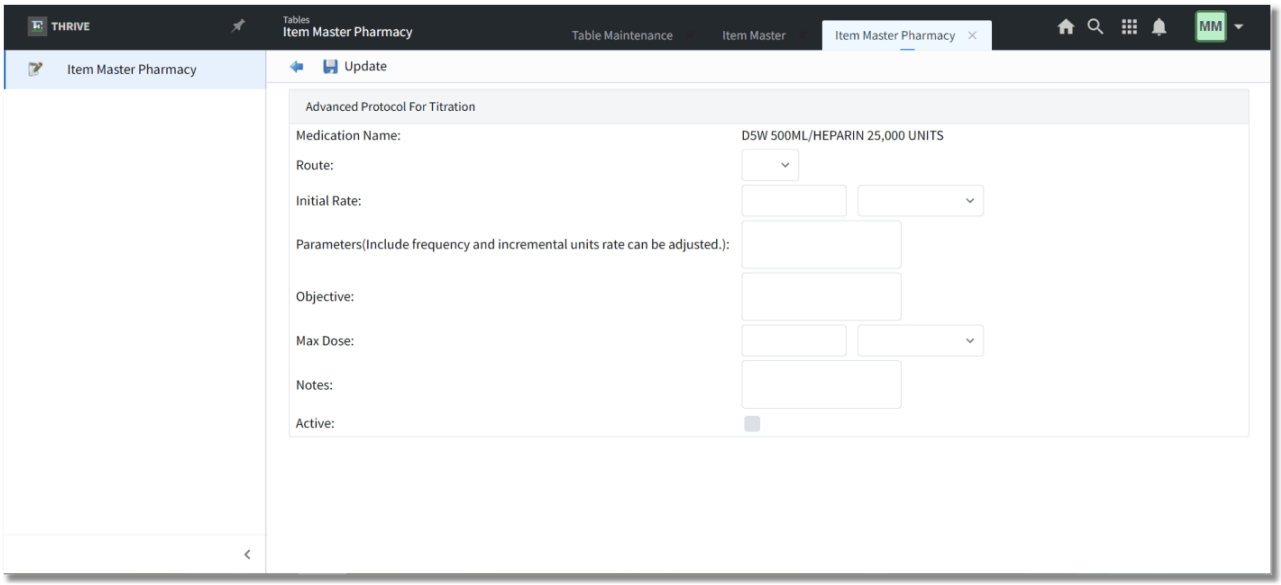


Predefined Info- IV

Desc/Comments	Enter the item description with associated comments as it is to appear on the MAR.
Flow Rate	Enter the desired flow rate.
Set Charge	If an IV set is to be included, enter the item number of the set.
Procedure Charge	Enter the item number of the admixture fee.
Frequency	Enter the dosage frequency.
Frequency Type	Standard Times will populate frequency information as set up in the Frequency Table. Otherwise, selecting Times, Hours Between Doses, or Days Of The Week allows you to enter desired Non-Standard Times information. ***NOTE:*** *Administration Time is based on Start Time.*
Resupply Quantity	Enter the quantity of doses to be charged during a 24-hour period.
Additive	Enter the item number, dosage unit, dosage quantity, and charge quantity of each additive or fluid.
Standard Protocol (Action Bar)	Opens the Standard Protocol for Titration screen, which allows entry of minimum required components for a protocol based on a single objective. Notes section allows for additional information to be entered related to the administration of the medication.
Advanced Protocol (Action Bar)	Opens the Advanced Protocol for Titration screen, which contains the same components as the Standard Protocol with larger text boxes allowing complicated protocols with multiple options to be entered.

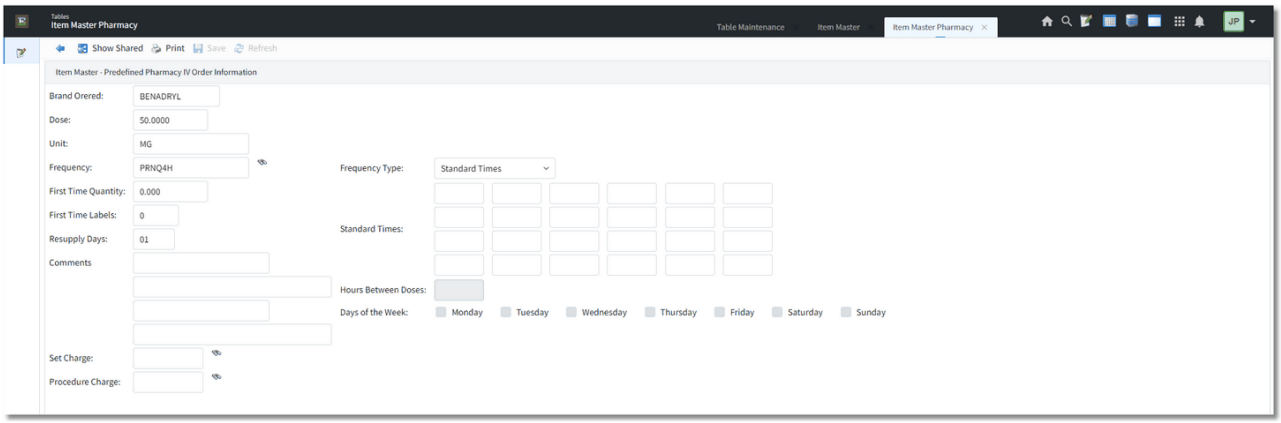


Standard Protocol



Advanced Protocol

Predefined Info Non-IV Setup



Predefined Info- Non-IV

Brand Ordered	This field is automatically generated from the item short description but may be changed if necessary.
Dose	Enter the dosage quantity.
Unit	Enter the dosage unit.
Frequency	Enter dosage frequency.
Frequency Type	Standard Times will populate frequency information as set up in the Frequency Table. Otherwise, selecting Times, Hours Between Doses, or Days Of The Week allows you to entered desired Non-Standard Times information.
First Time Quantity	Enter the first time quantity to default during order entry for charging.
First Time Labels	Enter the number of labels to default during order entry.
Resupply Days	This field should always be 1.
Resupply Quantity	Enter the quantity of doses to be charged during a 24-hour period.
Comments	Enter any needed instructions.
Set Charge	Enter the item number for any desired set charge.
Procedure Charge	Enter the item number for any applicable procedure charges.

- **Intervention -** This option is not accessed from this screen.

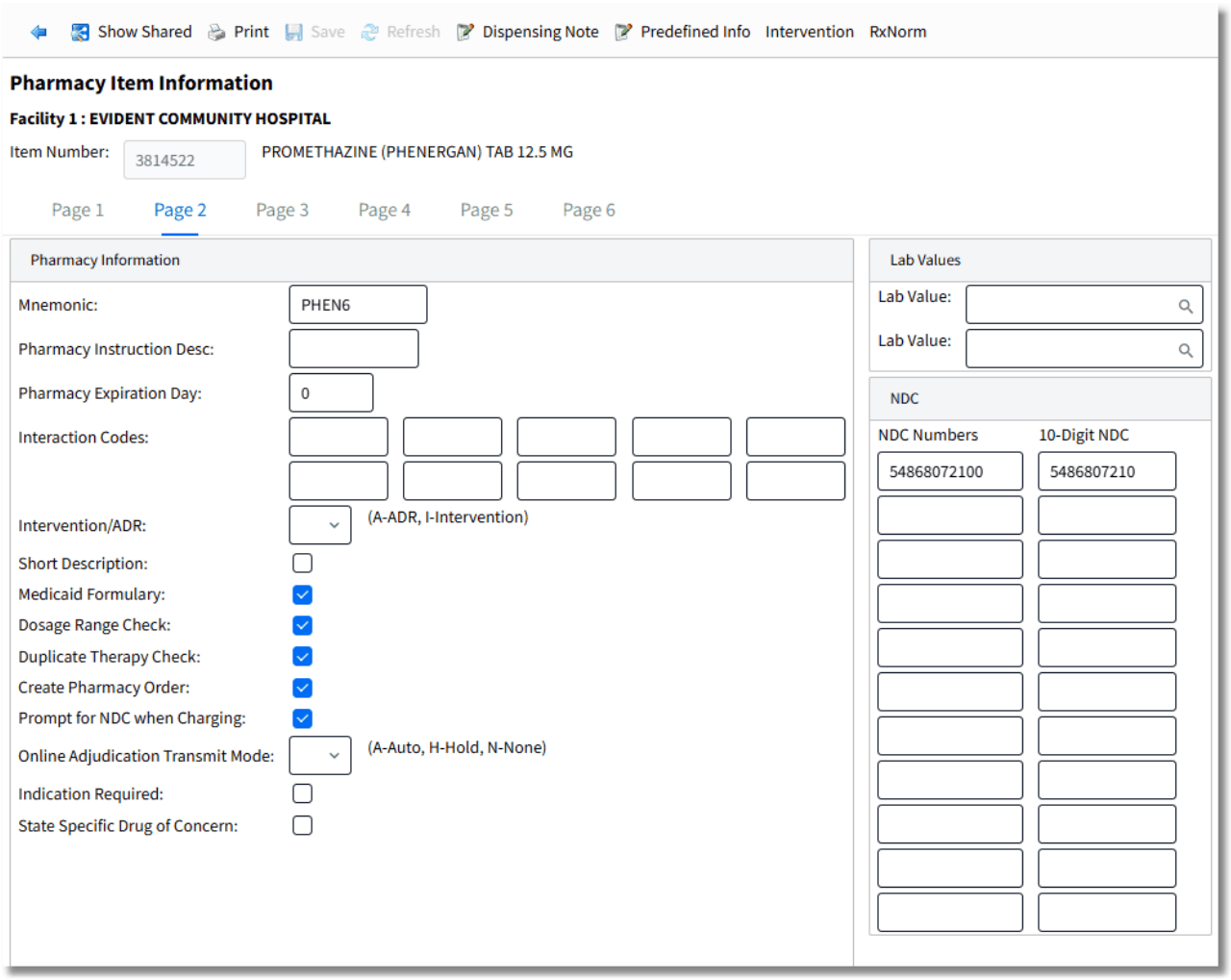
- The following options are available on the action bar:
  - **Show Shared**: When this option is selected, the fields that are shared between facilities will be highlighted in yellow.
  - **Print**: Displays the table settings in Adobe
  - **Save**: Saves changes made to the table settings
  - **Refresh**: Allows changes to the Pharmacy Information Pages to display immediately

Select the **Back Arrow**  to return to the previous screen.

NOTE: *A lookup may be accessed by selecting the* ***Magnifying Lens***  .

Pharmacy Information, Page 2

Select **Web Client > Tables > Control > Item Master > Select an item > Pharmacy Information > Page 2**



Pharmacy Information, Page 2

- **Mnemonic**
  - Default: First 4 letters of the description and number of the medication, ie: the first Acetaminophen item would default to ACET1
  - Options: The mnemonic can be changed and a mix of alpha and numeric characters can be used.
  - Usage: The mnemonic can be used to search for the medication when performing order entry.

- **Pharmacy Instruction Desc**
  - Default: Blank
  - Options: An abbreviated instruction title can be added to link an instruction to a drug.

- Usage: Allows a drug to be linked with a particular instruction. This instruction displays on line 6 and 6b of the pharmacy order, and prints on the label. This is not a required feature, and if a drug is linked with an instruction, the instruction can be changed. However, linking an instruction with a drug makes order entry easier and quicker, since one-keystroke displays the entire instruction.
  - To change a linked instruction, type over the old instruction with the new instruction. To remove a linked instruction, click and drag across the field with the mouse and hit the <Delete> key.

EXAMPLE: *WFM may be entered for the instruction "Take with food or milk". For more information about this feature see Pharmacy Instruction Table.*

- **Pharmacy Expiration Day**
  - Default: Blank
  - Options: Whole numbers from 1 to 99
  - Usage: Allows an expiration date to be entered for IV orders. The entry should indicate the number of days the drug or fluid is stable after mixing. This number will be used to calculate the IV expiration date printed on the IV label. When the IV label is printed, the system will add the quantity in this field to the current date and time, and print: EXPIRES AFTER MM/DD/YY (month, day, year).

NOTE: *If multiple components are used in an IV and the components have different expiration dates, then the system will use the shortest expiration date. Most policies state that a prepared fluid expires after a given time regardless of the stability of the components. In this case, it is easier to enter the expiration dates on the fluids.*

- **Interaction Codes**
  - Default: Blank
  - Options: Entry of an Interaction / Indicator code. Up to ten codes can be entered.
  - Usage: Links Interaction/Indicator Codes to a specific item. The Interaction/Indicator codes consist of one letter and one to four digits (i.e. F0001).
    - These codes are linked to a facility created monograph. The monographs are printed in a report format. The report is then sent to other departments to alert the departments of current drug therapy.
    - Example, the F series of codes is customarily used to indicate Food/Drug interactions. The appropriate report would then be sent to the Dietary Department. For more information about this feature, see Pharmacy Interactions/Indicator Table.

- **Intervention/ADR**
  - Default: Blank
  - Options: ADR or Intervention
  - Usage: When prompted in order entry to enter ADR or an Intervention, the system will default to the selection for this field.

- **Short Description**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Enables the pharmacy dept to specify whether the Long description or Short description is to be printed on medication labels and reports that list the drug name.

- **Medicaid Formulary**
  - Default: Yes, ✓ (check mark)

- Options: Yes, ✓ (check mark), or No, blank.
- Usage: Items set to No alert the system that this item is not covered by Medicaid and cannot be transmitted via Online Adjudication to Medicaid.

- **Dose Range Checking**
  - Default: Yes, ✓ (check mark)
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When deselected, dose range checking will not be performed for the individual drug during order entry.

- **Duplicate Therapy Check**
  - Default: Yes, ✓ (check mark)
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When deselected, duplicate therapy checking will not be performed for the individual drug during order entry.

- **Create Pharmacy Order**
  - Default: Yes, ✓ (check mark)
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows the system to determine if a pharmacy order should be created when an item is removed via Automated Dispensing Machines.

- **Prompt for NDC when Charging**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When this field is selected, the user will get a prompt to verify or change an item NDC number when entering charges via the Patient Charging feature.

- **Online Adjudication Transmit Mode**
  - Default: Blank
  - Options: Auto, Hold, None
  - Usage: In order entry this determines if the medication will transmit at that time or will the item be on hold until the Online Adjudication information is created.

- **Indication Required**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When this field is selected, physicians enter the indication to specify the reason the patient is being treated or given a particular medication from order entry. Once selected, select **Save**.

- **State Specific Drug of Concern**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When this field is selected, information on the item will pull to the Electronic Controlled Substance Report. It allows the user to report state- specific drugs of concern with their controlled substance reporting, regardless of the DEA Class on the item. ***NOTE:*** *The DEA Class field MUST be completed for the prescription to pull to the report.*

- **Lab Value 1**
  - Default: Blank
  - Options: To add a lab, select the magnifying glass icon to access a lookup.

- Usage: This feature allows labs to be associated with a medication. Any available results will display during order entry in the clinical monitoring screen.

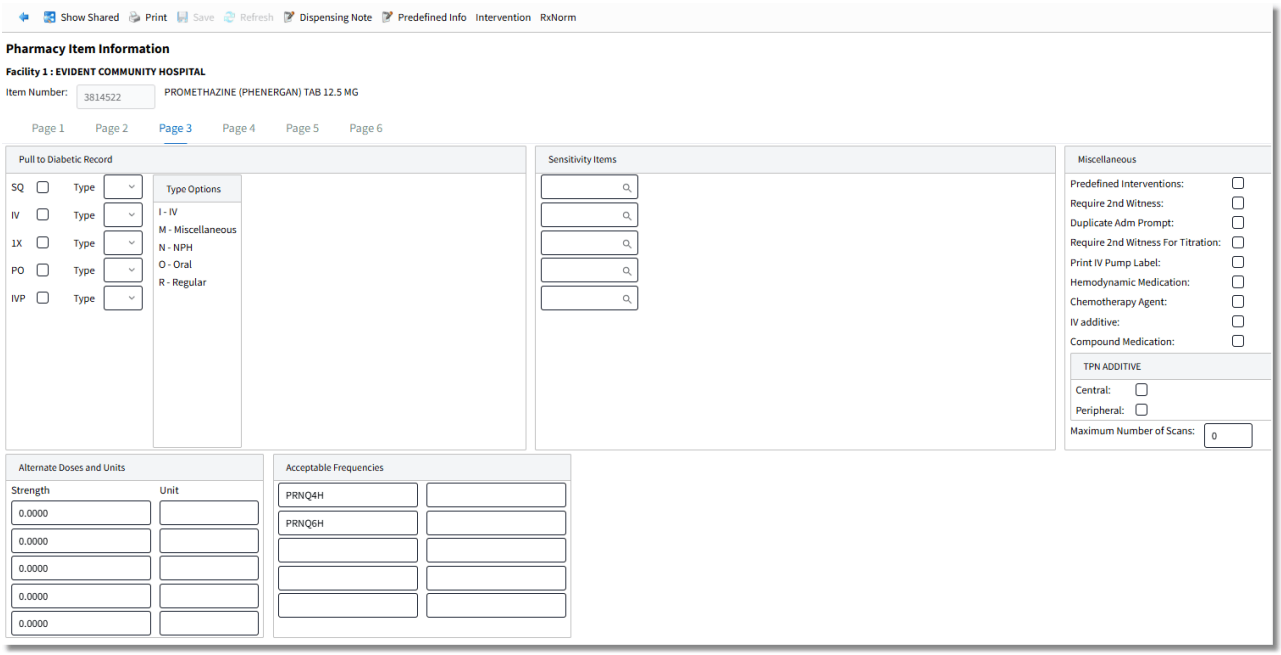
- **Lab Value 2**
  - Default: Blank
  - Options: To add a lab, select the magnifying glass icon to access a lookup.
  - Usage: This feature allows labs to be associated with a medication. Any available results will display during order entry in the clinical monitoring screen.

- **NDC Numbers**
  - Default: Blank
  - Options: Scan or free text additional NDC numbers
  - Usage: An additional ten NDC numbers containing 11-digits can be added to an item for Medication Verification. NDC numbers can be selected from a lookup table accessed via the magnifying glass icon to the right of the NDC field. The system will perform a check to verify that the NDC number entered matches the item listed on Pharmacy Information Page 1.

- **10-Digit NDC**
  - Default: Blank
  - Options: Scan or free text the 10-digit NDC number.
  - Usage: This field must be populated in order for the medication to scan correctly during Medication Verification Administration.

Pharmacy Information, Page 3

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 3**



Pharmacy Information, Page 3

- **Pull to Diabetic Record**
  - Default: Blank, or no entry

- Options: Yes (check mark ✓), or No (blank).
- Usage: Allows (SQ) subcutaneous, (IV) intravenous, (1X) one-time, and (PO) oral hypoglycemic insulin medications to pull to the diabetic record in Point of Care. Once selected, choose the drop-down and select the insulin type. The insulin type abbreviations are Reg, NPH, IV, Oral, and Miscellaneous.

- **Sensitivity Items**
  - Default: Blank
  - Options: Up to five, 5, Sensitivity Items
  - Usage: Enables up to five sensitivity items to be associated with the selected pharmacy item. If enabled and a positive culture sensitivity has been resulted on a patient, a sensitivity button will display during clinical monitoring. When selected, the sensitivity button will bring up the microbiology section of the laboratory cumulative report.
    - o Select the magnifying glass icon to display a lookup screen.
    - o Enter the department number and beginning description of the item to be associated.
    - o Double-click the desired item from the list.

- **Alternate Doses & Units** ******NO LONGER IN USE******
  - Default: Blank
  - Options: Up to five alternate doses can be entered for selection during Physician Order Entry.
  - Usage: Function in ChartLink Physician Order Entry. Enables the selection of doses from a drop-down box.

- **Acceptable Frequencies**
  - Default: Blank
  - Options: Up to 21 frequency codes.
  - Usage: Enables up to 21 acceptable frequencies for the selected medication to be selected from a drop-down box via the ChartLink application.

- **Miscellaneous**

- **Predefined Interventions**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: Allows items that often require the same interventions to be predefined. Multiple intervention types can be predefined for each item.
    - o Yes: Allows interventions to be predefined. Note that the **Intervention** option becomes active on the action bar. Refer to the Intervention 44 section of this guide for more information.
    - o No: Interventions cannot be predefined.

- **Require 2nd Witness**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected, POC will be prompted for a second witness to the medication order.

- **Duplicate ADM Prompt**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected, all medications administered that are marked for this prompt and are duplicate therapy will display a list of the last six administrations. This will include the Medication name, Dose, Route, Date. and Time.

- **Require 2nd Witness For Titration**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: When selected, POC will be prompted for a second witness to the medication order for Titration.

- **Print IV Pump Label**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank)
  - Usage: When selected the system will print an additional label with bar code information for Braun IV pumps. Patient ID, drug name, concentration, pump dosage, and weight in kilograms will each have their own bar code and will print to a separate label.

- **Hemodynamic Medication**
  - Default: Blank, or no entry
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: Designates an item as a hemodynamic medication. Allows the item to print to the Critical Care Flow Sheet in Point of Care when selected as a patient's medication. Items designated as hemodynamic medications can also be selected from a lookup via flowcharts in Point of Care.

- **Chemotherapy agent**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected a medication will be flagged as a Chemotherapy medication in the CPOE application.

- **IV additive**
  - Default: Blank
  - Options: Yes (check mark ✓) = additive, or No (check mark ✓) = base.
  - Usage: When selected the medication will be flagged as an IV additive.
  - Exceptions:
    - If there is one component, then that component is the base.
    - If there are two components and neither is marked as an additive, then the first component is the base.
    - If there are two components and one is marked as an additive, then the 'additive marked' is the additive and the remaining component is the base without regard to the position.
    - If there are more than two components then the first component is the base with the remaining components being additives.

- **Compound Medication**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected, the Administer Amount will not display for the order in Medication Administration, Order Detail, Order Entry or the Dose Calculator.

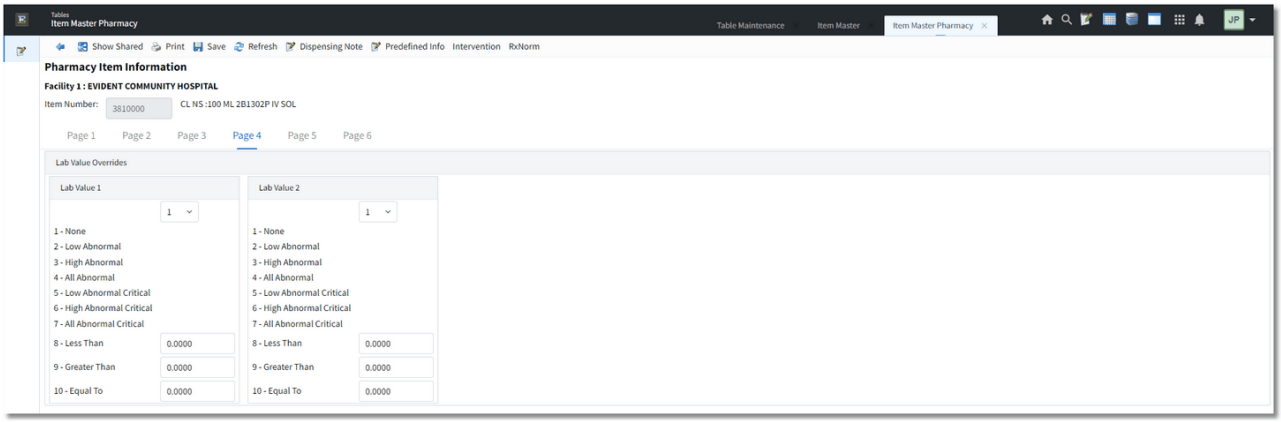
- **TPN additive Central**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected the medication will be flagged as a TPN additive Central in the CPOE application.

- **TPN additive Peripheral**
  - Default: Blank
  - Options: Yes (check mark ✓), or No (blank).
  - Usage: When selected the medication will be flagged as a TPN additive Peripheral in the CPOE application.

- **Maximum Number of Scans**
  - Default: Blank
  - Options: 1-99
  - Usage: For use with the Medication Verification application. When a numeric value is entered, the system will ignore the number of scans required to meet the ordered dose and allow nursing to scan only the number entered in this field.

Pharmacy Information, Page 4

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 4**

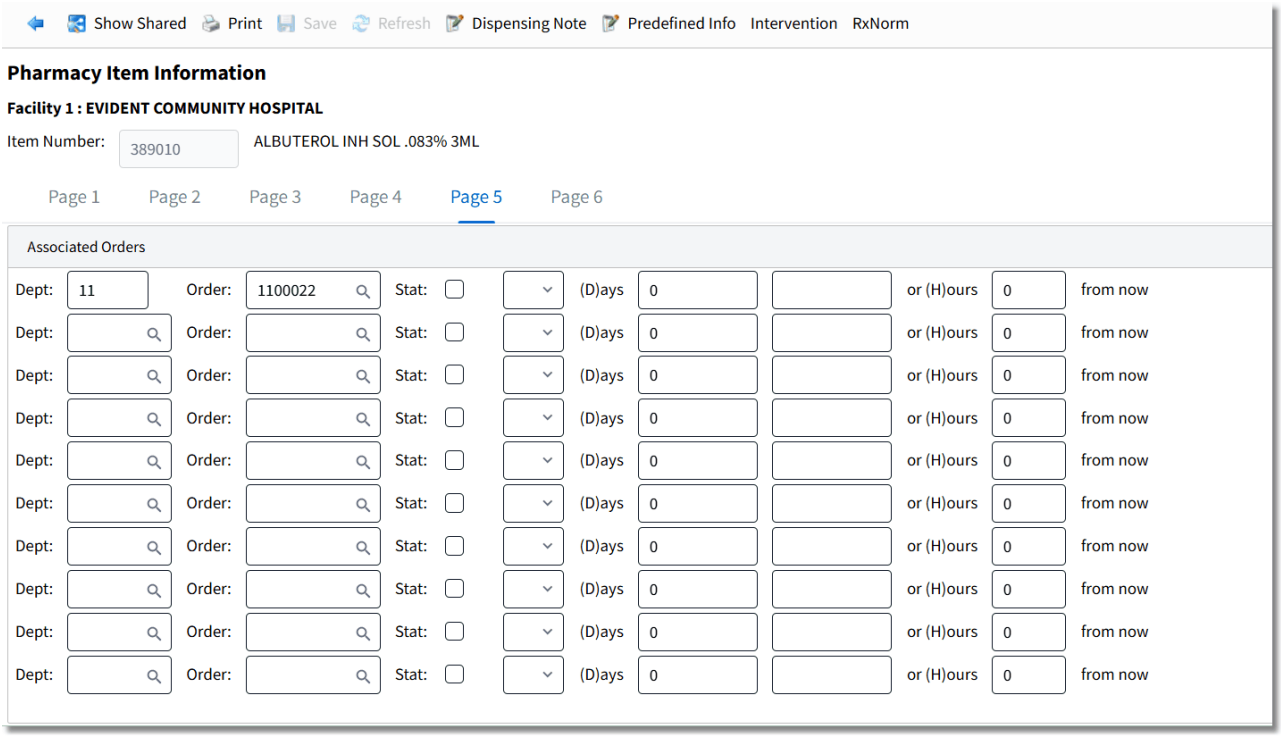


Pharmacy Info Page 4

- **Lab Value 1 & 2**
  - Default: None
  - Options: Allows parameters to be set for required overrides on lab values that display in Clinical Monitoring
  - Usage: Lab values are set in Pharmacy Information Page 2. Physicians will be required to enter an override reason to continue an order when lab results are flagged based on these settings.

Pharmacy Information, Page 5

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 5**

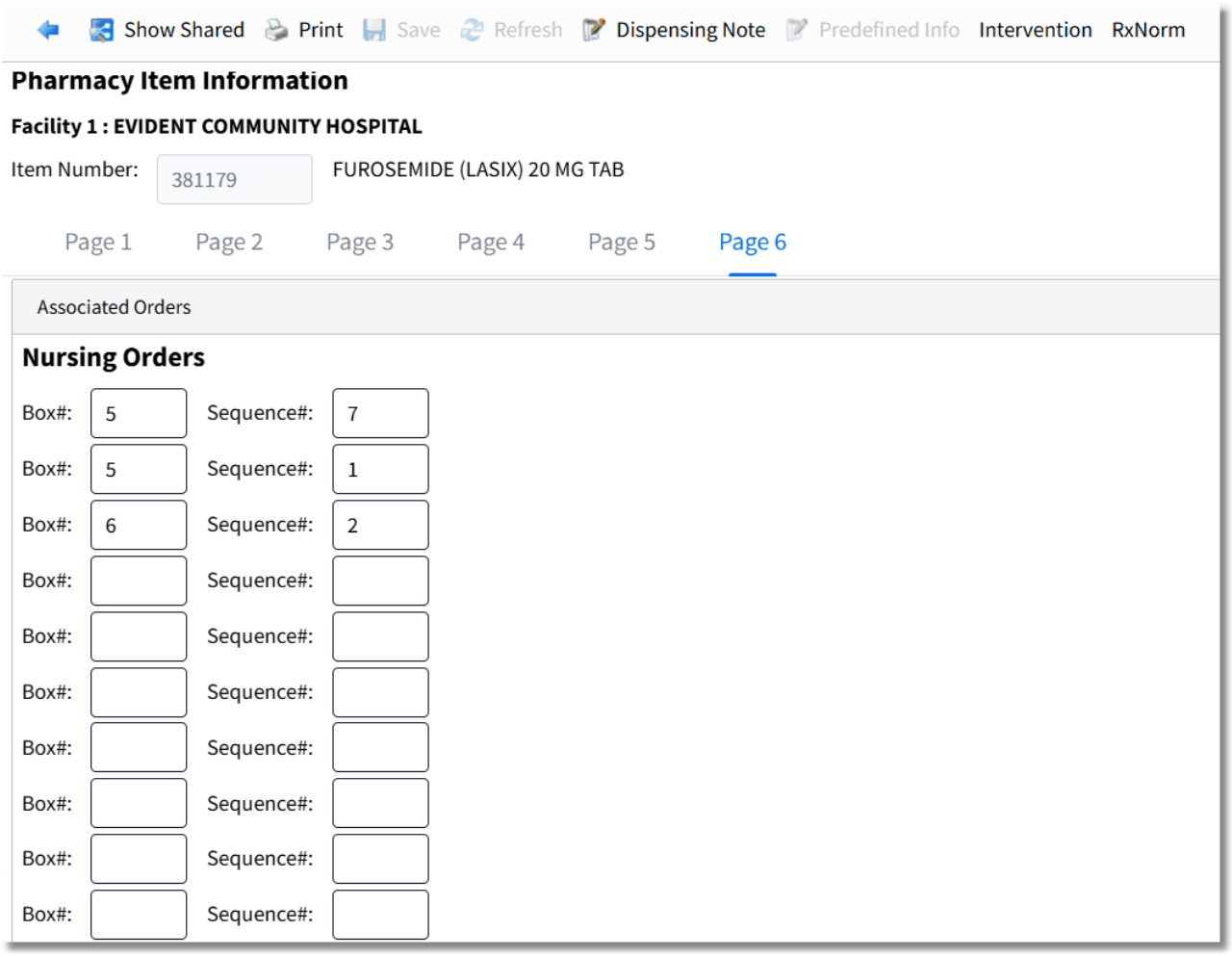


Pharmacy Info Page 5

- **ChartLink Associated Orders – Ancillary Orders**
  - Default: Blank
  - Options: Up to ten 10 ancillary item numbers.
  - Usage: Enables up to ten ancillary items to be associated with the selected pharmacy item. Upon ordering the pharmacy item via CPOE or Nursing OE, the associated order would also be processed according to the parameters set.
  - Add the ancillary order information.
    - o Select the magnifying glass icon to search for the ancillary dept number first.
    - o Select the magnifying glass icon to search for the ancillary order next. Enter a partial description of the item in the **Search** field. Double-click the desired item.
    - o Select **Stat** if the associated item is to be ordered immediately at the time the pharmacy item is ordered.
    - o The ancillary item can be set to order for a predetermined number of hours from the time the pharmacy item is ordered by selecting **H** (Hours from Now) from the drop-down box.
    - o The ancillary item can be set to order for a predetermined number of days from the time the pharmacy item is ordered by selecting **D** (Days from Now) from the drop-down box. Enter the number of days and the specific time the order is to be sent.

