

**TIU/ASU**

**Implementation Guide**

August 1999

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Product Development

Office of Information Technology

Department of Veterans Affairs

## Revision History

|  |  |  |
| --- | --- | --- |
| **Date** | **Page** | **Change** |
| March 2017 | Pg. [121](#tiu_308_a) | With Patch TIU\*1\*308, changed potential PII. |
| June 2013 | Pg. 89 | Added a note about the importance of testing Objects. |
| February 2013 | Pg. 10 | Added note about basic parameters that are set in the menu for divisional parameters, and permit entries for multiple divisions, but when implemented they respect only parameters set for the division of the person who schedules the TIU Nightly Task |
| January 2013 | Pg. 42-45 | Corrected Operative Reports to Operation Reports. |
| June 2008 | Pg. [17](#User_Classes) | Patch TIU\*1\*219—Discharge Summary Attending Requirements |
| December 2007 | Pg. 142, 154 | Patch TIU\*1\*234— Expected Cosigner Edit and Disallow Signed Document Edit |
| June 2007 | Pp. 155-159 | Patch USR\*1\*31—Business rule changes |
| Sept 2003 | Pp. 154, 194-197 | Patch 165—Patient Record Flags |
| August 2003 | Pp. 151, 155 | Patch 137—Anatomic Pathology |
| July 2002 | Pages 23, 29, 45, & 51 | Patch 131—Uploading Consults: Improve Reliability |
| June 2002 | Appendix C | Patch 109—Clinical Procedures |
| January 2002 | Parameter Setup Examples | Patch 129—Upload Op Reports to Surgery: Improve Reliability |
| October 2001 | Parameter Setup Examples | Patch 128—Upload Parameters |
| 4/16/01 | Appendix A & B | Explanation of Class Membership expiration.Interdisciplinary Notes Setup. |
| 8/12/99 |  | Added description of using Document Templates through CPRS |
| 8/12/99 |  | Updated Released Patches appendix |
| 6/24/99 |  | Updated Released Patches appendix |

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#  TIU/ASU Implementation Overview

This is a revised version of the Text Integration Utilities (TIU) Implementation Guide, updated to include changes resulting from patches, as well as helpful hints from those who have assisted in setting TIU and ASU up.

**What's in this Manual?**

Instructions and examples for setting up:

1. Document Parameters
2. Document Definitions
3. Boilerplate text and Objects
4. Upload capabilities
5. User Classes
6. Business Rules
7. Links to the Computerized Patient Record System (CPRS)
8. Patient Record Flags

Intranet Documentation

Documentation for this product is available on VA Software Document Library at the following address:

<http://www.va.gov/vdl/>tiu

# TIU Parameters

## Introduction

Options on the TIU IRM Maintenance Menu let IRMS Staff set and modify the various parameters controlling the behavior of the Text Integration Utilities Package, as well as the definition of TIU documents. TIU is exported with default settings for many of the parameters, which may be sufficient for your site to get started. Review the parameter settings to see if they meet your site’s needs.

This menu also contains sub-menus and options for managing the Document Definition hierarchy and for managing User Classes and Business Rules.

These options are described in the following sections.

#### TIU Maintenance Menu {TIU IRM MAINTENANCE MENU}

TIU Maintenance Menu

 1 TIU Parameters Menu ... [TIU SET-UP MENU]

 2 Document Definitions (Manager) ...[TIUF DOCUMENT DEFINITION MGR]

 3 User Class Management ... [USR CLASS MANAGEMENT MENU]

 4 TIU Template Mgmt Functions ... [TIU IRM TEMPLATE MGMT]

 5 TIU Alert Tools [TIU ALERT TOOLS]

 7 TIUHL7 Message Manager [TIUHL7 MSG MGR]

 Title Mapping Utilities ... [TIU MAP TITLES MENU]

 6 Active Title Cleanup Report [TIU ACTIVE TITLE CLEANUP]

1 TIU Parameters Menu...[TIU SET-UP MENU]

 1 Basic TIU Parameters [TIU BASIC PARAMETER EDIT]

 2 Modify Upload Parameters [TIU UPLOAD PARAMETER EDIT]

 3 Document Parameter Edit [TIU DOCUMENT PARAMETER EDIT]

 4 Progress Notes Batch Print Locations [TIU PRINT PN LOC PARAMS]

 5 Division - Progress Notes Print Params [TIU PRINT PN DIV PARAMS]

2 Document Definitions (Manager)...[TIUF DOCUMENT DEFINITION MGR]

 1 Edit Document Definitions [TIUFH EDIT DDEFS MGR]

 2 Sort Document Definitions [TIUFA SORT DDEFS MGR]

 3 Create Document Definitions [TIUFC CREATE DDEFS MGR]

 4 Create Objects [TIUFJ CREATE OBJECTS MGR]

 5 Create TIU/Health Summary Objects [TIUHS LIST MANAGER]

3 User Class Management ...[USR CLASS MANAGEMENT MENU]

 1 User Class Definition [USR CLASS DEFINITION]

 2 List Membership by User [USR LIST MEMBERSHIP BY USER]

 3 List Membership by Class [USR LIST MEMBERSHIP BY CLASS]

 5 Manage Business Rules [USR MANAGE BUSINESS RULES]

4 TIU Template Mgmt Functions <TEST ACCOUNT> Option: ??

 1 Delete TIU templates for selected user. [TIU TEMPLATE CAC USER DELETE]

 2 Edit auto template cleanup parameter. [TIU TEMPLATE USER DELETE PARAM]

 3 Delete templates for ALL terminated users. [TIU TEMPLATE DELETE TERM ALL]

## TIU Parameters Menu [TIU SET-UP MENU]

This menu contains options for setting up the basic parameters and upload parameters.

|  |  |  |
| --- | --- | --- |
| **Option** | **Option Name** | **Description** |
| Basic TIU Parameters | TIU BASIC PARAMETER EDIT | This option allows you to enter the basic or general parameters, which govern the behavior of the Text Integration Utilities. |
| Modify Upload Parameters | TIU UPLOAD PARAMETER EDIT | This option allows the definition and modification of parameters for the batch upload of documents into **V***IST***A**. |
| Document Parameter Edit | TIU DOCUMENT PARAMETER EDIT | This option lets you enter the parameters, which apply, to specific documents (i.e., Titles), or groups of documents (i.e., Classes, or Document Classes). |
| Division - Progress Notes Print Parameters | TIU PRINT PN DIV PARAM | These parameters are used by the [TIU PRINT PN BATCH INTERACTIVE] and [TIU PRINT PN BATCH SCHEDULED] options. If the site desires a footer other than what is returned by $$SITE^ VASITE the .02 field of the 1st entry in this file will be used. For example, Waco-Temple-Marlin can have the institution of their progress notes as “CENTRAL TEXAS HCF.” |
| Progress Notes Batch Print Locations | TIU PRINT PN LOC PARAMS | Option for entering hospital locations used for [TIU PRINT PN OUTPT LOC] and [TIU PRINT PN WARD] options. If locations are not entered in this file they will not be selectable from these options. |

Examples of these options are shown in the following pages.

### Parameter Setup Examples

Options: Basic TIU Parameters, Modify Upload Parameters, and Document Parameter Edit

These three options are demonstrated here with examples of Discharge Summary implementation and Progress Notes implementation. An example for other types of clinical documents follows.

### Discharge Summary Parameter Set-Up

1. If Discharge Summary version 1.0 is already implemented at your site, use VA FileMan to Print a “Captioned” listing of the existing GMRD SITE PARAMETERS (#128.99) and GMR REPORT TYPE (#128.1) file entries as follows:

> **D P^DII**

VA FileMan 21.0

Select OPTION: PRINT FILE ENTRIES

OUTPUT FROM WHAT FILE: **128.99** GMRD SITE PARAMETERS (2 entries)

SORT BY: NUMBER// **<Enter>**

START WITH NUMBER: FIRST// **<Enter>**

FIRST PRINT FIELD: **[CAP**TIONED

Include COMPUTED fields: (N/Y/R/B): NO// **<Enter>** - No record number (IEN), no Computed Fields

 \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Heading (S/C): GMRD SITE PARAMETERS LIST Replace **<Enter>**

DEVICE: **<device name>** ANYWHERE RIGHT MARGIN: 80// **<Enter>**

GMRD SITE PARAMETERS LIST JAN 22,1997 13:53 PAGE 1

---------------------------------------------------------------------------

DIVISION: SALT LAKE DOM ENABLE ELECTRONIC SIGNATURE: YES

 CHARACTERS PER LINE: 60 GRACE PERIOD FOR PURGE: 365

 GRACE PERIOD FOR SIGNATURE: 5 CHART COPY PRINTER: LTA35

 ASCII UPLOAD SOURCE: remote computer RECORD HEADER SIGNAL: $HDR

 BEGIN REPORT TEXT SIGNAL: $TXT UPLOAD HEADER FORMAT: captioned

 UPLOAD PROTOCOL: KERMIT STAT CHART COPY PRINTER: LASERJET 4SI

 REQUIRE AUTHOR TO SIGN: YES

 STAT SUMMARIES PRINTED: released and verified

 ROUTINE SUMMARIES PRINTED: released and verified

 ENABLE CHART COPY PROMPT: YES ENABLE IRT INTERFACE: YES

 REQUIRE MAS REVIEW: YES REQUIRE TRANSCRIPTION RELEASE: YES

 AMENDMENT SIGNATURE BLOCK: TIUPO,ONE Privacy Act Officer

 BLANK CHARACTER STRING: --- ENABLE NOTIFICATIONS DATE: NOV 21, 1994

ALERT RECIPIENT: TIUCOORDINATOR, ONE

ALERT RECIPIENT: TIUCOORDINATOR, TWO

ALERT RECIPIENT: TIUCOORDINATOR,THREE

ALERT RECIPIENT: TIUCOORDINATOR, FOUR

***Discharge Summary Implementation cont’d***

 DIVISION: SALT LAKE CITY ENABLE ELECTRONIC SIGNATURE: YES

 CHARACTERS PER LINE: 60 GRACE PERIOD FOR PURGE: 365

 GRACE PERIOD FOR SIGNATURE: 5 CHART COPY PRINTER: LTA35

 ASCII UPLOAD SOURCE: remote computer RECORD HEADER SIGNAL: $HDR

 BEGIN REPORT TEXT SIGNAL: $TXT UPLOAD HEADER FORMAT: captioned

 UPLOAD PROTOCOL: KERMIT STAT CHART COPY PRINTER: LTA35

 REQUIRE AUTHOR TO SIGN: YES

 STAT SUMMARIES PRINTED: released and verified

 ROUTINE SUMMARIES PRINTED: released and verified

 ENABLE CHART COPY PROMPT: YES ENABLE IRT INTERFACE: YES

 REQUIRE MAS REVIEW: YES REQUIRE TRANSCRIPTION RELEASE: YES

 AMENDMENT SIGNATURE BLOCK: TIUPO,ONE Privacy Act Officer

 BLANK CHARACTER STRING: --- ENABLE NOTIFICATIONS DATE: NOV 26, 1994

ALERT RECIPIENT: TIUCOORDINATOR, TWO

ALERT RECIPIENT: TIUCOORDINATOR, ONE

**Print site parameters for GMR REPORT TYPE File (#128.1)**

Select OPTION: **PR**INT FILE ENTRIES

OUTPUT FROM WHAT FILE: GMRD SITE PARAMETERS// **128.1** GMR REPORT TYPE

 (2 entries)

SORT BY: NAME// **<Enter>**

START WITH NAME: FIRST// **<Enter>**

FIRST PRINT FIELD: **[CAP**TIONED

Include COMPUTED fields: (N/Y/R/B): NO// **<Enter>** - No record number (IEN), no

Computed Fields

 \*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Heading (S/C): GMR REPORT TYPE LIST Replace **<Enter>**

DEVICE: **<device name>** ANYWHERE RIGHT MARGIN: 80// **<Enter>**

GMR REPORT TYPE LIST JAN 22,1997 13:54 PAGE 1

-----------------------------------------------------------------------------

NAME: DISCHARGE SUMMARY ABBREVIATION: DCS

 LAYGO ALLOWED?: YES TARGET FILE: GMR REPORTS

 TARGET TEXT FIELD SUBSCRIPT: 2;TEXT LOOK-UP LINETAG: LOOKUP

 LOOK-UP ROUTINE: GMRDFLRU

 DEFAULT REPORT FORMAT:

 DIAGNOSIS:

 OPERATIONS/PROCEDURES:

CAPTION: SOCIAL SECURITY NUMBER ITEM NAME: SSN

 FIELD NUMBER: .02 LOOKUP LOCAL VARIABLE NAME: GMRDSSN

 EXAMPLE ENTRY: 555-12-1234 CLINICIAN MUST DICTATE: YES

 TRANSFORM CODE: S:X?3N1P2N1P4N.E X=$E(X,1,3)\_$E(X,5,6)\_$E(X,8,12)

CAPTION: DATE OF ADMISSION ITEM NAME: ADMISSION DATE

 FIELD NUMBER: .07 LOOKUP LOCAL VARIABLE NAME: GMRDADT

 EXAMPLE ENTRY: 03/30/93 CLINICIAN MUST DICTATE: YES

CAPTION: DICTATED BY ITEM NAME: DICTATING PROVIDER

 FIELD NUMBER: 1.01 EXAMPLE ENTRY: ONE TIUPROVIDER, M.D.

 CLINICIAN MUST DICTATE: YES TRANSFORM CODE: S X=$$INAME^GMRDLIBS(X)

CAPTION: DICTATION DATE ITEM NAME: DICTATION DATE

 FIELD NUMBER: 1.03 EXAMPLE ENTRY: 04/03/93

***Discharge Summary Implementation cont’d***

 CLINICIAN MUST DICTATE: YES

CAPTION: ATTENDING PHYSICIAN ITEM NAME: ATTENDING PHYSICIAN

 FIELD NUMBER: 1.09 EXAMPLE ENTRY: SEVEN TIUPROVIDER, M.D.

 CLINICIAN MUST DICTATE: YES TRANSFORM CODE: S X=$$INAME^GMRDLIBS(X)

CAPTION: TRANSCRIPTIONIST ITEM NAME: TRANSCRIPTIONIST ID

 FIELD NUMBER: 1.05 EXAMPLE ENTRY: T1212

 CLINICIAN MUST DICTATE: NO

CAPTION: URGENCY ITEM NAME: STAT OR ROUTINE

 FIELD NUMBER: .09 EXAMPLE ENTRY: PRIORITY

 CLINICIAN MUST DICTATE: YES

NAME: OPERATIONREPORT ABBREVIATION: OPR

 LAYGO ALLOWED?: NO TARGET FILE: SURGERY

 TARGET TEXT FIELD SUBSCRIPT: 1.15;12

CAPTION: PATIENT ID ITEM NAME: PATIENT ID

 FIELD NUMBER: **<Enter>** EXAMPLE ENTRY: D4567

 CLINICIAN MUST DICTATE: YES

CAPTION: CASE NUMBER ITEM NAME: CASE NUMBER

 FIELD NUMBER: .001 EXAMPLE ENTRY: 3546

 CLINICIAN MUST DICTATE: YES

CAPTION: SURGERY DATE/TIME ITEM NAME: SURGERY DATE/TIME

 FIELD NUMBER: **<Enter>** EXAMPLE ENTRY: 4/1/94@09:45

 CLINICIAN MUST DICTATE: YES

☞ NOTE: In all cases, the examples given are for a site with multiple inpatient divisions. If you are implementing TIU at a site where this is NOT the case, only enter the parameters for a single institution.