Pharmacy Information, Page 6

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 6**



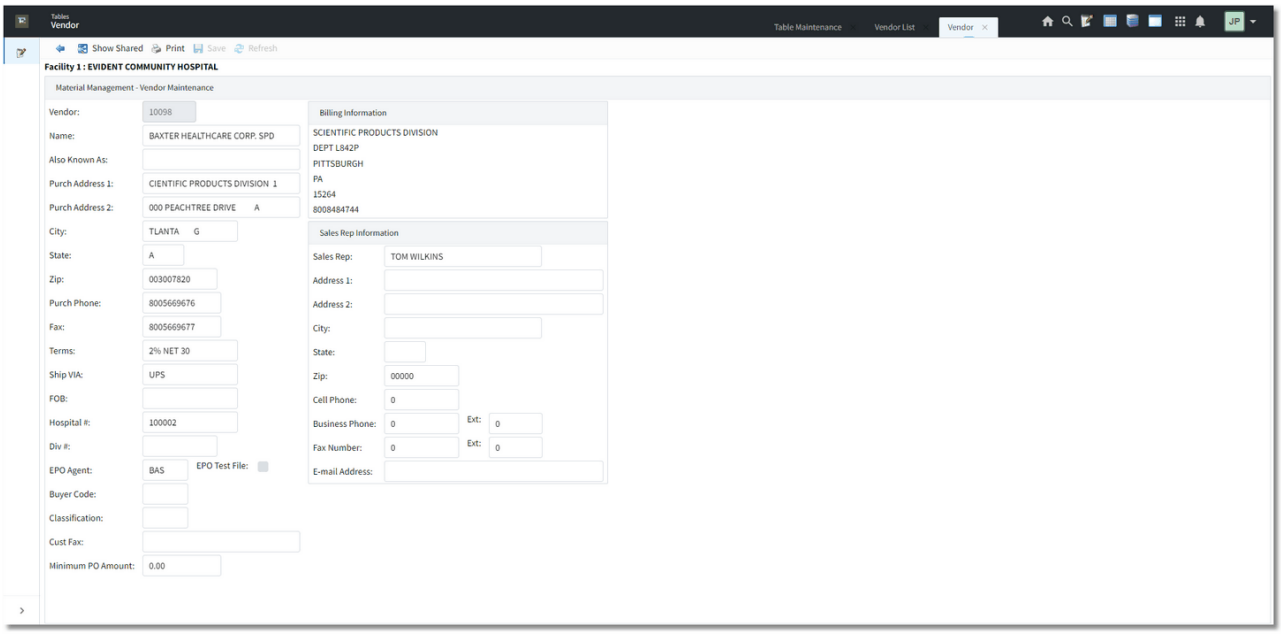
Pharmacy Info Page 6

- **ChartLink Associated Orders – Nursing Orders**
  - Default: Blank
  - Options: Up to ten 10 Nursing Orders
  - Usage: Enables up to ten medical orders to be associated with the selected pharmacy item. Upon ordering the pharmacy item via CPOE or Nursing OE, the associated order would also be processed according to the parameters set.
  - Enter the Box # (Category) of the Nurse order.
  - Enter the Sequence # (Order Description) of the Nurse order.

11.2 Vendor

Select **New** to create a new Vendor, or choose an existing Vendor then select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Materials Management** > **Vendor** > **Select a Vendor**



Vendor

- **Vendor**: The vendor number that has been assigned to a vendor name.
- **Name**: Enter the name of the Vendor.
- **Also Known As**: Enter in additional names that could be associated with the Vendor.
- **Purch Address 1**: Enter the address of the Vendor.
- **Purch Address 2**: Enter the address of the Vendor.
- **Purch City/St/Zip**: Enter the city,state, and zip code of the Vendor.
- **Purch Phone**: Enter the phone number for the Vendor.
- **Fax**: Enter the Vendor's fax number.
- **Terms**: Load any special payment schedule arranged with this Vendor.
- **Ship VIA**: Enter the means on transportation from this Vendor to the hospital.
- **FOB**: Enter the Freight on Board for this Vendor.
- **Hospital #**: Enter the hospital's account number into this field.

- **EPO Agent**: Enter the agent code assigned to the vendor. This field is mandatory for Electronic Purchase Orders. Refer to the Electronic Purchase Order section in this chapter for more information.
- **Buyer Code**: Enter the Buyer Code based on what is loaded in the Buyer Code Table.
- **Classification**: Enter a 3-digit alpha and/or numeric user defined Classification code.
- **Custom Fax**: This field allows the entry of any unique dialing instructions. Data in this field will pull to the Fax Phone Number field when Fax is selected from the PO Entry Screen. The fax number may be changed if needed.
- **Minimum Purchase Order Amount**: This field allows for a minimum amount to be specified per vendor. A warning message will appear if a purchase order is created for this vendor with an amount less than what is indicated.
- **Sales Rep Information**: The fields listed here are only for the Materials Management department. These fields do not pull to Purchase Orders or to any reports.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Delete**:Deletes the table settings
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Vendor list

Select the  **Back Arrow** to return to the previous screen.

Chapter 12 Physicians

The Physicians Table stores information about individual physicians working in the hospital.

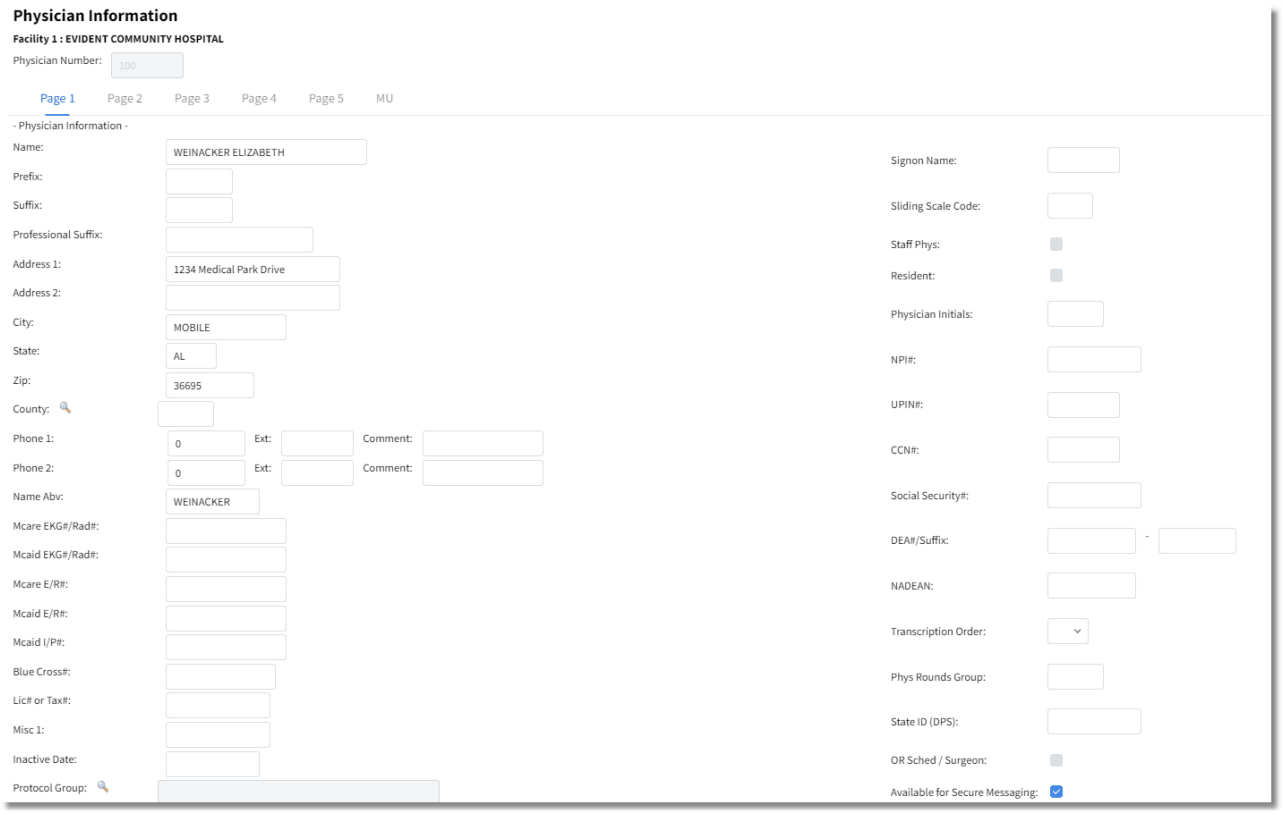
Select **New** to enter a new physician, or select an existing physician from the list and select **Edit**.

The Report option enables information from the Physicians table to be exported into a CSV format. After selecting **Report,** the Report Writer Parameters screen will appear, allowing filters to be applied as needed. Once all are set, select **Run Report** to generate the file**.**

NOTE: *This report is also available within the Report Dashboard and it titled "Physicians Master Table Report".*

12.1 Physicians Table, Page 1

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 1**



Physicians Maintenance, Page 1

- **Enter Physician's Number:** Enter a 6-digit numeric code to represent the physician. When the first four digits of the physician number are the same for multiple physicians, this can indicate they are in a group if "Group Physician Numbers?" is set to **Y**es on AHIS page 7. When a new physician is set up in the Physicians table and the first four digits entered are the same as another physician's then the Physician Group table will be updated with the new physician's Address 1 & 2, City, State, Zip, Phone 1 and Phone 2. See Physician Groups 114 for more information.

The Physician's Table **999999** is used primarily for facility-specific billing information. To customize facility-specific billing information see the Admin Groups 137 section of this user guide.

- **Name:** The first field in the Physician Maintenance stores the physician's name. The last name should be entered, followed by the first name and middle initial. Do not use any punctuation.
- **Prefix**: Enter the Prefix associated with this Physician using up to five characters.
- **Suffix**: Enter the Suffix associated with this Physician using up to five characters.
- **Professional Suffix**: Enter the Professional Suffix associated with this Physician using up to 20 characters.
- **Address 1 & 2**: Enter the address that will pull to statements and/or collection letters for this physician.
- **City:** Enter the city that will pull to statements and/or collection letters for this physician.
- **State:** Enter the state that will pull to statements and/or collection letters for this physician.
- **Zip Code:** Enter the zip code that will pull to statements and/or collection letters for this physician.
- **County**: Enter the county associated with this Physician.
- **Phone/Ext/Comment:** Enter the phone or fax number for this Physician and any associated phone extension or comments.
- **Name Abv (Abbreviation):** The abbreviation of the physician's name should be entered in this field. This will display when using the lookup option in Patient Registration.
- **Mcare EKG#/RAD#:** The physician's Medicare EKG or Radiology number should be entered in this field.
- **Mcaid EKG#/RAD#:** The physician's Medicaid EKG or Radiology number should be entered in this field.
- **Mcare E/R#:** The physician's Medicare Emergency Room number may be entered in this field.
- **Mcaid E/R#:** The Medicaid Emergency Room number may be entered for the physician.
- **Mcaid I/P#:** The physician's Medicaid Inpatient number may be entered in this field.
- **Blue Cross#:** The Blue Cross physician number should be entered in this field.

***NOTE**: The above six provider number fields may be left blank if the provider numbers are the same as the provider numbers used for the facility. If the numbers are different for specific physicians, they should be loaded on the individual physician's maintenance screen.*

- **Lic# or Tax#:** The physician's License or Tax Identification number should be loaded in this field. This pulls to locator 25 on the 1500.
- **Misc 1:** Records any miscellaneous information about this physician.

- **Inactive Date:** A date in this field makes the physician inactive and excludes the physician from any lookup windows. The date is for reference to show when the physician became inactive.

- **Protocol Group:** Defines the physician specific protocol group (sliding scales) for the Diabetic Record in the Point of Care Module. To add a protocol group, select **? > Protocol Group > Select**.

- **Signon Name:** Enter the physician name/number that will be used for the physician to signon the MP-EHR applications. This field is only needed if the physician needs to sign in differently than with the physician number.

- **Sliding Scale Code**:

- **Staff Physician?: Resident:** If this is a Staff Physician, this field should be selected. The switch will determine how the physician number is listed on screen displays. Select the box for Resident the physician is a Resident.

- **Physician Initials:** Records the Physician's Initials for use in the POC Ancillary order verification. This also pulls to Medical Records transcribed documents. The initials defined in this table will need to match those entered during transcription against ancillary orders in order for the signing physician to view, edit and sign their dictated transcriptions.

- **NPI #:** The physician's National Provider Identifier Number should be entered in this field. This field will be automatically updated when adding a new physician through Registration and entering the NPI number. This pulls to locator 76 on the UB.

- **UPIN #:** The physician's UPIN number should be entered in this field. This field may be automatically updated when adding a new physician through Registration and entering the UPIN number. This pulls to locators 2 and 76 on the UB.

- **CCN#**

- **Social Security #:** This field stores the physician's Social Security Number.

- **DEA #:** The physician's Drug Enforcement Agency number should be entered in this field.

- **NADEAN:** The physician's Narcotic Addiction DEA Number should be entered in this field which will store up to nine characters, alpha or numeric.

- **Transcription Order:** This field determines the order of selections in the Medical Record Transcription system. If answered **T**, the system will display the Transcription Document Types (e.g., History & Physical, Discharge Summary, etc.) first for selection and then the Patient Selection. If answered **P**, the system will display the selections in the opposite order. This switch overrides the Transcription Order switch in the Medical Records Control Information Table for the selected physician.

- **Phys Rounds Group:** Enter a 3-digit code that will group physicians together. This will be used when running the Physicians Round Sheet.

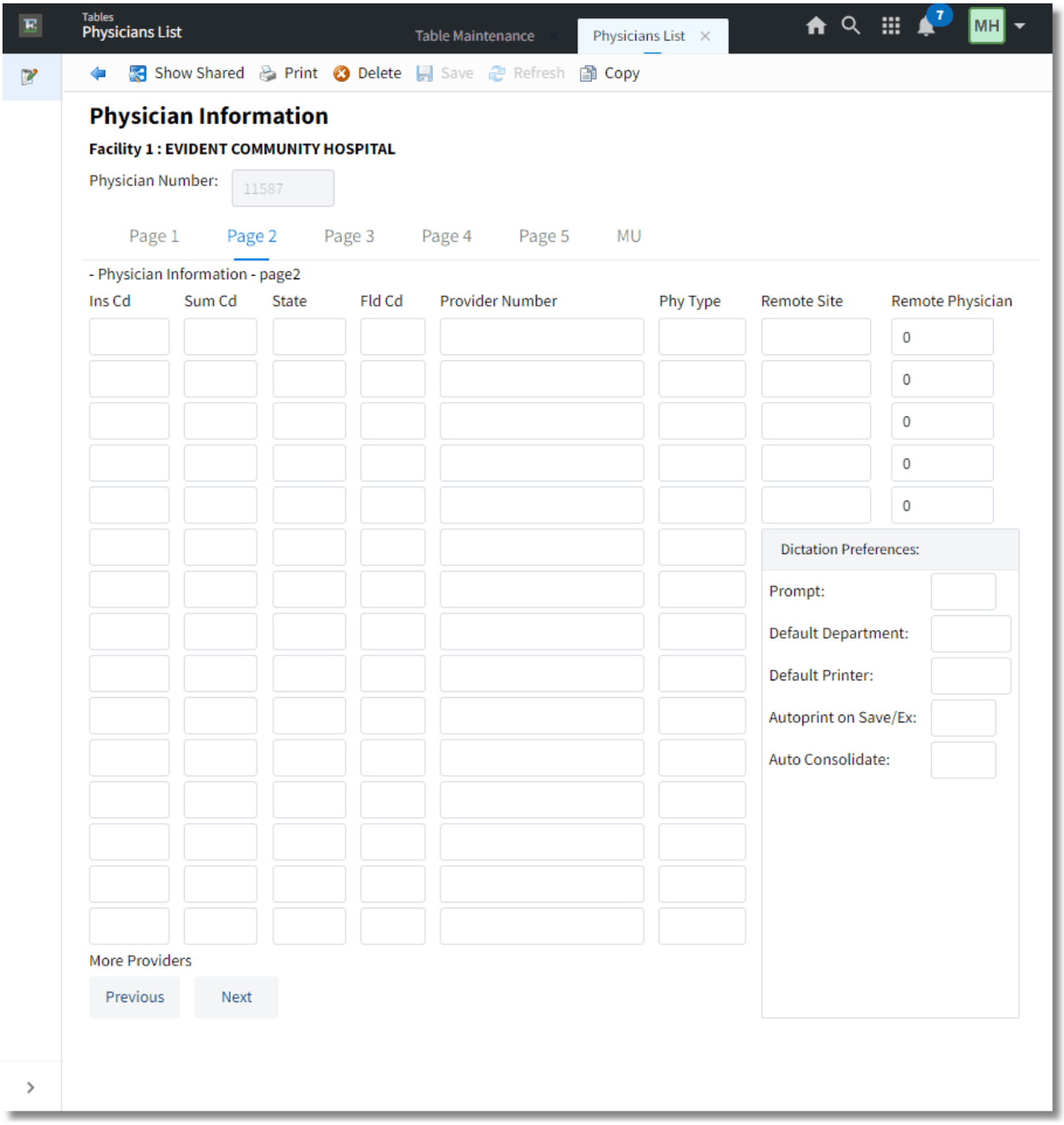
- **State ID (DPS):** Enter the Department of Safety ID number for the physician if the facility's pharmacy is required to submit a copy of each O/P Rx for class II controlled substances.

- **OR Sched/Surgeon:** If selected the OR Scheduler will be activated. This will also allow cases to pull to the Medical Records Operative Procedures report. This field defaults to blank.

- **Available for Secure Messaging**: If selected, the physician will display within the MyCareCorner Messaging To field which allows the patient to send secure messages to the physician. If not selected the physician will not display and the patient will not be able to send secure messages to the physician.

12.2 Physicians Table, Page 2

Select **Web Client > Tables > Control > Physicians > Select a Physician > Page 2**



Physicians Maintenance, Page 2

This page allows for the set up of Insurance Codes, Summary Codes and Provider Numbers to manipulate certain fields on the 1500s and UB04s. This table has specific codes the system recognizes, and these codes will determine where the physician numbers pull on 1500s and UB04s.

- **Ins Code:** The Financial Class code for the particular Insurance Company to be affected should be entered into this column.

- **Summ Code:** The 2-character Summary Charge Code should be entered in this column. The system will look at the Financial Class code then the Summary Code to determine the lines of detail for the claims that should be affected.

- **St:** Enter the 2-character state code for the claims that the change needs to effect.

- **Fld Cd (Field Code)**: Field codes may be used to get information to pull correctly to the locators on UB and 1500. See the 1500 and UB Field Code tables below for a list of available field codes and their purpose.

- **Provider Number:** This column stores a number, up to 15 digits long, that will print on the 1500 or the UB in the field designated by the fourth column.

- **Phy Type:** Enter the 4-character Physician Type that will pull to the electronic ANSI file for UB's and 1500's.

NOTE: *To set up more Provider Numbers, choose **Next** beneath the More Providers option.*

- **Remote Site:** These fields serve as a Physician number cross-reference table for the Multi-facility Clinical Networking Interface

- **Remote Physician:** These fields serve as a Physician number cross-reference table for the Multi-facility Clinical Networking Interface.

- **Prompt:** Defines the default prompt for the way in which this physician wants to select orders for dictation via the TruBridge Voice Recognition application. The options are: **O** - Order Number, **R** - Room Index, **N** - Name Index, or **A** - Account Number.

- **Default Dept:** Defines the default department for this physician's dictation via the TruBridge Voice Recognition application. This department number will precede the order number.

- **Default Printer:** Designates the printer to which dictated reports will print for this physician.

- **Autoprint on Save/Exit:** If answered **Y**, the completed report will automatically print to the above Default Printer.

- **Auto Consolidate?:** If set to **Y,** a single order will be dictated. When the dictation is saved, the system will look for all other orders for that patient in that department with the same ID Switch 1. If the complete time is within three minutes, the transcription will be applied to all the orders.

1500 Field Codes	
Field Code 1	Pulls the number loaded in column 5 - Provider Number to locator 17a on the 1500. If the claim is a North Carolina or Kentucky Medicaid claim, the physician table for the referring physician will override anything loaded on this page. When the system is searching for a code, the following hierarchy will be followed: • Referring Physician table - Field Code 1 • Charging Physician table - Field Code 1 • Billing Physician table - Page 4, Billing Physician • Attending Physician table - Field Code 1 • Attending Physician table - Page 1, UPIN#
Field Code 3	Pulls the number loaded in column 5 to the shaded portion of locator 24J on the 1500. When the system is searching for a code to pull to the shaded portion of locator 24J for all states except KY and NM, the following hierarchy will be followed: • Charging Physician table - Field Code 3 • Charging Physician table - Page 1, Lic# or Tax# (Commercial) Mcare EKG#/Rad# - Blue Cross# fields Provider # (All other Financial Classes) • Stay Info Physician table - Field Code 3 • Stay Info Physician table - Page 1, Lic# or Tax# (Commercial) Provider # (All other Financial Classes) For states of KY and NM, the following hierarchy will be followed: • Charging Physician table - Field Code T • Charging Physician table - Field Code 3 • Charging Physician table - Page 1,Lic# or Tax# (Commercial) Provider # (All other Financial Classes) • Stay Info Physician table - Field Code T • Stay Info Physician table - Field Code 3 • Stay Info Physician table - Page 1, Lic# or Tax# (Commercial) Provider # (All other Financial Classes)
Field Code 4	Pulls the number loaded in column 5 to the unshaded portion of locator 24J on the 1500. When the system is searching for a code to pull to the unshaded portion of locator 24J, the following hierarchy will be followed: • Charging Physician table - Field Code 4 • Charging Physician table - Page 1, NPI • Stay Info Physician table - Field Code 4 • Stay Info Physician table - Page 1, NPI • Physician 999999 table - Page 1, NPI

Field Code 5	Pulls the number loaded in column 5 to locator 33b on the 1500.
Field Code 6	Pulls the number loaded in column 5 to locator 33b on the 1500, if nothing is loaded for Field Code 5. When the system is searching for a taxonomy code to pull to locator 33b on the 1500, the following hierarchy will be followed: • Charging Physician table - Field Code 5 • Charging Physician table - Field Code 6 • Attending Physician table - Field Code 5 • Attending Physician table - Field Code 6 • Physician 999999 table - Field Code 5 • Physician 999999 table - Field Code 6 • Insurance Company table - Page 1 Provider Number
Field Code N	Pulls the number loaded in column 5 to locator 17b and 24J on the 1500. When the system is searching for a code to pull to locator 24J, the following hierarchy will be followed: • Charging Physician table - Field Code 4 • Charging Physician table - Field Code N • Charging Physician table - Page 1, NPI • Stay Info Physician table - Field Code 4 • Stay Info Physician table - Field Code N • Stay Info Physician table - Page 1, NPI • Physician 999999 table - Page 1, NPI
Field Code T	Pulls the number loaded in column 5 to the locator 24J if state code loaded in physician table page 1 is "KY" or "NM".
Field Code n	Pulls the number loaded in column 5 to locator 33a on the 1500. When the system is searching for a code to pull to locator 33a, the following hierarchy will be followed: • Charging Physician table - Field Code n • Attending Physician table - Field Code n • Physician 999999 table - Field Code N • Physician 999999 table - Page 1, NPI
Field Code E	Pulls the number loaded in column 5 to locator 25 on the 1500.

UB Field Codes

Field Code 1	Pulls the number loaded in column 5 to locator 79 on the UB if state code loaded in physician table page 1 is "KY".**
Field code T	If the claim is Kentucky Medicaid, the number loaded in column 5 will pull to locator 81a, if attending physician, or 81b, if operating physician.
Field Code N	Pulls the number loaded in column 5 to locator 78 and/or 79.**
Field Code U	Pulls the number loaded in column 5 to locator 76 QUAL on the UB. If the claim is an Iowa Medicaid claim, the number loaded in column 5 will pull to locator 79 on the UB.**

**When the system is searching for a code to pull to locator 78 and 79 on the UB, the following hierarchy will be followed:

Locator 78:

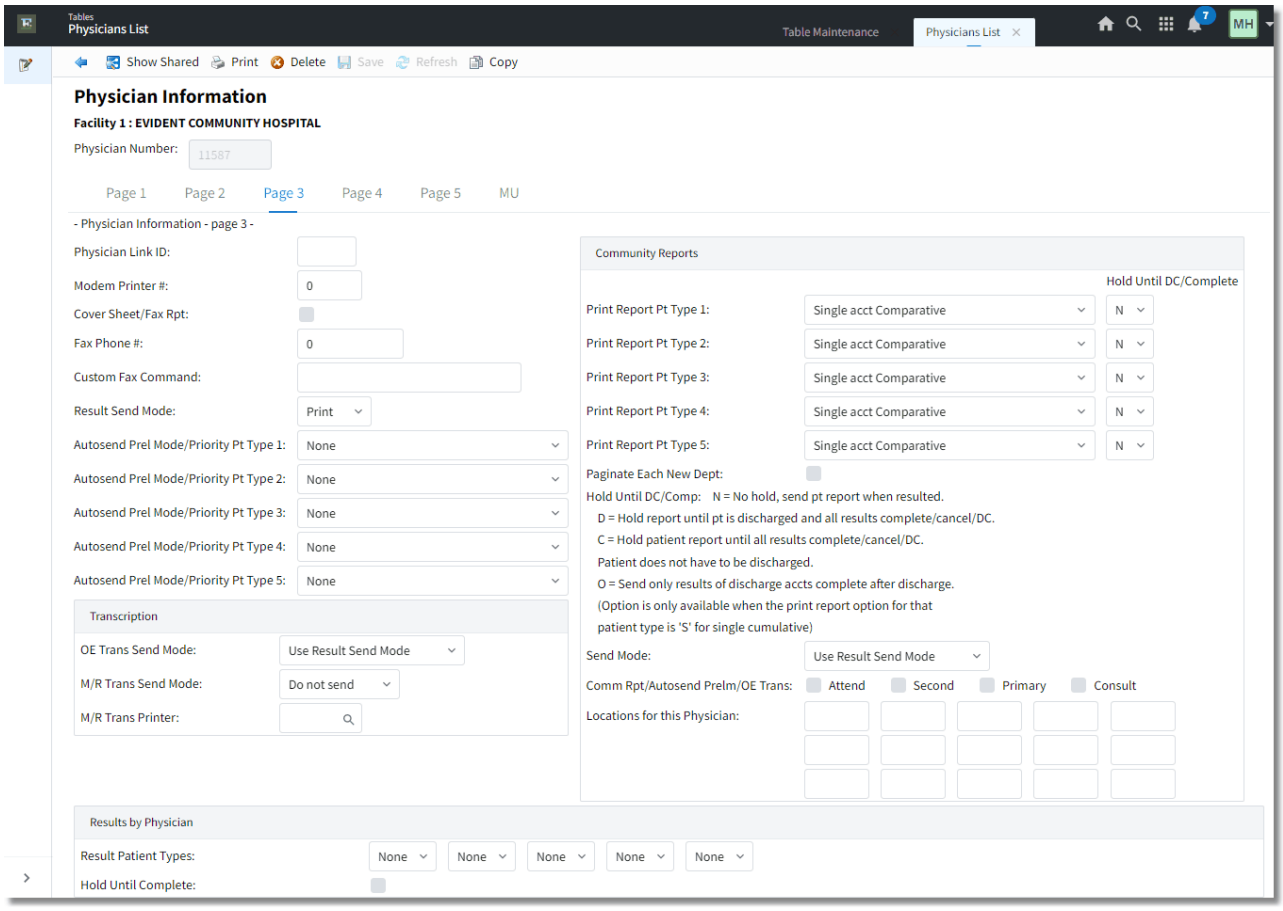
- Referring Physician table - NPI
- Referring Physician table - Provider Number
- Physician table - Field Code N (NPI)
  - If there is not a Field Code N loaded, ZZ will pull to the box in front of the NPI field.
- Physician table - Field Code U (QUAL)
- Physician table - Page 1, NPI
- Physician table - Page 1, Lic# or Tax# (QUAL)
- Physician table - Page 1, UPIN (QUAL)
- Blank field if Insurance Company table - Page 6, NPI Only is selected.

Locator 79:

- Physician table - Field Code N (NPI)
  - If there is not a Field Code N loaded, ZZ will pull to the box in front of the NPI field.
- Physician table - Field Code U (QUAL)
- Physician table - Page 1, NPI
- Physician table - Page 1, Lic# or Tax# (QUAL)
- Physician table - Page 1, UPIN (QUAL)
- Blank field if Insurance Company table - Page 6, NPI Only is selected.

12.3 Physicians Table, Page 3

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 3**



Physicians Maintenance, Page 3

The fields on page 3 are used to define report distribution for this physician. When a nursing or ancillary send option is selected, the system offers a menu that includes the admitting physician or other physician. The system finds the physician in Physician Table Maintenance and sends the report, transcription or document based on settings listed on page three. Community Report distribution for laboratory, Transcription by Physician and distribution of electronically signed reports are also sent based on information on page 3 of the Physician's table.

- **Physician Link ID: (Outreach Client Access)**
  - Options: Two-character Physician link ID assigned to this physician's group.
  - Usage: Identifies destination link for this physician. Required entry when field **Result Send Mode** is "L"ink.
    - Used for either preliminary, Comparative reports or transcriptions.
    - It may be used for Medical Practice Management EMR as well as Outreach Client Access.
    - Auto-send, Send, and Community reports refer to this field when the send mode is Link.

- **Modem Printer Number**
  - Options: Three-digit modem or line printer number, as defined in the device control table.
  - Usage: Identifies printer to print reports for this physician if the send mode selected in the **Result Send Mode** field is **Modem**. This field is used for:
    - Community Report Distribution
    - Transcription by Physician
    - Autosend
    - Send

- **Cover Sheet/Fax Rpt**
  - Default: N (no)
  - Options: Y (yes) or N (no)
    - If set to Y the physician will receive a fax cover sheet with each fax transmission.
    - If No, a cover sheet will not be generated.

- **Fax Phone #**
  - Options: Ten-digit fax number.
    - Enter the fax number without spaces or dashes.
    - Include the area code only if long distance.
    - Do not include access codes, these are entered under department security.
    - The TruBridge Fax Application must be installed prior to entries in this field.
  - Usage: Required entry to record the fax number of the physician if the **Result Send Mode** field is Fax. Preliminary and/or Comparative reports use this field. Auto-send, Send, Transcriptions by Physician and Community reports refer to this field when the send mode is Fax.

- **Custom Fax Command**
  - This is a 30-character field that may accommodate any special fax number needed. It may include the 1 for long distance, area code, extension, etc. When there is no entry in the **Fax Phone** field, the system will dial the number found in this custom command field.
  - For sites utilizing E-Distribution, this field will be populated with the physician's User Based Login which is specific for E-Distribution only. Multiple physicians may share a UBL. Also, **F** must be loaded in both the **Result Send Mode** and **Send Mode** fields. Please contact TruBridge Clinical Support to set up a recipient's EDIST UBL. The UBL will be loaded in this field as:
    - ubl:(name of ubl)

NOTE: *E-Distribution will require the use of a ClientWare license.*

- **Result Send Mode**
  - Default: **Print**
  - Options:
    - **Fax:** This physician will receive reports and transcriptions by fax. The TruBridge Fax application is required and the sending department must have the appropriate security settings. A fax number must be listed in the **Fax Phone #** or **Custom Fax Command** fields. If this physician is set up for EDIST, this option must be used. When using the Physician look up in the faxing screen, only Physicians that are set up to receive reports and transcriptions by fax will display.
    - **Link:** If this physician has Hospital/Outreach Client Acess in their office/clinic, results and transcriptions may be sent in this mode. A "REPORT" flash will appear on the link screen when reports are sent (if logged in). Reports are received via Incoming If using this mode, the link ID must be entered in the **Physicians Link ID** field.
    - **Modem:** Results and transcriptions may be sent via modem printer to this physician. Enter the modem or line printer number in the **Modem Printer Number** field**.**
    - **Print:** This mode is used to print preliminary or Comparative reports to laboratory's line printer (as defined in the Laboratory Control Table).
    - **Blank:** Reports will print to the printer designated when Community Reports or Transcriptions by Physician is initiated.
  - Usage: This field controls how results and/or transcriptions are sent to the physician when:
    - Preliminary reports are created and sent and Comparatives are sent via Community Reports Distribution if another mode is not chosen.
    - Results are transmitted by Send mode.
    - Transcriptions are distributed by Transcriptions by Physician or via Electronic Signature.

- **Autosend Prel Mode/Priority**
  - Default: **None-** Preliminary reports will not be automatically sent when completed no entry
  - Options: For each patient type, the options are as follows:
    - Physician link / Stat Orders only
    - Physician link / All Orders
    - Modem printer / Stat orders only
    - Modem printer / All Orders
    - Lab printer / Stat Orders only
    - Lab printer / All Orders
    - Fax / Stat Orders only
    - Fax / All Orders
  - Usage: Controls preliminary reports. When an order is resulted and completed, the system will refer to this field to determine if and how (mode) the physician receives the preliminary report. The order priority, Stat vs routine, may also be specified.

Community Reports

- **Print Report Patient Types 1 - 5**
  - Default: S-Single account Comparative
  - Options for various style reports:
    - Single account comparative
    - Multi-account comparative

  - Single account comparative by Sub-Department (This version of the comparative report is only produced when additional results for tests belonging to the same sub departments are completed. Only comparative results for the sub department will be printed.)
  - Multi-account comparative by Sub-Department (This version of the comparative report is only produced when additional results for tests belonging to the same sub departments are completed. Only comparative results for the sub department will be printed.)
  - Lab Results by Physician with Pending
  - Non-comparative vertical
  - Lab Results by Physician
  - Do NOT send
- Usage: Controls which comparative report is printed at runtime.
  - Determines the type of report produced for the corresponding patient types.

- **Paginate each new department**
  - Default: Unchecked
  - Options: Checked or Unchecked
  - Usage: Determines if laboratory sub-departments will print on separate pages for report options N, C, V, S and M.
    - Unchecked: Sub-departments will not print on separate pages.
    - Checked: Each sub-department on Community report options: Non comparative vertical, Multi-acct comparative by sub dept, Single Acct comparative by sub dept, Single-acct comparative and Multi-acct comparative will print on separate pages.
  - Requirements:
    - Each item printing to these report options must have a sub-department designated in the Control Switches field, switch number five of the Item master.
    - Sub-departments must be listed in the Department Print Order field, page 3 of the Laboratory Control Table.

- **Hold Until Disch & Complete**
  - Default: N (no)
  - Options:
    - **N:** NO hold, Send patient report when resulted
    - **D:** Hold report until patient is discharged and all results have been completed, canceled, or DC'd.
    - **C:** Hold patient report until all results have been completed, canceled, or DC'd. Patient does not have to be discharged.
    - **O:** Send only results of discharged accounts completed after discharged.
  - Usage: Controls when Comparative reports, designated in the Print Report Option field, will be distributed to this physician, via community report distribution, based on their patients' discharge status and status of laboratory orders. An entry is available for each of the five patient types.
  - Requirement: Distribution is based on the physician being designated as the admitting, secondary, family, consulting, or ordering physician at registration or in the Report Distribution field of Order Entry Information.
    - N: A physician with this option entered in any of the five fields, will receive copies of patient result reports for any account that has orders resulted during the time range used to generate the community report.
    - D: Entered in any of the five fields, then no reports will be sent to this physician for that patient type until the patient has been **discharged AND all** orders have been completed. This option should <u>not</u> be used if N-Non-cumulative vertical is designated in the **Print Report Option** field.

- C: The physician will receive a report if all laboratory orders on the account are complete, canceled, or discontinued. When using this option, the patient does not have to be discharged to receive a report. This option should not be used if N-Non-cumulative vertical is designated.
- O: The physician will receive a report for **only results completed after an account has been discharged.** This option may only be used when an 'S' is chosen for the Print Option. If an 'O' is indeed chosen for this field and the Print Option corresponding field does not contain an 'S', a message will appear: **Corresponding Print Report Option must be an 'S'.** Also, if this field is populated with an 'O', and the user then addresses the Print Report option and selects any other option than 'S', a message will appear: **You must remove the 'O' from the corresponding Hold Until Disch and Complete Field before this option may be used.** The 'O' cannot be removed by using a delete key; it must be replaced with an 'N'.
- Related fields: Item Order Entry Information: **View Unverified Order=Y (checked)**
- Laboratory Control Table: page 3, field for **Print View Unverified=Y (checked)**

NOTE: *Orders that are setup to allow printing/viewing of unverified results will be considered complete for the purpose of Community Report distribution regardless of the actual status.*

Example: *If a physician is set to Hold until all orders are Complete = C and the only order on the account that has not been completed, DC'd, or canceled is setup to print/view unverified = Y, they will receive a report when Community Reports are generated.*

- **Send Mode**
  - Default: **Use the Result Send Mode field**
  - Options:
    - **Use the Result Send Mode field**
    - **Fax:** This physician will receive Community Reports by fax. The TruBridge Fax application is required and the sending department must have the appropriate security settings. A fax number must be listed in the **Fax Phone #** or **Custom Fax Command** fields. If this physician is set up for EDIST, this option must be used.
    - **Link:** If this physician has Hospital/Physician link in their office/clinic, Community Reports may be sent in this mode. A **REPORT** flash will appear on the link screen when reports are sent (if logged in). Reports are received via Incoming If using this mode, the link ID must be entered in the **Physicians Link ID** field**.**
    - **Modem:** Community Reports may be sent via modem printer to this physician. Enter the modem or line printer number in the **Modem Printer Number** field**.**
    - **Print:**: This mode is used to print Community Reports to laboratory's line printer (as defined in the Laboratory Control Table).
  - Usage: This field defines how Comparative reports are sent via Community Reports Distribution if different than the **Result Send Mode** field.

- **Comm Rpt/Autosend Prelim/OE Trans when: Attending Second Primary**

- **Consult**
  - Defaults are as follows when options are not checked:
    - **Admit: Checked** (yes)
    - **Second: Y** (yes)
    - **Family: N** (no)
    - **Consult: N** (no)
  - Options: Y (yes), physician will receive a report or N (no), physician will not receive a report

- Usage: Determines if physician will receive patient report via:
  - Community Report Distribution
  - Auto-send preliminary lab results
  - Transcription by Physician
  - This field is used with report distribution to include or exclude when a physician receives a report based on their status as: The Admitting, Secondary, Family, and Consulting (if different from admitting) physician. The process may include up to five consulting physicians, as designated in the patient's Clinical Information.
- Related field: Option for **Report Distribution** of Order Entry Maintenance will display a control screen that allows a physician to be selected, de-selected, or additional physicians added that need to receive a copy of the patient's report. The Admitting, Secondary, Family, and Consulting physician names and numbers are displayed along with the settings of this field for the physicians. If the entry is a Y, the physician will receive a copy of the patient's report; N the physician will not. These entries may be changed at order entry.

- **Locations for this Dr**
  - Options: Up to fifteen location codes may be entered.
  - Usage: Directs reports to primary care **location** rather than to physician in the patient record.
    - Used to prevent duplicate reports being sent to the physician.
    - Example: If a physician treats patients at other locations (clinics, home health agencies, or nursing homes), the location code is entered in one of these fields.
    - The appropriate location code is entered in the **Patient Location** field at the time of order entry or with Temporary Registration.
    - The system will suppress printing Community reports to this physician for any patient with a location code listed in these fields.

Transcription

- **OE Trans. Send Mode**
  - Options:
    - **F- Fax:** This physician will receive signed transcriptions by fax. The TruBridge Fax application is required and the sending department must have the appropriate security settings. A fax number must be listed in the Fax Phone # or 5-Custom Fax Command fields
    - **L- Link:** If this physician has Hospital/Physician link in their office/clinic, signed transcriptions may be sent in this mode. The link ID must be entered in the Physician's **Link ID** field. A "REPORT" flash will appear on the link screen when reports are sent (if logged in) and reports will be received via the **Incoming Report** option if using this mode.
    - **M- Modem:** Signed transcriptions may be sent via modem printer to this physician. Enter the modem or line printer number in the Modem Printer Number field.
    - **P- Print:** This mode is used to print signed transcriptions to the default printer defined in System Maintenance-Physician Security, Autosend to Physicians/Location when signed field.
    - **X-Don't Send:** This option prevents this physician from receiving signed transcribed reports.
  - Blank: Reports will send via the designation in the Result Send Mode field. If that field is blank, the transcription will print to the printer designated in Physician Security (for the signing physician) table, Autosend to Physician field, when signed.
  - Usage: This field controls how signed transcriptions are auto-sent to the physician when transcriptions are signed and distributed via Electronic Signature module. The system also refers to this field when sending or printing the Transcription by Physician report.

- **M/R Trans. Send Mode:** The medical records department distributes transcriptions to physicians via options in this field.

- **M/R Trans Printer:** Defines the Line Printer number where the physicians Medical Record transcriptions are printed.

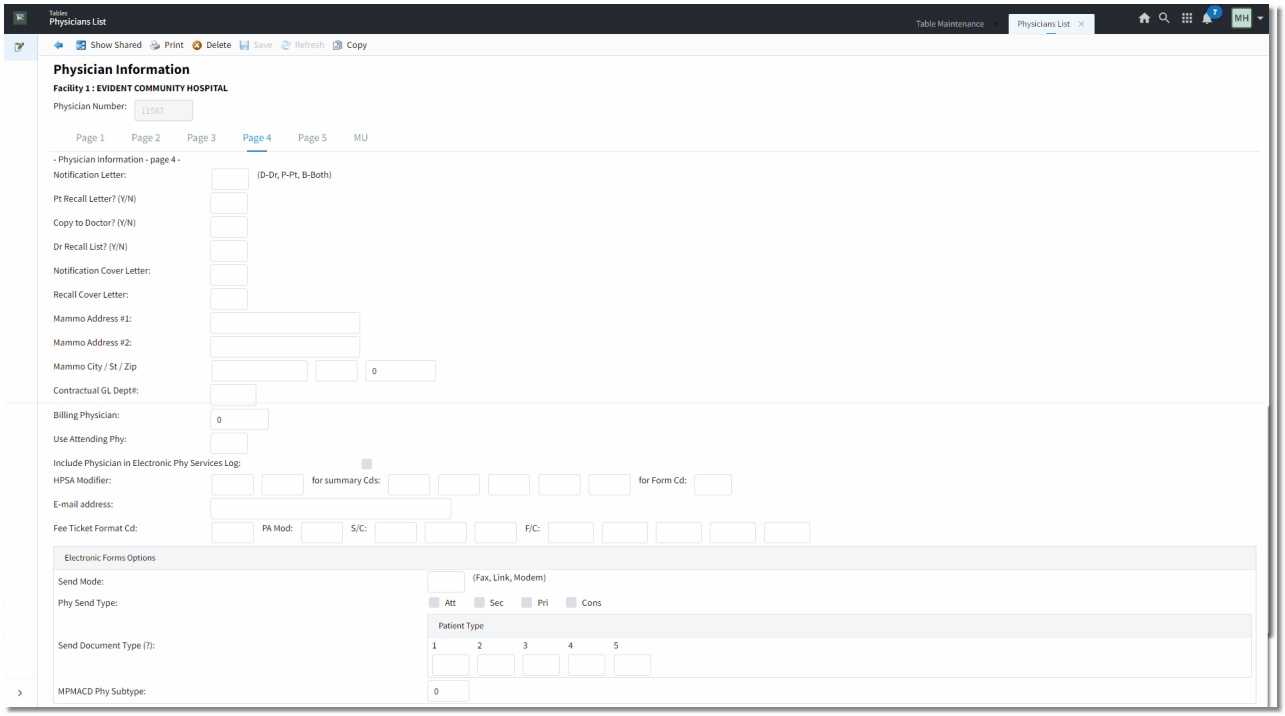
Results by Physician

- **Result Pat types**
  - Options: 1-5 indicating patient types in each of the five fields.
  - Usage: This field has five single character fields, one for each patient type. Facilities that use, **Results by Physician with Pending** under the Print Report option, will use this field to designate the patient types to print laboratory reports for physicians that have pending test results. Entries here will over-ride entries for patient type keyed at runtime. For sites using the Community Reports - Print Report Option, this field will not be used.

- **Hold Until Complete**
  - Options: Y (yes) or N (no)
  - Usage: This field is used by facilities that print option **@-Results by Physician with Pending**. It will provide the physician the option to suppress printing of patient reports until all orders are complete. Do not use this field if using the Hold Until Disch & Complete field .

12.4 Physicians Table, Page 4

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 4**



Physicians Maintenance, Page 4

- **Notification Letter:** Designates if this physician or physician's patients will receive Mammogram notification letters for referred patients. The physician must be the ordering (referring) physician. If a **D** is entered, only this physician will receive a letter notifying the patient of their mammogram results. If **P** is loaded, only the patient will receive a letter regarding the results. If this field is left **blank,** the system will default to **P**. If **B** is entered, both the patient and the physician will receive a mammogram notification letter. Notification letters are defined in /usr3/f/notify.

- **Pt Recall Letter?:** If answered **Y**, the physician's patients will receive a recall letter when it is time to return for the next mammogram. Patient Recall Letters are defined in /usr3/f/xray.

- **Copy To Dr?:** If answered **Y**, the physician will receive a copy of his patients' recall letters.

- **Dr Recall List?:** If answered **Y,** the physician will receive a printed list of all referred patients that are scheduled for recall the following month. This list may include short-term and long-term recall patients.

- **Notification Cover Letter:** If set to **Y**, the system will use the default notification cover letter defined in /usr3/f/notify/PHYNFY. If set to **N**, the cover letter that is set up in /usr3/f/notify for the corresponding ordering physician's Physician Number will be used.

- **Recall Cover Letter:** If set to **Y**, the system will use the default recall cover letter defined in /usr3/f/xray/PHYRC1 (PHYRC2 or PHYRC3 if running the second or third recalls). If set to **N**, the cover letter that is set up in /usr3/f/xray for the corresponding ordering physician's Physician Number will be used.

- **Mammo Address #1: Address #2: City/State/Zip:** This address will be used anytime mammogram letters are printed. If left blank, the address will pull from the Physician Table page 1, Physician Group Information fields.

  NOTE: *For facilities outside of the United States, "Prov" (Province/Territory) and "Postal code" fields will display in place of the State and Zip Code fields respectively. A TruBridge Representative will need to be contacted in order for these address fields to be activated.*

- **Contractual GL Dept#:** If a 5-digit General Ledger number is loaded in the contractual GL# field on page 1 of the Insurance Company Table, when receipting for that Insurance, the system will use the three digits loaded in this field as the last three digits of the General Ledger number. To determine the appropriate physician, the system will look to the detail charges screen of the patient's account for a charging physician, and if blank, will then look to the attending physician loaded in the stay information screen for the Insurance Claim.

- **Billing Physician:** If an alternate physician number is loaded in this field, the alternate physician's UPIN number will pull to locator 76 of the UB04 instead of this table's physician (when loaded as the Admitting Physician).

- **Use Attending Physician:** Setting this field to **N** allows the billing physician's information to pull to the 1500 form. If set to **Y,** the attending physician pulls from the Attending field in the Stay tab on the Registration and ADT screen.

- **Include Physician In Electronic Phy Services Log:** If selected, the **Services Log By Dictating Physician** for this physician will be generated through cron and placed in a file on the

hospitals NT server to be accessed by the physician's billing service. If not selected, the billing physician's information will only print on the Physician's Services Log.

- **HPSA Modifier: for Summary Cds: for Form Cd:** This field contains three parts. The first part allows up to two valid modifiers to pull automatically to a Medicare physician claim with the subsequent Charge Summary Code loaded. The second part is the summary codes that the modifiers need to pull. This field works in conjunction with the Medicare Part B Health Professional Shortage Area Program. The third part allows a **J** to be entered to pull modifiers to a 1500 or a **U** to pull the modifiers to a UB04 (if using Method II billing for Critical Access.)

- **E-Mail Addr**: Enter the physician's e-mail address. At the present, this is an informational field only.

- **Fee Ticket Format Cd:** This field will be set up by TruBridge MPEMR - Financial to load the appropriate code for the default fee ticket program.

- **PA Mod, S/C, F/C:** This field contains three parts. The first part allows a valid modifier for a pro fee charge to pull automatically to the claim. The second part allows up to three Summary Codes to be entered. If this field is left blank, the system will look at all Summary Codes. The third part allows up to five Financial Class codes to be entered. Wildcarding is allowed in this field.

  NOTE: *The modifier will pull to the Detail Charges screen for the listed Summary Code. If there are modifiers pulling from the Item Master, the modifiers listed above will pull to the Additional Modifiers screen.*

- **Send Mode:** Enter **F**-by fax, **M**-by modem, or **L**-by link to designate modes for sending Locked Electronic Forms. E-Mail is presently not being used.

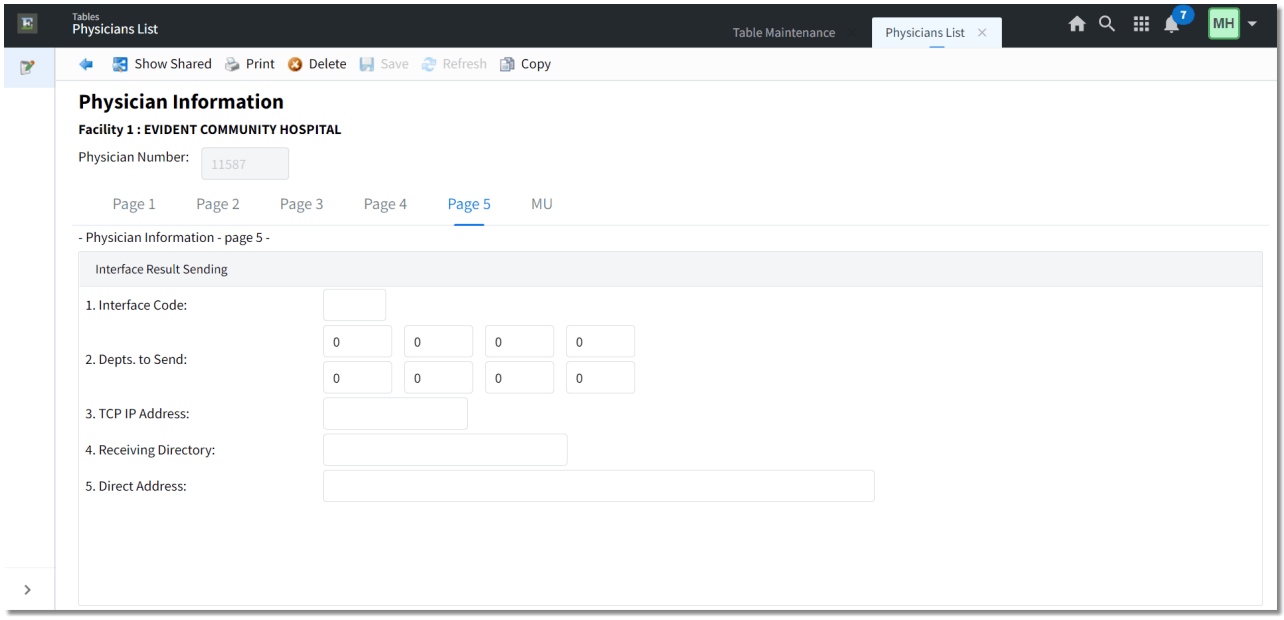
- **Phy Send Type:** The Electronic form will be sent via the send mode defined in the previous field, based on whether the particular physician is entered at registration as an attending, secondary or primary physician; or entered as a consulting physician via Clinical Information. Select **Attending**,**Secondary**, **Primary** or **Consulting Physician**. Any or all of these may be selected for this physician.

- **Send Document Type:** Enter **N**-Narrative (ACD forms), **T**-Template (Clinical forms), **B**-Both or **X**-will suppress the document to be sent to this physician for the selected Patient Type

- **MPMACD Phy Subtype:** The Sub Type associated with the physician may be loaded in this field. This works in conjunction with the Super Bill.

12.5 Physicians Table, Page 5

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 5**



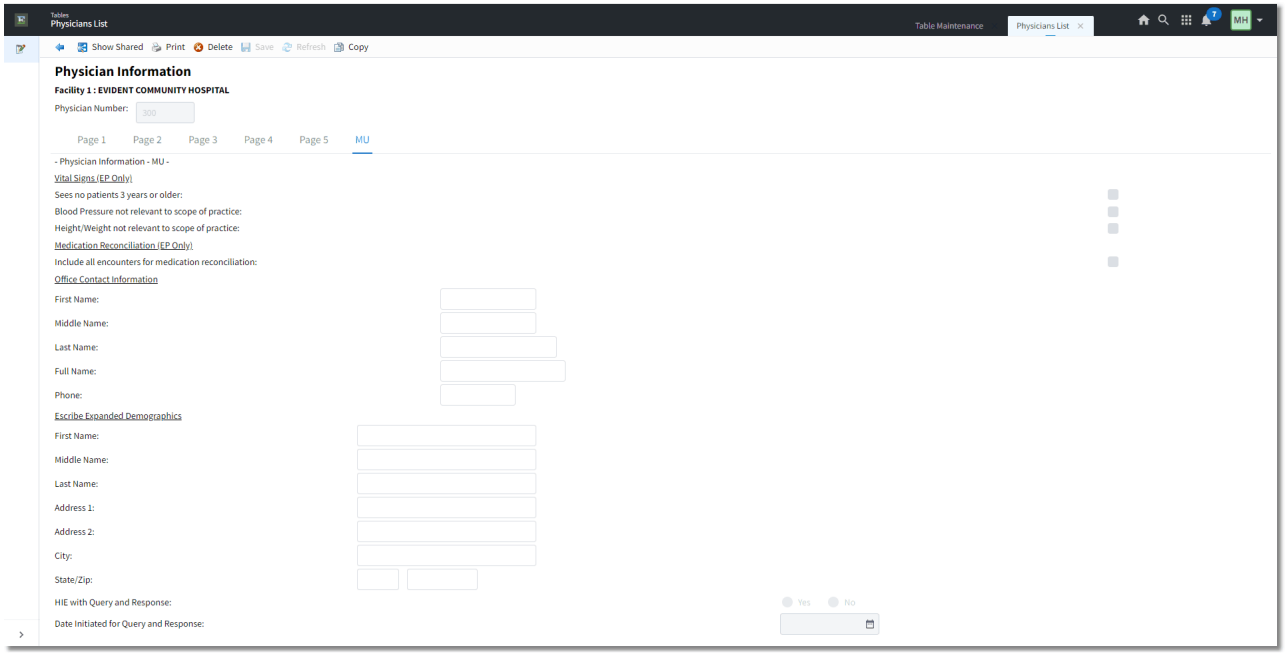
Physician Maintenance, Page 5

- **Interface Code:** Used for transmitting preliminary laboratory reports to Non-TruBridge physician practice systems
- **Depts. To Send:** This field should contain all facility departments that are sending results via the interface defined in Receiving Directory.
- **TCP/IP Address:** The TCP/IP Address of the interface PC should be entered in this field
- **Receiving Directory:** The TruBridge directory that the data should be sent via the interface
- **Direct Address**: Enter the Direct email address needed for Portal access. This may be up to 256 characters long.

NOTE: *The Direct Address pulls from the Physician 999999 table unless the user is logged into a department that has a Clinic Code loaded on page 5 of the Department Table, then the system will look to the Clinic Table for the Direct Address.*

12.6 MU

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **MU**



Physician Information

- **Vital Signs (EP Only)**: When selected, the Meaningful Use Statistics report will calculate based on the selected exclusion. For more information please see the Meaningful Use Statistics Report user guide.

- **Medication Reconciliation (EP Only)**: When selected, the Meaningful Use Statistics report will include existing patients for which the Summary of Care was not received in the denominator. For more information, please see the Meaningful Use Statistics report user guide.

- **Office Contact Information**: Information added here will display on the CCDA.

- **Escribe Expanded Demographics**: This field may be used to indicate the provider demographics when more space is needed than what has been allotted in the original demographics. The First, Middle, Last Name, Address Line 1, Address Line 2, and City have all been expanded to a limit of 35 characters. If the fields are blank, then the system will use the current logic.
  - o If the fields have been addressed (may use Copy as a shortcut), then the data will be used for:
    - Entering a new Non-Controlled Substance prescription
    - Entering a new Controlled Substance prescription
    - Refill Responses
    - Cancel prescription
    - Change Request
  - o When the fields are addressed and saved, the updated information will be sent to the Surescripts directories.

NOTE: *Use format 99999 or 999999999 for ZIP. Do not include a hyphen or other punctuation.*

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Delete**:Deletes the table settings
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Physicians list
- **Copy**: Copies demographic information entered from the following areas:
  - Identity Management: Provider First Name, Middle Name, and Last Name
  - Physicians table, page 1: Address Line 1, Address Line 2, City, State, ZIP

Select the  **Back Arrow** to return to the previous screen.

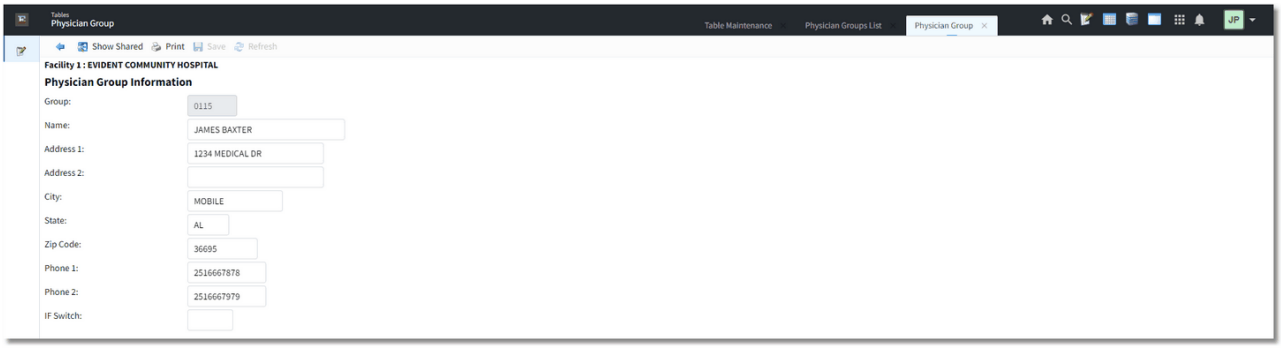
Chapter 13 Physician Groups

The Physician Groups table will display all physician groups at the facility and the contact information for each group. The system will recognize physicians as belonging to a group if the first four digits of the physician number are the same for the multiple physicians. In order to use Physician Groups, "Group Physician Numbers?" must be set to **Y**es on AHIS page 7. If "Group Physician Numbers?" is set to **N**o on AHIS page 7, the facility is not using physician groups, and the Physician Group table will not be displayed on the Control Tab or the Clinical Tab in Table Maintenance.

The search option allows physician groups to be looked up by group number or group name.

Select **New** to enter a new physician group, or select an existing group from the list and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Physician Groups** > **Select a Physician Group**



Physician Groups Maintenance

When a new physician is set up in the Physicians table and the first four digits entered are not the same as any other physician's, a new entry will be added to the Physician Group table. The system will use the first four digits of the physician's number as the group number and add the physician's contact information to the table. When a new physician is set up in the Physicians table and the first four digits entered are the same as another physician's, then the Physician Group table will be updated with the new physician's contact information.

If changes are made to the Address 1 & 2, City, State, or Zip Code fields in the Physicians table and that physician belongs to a group, the Physician Group table will be updated with the most recent information. If a physician is deleted from the Physicians table and there are no other physicians that belong to that physician's group, the Physician Group will also be deleted.

If changes are made to the Address 1 & 2, City, State, or Zip Code fields in the Physician Groups table, those changes will copy back to the Physicians table for all the physicians in that group.

- **Group**: The group number will be the first four digits of the physician number.
- **Name**: Enter the facility name associated with this physician group.
- **Address 1 & 2**: Enter the address for this physician group.
- **City:** Enter the city for this physician group.

- **State:** Enter the state for this physician group.
- **Zip Code:** Enter the zip code for this physician group.
- **Phone 1 & 2:** Enter the phone or fax number for this physician group.
- **IF Switch:** Contact a TruBridge Financial Interface Representative for assistance with this field.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Physician Groups list

Select the  **Back Arrow** to return to the previous screen.

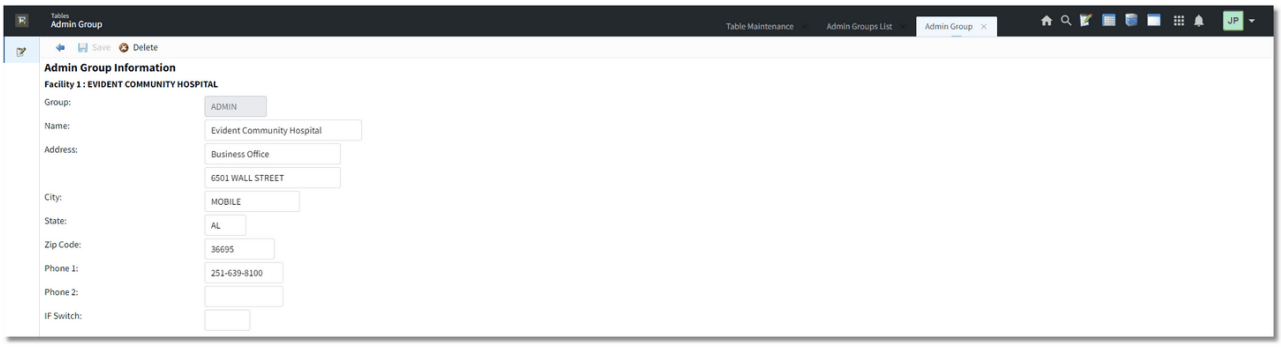
Chapter 14 Admin Groups

The Admin Groups table is used to print different addresses to statements and/or collection letters.

The search option allows admin groups to be looked up by group number or group name.

Select **New** to enter a new admin group, or select an existing group from the list and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Admin Groups** > **Select an Admin Group**



Admin Groups Maintenance

- **Group**: Enter one of the following admin groups:
  - **ADMIN**: Is used to print a different address for statements and collection letters. If ADMIN is not set up, the system will default to the address loaded in the Physician's Table 999999. All other applications that pull the facility address will continue to use the Physician's Table 999999.
    - o ***NOTE****: After editing the admin group* ***ADMIN****, the following dialog will display "Inaccurate data in the ADMIN record can adversely effect statement printing. Are you sure you want to continue saving changes?"*
  - **LTADMIN**: Is used to print a different address for long-term statements only. If LTADMIN is not set up, the system will default back to the address loaded in the admin group ADMIN, if loaded, or the Physician's Table 999999.
  - **#STAY** (where # is 1-5): Is used to print addresses for statements and collection letters based on the stay type. The first character denotes the stay type. For example 1STAY would be if the account is a stay type 1.
  - **###SUB** (where # is 000-999): Is used to print addresses for statements and collection letters based on the stay type and subtype.The first character denotes the stay type and the second and third denote the subtype. For example, 110SUB would be if the account is a stay type 1 with a sub type of 10. If using sub types, then **101SUB - 199SUB** or **201SUB - 299SUB** may be used.