1. Use the TIU BASIC PARAMETER EDIT option to initialize the electronic signature, notifications, chart copy prompting, grace periods, and blank character string parameters in a manner consistent with your current implementation of Discharge Summary:

Select TIU Parameters Menu Option: **1** Basic TIU Parameters

First edit Division-wide parameters:

Select INSTITUTION: **660**

 1 660 SALT LAKE CITY UT 660

 2 660AA SALT LAKE DOM UT VAMC 660AA

CHOOSE 1-2: **1** SALT LAKE CITY

 Are you adding 'SALT LAKE CITY' as a new TIU PARAMETERS (the 1ST)? **Y** (Yes)

ENABLE ELECTRONIC SIGNATURE: **Y** YES

ENABLE NOTIFICATIONS DATE: **11/26/97** (NOV 26, 1997)

GRACE PERIOD FOR SIGNATURE: **5**

GRACE PERIOD FOR PURGE:**<Enter>**

CHARACTERS PER LINE: **60**

OPTIMIZE LIST BUILDING FOR: performance//

**HINT**: Use a character string that isn’t likely to occur in any of your boilerplate templates. “@@@” is recommended.

SUPPRESS REVIEW NOTES PROMPT: YES//

ENABLE CHART COPY PROMPT: **Y** YES

BLANK CHARACTER STRING: **@@@**

Press RETURN to continue...**<Enter>**

**BASIC PARAMETER EDIT cont’d**

***Adding another Institution***

Select TIU Parameters Menu Option: **Basic** TIU Parameters

First edit Division-wide parameters:

Select INSTITUTION: **660AA** SALT LAKE DOM UT VAMC 660AA

 Are you adding 'SALT LAKE DOM' as a new TIU PARAMETERS (the 2ND)? **Y** (Yes)

ENABLE ELECTRONIC SIGNATURE: **Y** YES

ENABLE NOTIFICATIONS DATE: **11/21/97** (NOV 21, 1997)

GRACE PERIOD FOR SIGNATURE: **5**

GRACE PERIOD FOR PURGE: **<Enter>**

CHARACTERS PER LINE: **60**

OPTIMIZE LIST BUILDING FOR: performance// **<Enter>**

SUPPRESS REVIEW NOTES PROMPT: YES//**<Enter>**

ENABLE CHART COPY PROMPT: **Y** YES

BLANK CHARACTER STRING: **@@@**

Press RETURN to continue...**<Enter>**

☞ NOTE: Although the following parameters are set at the division level, the TIU NIGHTLY TASK which determines when OVERDUE alerts are sent recognizes the parameters set for one division only: the division of the person who scheduled the Nightly Task.

**GRACE PERIOD FOR SIGNATURE:**

**START OF ADD SGNR ALERT PERIOD:**

**END OF ADD SGNR ALERT PERIOD**:

**LENGTH OF SIGNER ALERT PERIOD**:

Sites should make sure that the parameter is set for the division of the person who set up the nightly task, so it won’t just use the defaults.

### Discharge Summary Upload Parameters

1. Use the TIU UPLOAD PARAMETER EDIT option to initialize both the institution-wide and document-specific upload parameters in a manner consistent with your current implementation of Discharge Summary. (The document-specific upload parameters can also be defined through Document Definition options.)

☞ NOTE: Some sites have defined additional captions for administrative use in resolving discrepancies. If you define additional captions *do not include field numbers for them*. Doing so can cause data to be overwritten with incorrect transcription data. For example, PATIENT may be overwritten with an incorrect patient.

Select TIU Parameters Menu Option: **2** Modify Upload Parameters

First edit Institution-wide upload parameters:

Select INSTITUTION: **660**

 1 660 SALT LAKE CITY UT 660

 2 660AA SALT LAKE DOM UT VAMC 660AA

CHOOSE 1-2: **1** SALT LAKE CITY

 ...OK? Yes// **<Enter>** (Yes)

ASCII UPLOAD SOURCE: **r** remote computer

UPLOAD PROTOCOL: **k** KERMIT

UPLOAD HEADER FORMAT: **c** captioned

RECORD HEADER SIGNAL: **$HDR**

BEGIN REPORT TEXT SIGNAL: **$TXT**

RUN UPLOAD FILER IN FOREGROUND: NO// **NO**

Now Select upload error alert recipients:

Select ALERT RECIPIENT: **CPRSCOORDINATOR, TWO**

 Are you adding ‘**CPRSCOORDINATOR, TWO’** as

 a new UPLOAD ERROR ALERT RECIPIENT (the 1ST for this TIU PARAMETERS)? **Y**

 (Yes)

Select ALERT RECIPIENT: **CPRSCOORDINATOR, TEN**

 Are you adding ' **CPRSCOORDINATOR, TWEN**' as

 a new UPLOAD ERROR ALERT RECIPIENT (the 2ND for this TIU PARAMETERS)? **Y**

 (Yes)

Select ALERT RECIPIENT: **<Enter>**

Now edit the DOCUMENT DEFINITION file:

DOCUMENT DEFINITION: **DISCHARGE SUMMARY**

 1 DISCHARGE SUMMARIES DOCUMENT CLASS

 2 DISCHARGE SUMMARY TITLE

 3 DISCHARGE SUMMARY CLASS

 4 DISCHARGE FINAL DISCHARGE NOTE TITLE

CHOOSE 1-4: **2**

ABBREVIATION: **DCS**

LAYGO ALLOWED?: YES// **<Enter>**

UPLOAD TARGET FILE: TIU DOCUMENT// **<Enter>**

Select TARGET TEXT FIELD: REPORT TEXT// **<Enter>**

UPLOAD LOOK-UP METHOD: D LOOKUP^TIUPUTU// **<Enter>**

UPLOAD POST-FILING CODE: D FOLLOWUP^TIUPUTU(TIUREC("#"))

 Replace **<Enter>**

UPLOAD FILING ERROR CODE: D GETPAT^TIUCHLP// **<Enter>**

Select CAPTION: **?**

 Answer with UPLOAD CAPTIONED ASCII HEADER, or ITEM NAME, or

 FIELD NUMBER, or LOOKUP LOCAL VARIABLE NAME

 You may enter a new UPLOAD CAPTIONED ASCII HEADER, if you wish

 Answer must be 2-40 characters in length.

Select CAPTION: **??**

 NOTE: Users can choose between two possible kinds of Upload Record

 Headers: Captioned or Delimited. Captioned headers should be used

 UNLESS the site has a way to generate upload headers automatically.

 CAPTION is the caption which the transcriber enters into the captioned

 upload record header immediately preceding the item data. It serves to

 distinguish one item of data from the next. Example: PATIENT NAME

Select CAPTION: **PATIENT SSN**

 CAPTION: PATIENT SSN// **SOCIAL SECURITY NUMBER**

 ITEM NAME: SSN// **<Enter>**

 FIELD NUMBER: .02// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: TIUSSN// **<Enter>**

 TRANSFORM CODE: S:X?3N1P2N1P4N.E X=$TR(X,"-/","")

 Replace **<Enter>**

 EXAMPLE ENTRY: 555-12-1234// **<Enter>**

 CLINICIAN MUST DICTATE: YES// **<Enter>**

 REQUIRED FIELD?: YES// **??**

 This field is used to determine whether a given header item is required

 by the application (e.g., Author and Attending Physician may be required

 for the ongoing processing of a Discharge Summary). Records lacking

 required fields WILL be entered into the target file, if possible, but

 will generate Missing Field Error Alerts.

 Choose from:

 1 YES

 0 NO

REQUIRED FIELD?: YES// **<Enter>**

***Modify Upload Parameters cont’d***

Select CAPTION: **DATE OF ADMISSION**

 CAPTION: DATE OF ADMISSION// **<Enter>**

 ITEM NAME: ADMISSION DATE// **<Enter>**

 FIELD NUMBER: .07// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: TIUADT// **<Enter>**

 TRANSFORM CODE: **<Enter>**

 EXAMPLE ENTRY: 03/30/93// **<Enter>**

 CLINICIAN MUST DICTATE: YES// **<Enter>**

 REQUIRED FIELD?: **Y** YES

Select CAPTION: **DIC**

 1 DICTATED BY

 2 DICTATION DATE

CHOOSE 1-2: **1**

 CAPTION: DICTATED BY// **<Enter>**

 ITEM NAME: DICTATING PROVIDER// **<Enter>**

 FIELD NUMBER: 1202// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: **<Enter>**

 TRANSFORM CODE: S X=$$INAME^TIULS(X) Replace **<Enter>**

 EXAMPLE ENTRY: ONE TIUPROVIDER, M.D. Replace **<Enter>**

 CLINICIAN MUST DICTATE: YES// **<Enter>**

 REQUIRED FIELD?: YES// **<Enter>**

Select CAPTION: **DICTATION DATE**

CAPTION: DICTATION DATE// **<Enter>**

 ITEM NAME: DICTATION DATE// **<Enter>**

 FIELD NUMBER: 1307// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: TIUDICDT// **<Enter>**

 TRANSFORM CODE: **<Enter>**

 EXAMPLE ENTRY: 04/03/93// **<Enter>**

 CLINICIAN MUST DICTATE: NO// **<Enter>**

 REQUIRED FIELD?: YES// **<Enter>**

Select CAPTION: **ATTENDING PHYSICIAN**

 CAPTION: ATTENDING PHYSICIAN// **<Enter>**

 ITEM NAME: ATTENDING PHYSICIAN// **<Enter>**

 FIELD NUMBER: 1209// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: **<Enter>**

 TRANSFORM CODE: S X=$$INAME^TIULS(X) Replace **<Enter>**

 EXAMPLE ENTRY: SEVEN TIUPROVIDER, M.D. Replace **<Enter>**

 CLINICIAN MUST DICTATE: YES// **<Enter>**

 REQUIRED FIELD?: YES// **<Enter>**

Select CAPTION: **TRANSC**RIPTIONIST

 CAPTION: TRANSCRIPTIONIST// **<Enter>**

 ITEM NAME: TRANSCRIPTIONIST ID// **<Enter>**

 FIELD NUMBER: 1302// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: **<Enter>**

 TRANSFORM CODE: **<Enter>**

 EXAMPLE ENTRY: T1212// **<Enter>**

 CLINICIAN MUST DICTATE: NO// **<Enter>**

 REQUIRED FIELD?: **<Enter>**

The header for the DISCHARGE SUMMARY DOCUMENT CLASS is now defined as:

***Modify Upload Parameters cont’d***

$HDR: DISCHARGE SUMMARY

SOCIAL SECURITY NUMBER: 555-12-1234

DATE OF ADMISSION: 03/30/93

DICTATED BY: ONE TIUPROVIDER, M.D.

DICTATION DATE: 04/03/93

ATTENDING PHYSICIAN: SEVEN TIUPROVIDER, M.D.

TRANSCRIPTIONIST: T1212

URGENCY: PRIORITY

$TXT

 DISCHARGE SUMMARY Text

\*\*\* File should be ASCII with width no greater than 80 columns.

\*\*\* Use "@@@" for "BLANKS" (word or phrase in dictation that isn't understood).

Press RETURN to continue... **<Enter>**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

**Modifying parameters for 2nd division**

Select TIU Parameters Menu Option: **<SPACE><Enter>** Modify Upload Parameters

First edit Institution-wide upload parameters:

Select INSTITUTION: **660AA** SALT LAKE DOM UT VAMC 660AA

 ...OK? Yes// **<Enter>** (Yes)

ASCII UPLOAD SOURCE: **R** remote computer

UPLOAD PROTOCOL: **K** KERMIT

UPLOAD HEADER FORMAT: **C** captioned

RECORD HEADER SIGNAL: **$HDR**

BEGIN REPORT TEXT SIGNAL: **$TXT**

RUN UPLOAD FILER IN FOREGROUND: NO// **<Enter>** NO

Now Select upload error alert recipients:

Select ALERT RECIPIENT: TIUCOORDINATOR, ONE

 Are you adding ‘TIUCOORDINATOR, ONE' as

 a new UPLOAD ERROR ALERT RECIPIENT (the 3RD for this TIU PARAMETERS)? **Y**

 (Yes)

Select ALERT RECIPIENT: TIUCOORDINATOR, TWO

 Are you adding ' TIUCOORDINATOR, TWO' as

 a new UPLOAD ERROR ALERT RECIPIENT (the 4TH for this TIU PARAMETERS)? **Y**

 (Yes)

Select ALERT RECIPIENT: **<Enter>**

**NOTE:** document upload parameters are independent of hospital divisions, so they don’t need to be re-entered in this case.

Now edit the DOCUMENT DEFINITION file:

DOCUMENT DEFINITION: **<Enter>**

Press RETURN to continue...**<Enter>**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option:

### Document Parameter Edit

1. Use the option *Document Parameter Edit* to define the special processing requirements for the Discharge Summary Class consistently with those used by your site with Discharge Summary v1.0

Select TIU Parameters Menu Option: **3** Document Parameter Edit

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **??**

Choose from:

 PROGRESS NOTES

 DISCHARGE SUMMARY

 This is the Document Definition to which the parameters described in

 the current record apply.

NOTE: All parameters are inherited from ancestor classes or document

 classes, unless overridden at a subordinate level in the document

 definition hierarchy (e.g., if you set the parameter to require release

 for class Progress Notes, then all progress note titles will require

 release, unless the parameter is set to NO for a subordinate Document

 Class or Title for which release should not be required).

Choose from:

 60 CHARACTER ENTRY 2 2345 7893 CLASS

 ACTIVE MEDICATIONS OBJECT

 ADDENDUM TITLE

 ADDENDUM DOCUMENT CLASS

 ADMISSION ASSESSMENT TITLE

 .

 .

 .

Select DOCUMENT DEFINITION: **DIS**CHARGE SUMMARY CLASS

 ...OK? Yes// (Yes)

DOCUMENT DEFINITION: DISCHARGE SUMMARY// **<Enter>**

REQUIRE RELEASE: YES// REQUIRE RELEASE: YES// **??**

 This parameter determines whether the person entering the document will

 be required (and therefore prompted) to release the document from a

 draft state, upon exit from the entry/editing process.

 Choose from:

 1 YES

 0 NO

REQUIRE RELEASE: YES// **<Enter>**

***Document Parameter Edit cont’d***

REQUIRE MAS VERIFICATION: **??**

 This parameter determines whether verification by MAS is required, prior

 to public access, and signature of the document.

 Choose from:

 1 YES

 0 NO

REQUIRE MAS VERIFICATION: **1** YES

REQUIRE AUTHOR TO SIGN: **??**

 This Boolean field indicates whether or not the author should sign the

 document (e.g., a discharge summary requires the signature of the

 attending physician, who may or may not himself be the author), before

 the expected cosigner.