NOTE: *#STAY and ###SUB entries will override the ADMIN and Physician's 999999 tables.*

- **Name**: Enter the facility name associated with this admin group.
- **Address 1 & 2**: Enter the address that will pull to statements and/or collection letters for this admin group.
- **City:** Enter the city that will pull to statements and/or collection letters for this admin group.
- **State:** Enter the state that will pull to statements and/or collection letters for this admin group.

- **Zip Code:** Enter the zip code that will pull to statements and/or collection letters for this admin group.
- **Phone 1 & 2:** Enter the phone or fax number for this admin group.
- **IF Switch:** Contact a TruBridge Financial Interface Representative for assistance with this field.

NOTE*: All new and existing groups can still be accessed through the physician table.*

The following options are available on the action bar:

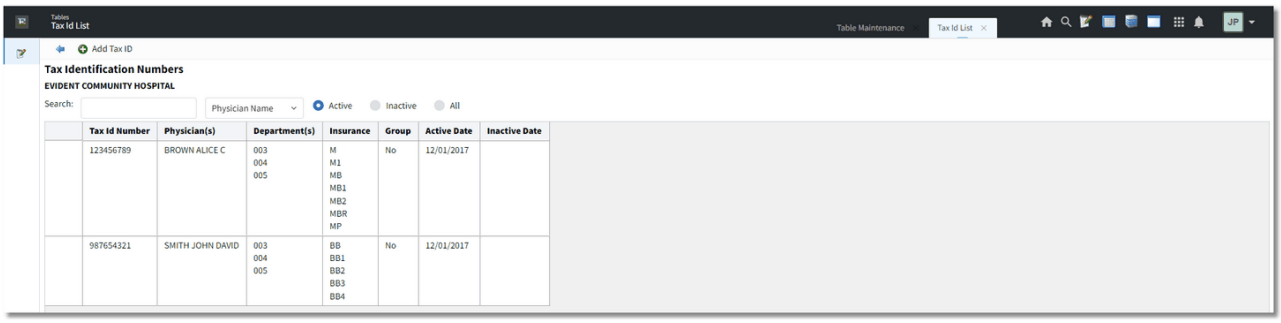
- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Delete**:Deletes the table settings
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Admin Groups list

Select the  **Back Arrow** to return to the previous screen.

Chapter 15 Tax Identification Numbers

The Tax Identification Numbers table is used for Meaningful Use statistics reporting.

Select **Web Client** > **Tables** > **Control** > **Tax Identification Numbers**

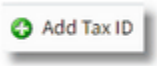


Tax Identification Numbers Table

The search option allows tax identification numbers to be looked up by physician name or tax ID number. The search may also be delimited to search for either **Active**, **Inactive**, or **All**.

The columns in the table will display the following:

- **Tax ID Number:** The tax id number for the physician(s)
- **Physician(s):** The physician(s) associated with the tax id number.
- **Department(s):** The department(s) associated with the tax id number.
- **Insurance:** The insurance(s) associated with the tax id number.
- **Group: No** will display if only one physician is associated with the tax id number. **Yes** will display if there is more than one physician associated with the tax id number.
- **Active Date:** The date the tax id number became active. Double-click this cell if the date needs to be changed.
- **Inactive Date:** The date the tax id number became inactive. Double-click this cell if the date needs to be changed.

Select 

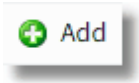
Add Tax ID from the action bar to create a new tax identification number.

- **Tax ID Number:** The tax identification number for the physician or group.
- **Active Date:** The date of when the tax ID number became active.
- **Inactive Date:** The date of when the tax ID number became inactive.

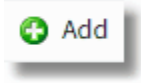
Select **Save** to save the information or **Delete** to delete the information.

Physicians

To add physician(s) to the tax ID, double-click the cell in the Physician(s) column.

Then select 

Add from the action bar.

Search for the physician(s) needed for the tax id. Select the physician(s) from the list and then select 

Add from the action bar.

NOTE: *Multiple physicians may be selected by holding the Ctrl key and selecting the desired physicians.*

If needing to add an Active Date, Inactive Date or Exclude ACI for a physician, select the physician and then select 

Edit on the action bar.

Enter in the appropriate information and then select 

Save from the action bar.

NOTE: *The Exclude ACI option will exclude the physician from the ACI Meaningful Use reports.*

Select the  **back arrow** to return to Tax Identification Numbers list.

Department(s)

To add department(s) to the tax ID, double-click the cell in the Department(s) column.

Then select 

Add from the action bar.

Search for the department(s) needed for the tax id. Select the department(s) from the list and then select 

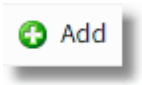
Select from the action bar.

NOTE: *Multiple departments may be selected by holding the Ctrl key and selecting each desired department.*

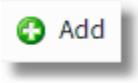
Select the  **back arrow** to return to Tax Identification Numbers list.

Insurance

To add insurance(s) to the tax ID, double-click the cell in the Insurance column.

Then select 

Add from the action bar.

Search for the insurance needed for the tax id. Select the insurance(s) from the list and then select 

Add from the action bar.

NOTE: *Multiple insurances may be selected by holding the Ctrl key and selecting the desired insurances.*

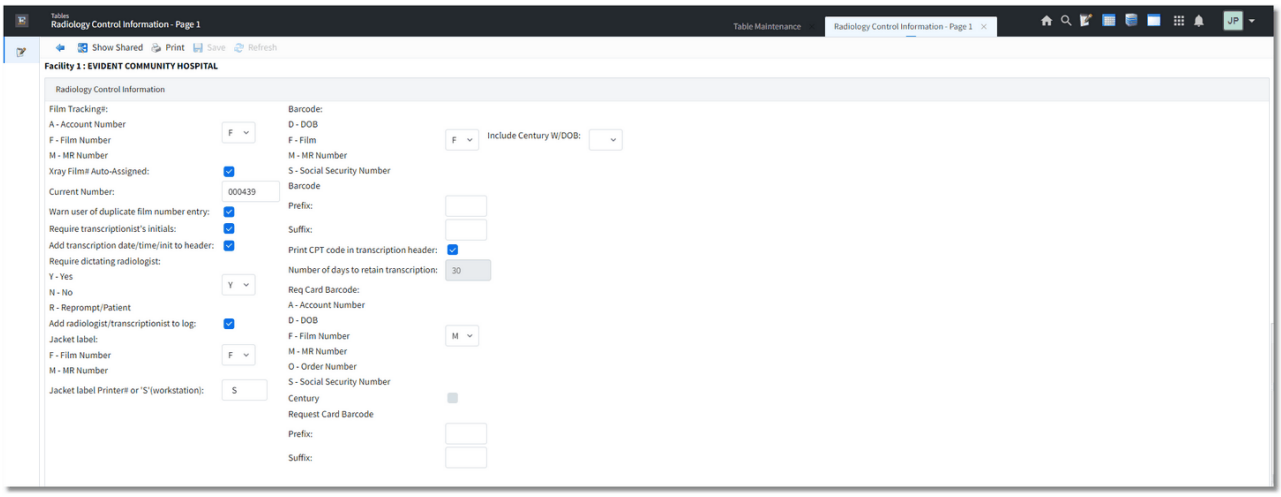
Select the  **back arrow** to return to Tax Identification Numbers list.

Chapter 16 Radiology Control Information, Page 1

The Radiology Control Table contains functions that affect a variety of radiology processes as a whole and some functions within other Revenue Generating departments.

This chapter will provide the user with the steps to access the table and information regarding all fields and their function. Access to the Radiology Control Table is based on department and employee security. Notify the computer contact or TruBridge Ancillary Department about changes to this table if access is not available.

Select **Web Client** > **Tables** > **Control** > **Radiology Control Information, Page 1**



Radiology Control Information Page 1

- **Film Tracking # (“A”CCT#, “F”ILM#, “M”R#)**
  - Options:
    - **A-**Account Number
      - **F-** Film number (x-ray number)
      - **M-** Medical record number
  - Usage: This field defines the index used for tracking the location of a patient’s radiology film. Patient films may be assigned a different location by using one of the following options:
    - Patient functions option **Film location.**
    - Hospital base option **Department Specific**, **Change film locations** for multiple patients.
  - Requirements:
    - Film locations must be defined in **Chart/Film locations** of the business office tables.
    - Main file location for Radiology and Medical records is defined on page 6 of AHIS, field **MR CHART PERM. LOCA**. The first entry of Chart/Film Locations for Radiology must match the name listed on page 6 of AHIS.
  - Report: The Xray Film # Index List provides a list of all film numbers that have been assigned along with the patient’s name.

- **Xray Film # Auto-Assigned?**
  - Default: N (no)
  - Options: Y (yes) or N (no)

- Usage: Determines if Xray Film number will be auto-assigned or manually entered. The Xray Film number may be a maximum of 11 digits.
  - Y: The system auto-assigns the next film number when **N** is entered in field **Xray Number:** of the Radiology patient functions screen or from incoming orders.
  - N**:** The film number may be manually entered in field **Xray Number:**

- **Current #:** If the option to auto-assign film numbers is set:
  - The current film number in use is entered in this line so that the system may assign the next sequential number.
  - When Xray Film number is set to equal Medical Record number, the next Medical Records number automatically populates the field.

- **Warn User Of Duplicate Film Number Entry**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: A **Y** in this field will display a message when an entered or auto-assigned x-ray number matches an existing x-ray number assigned to another patient or the same patient.

- **Require Transcriptionist's Initials**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage:
    - Y: Transcriptionist will be prompted for and required to enter their initials before transcription. This will insure that the initials of the transcriptionist may be added to the Physician services log if **Y** is in the **Add Radiologist/Transcriptionist To Log** field.
    - N: Transcriptionist will not be required to enter their initials when transcribing orders.

NOTE: *The Require Transcriptionist's Initials field controls the transcription initials being required for other departments that may be transcribing against orders.*

- **Add Transcription Date/Time/Init To Header**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage:
    - Y: System will automatically include the transcription date, time and transcriptionist's initials in the transcription header.
    - N: Transcription date, time and transciptionist's initials will not be added to transcription header.

NOTE: *If Microsoft Word® is being used for transcription, this option does not control the transcription information appearing in the header. Transcription date/time/initials will have to be formatted in the OEWORD header by TruBridge.*

- **Require Dictating Radiologist**
  - Default: N (no)
  - Options: Y (yes), N (no) or R=Reprompt/Patient
  - Usage:
    - Y: Transcriptionist will be required to enter the Radiologist's initials before transcription of the first patient. System will not prompt with each patient. This will insure that the Radiologist's initials may be added to the Physician services log if "Y" is in the Add

Radiologist/Transcriptionist To Log field. If only one Radiologist dictates transcriptions, then this option is preferable.
- N: Transcriptionist will not be required to enter the Radiologist's initials and the transcription will not be sent for Electronic Signature.
- R: Transcriptionist will be required to enter the Radiologist's initials before transcription of the first patient. System will re-prompt the transcriptionist for Radiologist's initials with each new patient number. This will insure that the Radiologist's initials may be added to the Physicians Services log if **Y** is in **Add Radiologist/Transcriptionist To Log** field. This is preferable if multiple Radiologists dictate.

NOTE: *The Require Dictating Radiologist field controls the same usage for dictating physician initials for other departments that may be transcribing against orders.*

- **Add Radiologist/Transcriptionist to Log**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage:
    - Y: System will print the Radiologist and Transcriptionist's initials on the Physician Services Log. To insure that both sets of initials are entered at transcription, enter a **Y** in both **Require Transcriptionist's Initials** and **Require Dictating Radiologist** fields.

- **Jacket Label "F"ILM# OR "M"R#**
  - Default: None
  - Options: "F"ilm number (x-ray number) and "M"edical record number
  - Usage: This field defines the number that will print on the x-ray jacket label.

- **Jacket Label Printer # or "S"Workstation**
  - Default: None
  - Options:
    - S for workstation printer
    - 3-digit line printer number
  - Usage: This field contains the printer designation for printing jacket labels.

- **Barcode: "F"ILM#, "M"R#, "D"OB OR "S"S#: Include Century W/Dob:** This is a two-line field.
  - Default: **Film number** for line 1-Barcode, **Y** for line 2-Include Century w/DOB
  - Options:
    - Line 1-Barcode:
      - **F-** Film number (x-ray number)
      - **M-** Medical record number
      - **D-** Date of birth
      - **S-** Social security number
    - Line 2-Include Century w/DOB: Y (yes) or N (no)
  - Usage: The options in this field define the information in the barcode on the jacket label.
    - The barcode information in line 1 may be used to change patient film location in mass sign-out option.
    - Barcode information may also be used by the Radiologist's dictating system to enter identifying information during dictation.
    - A **Y** in the second field determines if the century is to be included with the patient date of birth. Some dictating systems need a four(4)-digit date of birth to scan.

- **Barcode: Prefix: Suffix**
  - Default: None
  - Options: Two (2)-digit number
  - Usage: This field contains the barcode prefix or suffix needed by the Radiologist's dictating system for a tone to designate a new patient. This defines the prefix and suffix to be added to the barcodes printed on the Composite Requisition or User Defined Requisitions. The fields for jacket labels and barcodes accommodate 11 characters.

- **Print Cpt Code In Transcription Header**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: A "Y"es in this field will automatically print the CPT code for the procedure in the BODYTEXT of the transcription header.

- **Number of Days To Retain Transcriptions**
  - Default: Blank =14 days
  - Options: Up to 100 days
  - Usage: This field contains the number of days that transcriptions are kept before being purged and reports archived. In Item Order Entry Information, if **Transcribe results** field**,** is "Y"
    - The system will look in the Radiology Control table, field 13 for the number of days to retain a non-transcribed order before it is purged.
    - After the transcription is complete, the system will again refer to this field to retain the transcription before it is archived and moved to Clinical History.
    - This field requires a password to increase the number of days from the default. TruBridge Technical Support must check for adequate disk space prior to changing.

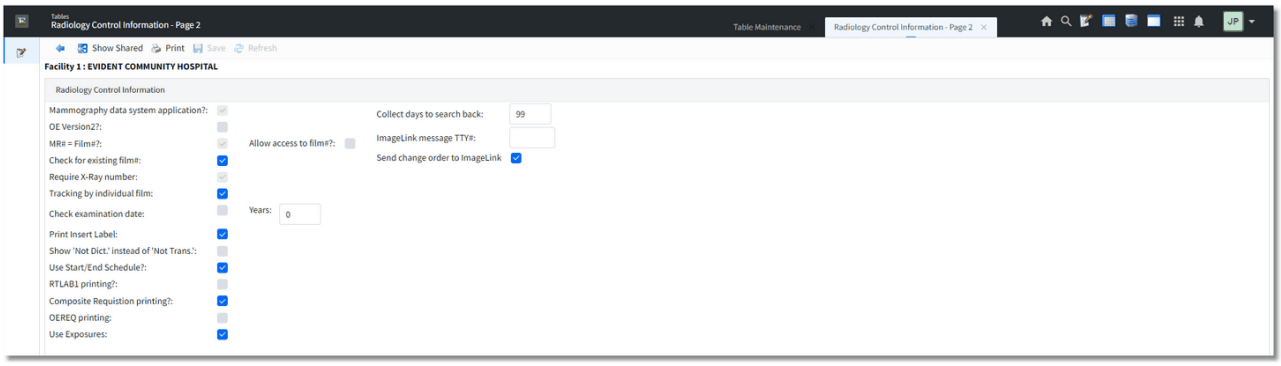
- **Req Card Barcode: "F"ILM#, "M"R#, "D"OB, "S"S# OR "A"CCT#: CENTURY:** This is a two-line field
  - Default: N- no barcode for line 1, Y for line 2 to include century with DOB
  - Options:
    - Line 1-Barcode:
    - **F-** Film number (x-ray number)
      - **M-** Medical record number
      - **D-** Date of birth**D -** Social security number
      - **A-** Account number
      - **O-** Order # (see usage)
      - **N-** No barcode
    - Line 2-Include century with DOB: Y (yes) or N (no)
  - Usage: The options in this field define the information in the barcode on the procedure card (export cards).
    - Barcode information may also be used by the Radiologist's dictating system to enter identifying information during dictation.
    - Order # will produce a barcode with a seven-digit order number. This option is for use with the Powerscribe Interface only and utilizes as specific export.
    - A **Y** in the second field determines if the century is to be included with the patient date of birth. Some dictating systems need a four (4)-digit date of birth to scan.

- **BARCODE: PREFIX: SUFFIX**
  - Default: Blank, no entry
  - Options: Two (2)-digit number

- Usage: This field contains the barcode prefix or suffix needed by the Radiologist's dictating system for a tone to identify to whom the dictation belongs (i.e.: which patient).

Chapter 17 Radiology Control Information, Page 2

Select **Web Client** > **Tables** > **Control** > **Radiology Control Information, Page 2**



Radiology Control Information Page 2

- **Mammography data system application?:** This field is for sites using the Mammography application.
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage:
  - o **Y**: Activates use of the TruBridge Mammography Data System application. Password is required.
    - o **N**: The New TruBridge Mammography Data System is not in use.

- **OE Version2: This option is for sites currently using the generic Radiology orders.**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: This field is used for sites who currently have the nursing departments still ordering the Generic radiology procedures.
    - o **N**: Standard Radiology application will be used by the system.
    - o **Y**:
      - Nursing departments access only the generic radiology items.(e.g.: CHEST XRAY)
      - Radiology will access a descriptive index that has the chargeable items. This mechanism will accommodate Medical Necessity, Enterprise Wide Scheduler and Interfaces to image storing devices (AGFA).
      - Option U-must be entered in the second line of field 3-Department Phase ID of Department System Security. This provides an alternate 14 Most Common screen for Radiology when orders are completed from the Radiology Schedule. The actual chargeable procedures are found in this location.
      - The Most Commonly ordered items for Radiology Exam is setup in AHIS, page 8, Alternate Radiology Charge Numbers field.
      - Order review - All Departments, select Radiology displays specific chargeable orders.

- **MR# = Film# ?:** This is a two-line field.
  - Default: N (no)
  - Options: Y (yes) or N (no)

- Usage: Allows the medical record number and film number to be interactive such that the update of one updates the other. Used for radiology departments where the film number is the patient's medical record number.
  - **Y**: Change/entry of either the MR # or film # will change/enter the other.
  - **N:** Medical record number and film number are distinct and not interactive.

- **Allow Access To Film#?**
  - Default: Y (Yes)
  - Options: Y (yes) or N (no)
  - Usage: Controls access to field **Xray Number** on Patient's Function Screen when **MR# = Film#** is **Y**.
    - **Y**: Allow access to field **Xray Number** on the Patient's Function Screen.
    - **N**: Disallows access to field **Xray Number**
  - Related Fields:
    - AHIS, page 7, field -Check Duplicate Numbers: If set to Y(Yes) for MR# field (and MR# = Film#), system will prompt when attempting to assign a duplicate MR# or Film#: "WARNING! CORRESPONDING FILM# HAS ALREADY BEEN ASSIGNED, USE ANYWAY?"
    - Radiology Control Table, field-Film Tracking # may be either F"ilm or MR #. If Film #, then field-Auto Assign=N. System will not auto-assign MR #s via auto-assigning film#.
  - Recommendations:
    - When MR# = Film#, every patient assigned a MR# will have a Film #, even patients who have never had a Radiology procedure performed in the department. The Film Index List will include all patients with a MR#.
    - Film # may be assigned during Temporary Registration, but MR# cannot. Procedures and policies must be in place to provide a mechanism for assigning MR# via Film #.

- **Check for existing Film#**
  - Default: Y (yes)
  - Options: Y (yes) or N (no)
  - Usage: Determines if the film number from the most recent prior account is copied forward each time a patient is registered or if a new film number may be assigned with each admission.
    - **Y**: System will check for existing film #.
      - When attempting to assign a film number (from Incoming Orders, Temporary Registration, or Patient Functions Screen) the system will check the Master Patient Index (MPI) for a prior account with a valid film number.
      - If the system finds an account with a valid number, it displays the prompt, "This patient has an existing film #XXXXXX Do you wish to use?
      - If a **Y** is entered, the film# displayed is applied to the account.
        - If a **N** is entered, the system will allow a new film # to be entered for this account.
      - If no prior account with a valid film # is found, the system will allow a new film# to be assigned.
    - **N**: The system will not check for existing film #s and allow a new film # to be assigned for each account.

NOTE: *The system will automatically apply the existing film# to the new patient account provided registration uses the Profile Listing and registers from that Patient Profile. TruBridge strongly recommends always using the Profile Listing to register all patients.*

- **Require X-Ray Number**
  - Default: N (no)
  - Options: Y (yes) or N (no)

- Usage: Controls if assigning an X-Ray# is required prior to printing Incoming Orders or placing orders from within the Radiology department.
  - **Y**: System requires an X-Ray # to be assigned.
    - Incoming Orders: Only orders with an assigned X-Ray# may be printed or acknowledged. Orders without an assigned film# will prompt: **"No X-Ray Number Assigned – Press any Key to Continue"**. Orders cannot be printed or acknowledged until an X-Ray # is assigned.
    - Radiology Order Entry: From the Radiology Patient Functions Screen, if Radiology/Imaging for Order Entry is selected, and the patient does not have an assigned X-Ray#, the system will prompt as described above. Once an X-Ray# is assigned, proceed with order entry.
  - **N**: Assigning an X-Ray# is not required prior to printing Incoming Orders or placing orders from within the Radiology department.

NOTE: *The system will prompt for password when selecting this field. Implementation of this feature will require assistance from TruBridge. Please contact an Ancillary Support Representative for assistance.*

- **Tracking by individual film**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Controls film tracking by individual patient procedure (when set to Y).
    - **Y**: Allows individual patient films to be tracked and includes the following Information:
    - Procedure: eg: Chest PA/Lateral. Accommodates up to 25 characters.
      - Date: The date the film was loaned. The number of days out will be calculated from the date in this field for the Loaned Films report.
      - Num: The actual number of films being loaned.
      - Location: Accommodates up to 10 characters. Includes a location and/or physician lookup for films being loaned. Given To: Accommodates up to 15 alpha/numeric characters for the name of the person taking the film(s).
      - By: 3-character field for the initials of the person loaning the film(s).
    - **N**: A film location for the patient is entered; individual films are not noted.

NOTE: *Before implementing this method of film tracking, the Film Location List should be printed. Once the new tracking method has begun, the list of films currently on lend cannot be accessed. Consequently, caution should be exercised in making the decision to change film-tracking methods. Please contact a TruBridge Ancillary Support Representative for assistance.*

- **Checking Examination Date**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines whether site will check prior exam dates based on last exam date listed in Clinical Notes.
    - **Y**: Allows entry in the Years field. Years: determines the number of calendar years system will check for last exam date.
    - **N**: Will not allow entry in the Years field. System will not check last exam date.

- **Years:** 0-99
  - Usage: Determines the number of calendar years system will check for last exam. If last exam exceeds the number of calendar years in this field, jacket label and/or insert label for each modality ordered will print when the following are selected:

- Incoming Orders and **B** Barcode.
- Manually ordering and verifying from the Patient Function Screen.

- **Print Insert Label**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines whether insert labels may be printed from Jacket Labels field on the Patient Function Screen.
    - **Y**: Allows manual printing of jacket and/or insert labels from Jacket Labels field on the Patient Function Screen.
    - **N**: Only jacket labels may be printed from Jacket Labels field on the Patient Function Screen.

- **Show "Not Dict." Instead of "Not Trans."**
  - Default: N (no)
  - Options: Y (yes) or N (no)
  - Usage: Determines whether **Not Dict** or **Not Trans** displays when reviewing status of orders for transcriptions.
    - **Y: Not Dict** displays under status of orders for non transcribed orders.
    - **N: Not Trans** displays under status of orders for non transcribed orders

***NOTE**: Radiology Department Security, **Patient Functions** field must be set to **R** for this option to function.*

- **Use Start/End Schedule**
  - Default: Blank (No)
  - Options: Blank or Yes
  - Usage: Determines whether or not the new Radiology schedule is utilized.
    - **Y**: New Radiology schedule is utilized.
    - **N**: Original Radiology schedule is utilized.

***NOTE:** Refer to Chapter for Ancillary Exam Type for complete set up.*

- **RTLAB1 printing?**Default: Blank (No)
  - Options: Blank or Yes
  - Usage: Determines the type label that will print when order is placed from within the Radiology department.
    - **Y:** When checked, generates a requisition defined by either User Defined Labels or the export defined for the item which is ordered. (Original labels).
    - **N:** Original Labels not being utilized. (Composite Requisition prints)

- **Composite Requisition printing?**
  - Default: Blank (No)
  - Options: Blank or Yes
  - Usage: Determines the type label that will print when order is placed from within the dept.
    - **Y:** When checked, generates the new composite requisition when orders are placed. (Composite requisition contains Demographic label, charge labels with barcode, flash card and transportation slip.)
    - **N:** Composite Requisitions not being utilized (Original Label prints)

NOTE: *If* ***not*** *using the Composite Requisition, fields* ***RTLAB1*** *and* ***OEREQ*** *must be checked. For Composite Requisitions to be utilized, site must have purchased ARDS Application.*

NOTE: *To print Composite Requisitions to a multiple tray printer field 28,* ***Multiple Trays****, must be set to* ***Y****es and "Custom Type 2" entered in the* ***Rad. Composite Req.*** *field in the Device Control Table for that port. You must also go into the print menu and change "Custom Type 2" under.*

- **OEREQ printing?**
  - Default: Blank (No)
  - Options: Blank or Yes
  - Usage: Determines the type label that will print when order is placed from nursing and processed through Incoming Orders.
    - **Y:** When checked, generates a requisition defined by either User Defined Labels or the export defined for the item which is ordered. (Original labels).
    - **N**: Original Labels not being utilized.

- **Use Exposures**
  - Default: Blank (No)
  - Options: Blank(N) or Yes
  - Usage: Controls whether the number of exposures will be tracked within the Repeat/Reject feature. If this feature is used, the graphical maps will be enabled and the Radiology Utilization Log will capture film analysis statistics.

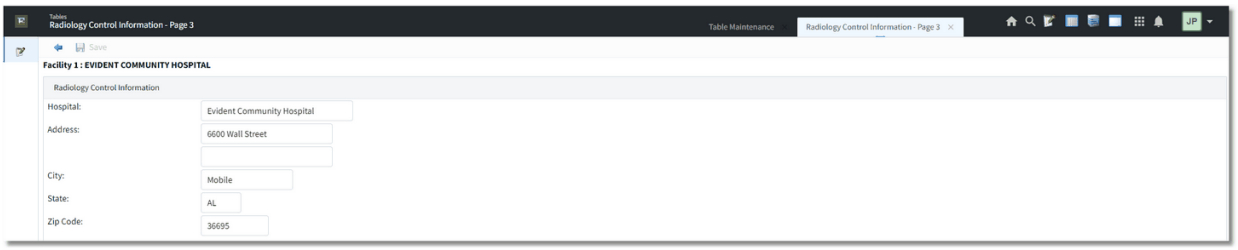
- **Collect days to search back**
  - Default: No Default
  - Options: Define number of days to search back for result 1-90
  - Usage: Controls the number of days to search in the system for the lab results that are defined in this table.

- **ImageLink message TTY#**
  - Default: Blank
  - Options: Blank or enter a TTY#
  - Usage: Allows a defined TTY in the Radiology department to receive a duplicate accession number warning if duplicate accession numbers are assigned via the ImageLink™ application.

Send Change Order To Image Link--This option is under construction at this time.

Chapter 18 Radiology Control Information, Page 3

Select **Web Client** > **Tables** > **Control** > **Radiology Control Information, Page 3**



Radiology Control Information Page 3

Page 3 of the Radiology Control Table is designated to define Radiology Requisition header information.

This allows the Radiology department to define Hospital Name/Address information that may be different from the Corporate Address that is loaded in physician 999999.

If this page is not addressed, the system will look at the physician 999999 for Radiology Requisition Header information.

This pulls to the Composite Requisition and Pull Slip for Radiology.

The following fields will need to be defined:

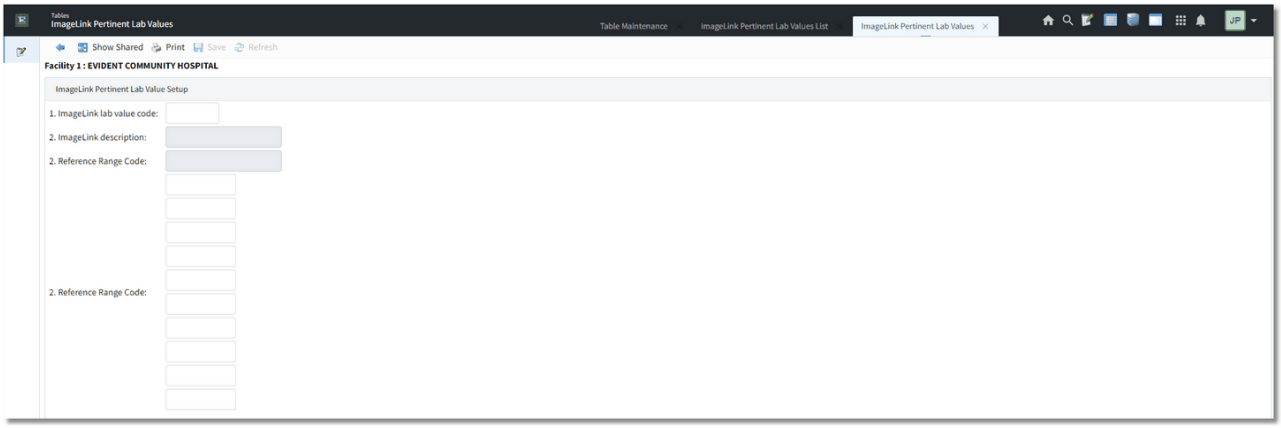
- Hospital
- Address 1
- Address 2 (if applicable)
- City
- State
- Zip Code

NOTE: *For facilities outside of the United States, "Prov" (Province/Territory) and "Postal code" fields will display in place of the State and Zip Code fields respectively. A TruBridge Representative will need to be contacted in order for these address fields to be activated.*

Chapter 19 ImageLink Pertinent Lab Values

To add Lab Tests to this table, select **New**.

Select **Web Client** > **Tables** > **Control** > **ImageLink Pertinent Lab Values** > **New**



ImageLink Pertinent Lab Value Setup

- **ImageLink lab value code**: Five-character user-defined code that serves as a unique identifier for the HIS. This code does not have to match the Reference Range Table. However, a code cannot be used twice once defined.
- **ImageLink description**: Description that will display on the ImageLink viewer when lab values are pulled from the HIS to ImageLink.
- **Reference Range code**: Allows the User to define the Reference Range from which the lab values will pull to the ImageLink Viewer. A lookup of the Reference Range table may be utilized by type a question mark (?) in this field.

  NOTE: *Only one reference range code may be used per entry in the table. If a duplicate is entered, the results* ***will not*** *display on the ImageLink Viewer.*

- **Items**: Allows the User to define specific items or panels that use the desired Lab test. This ensures that when these items or panels are ordered and resulted via the HIS, that the lab values will display on the ImageLink Study Information Index.