Choose from:

 1 YES

 0 NO

REQUIRE AUTHOR TO SIGN: **Y** YES

ROUTINE PRINT EVENT(S): **??**

 These are the processing events (e.g., release, verification, or both)

 on which documents of the type specified should be automatically

 printed.

 Choose from:

 R release

 V verification

 B both

ROUTINE PRINT EVENT(S): **B** both

STAT PRINT EVENT(S): **??**

 Indicate the processing event(s) (e.g., release, verification, or both)

 on which STAT documents of the specified type will be printed for the

 chart to the device indicated.

 Choose from:

 R release

 V verification

 B both

STAT PRINT EVENT(S): **B** both

MANUAL PRINT AFTER ENTRY: **??**

 Though primarily implemented for PROGRESS NOTES, this parameter may be

 useful for any document for which a hard copy is desirable following

 entry. If set to YES, the user will be prompted to print a copy

 on exit from their preferred editor.

 Choose from:

 1 YES

 0 NO

MANUAL PRINT AFTER ENTRY: **N** NO

ALLOW CHART PRINT OUTSIDE MAS: **??**

 This field indicates whether the non-MAS user (e.g., providers) may

 print copies of the document for the chart.

 Generally, this will be set to YES for PROGRESS NOTES, which are likely

 to be printed on the Ward or in the Clinic for immediate inclusion in the

 chart, and to NO for DISCHARGE SUMMARIES, which are typically printed

 centrally, and for which extraneous or duplicate CHART COPIES are a

 particular problem.

***Document Parameter Edit cont’d***

 Choose from:

 1 YES

 0 NO

ALLOW CHART PRINT OUTSIDE MAS: **N** NO

ALLOW >1 RECORDS PER VISIT: NO// **??**

 This field determines whether a given document may be created more than

 once per visit. For example, it may be necessary and appropriate to

 enter multiple Nurses Notes for a single hospitalization, although only

 one discharge summary may be entered for that care episode.

 Choose from:

 1 YES

 0 NO

ALLOW >1 RECORDS PER VISIT: NO// **<Enter>**

ENABLE IRT INTERFACE: **??**

 This enables TIU's interface with Incomplete Record Tracking, which will

 update deficiencies when transcription, signature, or cosignature

 (review) events are registered for a given document.

 Choose from:

 0 NO

 1 YES

ENABLE IRT INTERFACE: **Y** YES

IRT DEFICIENCY: DISCHARGE SUMMARY// **??**

 This field provides for a mapping between the TIU DOCUMENT DEFINITION

 and the corresponding IRT DEFICIENCY TYPE (e.g., Document Class

 Discharge Summary maps to Deficiency Type Discharge Summary, while

 Document type LIPID CLINIC NOTE maps to Deficiency Type DRS PROGRESS

 NOTES, etc.).

Choose from:

 DISCHARGE SUMMARY

IRT DEFICIENCY: DISCHARGE SUMMARY// **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **??**

 Please indicate whether to suppress prompting for Diagnostic and

 Procedure codes following signature of a document where an Ambulatory or

 Telephone visit was created when the document was first entered.

 NOTE: If you set this parameter to YES, you will need to capture this

 information by some other uniform means (e.g., an AICS encounter form,

 etc.) in order to receive workload credit for these visits.

 Choose from:

 1 YES

 0 NO

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

FORCE RESPONSE TO EXPOSURES: ??

 This parameter determines whether the user will be forced to enter a Yes

 or No response when asked to specify the Service Connection

 Classification of a Veteran, when creating a standalone visit (i.e., AO,

 IR, or EC).

 Choose from:

 1 YES

 0 NO

***Document Parameter Edit cont’d***

FORCE RESPONSE TO EXPOSURES:

ASK DX/CPT ON ALL OPT VISITS: ??

 Please indicate whether the Diagnosis and Procedural questions should be

 asked on Scheduled Appointments, in addition to Walk-ins and Telephone

 (i.e., Standalone) Encounters.

 Choose from:

 1 YES

 0 NO

ASK DX/CPT ON ALL OPT VISITS: EDITOR SET-UP CODE: **??**

 This is MUMPS code to be executed prior to invoking the user's preferred

 editor through ^DIWE. It will ordinarily set local variables to be used

 in the editor's header, etc.

**If your site wishes to route alerts for filing errors to different recipients by document type (Discharge Summary alerts to one MRT, Operation Report alerts to another, etc.), this is where to specify that.**

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS: TIUCLERK, TWO

Are you adding TIUCLERK, TWO ' as a new FILING ERROR ALERT RECIPIENTS (the 1ST for this TIU DOCUMENT PARAMETERS)? **Y** (Yes)

Select FILING ERROR ALERT RECIPIENTS: **<Enter>**

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: **??**

 You may enter a new USERS REQUIRING COSIGNATURE, if you wish

 Please indicate which groups of users (i.e., User Classes) require

 cosignature for the type of document in question. For example,

 STUDENTS, INTERNS, LPNs, and other user classes may be identified

 as requiring a cosignature for PROGRESS NOTES.

 NOTE: Users specified as requiring a cosignature for DISCHARGE

 SUMMARY documents cannot be selected as Attending Physicians for

 these documents. This ensures that users who require a cosignature

 cannot cosign these documents.

 Choose from:

 ALLERGIST

 ALLERGY & IMMUNOLOGY

 ANESTHESIOLOGIST

 ARTHRITIS RESEARCH STUDY MANAG

 ARTHRITIS RESEARCH STUDY PROVI

 ASSOCIATE CHIEF OF STAFF

 ATTENDING PHYSICIAN

 AUDIOLOGIST

 CARDIOLOGIST

 CHAPLAIN

 CHIEF RESIDENT

 CHIEF, MEDICAL SERVICE

 CHIEF, MIS

 CHIEF, PSYCHIATRY SERVICE

 CHIEF, SURGICAL SERVICE

 CLINICAL CLERK

 CLINICAL COORDINATOR

 CLINICAL COORDINATOR -MGR

 CLINICAL DIETITIAN

 '^' TO STOP: **^**

Select USERS REQUIRING COSIGNATURE: **<Enter>**

Now enter the DIVISIONAL parameters:

Select DIVISION: **??**

 This is the Medical Center Division for which the parameters are being

 defined.

Choose from:

 1 SALT LAKE CITY 660

 2 SALT LAKE DOM 660AA

Select DIVISION: **1** SALT LAKE CITY 660

 Are you adding 'SALT LAKE CITY' as a new DIVISION (the 1ST for this TIU DOCUMENT PARAMETERS)? **Y**

 (Yes)

 CHART COPY PRINTER: LASERJET 4SI MARCIE'S CUBE \_LTA318:

 STAT CHART COPY PRINTER: LAZER PRINTER ROOM LN11 12 PITCH \_LTA36:

Select DIVISION: **660AA** SALT LAKE DOM 660AA

 Are you adding 'SALT LAKE DOM' as a new DIVISION (the 2ND for this TIU DOCUMENT PARAMETERS)? **Y** (Yes)

 CHART COPY PRINTER: **LTA35** C-ITOH 300 LINE PRINTER \_LTA35

STAT CHART COPY PRINTER: **LTA35** C-ITOH 300 LINE PRINTER \_LTA35

Select DIVISION: **<Enter>**

Press RETURN to continue...**<Enter>**

## Progress Notes Example of Modify Upload Parameters

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **Modify** Upload Parameters

First edit Institution-wide upload parameters:

Select INSTITUTION: **SALT LAKE CITY**

ASCII UPLOAD SOURCE: remote computer// **<Enter>**

UPLOAD PROTOCOL: KERMIT// **<Enter>**

If there are other titles under Progress Notes with distinct upload parameters, you need to repeat this setup for them.