NOTE: *Please refer to the Study Information Index section of the ImageLink User Guide for information on statuses of orders and information on how defined lab values will display on the ImageLink viewer.*

Chapter 20 System Security

20.1 Department Security

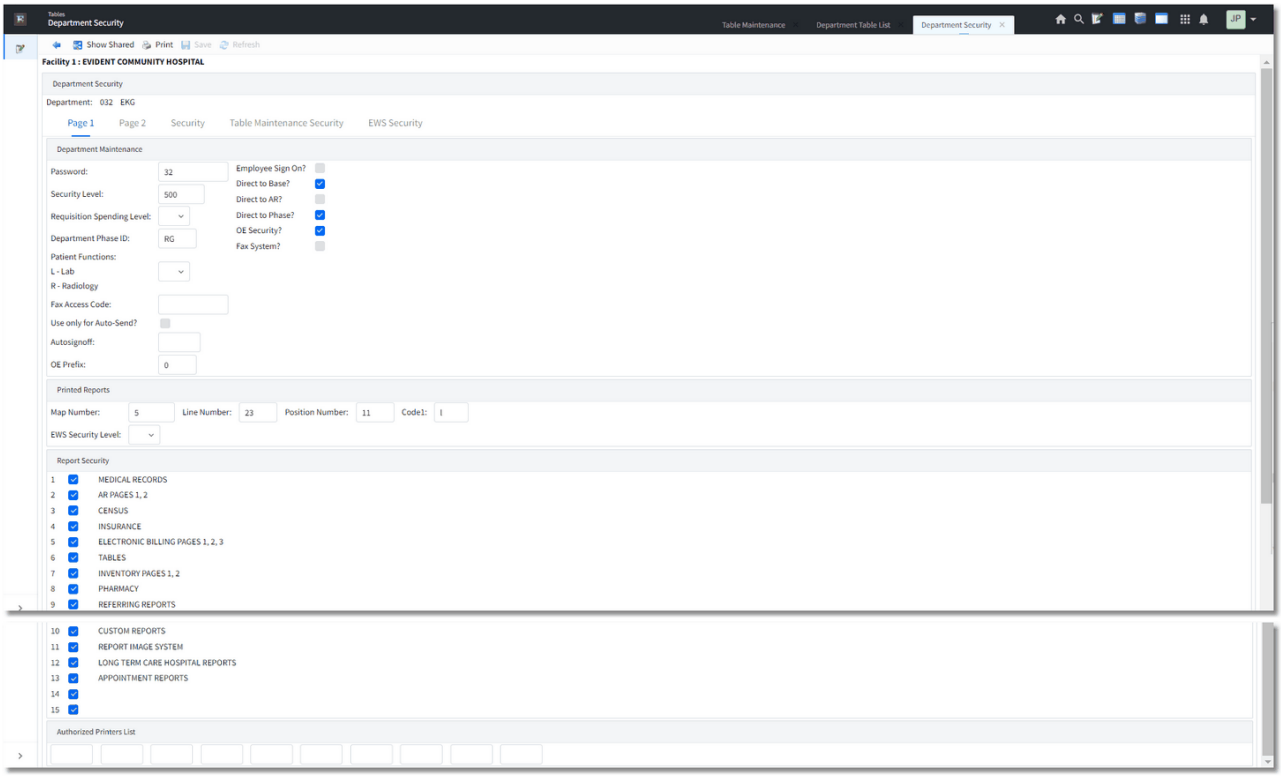
The first line of security in Patient Accounting is at the department level. When accessing Patient Accounting, an assigned department is required before access to anything is allowed. Department passwords and the path to change departments should only be given to a limited number of personnel in the hospital.

Each department will have security defined in Department Security. In addition, departments that utilize Employee Sign On or Order Entry Security will have security options defined for each employee.

Select **New** to enter a new Department, or select an existing Department from the list and select **Edit**.

Department Security, Page 1

Select **Web Client** > **Tables** > **Control** > **Department Security** > **Select Department**



Department Security, Page 1

- **Password:** This field sets the password to login or change to a different department. Up to 10 characters or digits may be entered. If this field is left blank, the department will be unable to be accessed.

- **Security Level:** This field allows each department access to specific tables within the Patient Accounting module. One of the four following security levels should be assigned to each department:
  - **Level 10:** Allows access to all tables and options within the Patient Accounting module.
  - **Level 12:** Allows access to all tables and options within the Patient Accounting module, except the Department Tables and AHIS.
  - **Level 250:** Allows access to the Print Report Menu but no access to the Business Office Tables.
  - **Level 500:** Stops access to the Print Report Menu and the Business Office Tables.

- **Requisition Spending Level:** This field is a function of the TruBridge Materials Management module and works in conjunction with the Restock Requisition Control Record in Patient Accounting. To access the Control Record, Select Hospital Base Menu > Charge Tables and Inventory > Restock Requisition System > Restock Control Record. The appropriate spending level of 1-9 should be entered for the selected department. Level 1 has no limit, which means the department with this level can send a restock sheet without requiring approval. The remaining levels (2-9) should be updated with the appropriate dollar values in the Restock Requisition Control Record, by selecting **Spending Levels**.

- **Dept Phase ID:** This field determines the application-specific map displayed for the Patient Functions screen and Department Specific. Departments without a phase ID will not be able to access Department Specific. Valid options are **RG** for Clinical Ancillary departments, **OE** for Nursing departments and **PC** for Pharmacy.

- **Patient Functions:** This field determines if the Patient Functions screen for "RG" phase departments will have **R-**Radiology or **L-**Laboratory options. Other options for this field are **U-** Alternate Radiology and the system default of blank denoting generic Ancillary.

- **Fax Access Cd:** The first portion of this field defines the long distance access code for this department. An entry is made here if long distance access codes are used to limit charges. When applicable, up to a ten digit access code may be entered.

- **Use only for Auto-Send?:** The second portion of this field controls if the system will supply the access code only for fax transmissions that are automatically sent by the TruBridge EHR. The software will prompt for the codes at all other times. Selecting this field will have the system only supply the access code without prompting when fax transmissions are automatically sent by the TruBridge EHR. Leaving this field blank will require the access code to be entered whenever a fax transmission is sent.

- **Autosignoff:** This field controls the Inactivity Timeout Settings for the department. It will override the overall system settings loaded in Automatic Log-Off section of Identity Management. The number of inactive minutes to trigger the auto sign off function should be loaded in this field. Leave this field blank to default back to the overall system setting.

- **OE Prefix:** The Order Entry Prefix established in the option Order Entry Prefix of System Security should be loaded, if the department utilizes the Order Entry applications.

- **Emp. Sign On:** This field determines if the employee assigned to this department must sign-on with an employee number and password, after logging into the system, before any options can be selected. Access to those hospital base options are then controlled via employee security. Select this field to require Employee Sign On and leave it blank to not require Employee Sign On.

Employees in departments utilizing this option must be defined in the Payroll module and Employee Security in System Management.

- **Direct to Base:** This field controls if the Hospital Base Menu is displayed directly after logging on the system. When selected, the system will display the department Hospital Base Menu when logging onto the system. When blank, the system will display the TruBridge Server menu when logging onto the system if Direct to AR is blank as well. If field Direct to AR is selected, the system will go directly to the Master Selection screen. All nursing and clinical ancillary departments typically have this selected.

- **Direct to AR:** This field controls if the Master Selection screen is displayed directly after logging on the system. When selected, the system will display the department Master Selection screen when logging onto the system if Direct to Base is blank. When blank, the system will display the TruBridge Server menu when logging onto the system if Direct to Base is set to blank as well. If Direct to AR is selected, the system will go directly to the Master Selection screen. All nursing and clinical ancillary departments typically have this blank.

- **Direct to Phase:** This field controls if the Phase-specific Patient Functions screen is displayed when a patient is selected. When blank, the system will display the Patient Accounting Patient Functions screen. When selected, when a patient is selected from the Hospital Base Menu or Master Selection screen, the system will display the Patient Functions screen for the Phase indicated in the Dept Phase ID field.

- **OE Security:** This field controls if the employee must enter their password when orders are verified, resulted or reviewed. Select this field to have the system prompt employees for their password and only allow access to options defined at department level or as defined in the employee's security. If this field is blank**,** employees will not be prompted for their password.

- **Fax System:** This field controls if the department has access to the FAX applications from Send in Order Review, Comparative Results or Help Information. Selecting this field provides access at the department level to the FAX application. To suppress access to the FAX application leave blank.

- **Printed Reports Map# Line# Pos # Code1:** Lines in this field provide the specifications necessary for the Print Report option from the Hospital Base Menu for ancillary departments. Please contact a TruBridge Ancillary Support Representative before making changes to these fields.
  - **Map#:** 3-digit print report map number.
  - **Line#:** 2-digit number defining the cursor line number on the print report map.
  - **Position#:** 2-digit number defining the cursor position number on the print report map.
  - **Code1:** Single character designation for the CSTM group that the system is to refer to when an option is selected from the print report menu.

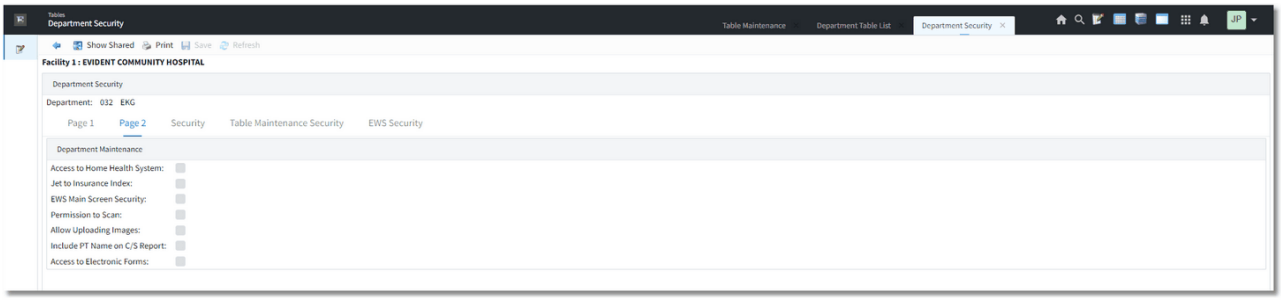
- **EnterpriseWide Sch. Sec. Level:** This field controls the level of access for this department to the Enterprise Wide Schedule application. Valid levels are 0-5.
  - **0:** Does not allow access to the scheduler.
  - **1:** Allows employees to lookup entries only.
  - **2:** Provides employees the ability to schedule tasks.
  - **3:** Allows employees to override defined number of tasks scheduled, if closed, for their department only.
  - **4:** Allows employees 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.

- **Report Security:** Each section of the reports listed under Print Reports, can be accessed by selecting the corresponding field. When these fields are blank, access from the Print Reports menu is restricted.

- **Authorized Printers List:** This field gives the ability to allow departmental access to specific line printers as well as limit the access to all other printers. Up to 10 line printer numbers can be entered in this field, allowing the department to print to the listed printers only, in addition to any workstation printer that may be set up. To restrict a department to using workstation printers only, enter a **WS** in the first space. If these fields are left blank, no limitations are set on printers.

Department Security, Page 2

Select **Web Client** > **Tables** > **Control** > **Department Security** > **Select Department** > **Page 2**



Department Security, Page 2

- **Access to Home Health System:** If this field is selected, the Home Health Application may be accessed from the **Hospital Base Menu** by selecting **Other Applications/Functions** then **Home Health System**.

- **Jet to Insurance Index:** This field controls if the Insurance System - Claim Indices screen is displayed directly after logging on the system. When set to **Y**, the system will display the Insurance System - Claim Indices screen when logging onto the system if Direct to Base is also set to **Y**. When this field is set to **Y**, the system will display the TruBridge Server menu when logging onto the system if Direct to Base is set to **N** and will display the Insurance System - Claim Indices screen once Patient Accounting is accessed. All nursing and clinical ancillary departments typically have this set to **N**.

- **EWS Main Screen Security: If** selected, security may be set for all options on the EWS screen via the EWS Security section within Department Security. For more information, please see the section on EWS Security 160.

- **Permission to Scan:** If this field is selected, the department has the ability to scan a document.

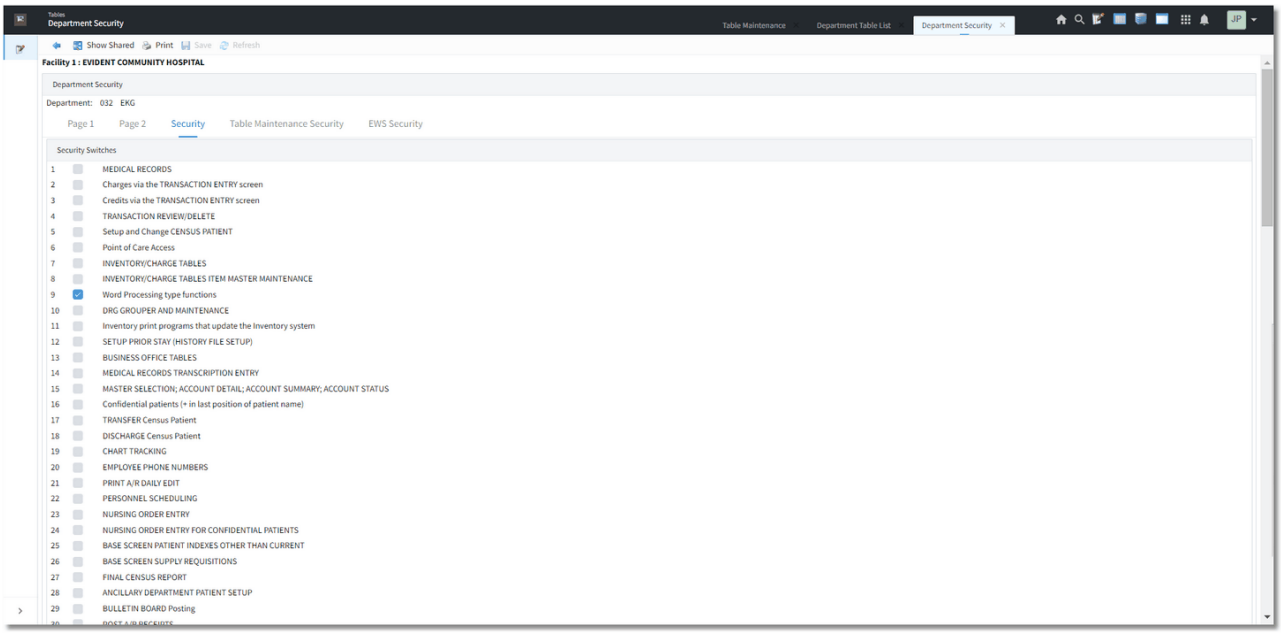
- **Allow Uploading Images:** If the field is selected, any image in Electronic File Management marked as upload can be uploaded into system.

- **Include PT Name on C/S Rept:** If the field is selected, the Central Supply Restocking Report will include the patient name.

- **Access to Electronic Forms:** Allows access to electronic forms via the following paths: Hospital Base Menu > Patient Account > Other Functions or Hospital Base Menu > Patient Account > Medical Records.

Security

Select **Web Client** > **Tables** > **Control** > **Department Security** > **Select Department** > **Security**

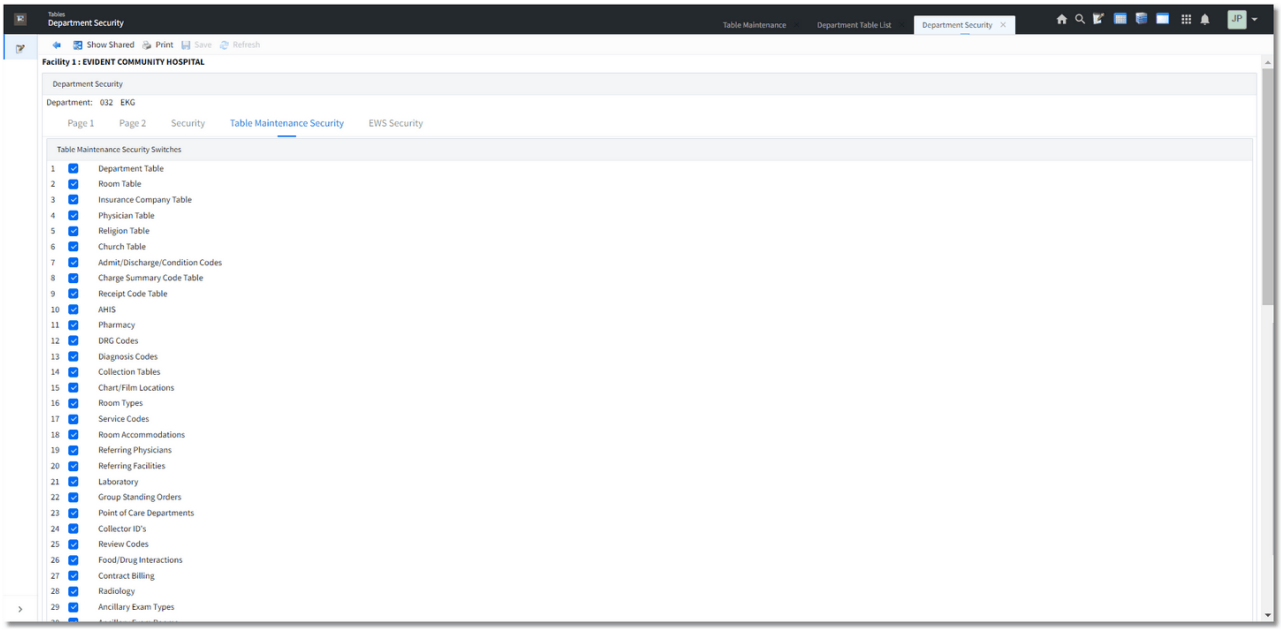


Department Security, Security

- **Security Switches:** Each switch controls access to the specified area designated to the right of the switch number. Please see the Security Switches List in the System Management user guide for detail on each of these switches.

Table Maintenance Security

Select **Web Client** > **Tables** > **Control** > **Department Security** > **Select Department** > **Table Maintenance Security**

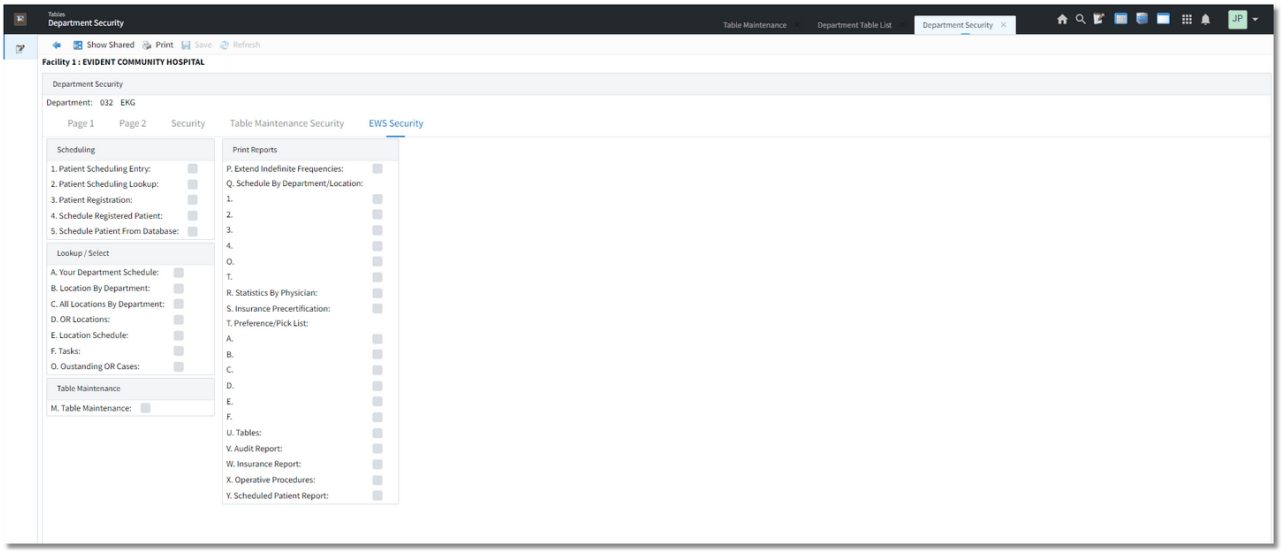


Department Security, Table Maintenance Security

- **Table Maintenance Security Switches:** Additional security switches have been created within the TruBridge System to allow access to individual Business Office Tables. Each Business Office Table has a switch and can be answered **Y**es, **N**o or **V**iew Only. If the security switches are answered **Y**, it will override any security level and will allow access into that Business Office Table. These switches do not override security switch 13, in the security switches, if set to **N**.

EWS Security

Select **Web Client** > **Tables** > **Control** > **Department Security** > **Select Department** > **EWS Security**



Department Security, EWS Security

- **EWS Security:** This section allows security to be set for all options on the EWS screen.

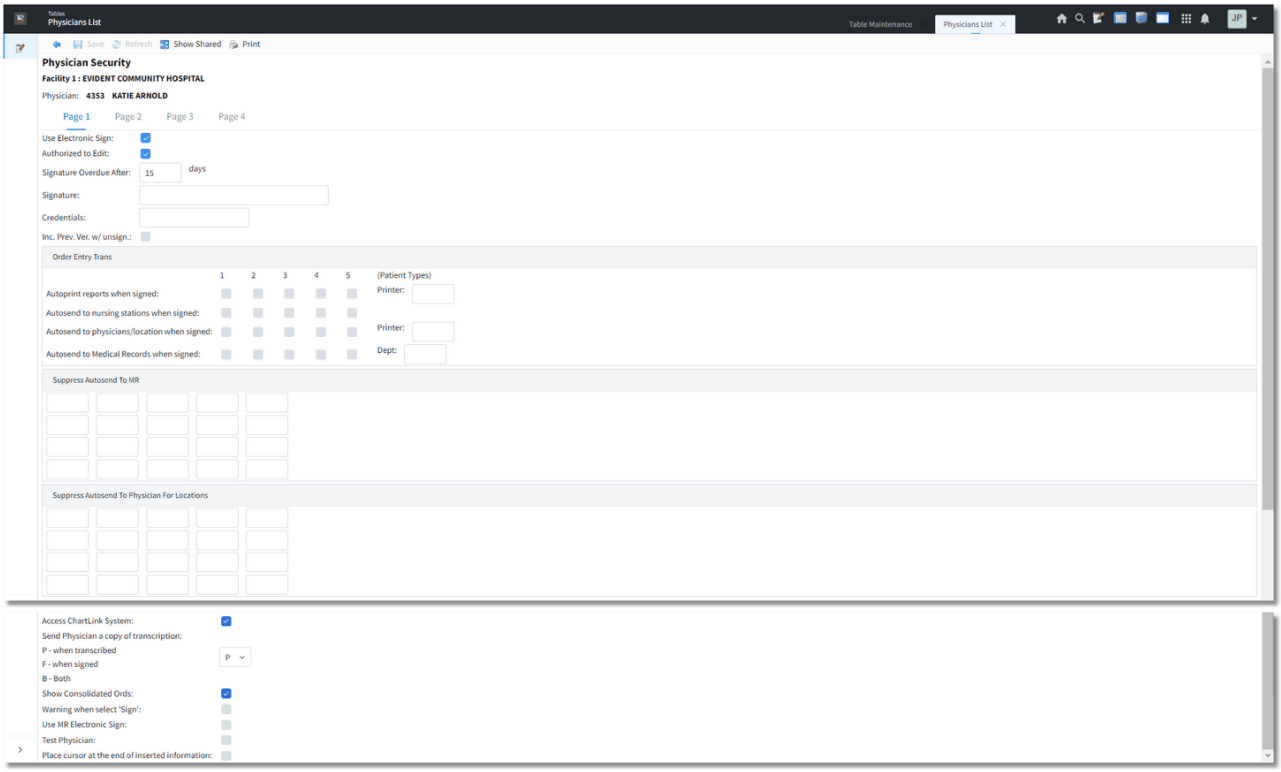
20.2 Physician Security

With the use of the TruBridge Electronic Signature application, each “signing physician” must be defined in Physician Security. Signing physicians will need to sign on in order to access unsigned transcriptions. Physicians are defined within the TruBridge System in order to help maintain the integrity of system information as well as confidentiality. These fields determine how the physician’s signed reports will be auto-distributed to patient nursing stations, referring physicians, patient report locations and the Medical Records department.

To make changes to Physician Security, select an existing physician from the list and select **Edit**.

Physician Security, Page 1

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Page 1**



Physician Security Maintenance, Page 1

- **Physician:** This is the six-digit physician number assigned to this physician. Prior to setting up Physician Security the Physician must be defined in Physicians table on the Control tab within Table Maintenance.

- **Use Electronic Signature?:** Determines when transcribed reports that qualify for Electronic Signature (field 23 of Order Entry Information) are automatically transmitted when signed. If selected, order transcriptions are automatically sent when they have been electronically signed through the Electronic Signature application. If this field is blank, then order transcriptions are automatically sent when field 13 of Order Entry Maintenance is completed.

- **Authorized to Edit?:** Determines if the signing physician has the ability to edit transcriptions in Microsoft® Word. If selected, then the Physician will have the ability to edit transcribed documents to be signed. If field is left blank, then if Edit option is selected from the Electronic Signature screen, a prompt will display, “Unauthorized to Edit, Send back to transcription?”

- **Signature Overdue After: days:** Determines the number of days after which a transcribed report is considered overdue for this physician. This field is used by Ancillary’s Overdue Electronic Signature report and the E-Sign Deficiency Report from the Medical Records Report menu.

- **Signature:** Contains the 40 character alpha/numeric signature that will pull to the transcription mnemonic DICTNAME in a transcription document, and DCTNAME in an electronically signed document.

- **Credentials:** Contains the signing physician's credentials that will pull to the transcription mnemonic RADCRED in an electronically signed document.

  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.*

- **Include Prev Ver w/unsig?:** Determines if previous versions of a transcription are included with unsigned reports on the Electronic Signature screen. If a document has been addended or amended, the system will display the original and any other versions if this field is selected. If blank, then previous versions of a transcription will not display for this physician, only the current version is available for review for this physician.

  NOTE: *The field Autoprint reports when signed through the Suppress autosend to MRFields control Auto-report distribution for signed order transcriptions through Electronic Signature for this physician. Each option is Patient Type specific.*

- **Autoprint reports when signed?:** Controls, by patient stay type, which order transcriptions automatically print once electronically signed to the printer defined in the second field.

  NOTE: *If any of these fields are selected, a printer must be defined.*

- **Autosend to Nursing Stations when signed?:** Controls, by patient stay type, if signed order transcriptions for this physician will automatically be sent to the patient's nursing station. If patient is admitted to a room, a report is sent to the department designated for that room. Nursing stations will receive the report based on the entry of Department Table, Incoming Report Printer. If there is no entry in the Incoming Report Printer field, the report is sent to the tty# loaded in Department Table, Crt TTY#. If the patient does not have a room, and the ordering department is not the same as the ancillary department, then the system will return the report to the ordering department.

- **Autosend to Physicians/Location when signed?:** Controls, by patient stay type, if signed order transcriptions for this physician will automatically be sent to the patient's referring physicians and/or report location.
  - With regard to physicians, the send mode is defined in the OE Transcription Send Mode field, on page three of the Physician's table. If this field is blank, the system will refer to the mode defined in the Result Send Mode field of the referring physician's table. If the referring physician's Result Send Mode field is blank, the report will print to the printer defined on the second line of this field.
  - With regard to locations, the send mode is defined in the OE Transcription Send Mode field found in the Location Table of the Business Office Tables. The patient's report location is defined in the Loc field on the Patient's function screen. If the OE Transcription Send Mode field is blank, the system will refer to the mode defined in the Result Send Mode field also found in the Location Table. If the Result Send Mode field is blank, the report will print to the printer defined on the second line of this field.

  NOTE: *If any of these fields are selected, a printer must be defined.*

- **Autosend to Medical Records when signed?:** Controls, by patient stay type, if signed order transcriptions for this physician will automatically be sent to the Medical Records department. The

second field is for entry of Medical Record's three-digit department number. Medical Records will receive the report based on the entry of Department Table, Incoming Report Printer. If there is no entry in the Incoming Report Printer field, the system will send the report to the tty# loaded in Department Table, CRT TTY#.

- **Suppress autosend to MR:** The system will not auto-send a signed order transcription for this physician to Medical Records if a patient has a location code defined in this field. Any three-character location code defined in the Location Table may be entered. Up to ten location codes may be loaded.

- **Suppress autosend to Physician for Locations:** The system will not auto-send a signed order transcription for this physician to the patient's referring physician, if a patient has a location code defined in this field. Any three-character location code defined in the Location Table may be entered. Up to ten location codes may be loaded.

- **Access ChartLink System:** Controls the physician access to the ChartLink application.

- **Send Physician a copy of transcription:** Controls when the physician's copy of the transcription document will print. Valid options: **P** for a preliminary report when transcribed, **F** for a final report when signed or **B** for a copy at both times.

- **Show consolidated Ords:** Determines if the signing physician sees the original order, and the orders consolidated in the transcription for specific procedures. If selected, the original order and any consolidated orders will appear on the Electronic Signature display. If left blank, then only the original order will display on the Electronic Signature display.

- **Warning when select 'Sign':** Controls the warning prompt when a physician attempts to sign multiple documents at one time without viewing or editing the reports. If the field is selected, the system prompts, "Are you sure you want to sign documents without viewing or editing? Y/N". If the field is blank, the physician will not receive the warning message.

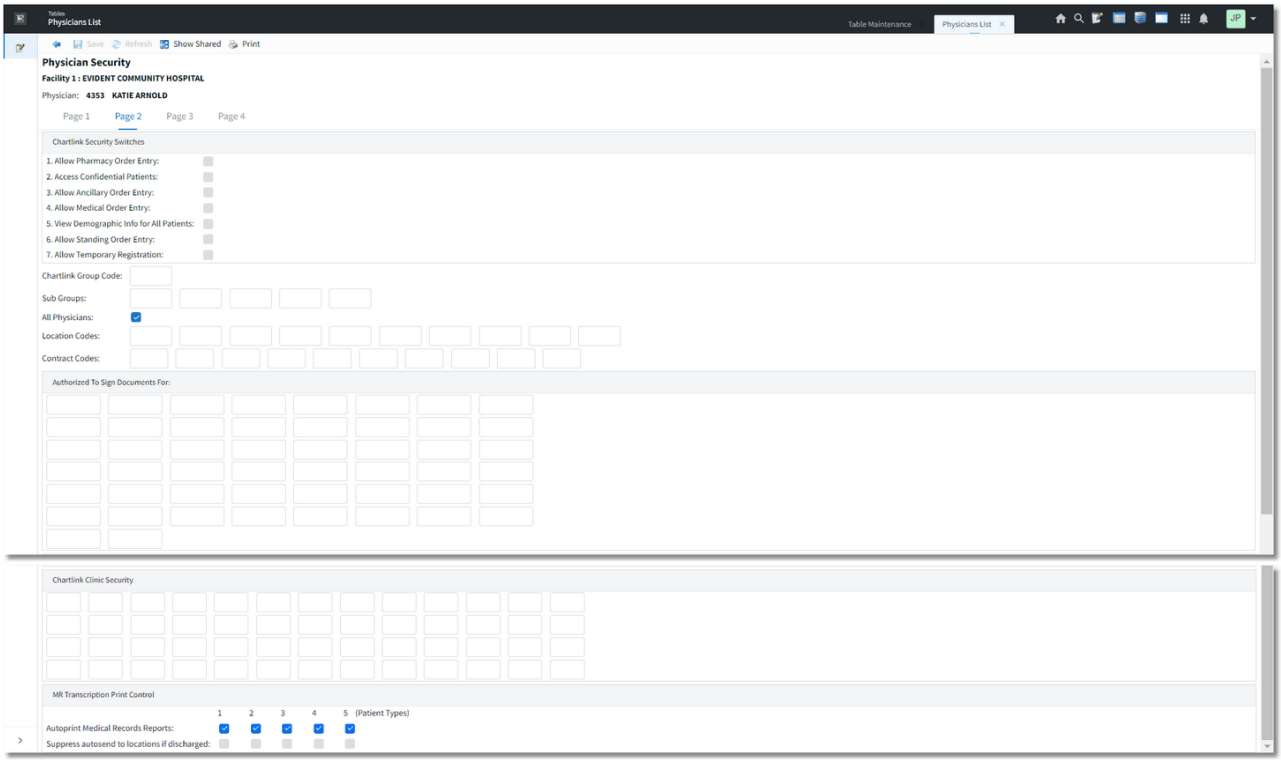
- **Use MR Electronic Sign?:** Controls the physician's use of the Electronic Signature application for Medical Records Transcription documents.