UPLOAD HEADER FORMAT: captioned// **^**

Now edit the DOCUMENT DEFINITION file:

DOCUMENT DEFINITION: **PROGRESS NOTES** CLASS

ABBREVIATION: PN// **<Enter>**

LAYGO ALLOWED?: YES// **<Enter>**

UPLOAD TARGET FILE: TIU DOCUMENT// **<Enter>**

Select TARGET TEXT FIELD: REPORT TEXT// **<Enter>**

UPLOAD LOOK-UP METHOD: D LOOKUP^TIUPUTPN// **<Enter>**

UPLOAD POST-FILING CODE: D FOLLOWUP^TIUPUTPN(TIUREC("#"))

 Replace **<Enter>**

UPLOAD FILING ERROR CODE: D GETPN^TIUCHLP//**D PNFIX^TIUPNFIX<Enter>**

Select CAPTION: LOCATION//**<Enter>**

 CAPTION: LOCATION// **<Enter>**

 ITEM NAME: PATIENT LOCATION// **<Enter>**

 FIELD NUMBER: 1205// **<Enter>**

 LOOKUP LOCAL VARIABLE NAME: TIULOC// **<Enter>**

 TRANSFORM CODE: **<Enter>**

 EXAMPLE ENTRY: MEDICAL-CONSULT 6200 Replace **<Enter>**

 CLINICIAN MUST DICTATE: YES// **<Enter>**

 REQUIRED FIELD?: YES// **<Enter>**

Select CAPTION: **AUTHOR**

 CAPTION: AUTHOR// <**Enter**>

 ITEM NAME: DICTATING PROVIDER//<**Enter**>

 FIELD NUMBER: 1202//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: <**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: TIUPROVIDER,ONE//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **DATE/TIME OF DICT**

 CAPTION: DATE/TIME OF DICT Replace<**Enter**>

 ITEM NAME: DICTATION DATE/TIME//<**Enter**>

 FIELD NUMBER: **1307**<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUDDT//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: 5/16/97@09:25//<**Enter**>

 CLINICIAN MUST DICTATE: NO//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

***Modify Upload Parameters cont’d***

Select CAPTION: **EXPECTED COSIGNER**

 CAPTION: EXPECTED COSIGNER//<**Enter**>

 ITEM NAME: EXPECTED COSIGNER//<**Enter**>

 FIELD NUMBER: 1208//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: <**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: TIUPROVIDER,SEVEN//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: NO//<**Enter**>

Select CAPTION: **SSN**

 CAPTION: SSN//<**Enter**>

 ITEM NAME: PATIENT SSN//<**Enter**>

 FIELD NUMBER: .02//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUSSN//<**Enter**>

 TRANSFORM CODE: S X=$TR(X,"-/","")// <**Enter**>

 EXAMPLE ENTRY: 555-12-1234//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **VISIT/EVENT DATE**

 CAPTION: VISIT/EVENT DATE//<**Enter**>

 ITEM NAME: VISIT/EVENT DATE/<**Enter**>/

 FIELD NUMBER: .07//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUVDT//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: 5/15/97@08:15//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **TITLE**

 CAPTION: TITLE//<**Enter**>

 ITEM NAME: TITLE OF NOTE//<**Enter**>

 FIELD NUMBER: .01//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUTITLE//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: PULMONARY NOTE//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION:<**Enter**>

☞ NOTE: Some sites have defined additional captions for administrative use in resolving discrepancies. If you define additional captions, *do not include field numbers for them*. Doing so can cause data to be overwritten with incorrect transcription data. For example, PATIENT may be overwritten with an incorrect patient.

***Modify Upload Parameters cont’d***

The header for the Progress Notes CLASS is now defined as:

$HDR: PROGRESS NOTES

TITLE: PULMONARY NOTE

SSN: 555-12-1234

VISIT/EVENT DATE: 5/15/97@08:15

AUTHOR: TIUPROVIDER,ONE

TRANSCRIBER: K5420

DATE/TIME OF DICT: 5/16/97@09:25

LOCATION: MEDICAL-CONSULT 6200

EXPECTED COSIGNER: TIUPROVIDER,SEVEN

$TXT

 PROGRESS NOTES Text

\*\*\* File should be ASCII with width no greater than 80 columns.

\*\*\* Use "@@@" for "BLANKS" (word or phrase in dictation that isn't understood).

## Setting up Consult/Request Tracking in TIU

You can set Consults up as a separate Class (comparable to Discharge Summary or Progress Notes) or you can define Consults as a document class under Progress Notes. There are pros and cons to either strategy.

***A:*** *Create Consults as an independent CLASS, under Clinical Documents*

**Pro:** 1. Provides a *clear* separation of Consults from Progress Notes, and minimizes the number of choices for the end-user.

2. Simple, with few concerns for maintainability (e.g., no question as to whether heritable methods and properties of Progress Notes were appropriately overridden, etc.).

**Con**: 1. Not necessarily consistent with the way providers have been documenting their Consult Results in the past. (i.e., if they've been using PN titles to “result” consults, and referring to the notes on the 513's in the past, this will be a departure from that practice).

2. Limits flexibility of access to the information. (i.e., if set up this way, they may only access the data through Integrated Document Management options on the TIU side, and through the Consults tab of the CPRS chart).

***B:*** *Create Consults as a document class under Progress Notes.*

**Pro**: 1. Consistent with the way many providers have been documenting their Consult Results in the past.

2. Enhances flexibility of access to the information. (allows access to data through any option in TIU, as well as through *either* the Consults or Progress Notes tabs of the CPRS chart).

**Con**: 1. Does not provide a clear separation of Consults from Progress Notes, and may offer too many choices for the end-user.

2. Complex, with some concerns for maintainability (e.g., if printing or filing appear incorrect, may result from heritable methods and properties of Progress Notes not being appropriately overridden, etc.).

***TIU, cont’d***

**Define CONSULTS for TIU/CT Interface**

Patch TIU\*1.0\*4 contains an option that allows you to set Consults up as part of the Document Definition hierarchy. The following is a description of the option and the other steps necessary for allowing Consults to be accessed through TIU and CPRS.

1. Select the option *Define Consults for TIU/CT Interface* and enter the relevant information.

Select OPTION NAME: **TIU DEFINE CONSULTS** Define CONSULTS for

TIU/CT Interface

Define CONSULTS for TIU/CT Interface

I'm going to create a new Document Definition for CONSULTS now.

GREAT! A new Document Definition has been created for CONSULTS.

Next, you need to decide whether you want CONSULTS to be set up

as a separate CLASS (comparable to DISCHARGE SUMMARY or PROGRESS

NOTES), or whether you want CONSULTS defined as a DOCUMENT CLASS

under PROGRESS NOTES. The benefits of each strategy are outlined

in the POST-INSTALLATION instructions for this patch.

NOTE: If you're not yet CERTAIN which strategy you want your site

to adopt, then quit here, and get consensus first (it's easier to

get permission than forgiveness, in this case)!

 Select one of the following:

 CL Class

 DC Document Class

Define CONSULTS as a CLASS or DOCUMENT CLASS: DC Document Class

Okay, you've indicated that you want to make CONSULTS a Document Class.

 Okay to continue? NO// **YES**

FANTASTIC! Your NEW DOCUMENT CLASS CONSULTS will now be added under

the PROGRESS NOTES Class...

Okay, I'm done...Please finish your implementation of CONSULTS by adding

any Titles as appropriate using the Create Document Definitions Option

under the TIUF DOCUMENT DEFINITION MGR Menu, as described in Step #3 of

the Post-Installation Instructions.

Press RETURN to continue...

***TIU, cont’d***

2. You can verify that the upload header is appropriately defined for Consults using the option [TIU UPLOAD HELP]. The output will look something like this:

<Message Header Signal>: CONSULTS

TITLE: CARDIOLOGY CONSULT

SSN: 555-12-1234

VISIT/EVENT DATE: 5/13/97@08:00

AUTHOR: TIUPROVIDER,ONE

TRANSCRIBER: K5420

DATE/TIME OF DICTATION: 5/13/97@11:00

LOCATION: MEDICAL-CONSULT 6200

EXPECTED COSIGNER: TIUPROVIDER,SEVEN

CONSULT REQUEST NUMBER: 1455

<Begin Text Signal>

 CONSULTS Text

* File should be ASCII with width no greater than 80 columns.
* Use "@@@" for “BLANKS” (word or phrase in dictation that isn’t understood), where <Message Header Signal> and <Begin Text Signal> will appear as you’ve defined them in your Upload Parameters for your site (e.g., $HDR and $TXT, etc.).

Another way of verifying this setup is to use the [MODIFTY UPLOAD PARAMETERS OPTION] as in this example:

Select TIU Parameters Menu Option: **2**  Modify Upload Parameters

First edit Institution-wide upload parameters:

Select INSTITUTION: SALT LAKE CITY HCS<**Enter**>

ASCII UPLOAD SOURCE: remote computer//<**Enter**>

UPLOAD PROTOCOL: KERMIT// <**Enter**>

UPLOAD HEADER FORMAT: captioned//<**Enter**>

RECORD HEADER SIGNAL: $HDR//<**Enter**>

BEGIN REPORT TEXT SIGNAL: $TXT//<**Enter**>

RUN UPLOAD FILER IN FOREGROUND: YES//<**Enter**>

Now Select upload error alert recipients:

Select ALERT RECIPIENT: SCRIPTION,BERTRAND//<**Enter**>

If there are other titles under Consults with distinct upload parameters, you need to repeat this setup for them.

Now edit the DOCUMENT DEFINITION file:

DOCUMENT DEFINITION: **CONSULTS**

 1 CONSULTS DOCUMENT CLASS

 2 CONSULTS CLASS (RETIRED) CLASS

 3 CONSULTS BAD MEDICINE CONSULTS DC DOCUMENT CLASS

 4 CONSULTS MEDICINE CS CONSULTS TITLE

 5 CONSULTS BAD MEDICINE CONSULTS TITLE

Press <RETURN> to see more, '^' to exit this list, OR

CHOOSE 1-5: **1** CONSULTS DOCUMENT CLASS

***Verify Consults Setup cont’d***

ABBREVIATION: CNST//<**Enter**>

LAYGO ALLOWED: YES//<**Enter**>

UPLOAD TARGET FILE: TIU DOCUMENT//<**Enter**>

Select TARGET TEXT FIELD: REPORT TEXT//<**Enter**>

UPLOAD LOOK-UP METHOD: D LOOKUP^TIUPUTCN//<**Enter**>

UPLOAD POST-FILING CODE: D FOLLOWUP^TIUPUTCN(TIUREC("#"))

 Replace<**Enter**>

UPLOAD FILING ERROR CODE: D GETPN^TIUCHLP//**D CNFIX^TIUCNFIX**<**Enter**>

Select CAPTION: CONSULT REQUEST NUMBER//<**Enter**>

 CAPTION: CONSULT REQUEST NUMBER Replace<**Enter**>

 ITEM NAME: CONSULT REQUEST #//<**Enter**>

 FIELD NUMBER: 1405//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUCNNBR//<**Enter**>

 TRANSFORM CODE: S X="C."\_X//<**Enter**>

 EXAMPLE ENTRY: 1455//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **AUTHOR**

 CAPTION: AUTHOR// <**Enter**>

 ITEM NAME: DICTATING PROVIDER//<**Enter**>

 FIELD NUMBER: 1202//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: <**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: TIUPROVIDER,ONE//**<Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **DATE/TIME OF DICTATION**

 CAPTION: DATE/TIME OF DICTATION Replace<**Enter**>

 ITEM NAME: DICTATION DATE/TIME//<**Enter**>

 FIELD NUMBER: 1301//**1307**<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUDDT//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: 5/16/97@09:25//<**Enter**>

 CLINICIAN MUST DICTATE: NO//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **EXPECTED COSIGNER**

 CAPTION: EXPECTED COSIGNER//<**Enter**>

 ITEM NAME: EXPECTED COSIGNER//<**Enter**>

 FIELD NUMBER: 1208//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: <**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: TIUPROVIDER,SEVEN//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: NO//<**Enter**>

Select CAPTION: **LOCATION**

 CAPTION: LOCATION//<**Enter**>

 ITEM NAME: PATIENT LOCATION//<**Enter**>

 FIELD NUMBER: 1205//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIULOC//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: MEDICAL-CONSULT 6200 Replace<**Enter**>

***Verify Consults Setup cont’d***

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **SSN**

 CAPTION: SSN//<**Enter**>

 ITEM NAME: PATIENT SSN//<**Enter**>

 FIELD NUMBER: .02//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUSSN//<**Enter**>

 TRANSFORM CODE: S X=$TR(X,"-/","")// <**Enter**>

 EXAMPLE ENTRY: 555-12-1234//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **VISIT/EVENT DATE**

 CAPTION: VISIT/EVENT DATE//<**Enter**>

 ITEM NAME: VISIT/EVENT DATE/<**Enter**>/

 FIELD NUMBER: .07//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUVDT//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: 5/15/97@08:15//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION: **TITLE**

 CAPTION: TITLE//<**Enter**>

 ITEM NAME: TITLE OF CONSULT//<**Enter**>

 FIELD NUMBER: .01//<**Enter**>

 LOOKUP LOCAL VARIABLE NAME: TIUTITLE//<**Enter**>

 TRANSFORM CODE: <**Enter**>

 EXAMPLE ENTRY: PULMONARY CONSULT//<**Enter**>

 CLINICIAN MUST DICTATE: YES//<**Enter**>

 REQUIRED FIELD?: YES//<**Enter**>

Select CAPTION:<**Enter**>

☞ NOTE: Some sites have defined additional captions for administrative use in resolving discrepancies. If you define additional captions *do not include field numbers for them*. Doing so can cause data to be overwritten with incorrect transcription data. For example, PATIENT may be overwritten with an incorrect patient.

The header for the CONSULTS DOCUMENT CLASS is now defined as:

$HDR: CONSULTS

TITLE: PULMONARY CONSULT

SSN: 555-12-1234

VISIT/EVENT DATE: 5/15/97@08:15

AUTHOR: TIUPROVIDER,ONE

DATE/TIME OF DICTATION: 5/16/97@09:25

LOCATION: MEDICAL-CONSULT 6200

EXPECTED COSIGNER: TIUPROVIDER,SEVEN

CONSULT REQUEST NUMBER: 1455

***Verify Consults Setup cont’d***

$TXT

 CONSULTS Text

$EOM

\*\*\* File should be ASCII with width no greater than 80 columns.

\*\*\* Use "@@@" for "BLANKS" (word or phrase in dictation that isn't understood).

3. Use the *Create Document Definitions* option [TIUFC CREATE DDEFS MGR], under the IRM Maintenance Menu option [TIU IRM MAINTENANCE MENU], to construct a new document definition sub-tree for Consults that looks something like this:

**Edit Document Definitions** Sep 03, 1997 11:59:04 Page: 1 of 1

BASICS

 Name Type

 1 CLINICAL DOCUMENTS CL

 2 +DISCHARGE SUMMARY CL

 3 +PROGRESS NOTES CL

 4 CONSULTS DC

 5 MEDICINE CONSULTS DC

 6 MEDICINE CONSULT TL

 7 ENDOSCOPY TL

 8 CARDIOLOGY CONSULTS DC

 9 CARDIOLOGY COSULT TL

 10 ELECTROCARDOGRAM TL

 11 ECHOCARDIOGRAM INTERPRETATION TL

 12 +ADDENDUM DC

 **?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move

Select Action: Quit//

***TIU, cont’d***

The example above suggests a Service-oriented set of document classes with one or more titles under each. Of course, just like Progress Notes, these can include boilerplate text with embedded objects. It will probably take some time, with substantial cooperation between your Clinical

Coordinator, IRMS, and the Consulting Services, to develop a complete set of Document Definitions for Consults at your site.