  NOTE: *This field is used for transcription documents done through Medical Records. The Use Electronic Sign field is used for transcribed reports done through Order Entry.*

- **Test Physician**: By selecting this field, the physician will be considered a test physician and will not be included on the Physician Order Log report. The default for this field is blank.

Physician Security, Page 2

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Page 2**



Physician Security Maintenance, Page 2

- **Chartlink Security Switches:** The following list gives an explanation of each Security Switch. Switches 9-20 have not been defined.
  - **Switch 1- Allow Chartlink Pharmacy Order Entry:** This switch allows pharmacy order entry via ChartLink when set to **Y**.
  - **Switch 2- Access Confidential Patients:** This switch allows access to data on patients defined as confidential patients when set to **Y**.
  - **Switch 3- Allow Chartlink Ancillary Order Entry:** This switch allows physician to place orders through the Ancillary tab in order entry.
  - **Switch 4- Allow Chartlink Medical Order Entry:** This switch allows physician to place orders through the Medical tab in order entry.
  - **Switch 5- View Demographic info for all patients:** This switch allows the physician to view face sheets for all patients in the system when set to **Y**.
  - **Switch 6- Allow Chartlink Standing Order Entry:** This switch allows physician to place standing orders.
  - **Switch 7- Allow Chartlink Temporary Registration:** This switch allows physician to complete a temporary registration of a patient.
  - **Switch 8- Allow OP's without Results to go straight to OP Tab of Whiteboard:**This switch is currently under development.

- **Chartlink Group Code:** The Chartlink Group Code is used to define each physician associated with the same group. The same code is entered in this field for each physician associated with the same group. The code defined for this physician's group is defined in the Chartlink Group Code Table in the Business Office Tables.

- **Sub Groups**

- **All Physicians?:** Allows this physician access to data on all hospital patients.

- **Location Codes:** Allows this physician access to all patients defined with the location code(s) in this field. The Report Locations table is located in the Business Office Tables. Up to 10 location codes can be loaded.

- **Contract Codes:** Allows this physician access to all patients defined with the contract code(s) in this field. The Contract Billing Codes table is located in the Business Office Tables. Up to 10 valid contract codes can be loaded.

- **Authorized to Sign Documents for:** Allows this physician to sign transcriptions for any of the physicians listed in this field. If the physician(s) number is unknown, an alpha look-up display is available for staff and non-staff physicians. The list pulls from the Physician Table in the Business Office tables.

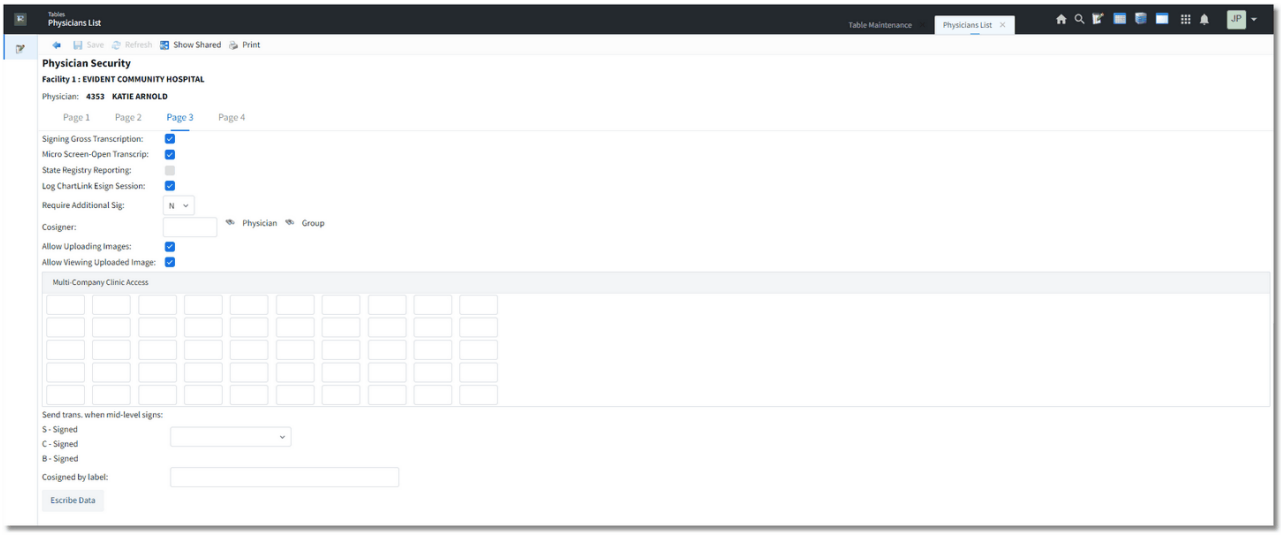
- **Chartlink Clinic Security:** Enter the codes for each clinic the Physician will be able to access.

- **Autoprint Medical Records Reports:** Select the Stay Types for reports to automatically distribute for electronic signature physicians, according to the associated table setup.

- **Suppress autosend to locations if discharged:** Select the Stay Types for which the auto distribution of documents will be suppressed if the patient is discharged, for electronic signature physicians.

Physician Security, Page 3

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Page 3**



Physician Security Maintenance, Page 3

- **Signing Gross Transcription?:** If selected, the Gross case will move to the next stage when appropriate. It also goes to the transcription queue following normal protocol. If this is not selected the Gross case goes to the transcription queue for transcription. This follows normal protocol.

- **Micro Screen-Open Transcrip?:** If selected, the transcriptions automatically opens.

- **State Registry Reporting**: If selected, Pathologists will have the ability to report positive cancer cases to the state registry during the e-sign process. For more information please see the documentation on Electronic Signature.

- **Log Chartlink esign session?:** If selected, logging can be enabled that will log every minor detail of a E-Sign session for a user.

- **Require Additional Sig?: Cosigner?:** If selected, the physician will have the capability to co-sign the orders via electronic signature when accessing ChartLink.

- **Allow Uploading Images?:** If selected, any image in Electronic File Management marked as upload can be uploaded into system.

- **Allow viewing of Uploaded Images?:** If selected, gives access to view any document title that has upload marked in the image title.

- **Multi-company clinic access:** Enter up to 50 two-digit company numbers.This field will give the physician access to the MPM clinic data for multiple companies.

- **Send trans. when mid-level signs?:** This field determines when a transcription is auto-distributed after Electronic Signature. This field need only be set for physicians or providers (NOT requiring a co-signature) with mid- levels working under their supervision. This field works in conjunction with the existing report distribution fields and settings for both order entry and medical records transcriptions. The options are as follows:
  - **S-**The transcription will be auto-distributed when the mid-level signs the document (1st signature)
  - **C-**The transcription will be auto-distributed after the supervising physician co-signs the document (2nd signature)
  - **B-**The transcription will be auto-distributed after the mid-level signs and again after the supervising physician signs. In this scenario the report will be sent twice.

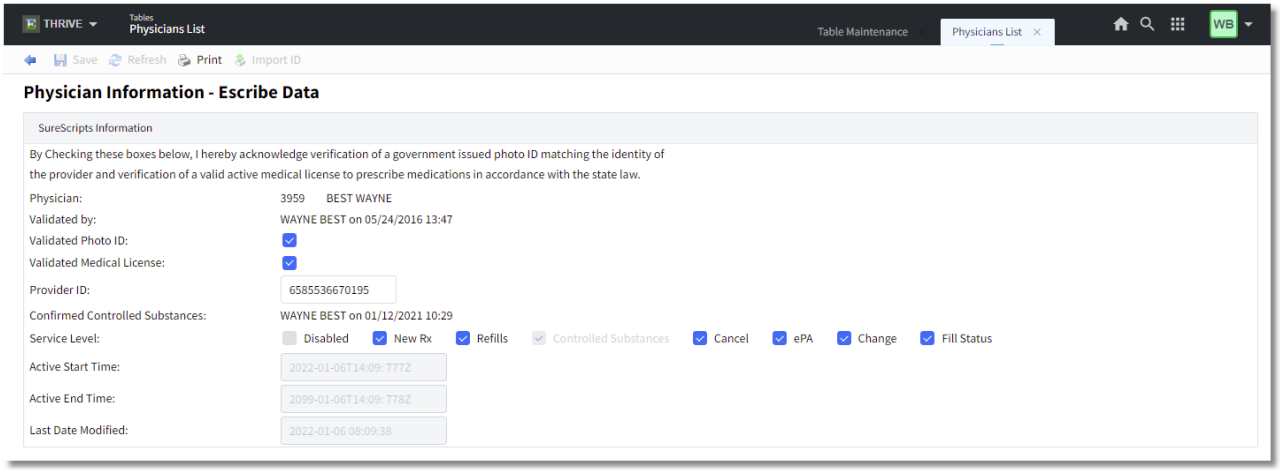
- **Cosigned by label:** The information in this field will pull to any transcription that uses the <<COSIGNATURE_PENDING>> mnemonic. The wording in this field is used in combination with a co-signing supervising physician.

  Example: *Cosigned by label has the following phrase loaded in the field:* ***"Electronically Reviewed and Co-signed by:"*** *When the co-signing physician (ex John Doe M.D) signs the document that was previously signed by the mid-level provider, the co-signing physician's name will pull to the transcription and it will read:* ***Electronically Reviewed and Co-signed by John Doe M.D.***

  NOTE: *The co-signing physicians credentials will pull from page 1 of the physician security.*

- **Escribe Data:** When selecting **Escribe Data**, the user must verify then select the Validated Photo ID and Validated Medical License check boxes when generating an SPI #. This documents the employee which validated the physician credentials. For more information, see the Prescription Entry user guide.

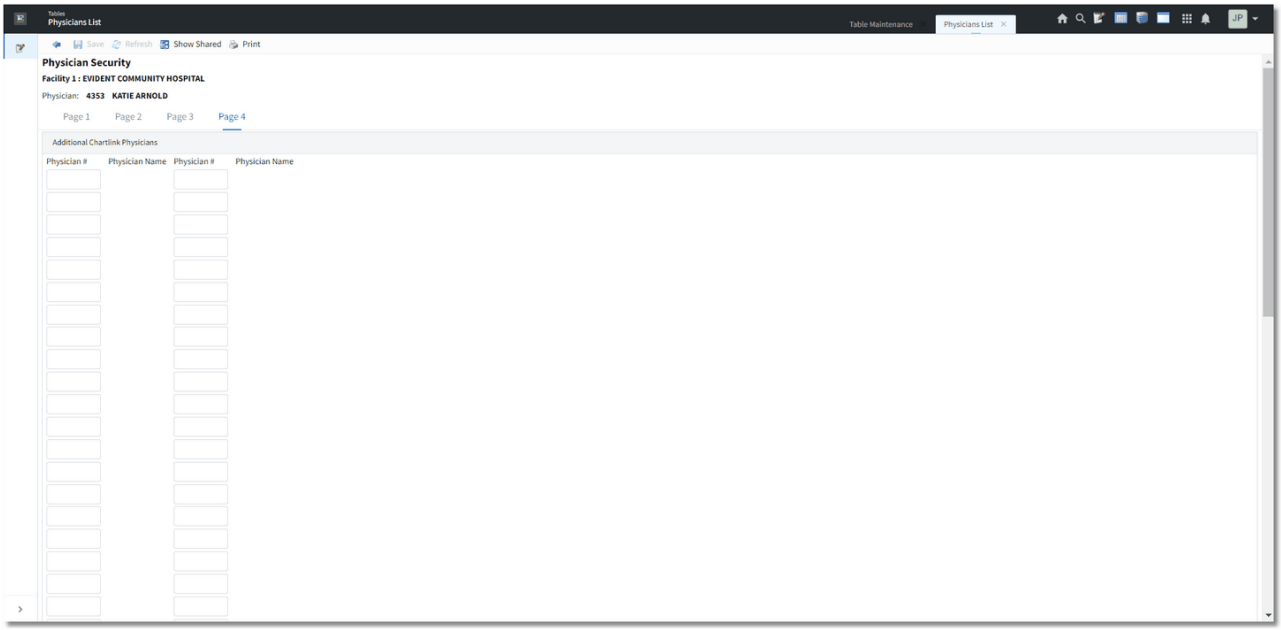
Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Page 3** > **Escribe Data**



Physician Information - Escribe Data

Physician Security, Page 4

Select **Web Client** > **Tables** > **Control** > **Physician Security** > **Page 4**



Physician Security Maintenance, Page 4

Enter the physician's number to add a physician to the group.

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Delete**:Deletes the table settings
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to show immediately in the Physician Security list

Select the  **Back Arrow** to return to the previous screen.

20.3 Supervisor Setup

The Supervisor Setup table allows the ability to associate a supervisor with a physician or user.

Select **New** to enter a new supervisor association, or select an existing association from the list and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Supervisor Setup** > **Select Existing Association**

User Supervisor Maintenance

- **User ID:** Enter the User ID or Physician ID to link to a specific Supervisor. Select the lookup to display a list of UBLs for the facility.
- **Supervisor ID:** Enter the supervisor's User ID to link to a specific User or Physician. Select the lookup to display a list of UBLs for the facility. A non-provider may be set up as a Supervisor for providers to gain access to the Prior Authorization List for ePA, if enabled. The non-provider must have an SPI loaded in the EScribe Approval table.

- **Type:** Enter the type of supervisor.

The following options are available on the action bar:

- **Delete**: Deletes the table settings

- **Save**: Saves changes made to the table settings

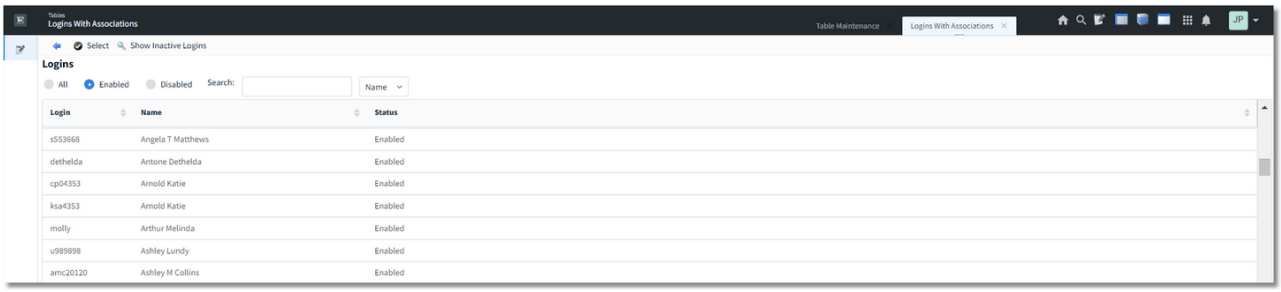
Select the **Back Arrow** to return to the previous screen.

20.4 Login Associations

Login Associations allow a user to view the Home Screen of another user. Login Associations allow logins to be linked together using Covering, Monitoring, Use CPOE, or Prescribing associations.

Select **New** to enter a new login association, or select an existing association from the list and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Login Associations** > **New**



Login Associations

Search for a login in the search box. Double-click a login or select a login from the list and choose **Select** to enter a new login association.

The following options are available on the action bar:

- **New:** Allows a new association to be selected for the selected Login.
- **Edit:** Allows an existing association from the list to be modified.
- **Delete:** Allows the selected association to be removed.
- **Refresh:** Allows the changes made to the associations to update on the Login Association List.
- **Back Arrow:** Allows the user to return to the previous screen.

Select **New** and search for a login in the search box. Double-click a login or select a login from the list and choose **Select** to associate that login to the previously selected login.

Select **Save** to save the newly created association or select **Delete** to remove the selected association.

Select the  back arrow to return to the previous screen.

Select the **Association Type** drop-down to choose the type of association for the logins listed above. For more information on the Covering and Monitoring association types, see Home Screen. The Prescribing association type assigns a supervisor to a provider or user for EScribe and Prescription Entry. A supervisor may also be assigned by accessing Supervisor Setup 169 in Table

Maintenance. The Use CPOE login association allows users who have the "Use CPOE" association type in the Login Associations table to access CPOE with their non-provider login. When the user signs orders, it will apply the credentials/signature of the associated provider login to the order.

Chapter 21 Specimen Tables

Specimen tables will function as a database from where specimen information may be added to laboratory results that need to be reported to a third-party vendor, state and federal agencies.

The user may add to the existing tables or edit entries by using the 

New and 

Edit options in the action bar of each database:

- **Specimen Type**: Contains a database of various types of specimens that may be tested
- **Specimen Modifiers**: Contains a database of various specimen modifiers
- **Specimen Additives**: Contains a database of all additives that may have been added to the specimen
- **Specimen Source Site**: Contains a database of all source sites from where a testing sample may be obtained
- **Specimen Condition**: Contains a database of all conditions for which a sample may be described such as clotted and contaminated
- **Specimen Role**: Contains a database of all roles for which a specimen may act. The default for all specimens will be 'P' for Patient.
- **Specimen Rejection Reason**: Contains a database of all possibilities for which a specimen may have been rejected for testing
- **Specimen Collection Site**: Contains a database of all various sites from which a sample may come
- **Specimen Collection Method**: Contains a database of all methods of collection for specimens
- **Specimen Information Defaults**: This table allows the user to create specimen information defaults via using the database information. As codes are entered, full code descriptions will appear to the right of the related specimen code field. Enter the Units code by either free-texting a valid UCUM code directly into the field or select the magnifying glass icon to initiate a search.
- **Item Specimen Defaults**: Allows the user to attach a default, defined in the Specimen Information Defaults table, to specific Items

Chapter 22 Tracking Board

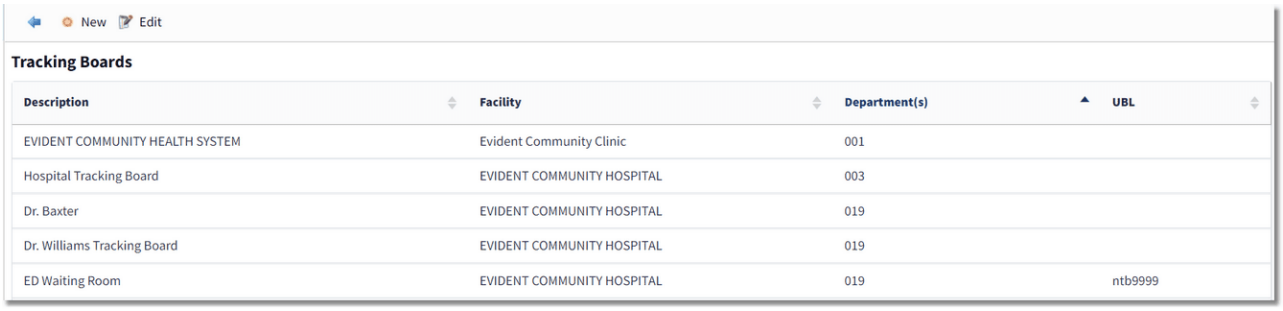
Tracking boards may be used in the Hospital, Clinic (TruBridge Provider EHR software) and Emergency Department (EDIS software). Tracking Boards are built according to the needs and preferences of the department and can be interactive or non-interactive (view only). Multiple Tracking Boards can be created and patient lists can be customized.

This functionality is based on the following settings within the Department Table:

- Clinic Departments are determined by the Clinic Code entered on page 5 of the Department Table 13.
- The Emergency Department is determined by the Emergency Department switch on page 2 of the Department Table 6.
- Hospital Departments are determined by the Nursing Station switch on page 2 of the Department Table 6.

22.1 Tracking Board Setup

Select **Tables > Control > Tracking Board Setup**. The screen displays a list of existing Tracking Boards for the departments the logged-in user has access to.



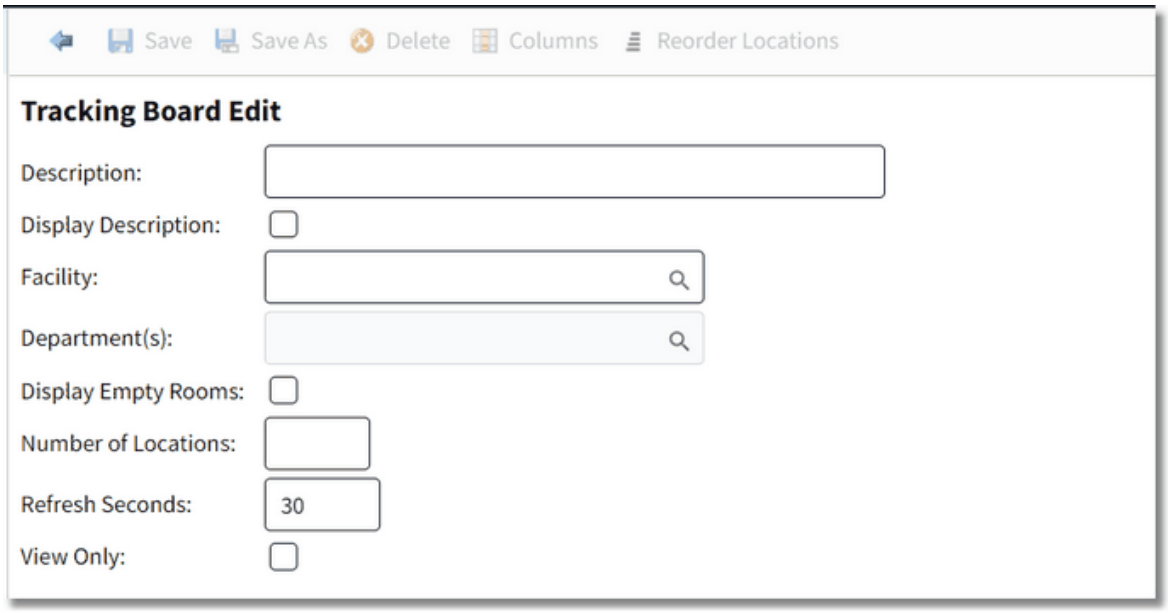
Tracking Boards

The following options are available on the action bar:

- **Blue Back Arrow:** Returns to the previous screen.
- **New:** Allows a new Tracking Board to be created.
- **Edit:** Allows a Tracking Board to be edited.

To Create a New Tracking Board

1. Select **New** on the action bar. The Tracking Board Edit screen is displayed.



Tracking Board Edit

2. Complete the following fields:

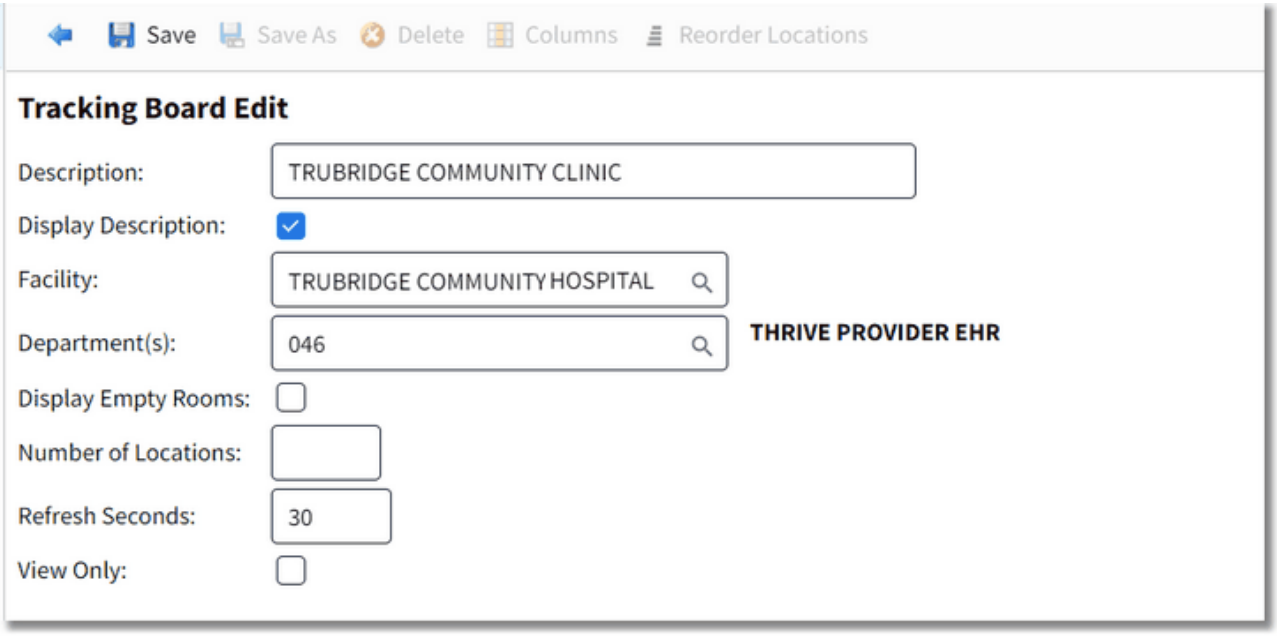
- **Description:** Enter the Tracking Board name.
- **Display Description:** Select the check box to display the description on the Tracking Board.
- **Facility:** Select the Lookup icon and select the facility that will use the Tracking Board.
- **Department(s):** Select the Lookup icon and select the department(s) that will use the Tracking Board. Then select **Add** and select **Update** to return to the Tracking Board Edit screen.

  NOTE: *Patients must be registered and checked in or admitted to the selected department to display on the Tracking Board. A user must have access to all departments associated with the Tracking Board to access the Tracking Board.*

- **Display Empty Rooms:** This option is applicable for non-interactive Tracking Boards. The check box will be active once the View Only check box is selected and a user login is selected in the UBL for Tracking Board Access Only field. Select the check box to display all rooms that are set up as "Active" and to "Show When Empty" on the Tracking Board.
- **Number of Locations:** This option is applicable for non-interactive Tracking Boards. Enter the number of locations (rows) to be displayed on the screen. This field accepts a maximum of 2 characters.
- **Refresh Seconds:** Determines how often the Tracking Board will automatically refresh. For non-interactive Tracking Boards, this will determine when the screen will refresh and allow the next sequence of locations to display. The default setting for this field is 30 seconds.
- **View Only:** This option is applicable for non-interactive Tracking Boards. Select the check box to create a non-interactive Tracking Board.

- **UBL for Tracking Board Access Only:** This field displays when the **View Only** check box is selected. Select the Lookup icon and select the user login to associate with the Tracking Board.

  NOTE: *Once a user login is assigned, it cannot be deleted. A new login should be created that will not be used for anything other than the non-interactive Tracking Board . If a current user login is selected, it cannot be used for anything other than accessing the non-interactive Tracking Board.*



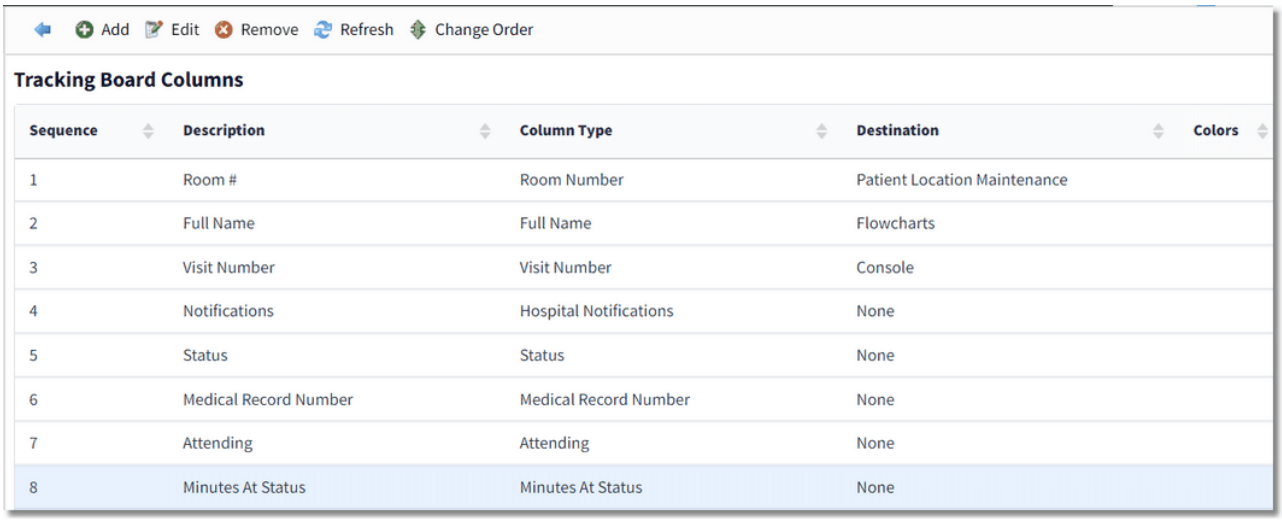
Tracking Board Edit

3. Select **Save**.

   NOTE: *In addition to **Save**, the following options are also available on the action bar:*

   - **Save As:** This option is only active for Tracking Boards that have been previously created and saved. When selected, a copy of the existing Tracking Board is created which can be edited.
   - **Delete:** Deletes the selected Tracking Board.
   - **Columns:** Opens the Tracking Board Columns screen, where columns can be added, edited, removed, and rearranged.
   - **Reorder Locations:** Opens the Tracking Board Locations screen, where room order can be rearranged.

4. When a Hospital Tracking Board is created and saved, a list of default columns display. These columns are intended to be used as a starting point for the new Tracking Board and may be edited as needed. For all other Tracking Boards, select **Columns** on the Tracking Board Edit screen to display the Tracking Board Columns screen.



Tracking Board - Default Columns

5. To customize the Tracking Board columns, use the options on the action bar:

   - **Add:** Launches the Tracking Board Column Selection screen, where new or additional columns can be added to the Tracking Board.
   - **Edit:** Launches the Tracking Board Column Edit screen, where the column descriptions can be changed, destinations assigned or changed, and colors added (if applicable).

     NOTE: *When a destination is assigned and the column cell is selected on the Tracking Board, the system will launch to that destination on the patient's chart. A color can be assigned only to the Triage Level, Code Status and Status column selections. When a color is assigned, the column cell on the Tracking Board will be highlighted in that color.*

   - **Remove:** Deletes the selected column.
   - **Refresh:** Updates the screen to reflect any recent changes.
   - **Change Order:** Allows the column order to be rearranged. Columns can be moved to top, to bottom, up, or down.

To Add Columns

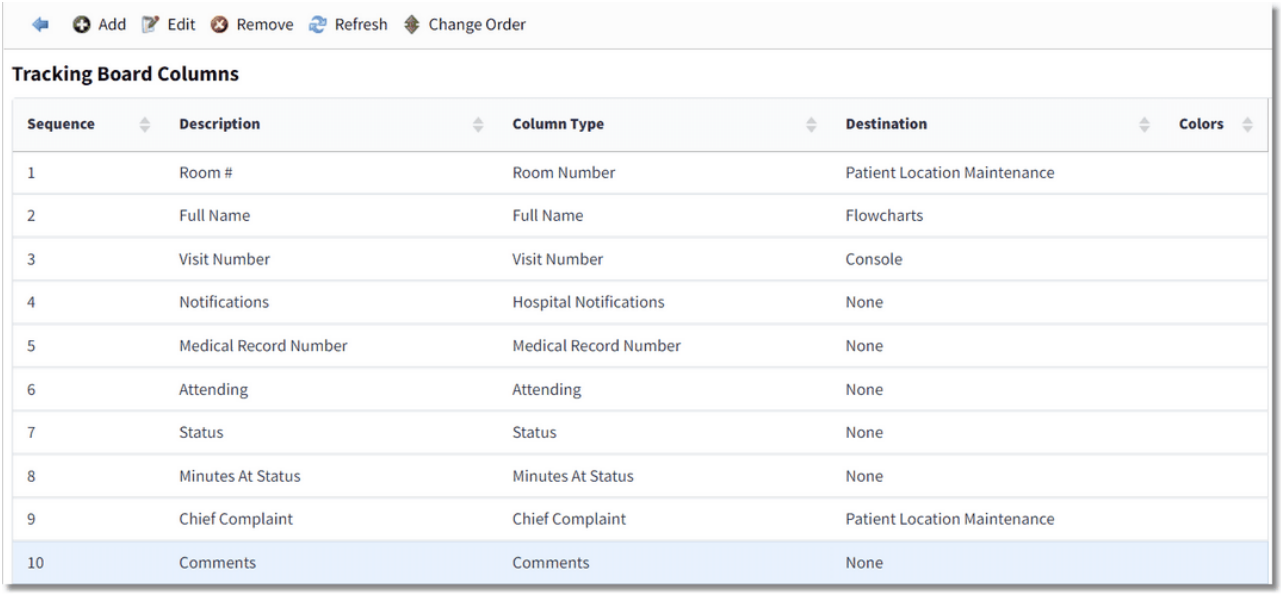
1. From the Tracking Board Columns screen, select **Add**.
2. The Tracking Board Column Selection screen displays. Select the columns to be included on the Tracking Board. The following is a list of available columns:

   - **Admit Date:** Displays the admit date.
   - **Admit Date/Time:** Displays the admit date and time.
   - **Age:** Displays the patient's age.

- **Alerts:** The  icon displays in the column when the patient has unacknowledged alerts. Once the alerts are acknowledged, the notification will be removed. See the Alerts User Guide for more information.
- **Attending:** Displays the attending physician.
- **Authorized Representative:** Displays the authorized representative.
- **Check in Time:** Displays the time the patient was checked in.
- **Chief Complaint:** Displays the patient's chief complaint.
- **Code Status:** Displays the patient's code status. Code Statuses may have colors assigned.
- **Comments:** Displays the last comment entered on the patient. Selecting the column allows for the entry of public and/or private comments. These comments are not intended to be a part of the patient's chart.
- **Consulting:** Displays the consulting physician.
- **Date of Birth:** Display the patient's date of birth.
- **ED/Clinic Notification:** (Clinic and ED only) Displays notifications specific to the Clinic and Emergency Department. Please refer to the Tracking Board - Provider EHR User Guide or Tracking Board - EDIS User Guide for additional information.
- **First Name:** Displays the patient's first name.
- **Full Name:** Displays the patient's full name.
- **Gender:** Displays the patient's gender.
- **Hospital Notifications:** Displays notifications specific to the Hospital. Please refer to the Tracking Board - Hospital User Guide for additional information.
- **Hospitalist:** Displays the hospitalist assigned in Patient Location Maintenance.
- **Last Name:** Displays the patient's last name.
- **Medical Record Number:** Displays the patient's medical record number.
- **Minutes At Location:** Displays the minutes since the last location change.
- **Minutes At Status:** Displays the minutes since the last status change.
- **Minutes Since Check In:** (Clinic and ED only) Displays the minutes since the check-in time.
- **Nurse:** Displays the nurse assigned in Patient Location Maintenance.
- **Physician Admit Reason**: Displays the physician admit reason.

- **Primary Care:** Displays the primary care physician.
- **Primary Insurance:** Displays the name of the primary insurance.
- **Priority Patient:** (Clinic only) Identifies the patient as a priority patient when selected in Patient Location Maintenance.
- **Provider of Care:** Displays the provider of care assigned in Patient Location Maintenance.
- **Room Description:** Displays the room description.
- **Room Number:** Displays the room number.
- **Secondary Insurance:** Displays the name of the secondary insurance.
- **Status:** Displays the patient status. Selecting the column displays a list of patient statuses to choose from. A patient's status may also be selected in Patient Location Maintenance. Statuses may have colors assigned.
- **Stay Type:** Displays the patient stay type.
- **Triage Level:** (ED only) Displays the triage level selected in Patient Location Maintenance. Triage levels may have colors assigned.
- **Visit Number:** Displays the visit number.

3. Once the columns have been selected, select **Add**. The Tracking Board Columns screen displays the selected columns.



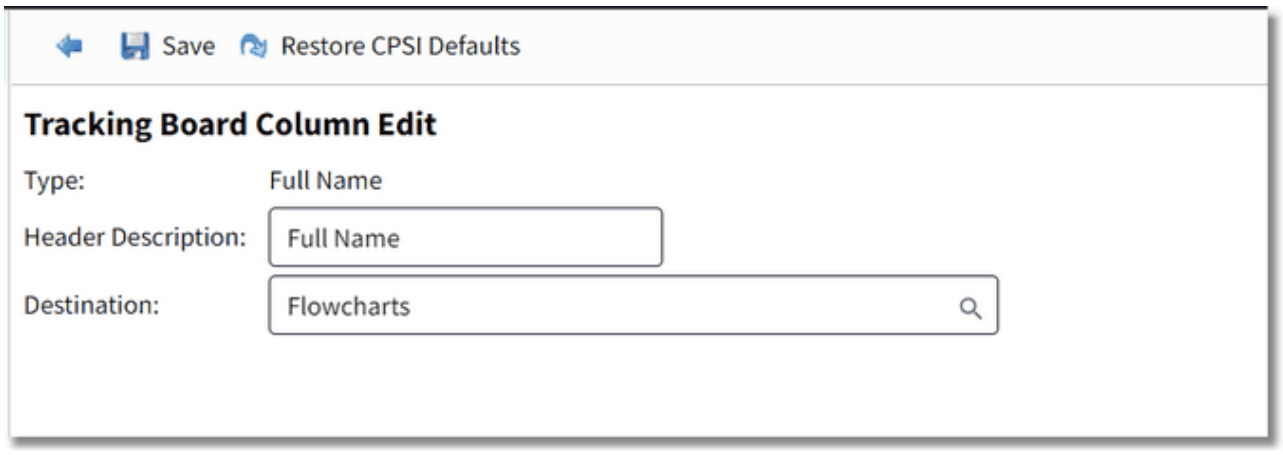
Tracking Board Columns

The following columns display on the Tracking Board Columns screen:

- **Sequence:** Designates the order in which the columns will display on the Tracking Board from left to right.
- **Description:** Displays the column header description.
- **Column Type:** Displays the column type.
- **Destination:** Displays the destination assigned to the column. When a destination is defined for a column, the system will launch to the specified application when the Tracking Board column cell is selected.
- **Colors:** If a color is assigned to a column, a **Y** appears in this column. Colors can only be assigned to the Code Status, Status and Triage Level columns. When a color is assigned, the column cell on the Tracking Board will be highlighted in that color when the value is selected.

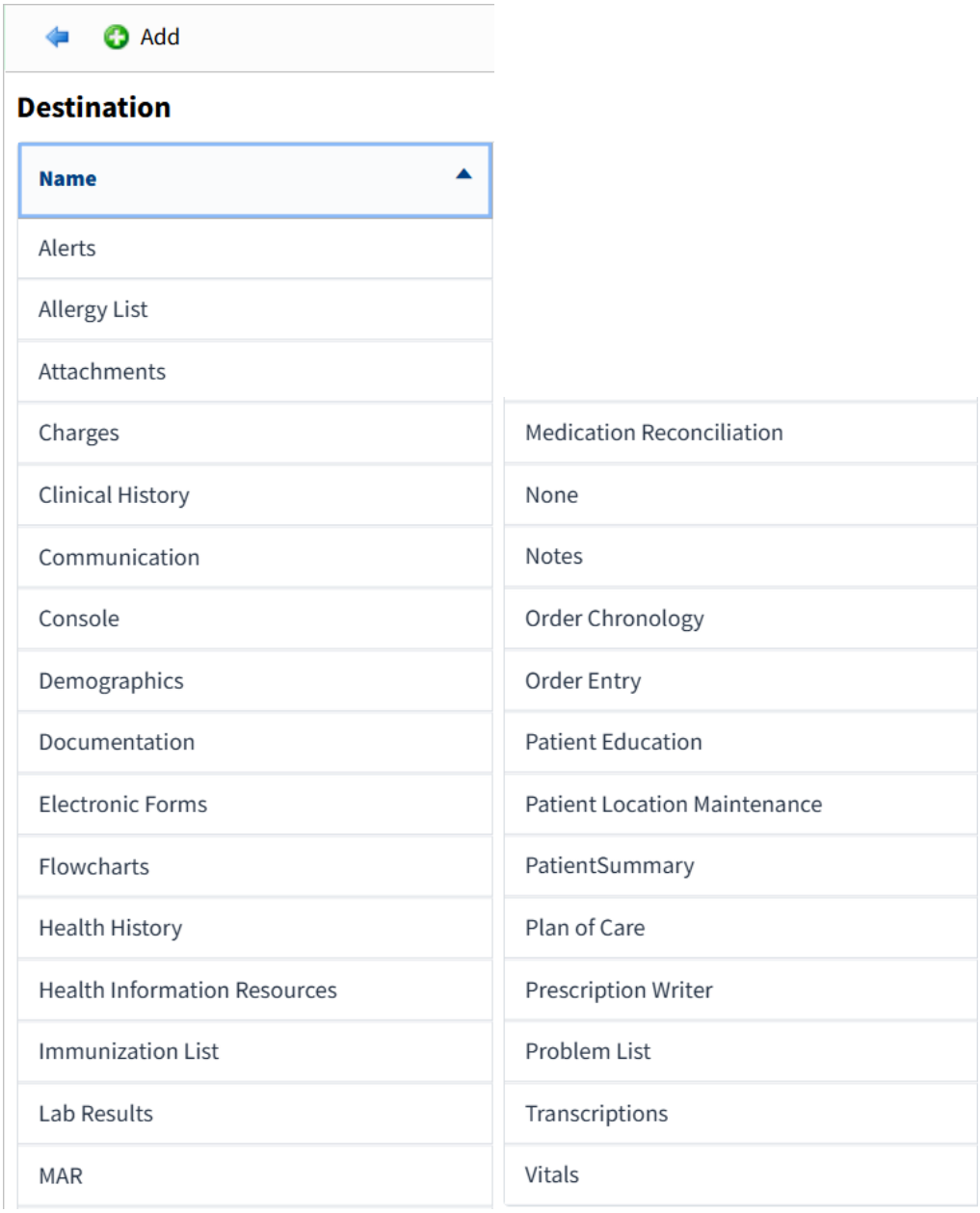
To Edit a Column

1. From the Tracking Board Columns screen, select (highlight) the desired column and select **Edit** (or double-click that column entry). The Tracking Board Column Edit screen displays.



Tracking Board Column Edit

2. In the **Header Description** field, make the desired changes. This is a free-text field that will allow up to 25 characters.
3. In the **Destination** field, select the Lookup icon and select the column destination. Then select **Add**.



Tracking Board Destinations

The following destinations have default columns but may be edited:

- **Alerts:** The destination default for the Alerts column.
- **Lab Results:** The destination default for the Full Name, First Name, and Last Name columns.
- **Order Chronology:** The destination default for the ED/Clinic Notifications column.
- **Patient Location Maintenance:** The destination default for the Chief Complaint, Priority Patient, Room #, and Room Description columns.

4. Select **Save**.

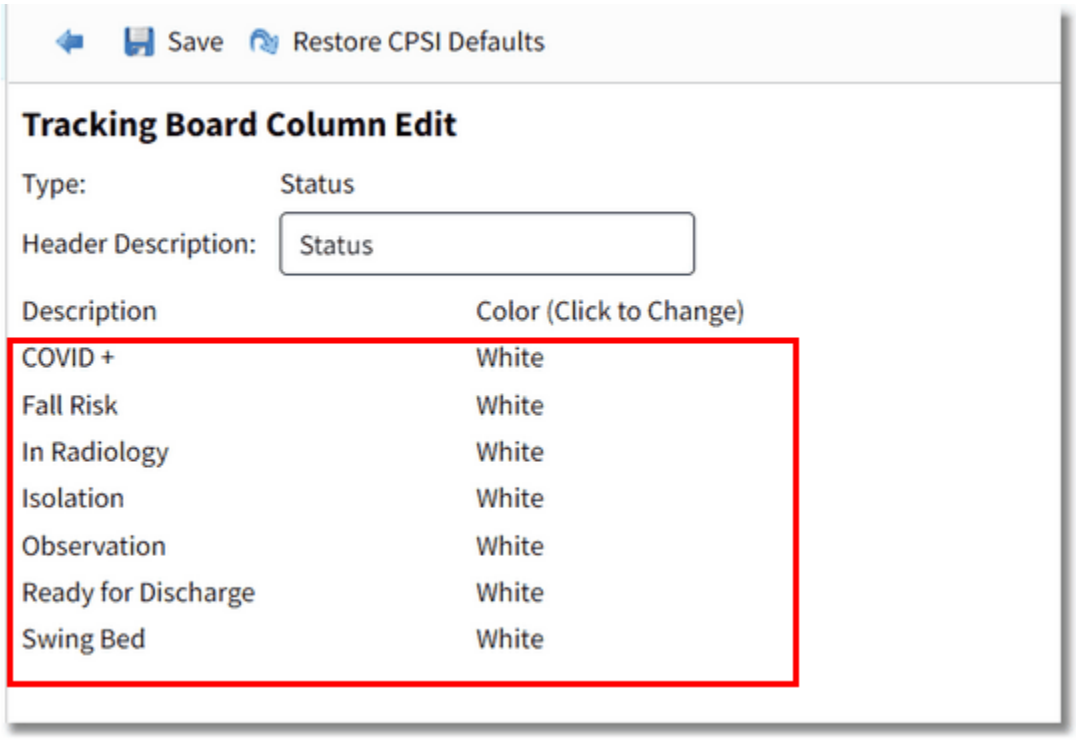
5. Select the blue back arrow to return to the Tracking Board Columns screen.

To Assign a Color to a Column Value

Only the Code Status, Triage Level and Status columns can have colors assigned to the column values.

1. From the Tracking Board Columns screen, select (highlight) the desired column and select **Edit** (or double-click on the appropriate column entry). The Tracking Board Column Edit screen displays.

2. The **Description** column displays the column values and the **Color** column displays the assigned colors. The default color is white. Select a description entry to assign a color.

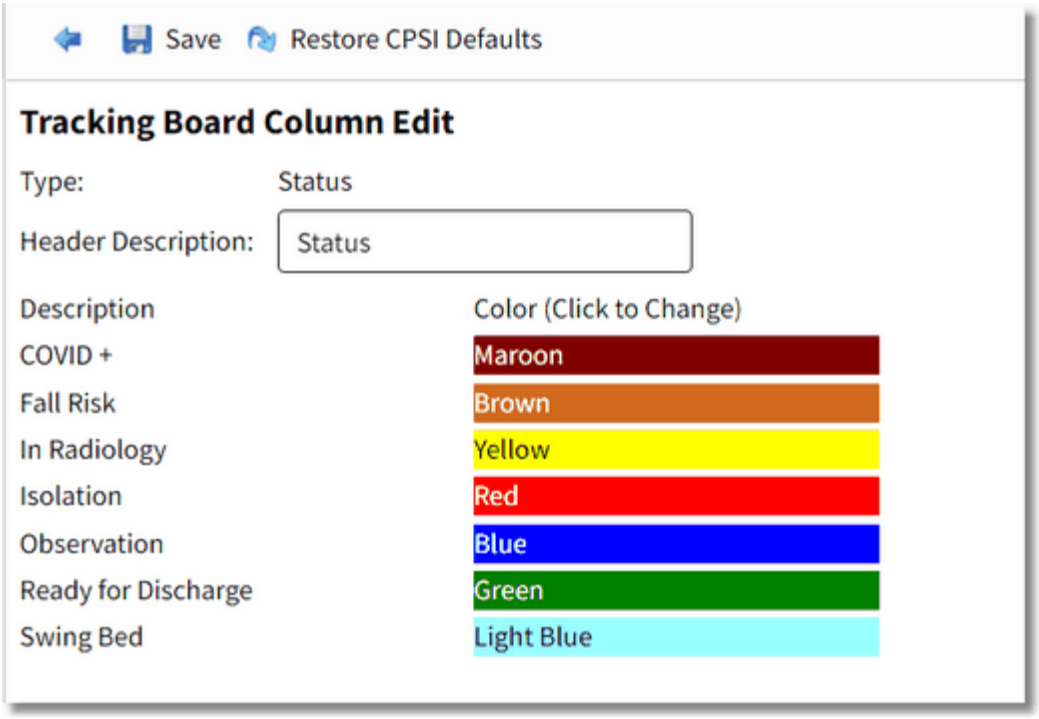


Tracking Board Column Edit

3. The Color Selection screen displays. Select (highlight) a color and click **Select**.

Color Selection

4. Repeat steps 2 and 3 until all colors have been assigned. Then select **Save**.



Tracking Board Column Edit - Column Value Colors

5. Select the blue back arrow to return to the Tracking Board Columns screen.

To Remove a Column

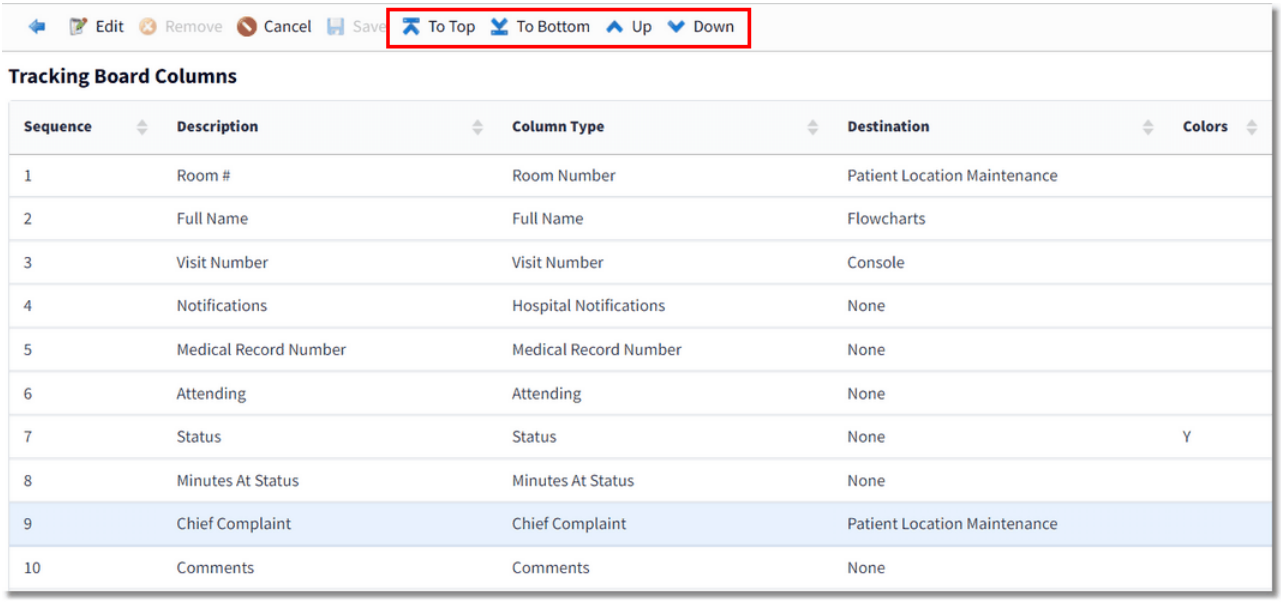
On the Tracking Board Columns screen, select (highlight) the column entry and select **Remove**.

To Change the Column Order

By default, the first column on all Tracking Boards is the **+** / **-** column, which allows users to manage their My Patient list. Then, the column selections display in the sequence order from left to right on the Tracking Board.

1. On the Tracking Board Columns screen, select **Change Order**.
2. Select (highlight) the column entry you want to move; then select the appropriate option on the action bar to move it to the desired position.

- **To Top:** Moves the column to the top of the list.
- **To Bottom:** Moves the column to the bottom of the list.
- **Up:** Moves the column up one sequence in the list.
- **Down:** Moves the column down one sequence in the list.



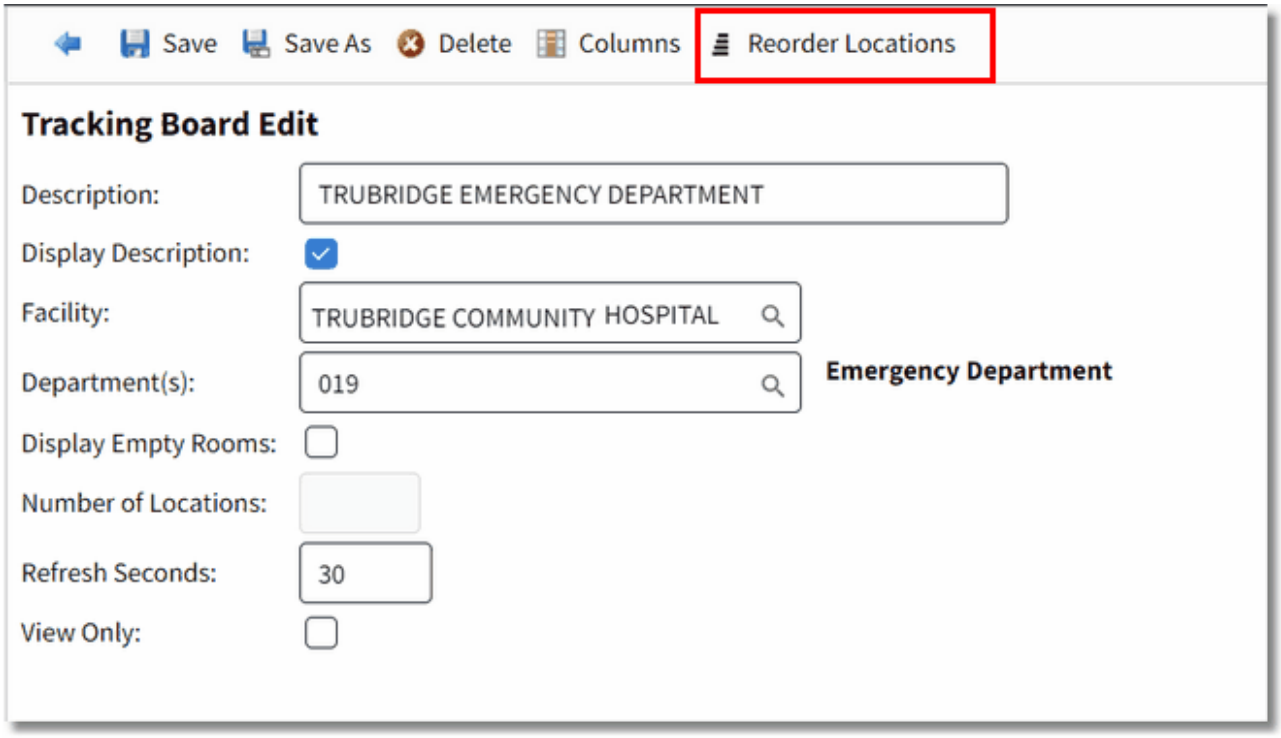
Sequence	Description	Column Type	Destination	Colors
1	Room #	Room Number	Patient Location Maintenance	
2	Full Name	Full Name	Flowcharts	
3	Visit Number	Visit Number	Console	
4	Notifications	Hospital Notifications	None	
5	Medical Record Number	Medical Record Number	None	
6	Attending	Attending	None	
7	Status	Status	None	Y
8	Minutes At Status	Minutes At Status	None	
9	Chief Complaint	Chief Complaint	Patient Location Maintenance	
10	Comments	Comments	None	

Tracking Board Columns - Change Order

3. Select **Save**.

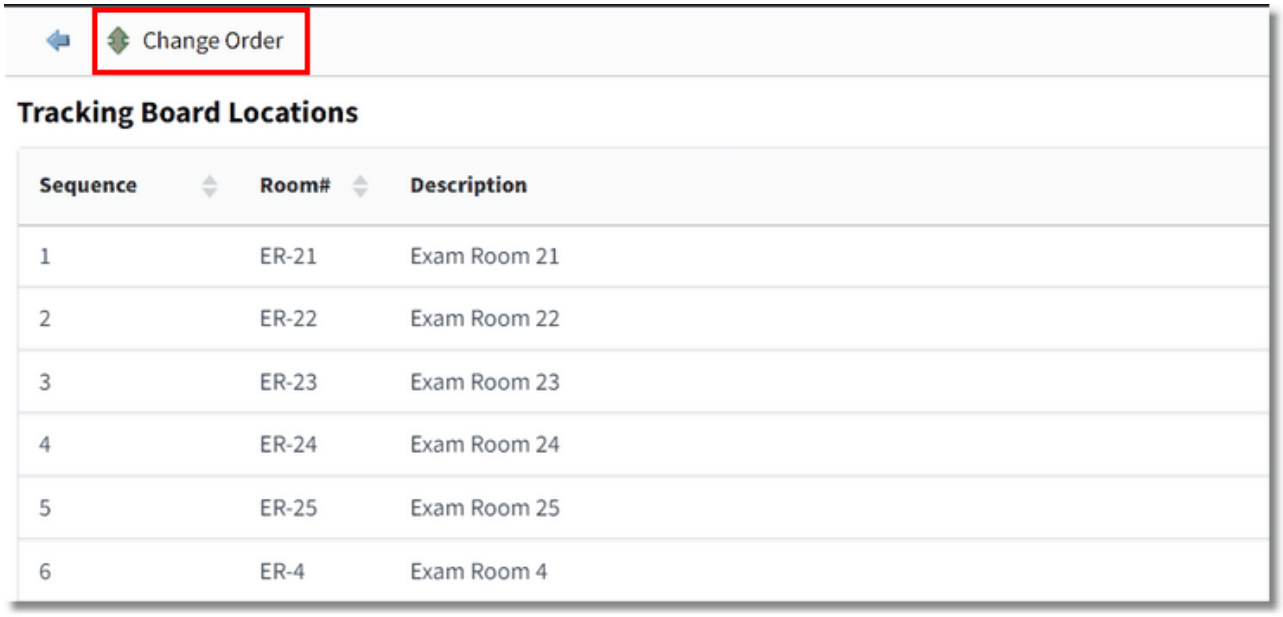
To Reorder Locations

1. On the Tracking Board Edit screen, select **Reorder Locations**.



Tracking Board Edit

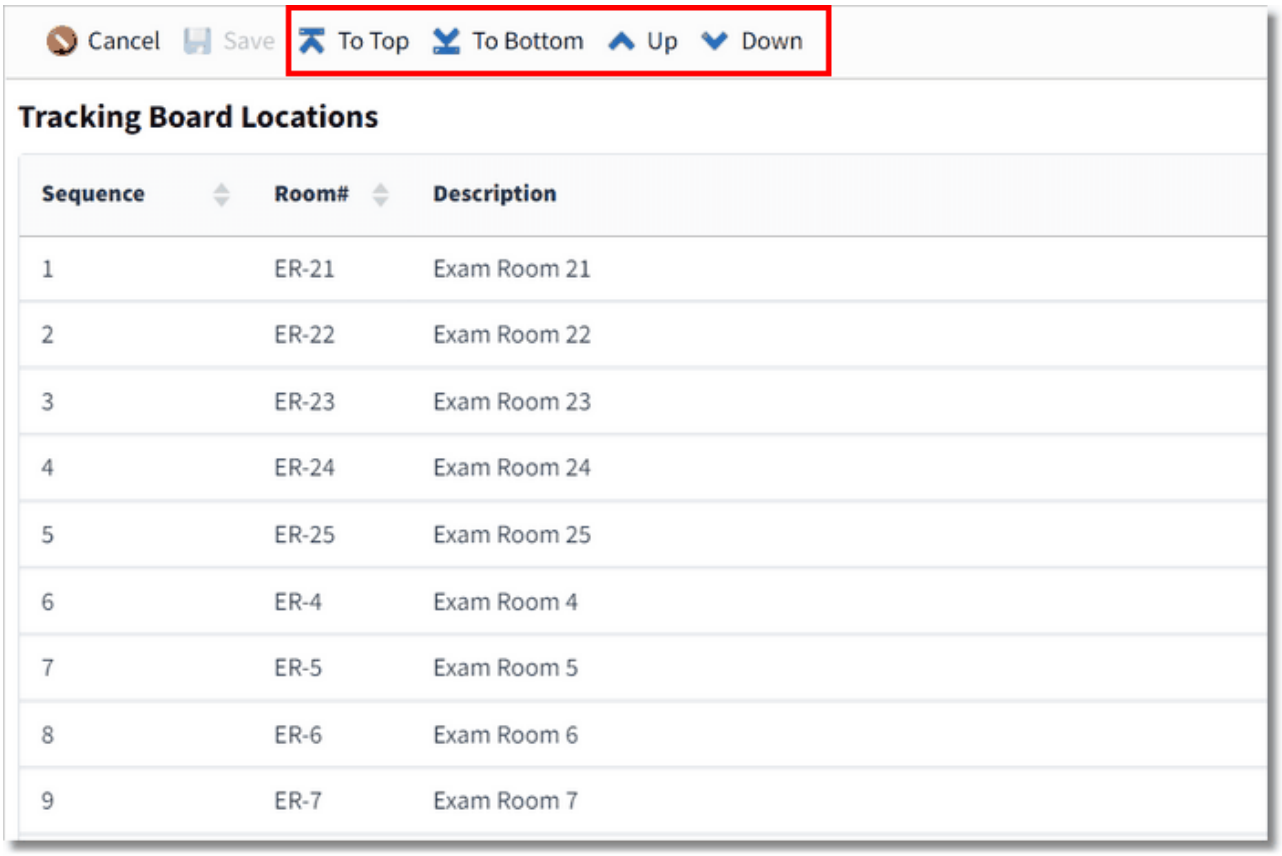
2. The Tracking Board Locations screen displays. To change the order in which rooms display on the Tracking Board, select **Change Order**.



Tracking Board Locations

3. Select (highlight) the room entry and select the appropriate option on the action bar to move the room entry to the desired position.

- **To Top:** Moves the room to the top of the list.
- **To Bottom:** Moves the room the bottom of the list.
- **Up:** Moves the room up one sequence in the list.
- **Down:** Moves the room down one sequence in the list.



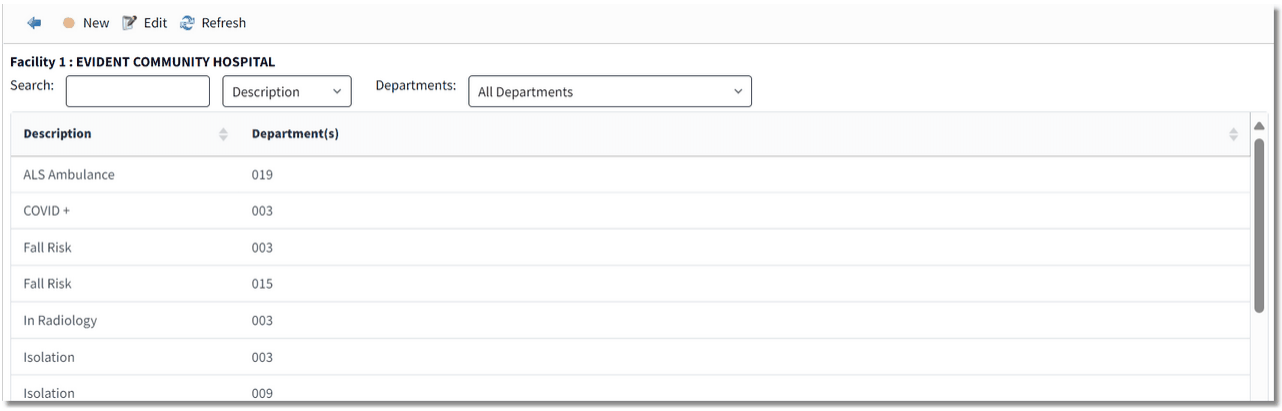
Tracking Board Locations

4. Select **Save**.

22.2 Patient Status

Patient statuses display in a drop-down list for selection when the Status cell is selected on a Tracking Board.

Select **Tables > Control > Patient Status**.



Patient Status List

A list of patient statuses for all departments display. By default, the list is sorted by **Description**. Select the drop-down in the **Departments** field to view the statuses of a specific department, or select the **Department(s)** column heading to sort the list by departments.

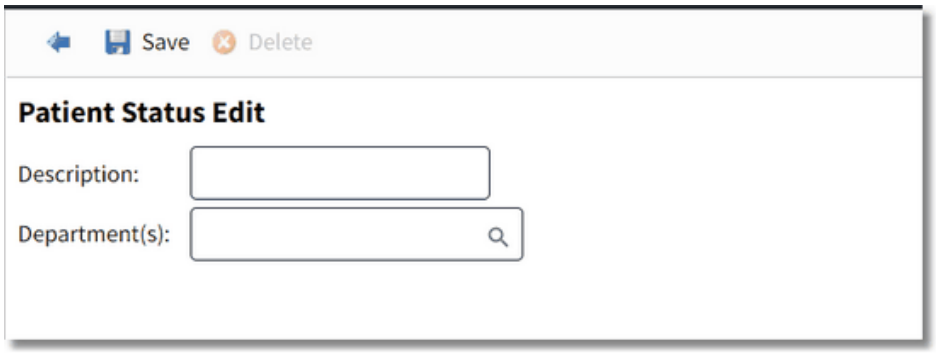
The following options are available from the action bar:

- **Blue Back Arrow:** Select to go to the previous screen.
- **New:** Select to create a new patient status.
- **Edit:** Select to edit an existing patient status.
- **Refresh:** Select to refresh the status list.

The following default statuses are displayed: **Lab**, **Nurse**, **Pending Discharge**, **Pending Results**, **Provider, Radiology**, **Ready for Nurse** and **Ready for Provider**.

To Create a New Patient Status

1. Select **New**. The Patient Status Edit screen displays.



Patient Status Edit

2. In the **Description** field, enter the status description.

3. In the **Department(s)** field, select the Lookup icon and select the department(s) that the status should be associated to. After selecting the appropriate department(s), select **Add**, then select **Update** to save the selections and return to the Patient Status Edit screen.

4. Select **Save** to save the new status.

To Edit a Patient Status

1. Select (highlight) the patient status from the list and select **Edit**.

Patient Status Edit

2. Make the desired edits to the status **Description** and/or **Department(s)**.

3. Select **Save**.

To Delete a Status

1. Select (highlight) the patient status from the list and select **Edit**.

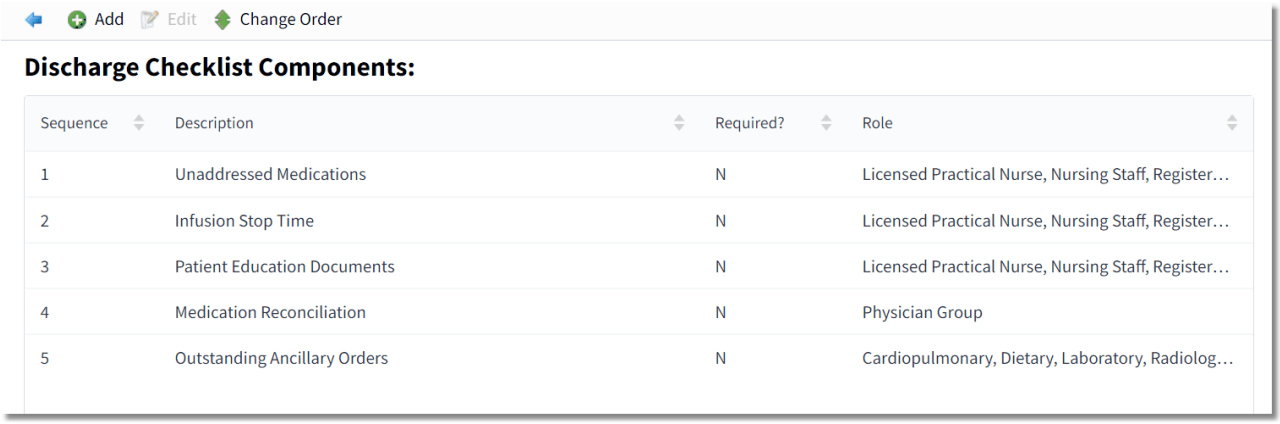
Patient Status Edit

2. Select **Delete**.

22.3 Discharge Checklist

The Discharge Checklist reviews specified fields in the chart for completion. Facilities may choose which discharge components are recommended or required for the Discharge Checklist during the discharge process. Patients which are checked into a department using the Discharge Checklist will automatically be marked as Incomplete.

Select **Tables > Control > Discharge Checklist > Select department > Edit**



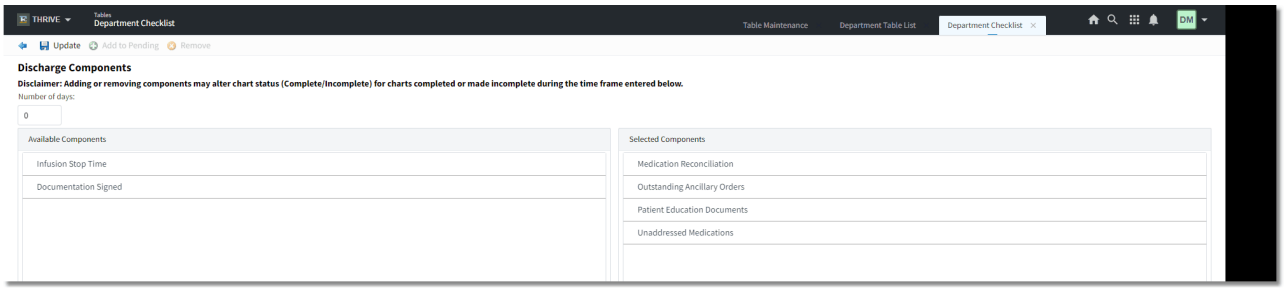
Discharge Checklist Components

Select **Edit** to display the Discharge Checklist Components screen.

The Discharge Checklist Components screen will display with the following columns:

- **Sequence:** Displays the order in which the discharge components will be displayed on the Discharge Checklist
- **Description:** Displays the discharge component description
- **Required?:** Displays Y (Yes) or N (No). A Required discharge component will prevent users from manually marking a patient's chart Complete until the discharge component is addressed.
- **Role:** Displays the selected user role(s) assigned to the discharge component

Select **Web Client** > **Tables** > **Control** > **Discharge Checklist** > **Select department** > **Edit** > **Add**



Discharge Components

Select **Add** to display the Discharge Components screen with available components listed on the left and selected components on the right. A disclaimer is displayed to alert users that when modifying Discharge Component selections, "Adding or removing components may alter chart status (Complete/Incomplete) for charts completed or made incomplete during the time frame entered below."

Number of Days: Default is zero days. Set the number of days up to 999 for the TruBridge EHR to look back to determine final chart status for affected patient visits. This field is "sticky" in order to display the last designation for Discharge Components.

- If no new Discharge Components were added to the Discharge Checklist, no change to any patient's chart status is necessary and all chart statuses will remain the same as before Number of Days was set.
- When a new component is added to the Discharge Checklist, the TruBridge EHR will first review previously discharged patients within the set time frame and determine if there are any charts that were completed during the time frame. Of the completed charts, the system will determine if the new Discharge Component has been satisfied for that patient visit. If it has been satisfied, then the chart will remain at a Complete status. If it is outstanding, the system will automatically reset the chart status back to Incomplete.
- Conversely, removing a component from the Discharge Checklist may result in the system automatically completing patients' charts if the removed component was the only outstanding component.

Select the desired discharge components to be validated. Either double-click the component in the Available Components list or highlight one or more components using either the **Ctrl** or **Shift** buttons on the keyboard and select **Add to Pending** in the Action Bar to move them to the Selected Components list. The discharge components are:

- **Documentation Signed (**Not currently used with the Notes application**)**
- **Infusion Stop Time**
- **Medication Reconciliation**
- **Outstanding Ancillary Orders**
- **Patient Education Documents**
- **Unaddressed Medications**

To remove a discharge component from the Selected Components list, either double-click the component or highlight one or more components using either the **Ctrl** or **Shift** buttons on the keyboard and select **Remove o**n the Action Bar to move them back to the Available Components list.

Select **Update** to save changes.

NOTE: *Selecting the Back Arrow without updating will give the prompt, "Are you sure you wish to exit without saving?" Answering* ***Yes*** *will return users back to the Discharge Checklist Components screen without saving any changes. Answering* ***No*** *will return users to the Discharge Components screen.*

Select the  **Back Arrow** to return to the Discharge Checklist Components screen.

To remove a discharge component, select the desired discharge component then select **Remove**. The discharge component will no longer be displayed in the Discharge Checklist.

Discharge components may be set to be required and roles may be assigned on an individual basis. Assigning roles to discharge components will allow users to filter the Discharge Checklist to display only those discharge components that apply to the user's role. If there are no roles assigned, all discharge components will display as normal for all users. Please see the Tracking Board User Guide for information regarding the My List check box to take advantage of this functionality.

1. Select the desired discharge component then select **Edit** or double-click it to access the Discharge Department Checklist Edit screen.

2. Select the **Required check box** to prevent users from marking a patient's chart Complete until the discharge component is addressed.

3. Select **Add Role** to display the Roles selection screen.

4. Select the desired role then select **OK** or double-click it to assign it to the selected discharge component. The assigned roles will display in the Role column with their accompanying code.

   NOTE: *Selecting the* ***Back Arrow*** *will return to the Discharge Department Checklist Edit screen without assigning a role.*

5. Select **Save** to save the changes.

6. To remove a role assignment, select the role to be removed and select **Remove Role**. The selected role will no longer display on the Assigned Roles list.

7. Select the **Back Arrow** to return to the Department Checklist Components screen.

NOTE: *Selecting the Back Arrow without saving will display the prompt, "Are you sure you wish to exit without saving?" Answering* ***Yes*** *will return users to the Discharge Checklist Components screen without saving any changes. Answering* ***No*** *will return users to the Discharge Department Checklist Edit screen.*

NOTE: *Removing a discharge component from the Discharge Checklist will also remove any roles assigned. If the discharge component is added back to the Discharge Checklist at a later time, all applicable roles will need to be reassigned.*

The sequence of the discharge components may be rearranged by selecting **Change Order**.

The following options are available:
- **Cancel**: Aborts the Change Order process without saving
- **Save**: Saves the selected column order
- **To Top**: Moves the selected discharge component to the top of the listing
- **To Bottom**: Moves the selected discharge component to the bottom of the listing
- **Up**: Moves the selected discharge component up one sequence on the listing
- **Down**: Moves the selected discharge component down one sequence on the listing
- **Back Arrow:** Will return the user to the Department List screen.

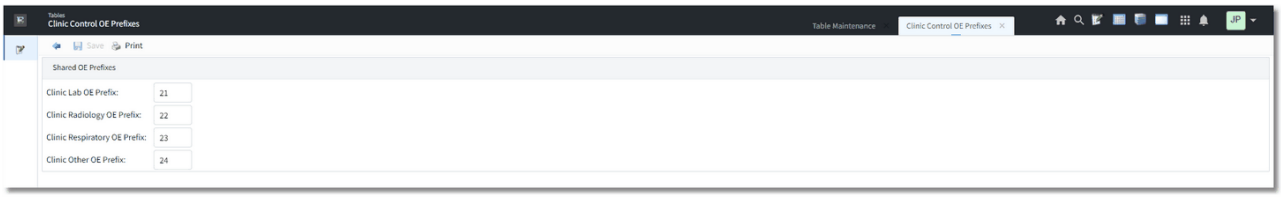
Chapter 23 Clinic Control Information

The Clinic Control Information tables allow clinics to define Order Entry Prefixes and set specific controls for lab and medication.

23.1 Shared OE Prefix

Order Entry Prefixes allow multiple departments to be set up for Order Entry. The four Clinic order entry departments must have an Order Entry Prefix created different from the hospital OE Prefixes. These are defined in the Shared OE Prefixes by entering the Order Entry Prefix in the specified field.

Select **Web Client** > **Tables** > **Control** > **Shared OE Prefix**



Shared OE Prefixes

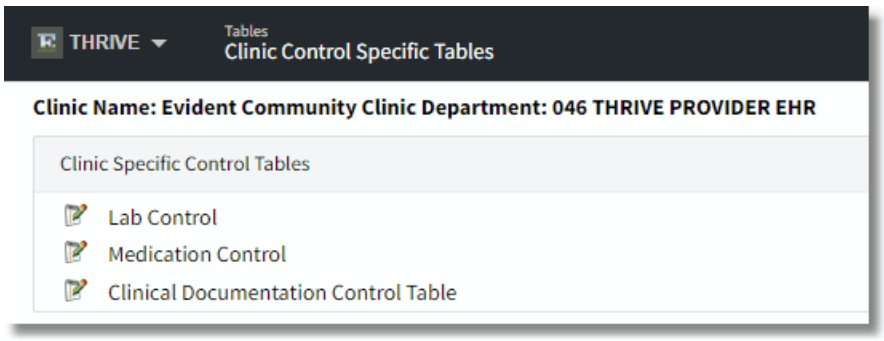
NOTE: *An Order Entry Prefix that is associated with a Clinic Order Entry department in Shared OE Prefixes may not be entered in the Order Entry Department prefix table on page 3 of AHIS.*

- **Clinic Lab OE Prefix**: Designates the order entry prefix for the clinic lab orders. This is a 2-digit field.
- **Clinic Radiology OE Prefix**: Designates the order entry prefix for the radiology lab orders. This is a 2-digit field.
- **Clinic Respiratory OE Prefix**: Designates the order entry prefix for the clinic respiratory orders. This is a 2-digit field.
- **Clinic Other OE Prefix**: Designates the order entry prefix for the clinic other orders. This is a 2-digit field.

23.2 Clinic Specific Control Tables

The Clinic Specific Control Tables are used to to set controls for individual clinics within the TruBridge EHR. If there is more than one clinic department available within the selected facility, the system will require the department to be selected.

Select **Web Client** > **Tables** > **Control** > **Clinic Specific Control Tables** > **Select Department**



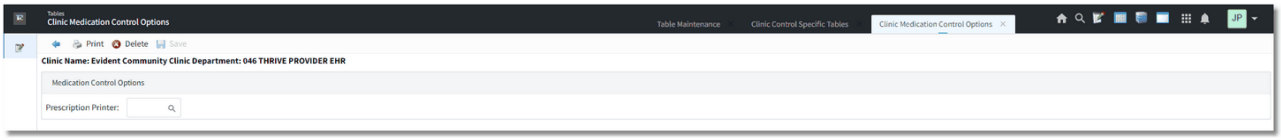
Clinic Specific Control Tables

Lab Control

NOTE: *These fields are for future development.*

Medication Control

Select **Web Client** > **Tables** > **Control** > **Clinic Specific Control Tables** > **Select Department**



Medication Control Options

Prescription Printer: This field creates a default printer for the TP EHR clinic department when prescriptions are printed from Prescription Entry in the clinic department. If the default printer number is changed during prescription entry, the new printer number will be sticky for that user until changed again.

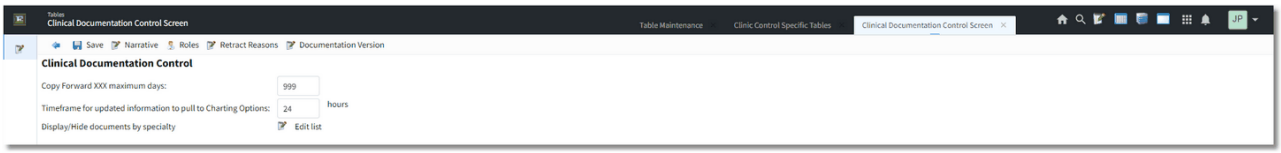
Clinical Documentation Control Table

The Clinical Documentation Control Table is used to set different controls available for TruBridge Provider EHR Documentation within the TruBridge EHR.

The action bar options are as follows:

- **Save:** Allows any changes made to the Clinical Documentation Control to be saved.
- **Roles:** TruBridge Use Only within this table. Please see Roles for additional setup.
- **Retract Reasons:** TruBridge Use Only within this table. Please see Retract Reasons for additional information.

Select **Web Client** > **Tables** > **Control** > **Clinic Specific Control Tables** > **Select Department**



Clinical Documentation Control Table

- **Copy Forward XXX maximum days:** Sets the number of days that the TruBridge EHR looks back to pull documentation from visit to visit. This field will hold up to three characters with a default of 365 days and a maximum of 999 days. This setting will apply to TruBridge Provider EHR software.
- **Timeframe for updated information to pull to Charting Options:** Sets the number of hours the TruBridge EHR will look back to pull data to the right side of the Charting Options screen within the Documentation application. The time should be in hours, with a max of three characters. The starting point of time will be the patient's admit date and time. If this field is left blank, then charting options will look at the setting in the Clinical Documentation Control Table. Please see Documentation Setup for additional setup information.
- **Timeframe for late entry documentation:** Allows for documentation to be tagged as late entry based on a value placed in this field when Change Date/Time is used in documentation. "Late Entry: (actual date/time)" is added to the existing user/date/time stamp on the narrative. Up to three digits may be entered and will read in hours. If this field is left blank, the feature is turned "off."
- **Display/Hide documents per specialty:** TruBridge use only.
- **Requires Signature:** TruBridge Use Only within this table. Please see Documentation Setup for additional information.

Chapter 24 Navigation

24.1 Embedded Version

The Embedded Version table determines how users will view embedded screens in TruBridge software future development.

Select **New** to add a new Logname to the list, or choose and existing Logname and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Embedded Version** > **Select Logname**

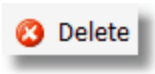
User Embedded Version Edit

The following options will be displayed:

- **Logname:** This is the logname assigned to the user.
- **Version:** Select **1** or **2** for this user.

Select 

Save to keep any changes.

Select 

Delete to remove the Logname from the Embedded Version list.

Select  **Back Arrow** to return to the previous screen.

24.2 Navigation Customization

The order that applications are displayed on the Patient Chart screens may be customized through Navigation Customization.

Enter the **Logname** of the user or select the  **magnifying glass** to display a list of logins. Once a login is selected, select a Patient Chart screen to customize.

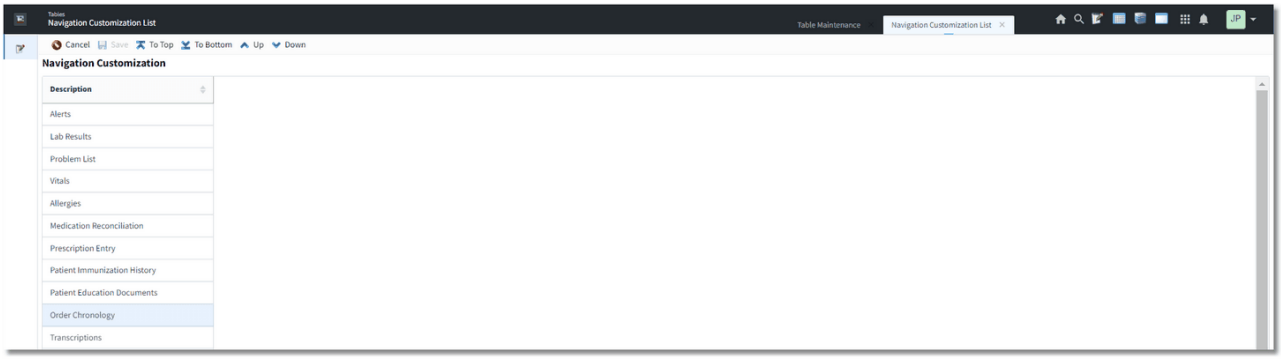
Clinic Patient Chart

Once the **Clinic Patient Chart** is selected, the available applications are listed for customization.

Select **Change Order** to customize the order of the applications. Or select the  **Back Arrow** to return to the previous screen.

NOTE: *If there are active alerts on a patient chart, the Alerts application will be the default application when selecting a patient from the search options available in Charts. If there are no active alerts on the patient chart, the first application selected on the Navigation Customization will be the default application for the user when selecting a patient.*

Select **Web Client** > **Tables** > **Control** > **Navigation Customization** > **Select Patient Chart Screen** > **Change Order**



Change Order - Navigation Customization

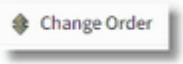
Select the application from the list, then use the options available on the action bar to change the order in which it is displayed:

- **To Top**: This will move the application to the top of the list.
- **To Bottom**: This will move the application to the bottom of the list.
- **Up**: This will move the application up in the list.
- **Down**: This will move the application down in the list.

Once all applications are displayed in the desired order, select **Save** to keep any changes or select **Cancel** to exit to the previous screen without saving any information.

NOTE: *If the Notes application is set to deny for a user, and the user login is customized, the Notes application will not display in the navigation panel.*

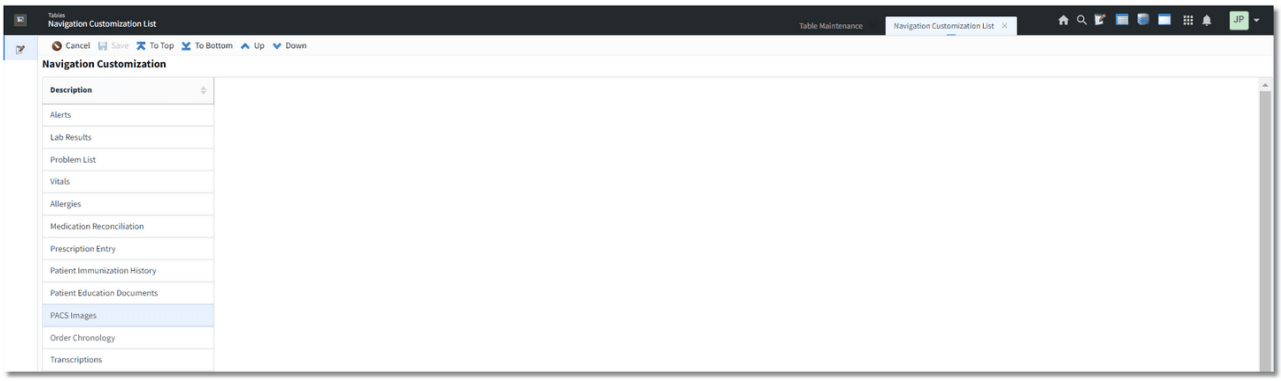
Hospital Patient Chart

Once the **Hospital Patient Chart** is selected, the Navigation Customization screen displays. The Navigation Customization screen displays all of the available applications. Select 

Change Order to rank the applications as needed or select the  **Back Arrow** to return to the previous screen.

***NOTE**: If there are active alerts on a patient chart, the Alerts application will be the default application when selecting a patient from the search options available in Charts. If there are no active alerts on the patient chart, the first application selected on the Navigation Customization will be the default application for the user when selecting a patient.*

Select **Web Client** > **Tables** > **Control** > **Navigation Customization** > **Hospital Patient Chart** > **Change Order**



Change Order - Navigation Customization List

Select the application from the list, then use the options available on the action bar to change the order in which it is displayed:

- **To Top**: This will move the application to the top of the list.
- **To Bottom**: This will move the application to the bottom of the list.
- **Up**: This will move the application up in the list.
- **Down**: This will move the application down in the list.

Once all applications are displayed in the desired order, select **Save** to keep any changes or select **Cancel** to exit to the previous screen without saving any information.

***NOTE:** If the Notes application is set to deny for a user, and the user login is customized, the Notes application will not display in the navigation panel.*

24.3 Navigation Mode

The Navigation Mode table determines if a user will have Breadcrumb navigation turned on or off.

***NOTE:** Breadcrumb navigation is required only for facilities that have not purchased TruBridge UX.*

Select **New** to add a new Logname to the list or choose and existing Logname and select **Edit**.

Select **Web Client** > **Tables** > **Control** > **Navigation Mode** > **Select Logname**

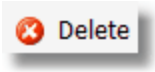
Navigation Mode Maintenance

The following options will be displayed:

- **Logname:** This is the logname assigned to the user.
- **Use Breadcrumbs:** Select this option to turn on Breadcrumb navigation for this user.

Select 

Save to keep any changes.

Select 

to remove the Logname from the Navigation Mode list.

Select  **Back Arrow** to return to the previous screen.

Chapter 25 ED Control Information

The ED Control Information section includes the General Control table(s) and the Resulting Items table for designated Emergency Departments.

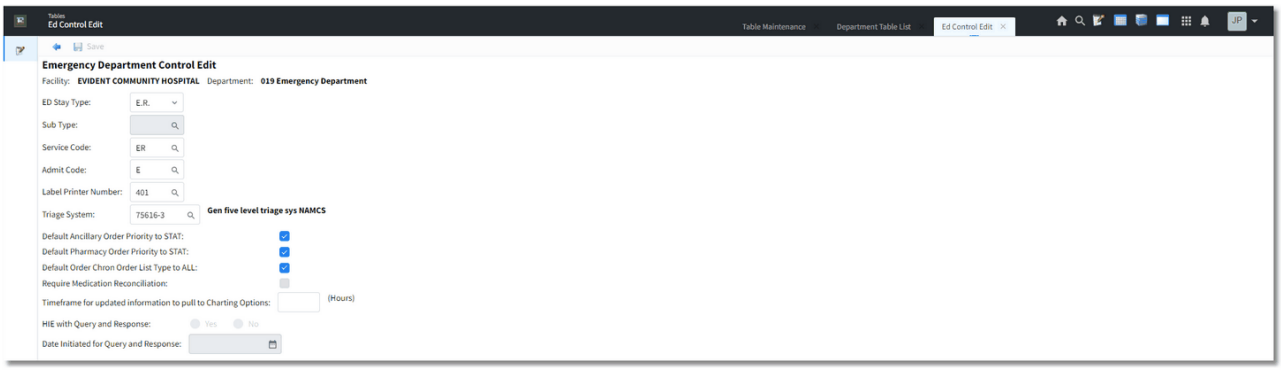
25.1 General Control

Each department that is designated as an Emergency Department on page two of the Department table will have its own General Control table and the settings will only apply to their respective department.

Select the Emergency Department from the Department List and select 

Edit. For hospitals that have more than one emergency department, each department may be set up independently from any others. There is a smart search field available to assist in delimiting the list. The emergency departments may be searched by number (which is the default) or description.

Select **Web Client** > **Tables** > **Control** > **General Control** > **Emergency Department** > **Edit**



Emergency Department Control Edit

The following settings are available:

- **ED Stay Type**: Information loaded in this field establishes the department's default stay type.
- **Sub Type**: Information in this field establishes the department's default sub type. This field will only be available if the ED Stay Type is set to I/P (inpatient).
- **Service Code**: Information in this field establishes the department's default service code.
- **Admit Code**: This field does not currently have any functionality as the admit code does not appear on the new visit screen. Functionality for this field will be coming soon.
- **Label Printer Number**: Information in this field establishes the printer to which lab labels will print if the department has been set to print its own lab labels on Page 1 of the Department table. A

change to this field will automatically update the Label Printer field on Page 1 of the Department table (and vice versa).

- **Triage System**: Information in this field establishes the default triage system the ED will use. The Table contains the following triage systems with their accompanying concept codes:
  - Emerg Sev index ESI: 75636-1
  - Four Level triage system NAMCS: 75615-5
  - Gen five level triage sys NAMCS: 75616-3
  - Three level triage system NAMCS: 75614-8
  - Triage CTAS: 75910-0

- **Default Ancillary Order Priority to STAT**: This field defaults to checked. If checked, ancillary orders will default to Stat.

- **Default Pharmacy Order Priority to STAT**: This field defaults to checked. if checked, pharmacy orders will default to Stat.

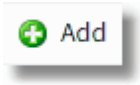
- **Default Order Chron List Type to ALL**: This field defaults to checked. If checked, patients' Order Chronology lists will default to the All radio button.

- **Require Medication Reconciliation**: This field defaults to checked. If checked, a discharge reconciliation will be required for patients before Prescription Writer may be accessed.

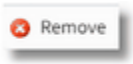
- **Timeframe for updated information to pull to Charting Options:** Sets the number of hours the software will look back to pull data to the right side of the Charting Options screen within the Documentation application. The time should be in hours, with a max of 3 characters. The starting point of time will be the patient's admit date and time. If the field is left blank, then charting options will look at the setting in the Clinical Documentation Control Table. Please see Documentation Setup for additional setup information.

25.2 Resulting Items

The Resulting Items table designates which lab items may be resulted in the Emergency Department.

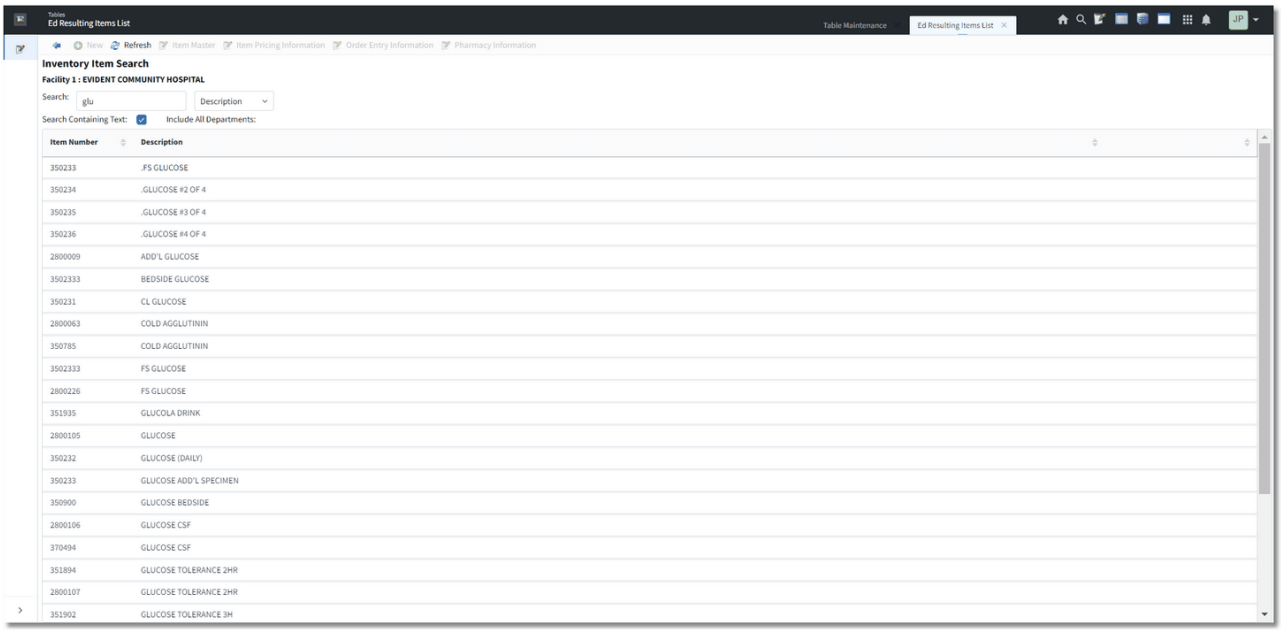
Select 

Add from the Resulting Items List to launch the Laboratory's Item Master Table List screen to initiate an item search.

To remove an item from Ed Resulting Items List, select the item and then select 

Remove in the Action Bar.

Select **Web Client** > **Tables** > **Control** > **Resulting Items** > **Add**



Lab Item Master Table List Screen

A Search field is available for initiating a smart search from the Laboratory's item master. The Search drop-down menu allows a search by Description or Item Number. Any item that meets the search criteria and has the laboratory department as an issuing department will be listed along with item number and description.

The Search Containing Text check box defaults to checked (Yes) and allows all items that have the specified text included in their descriptions to be listed. When Search Containing Text is unchecked (No), only items whose descriptions begin with the specified text will be listed.

Double-clicking the desired item will return the user to the Resulting Items List with the item displayed in the list.

Select the  **Back Arrow** to exit the Resulting Items List and return to the Control page.