4. Next, define a set of Document Parameters for the new Consults class, using the Document Parameter Edit [TIU DOCUMENT PARAMETER EDIT] option under the TIU IRM MAINTENANCE MENU option, as follows:

 1 TIU Parameters Menu ...

 2 Document Definitions (Manager) ...

 3 User Class Management ...

Select TIU Maintenance Menu Option: **1** TIU Parameters Menu

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **DOC**ument Parameter Edit

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **CONSULTS** DOCUMENT CLASS

 ...OK? Yes// **<Enter>** (Yes)

DOCUMENT DEFINITION: CONSULTS// <Enter>

REQUIRE RELEASE: **n** NO

REQUIRE MAS VERIFICATION: **u** UPLOAD ONLY

REQUIRE AUTHOR TO SIGN: **y** YES

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: **y** YES

ALLOW CHART PRINT OUTSIDE MAS: **y** YES

ALLOW >1 RECORDS PER VISIT: **n** NO

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

Identify local recipients as appropriate.

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS:

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: STUDENT//

Now enter the DIVISIONAL parameters:

Identify per local requirements

Select DIVISION: [optional...you probably won't need to set up

auto-printing devices]

Press RETURN to continue...

5. Finally, use the option to Manage Business Rules, under the User Class Management Menu to specify the following rules, allowing Linking (or re-linking) of TIU documents with “requests” in a client application:

1 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be LINKED by An AUTHOR/DICTATOR

2 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be LINKED by An EXPECTED

 COSIGNER

3 A COMPLETED (CLASS) CLINICAL DOCUMENT may be LINKED by A CHIEF, MIS

4 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be LINKED by A MEDICAL

 RECORDS TECHNICIAN

## TIU Document Parameter Inheritance

TIU Document Parameters are set with the option *Document Parameter Edi* on the TIU Maintenance Menu:

TIU Maintenance Menu [TIU IRM MAINTENANCE MENU]

 TIU Parameters Menu [TIU SET-UP MENU]

 Document Parameter Edit [TIU DOCUMENT PARAMETER EDIT]

At present, document parameters are *not* independently heritable.

Therefore, if one of these parameters is set for a given Document Definition, then *all* parameters set at higher Document Definition levels are ignored for that Document Definition. For example, if you set one of these parameters for the Title POSTOPERATIVE NOTE, then any other parameters which should hold for POSTOPERATIVE NOTE must also be explicitly set at that level; they are *not* inherited from higher levels.

**Example:**

Suppose you want residents to require cosignature, but only for the Title POSTOPERATIVE NOTE. To accomplish this, use the option *Document Parameter Edit*, select Title POSTOPERATIVE NOTE, and set the parameter USERS REQUIRING COSIGNATURE to User Class RESIDENT PHYSICIAN. Then residents will require cosignature for the Title POSTOPERATIVE NOTE.

We show this process in several steps in the screen captures on the next page. We first set the parameter USERS REQUIRING COSIGNATURE for Title POSTOPERATIVE NOTE, leaving other parameters alone. Then we look up parameter values for PROGRESS NOTES. Last, we set previously inherited parameter values for POSTOPERATIVE NOTE:

**Example: Setting Cosignature Requirement**

Select TIU Parameters Menu Option: **3** Document Parameter Edit

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **POSTOPERATIVE NOTE** TITLE

 Are you adding 'POSTOPERATIVE NOTE' as

 a new TIU DOCUMENT PARAMETERS (the 12TH)? No// **Y** (Yes)

DOCUMENT DEFINITION: POSTOPERATIVE NOTE// **<Enter>**

REQUIRE RELEASE: **<Enter>**

REQUIRE MAS VERIFICATION: **<Enter>**

REQUIRE AUTHOR TO SIGN: **<Enter>**

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: **<Enter>**

ALLOW CHART PRINT OUTSIDE MAS: **<Enter>**

ALLOW >1 RECORDS PER VISIT: **<Enter>**

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS:

***Now enter the USER CLASSES for which cosignature will be required:***

Select USERS REQUIRING COSIGNATURE: **RESIDENT PHYSICIAN**

 Are you adding 'RESIDENT PHYSICIAN' as a new USERS REQUIRING COSIGNATURE (the 1ST for this TIU DOCUMENT PARAMETERS)?

 No// **Y** (Yes)

Select USERS REQUIRING COSIGNATURE:

Now enter the DIVISIONAL parameters:

Select DIVISION:

This accomplishes the goal for residents for POSTOPERATIVE NOTES. But, in creating this new entry, we have overridden ALL previously inherited document parameter values for POSTOPERATIVE NOTES.

If we want POSTOPERATIVE NOTE to function like other notes (apart from requiring cosignature for residents), we’ll need to enter the parameter values for POSTOPERATIVE NOTE that it previously inherited. Use the option *Document Parameter Edit* and select Class PROGRESS NOTES to see what values PROGRESS NOTES has on your system. Don’t change the values; just take the defaults so you can look at them. Your values may be different from ours.

**Example: Re-entering parameter values**

Select TIU Parameters Menu Option: **Document Parameter Edit**

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: PROGRESS NOTES TITLE

 ...OK? Yes// **<Enter>** (Yes)

DOCUMENT DEFINITION: PROGRESS NOTES// **<Enter>**

REQUIRE RELEASE: **NO** NO

REQUIRE MAS VERIFICATION: **NO** NO

REQUIRE AUTHOR TO SIGN: **Y** YES

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: YES// **<Enter>**

ALLOW CHART PRINT OUTSIDE MAS: YES// **<Enter>**

ALLOW >1 RECORDS PER VISIT: YES// **<Enter>**

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS: CLERK,F.W.D. // **<Enter>**

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: STUDENT// **<Enter>**

Now enter the DIVISIONAL parameters: **<Enter>**

Select DIVISION: SALT LAKE CITY// **<Enter>**

 CHART COPY PRINTER: LASER//**<Enter>**

 STAT CHART COPY PRINTER: **<Enter>**

Select DIVISION: **<Enter>**

☞ NOTE: If TIU Document Parameters are defined for the document class parent of the Title POSTOPERATIVE NOTES, look up and fill in those values instead of the values for PROGRESS NOTES.

***Example, cont’d***

Now edit parameters for POSTOPERATIVE NOTE again, and fill in the values *your site* is using for PROGRESS NOTES:

Select TIU Parameters Menu Option: **Document Parameter Edit**

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **POSTOPERATIVE NOTE** TITLE

 ...OK? Yes// **<Enter>** (Yes)

DOCUMENT DEFINITION: POSTOPERATIVE NOTE// **<Enter>**

REQUIRE RELEASE: **NO** NO

REQUIRE MAS VERIFICATION: **NO** NO

REQUIRE AUTHOR TO SIGN: **Y** YES

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: **Y** YES

ALLOW CHART PRINT OUTSIDE MAS: **Y** YES

ALLOW >1 RECORDS PER VISIT: **Y** YES

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS: **CPRSCLERK,ONE.**  OC MEDICAL RECORD TECHNICIAN

Are you adding 'CLERK,ONE.' as a new FILING ERROR ALERT RECIPIENTS (the 1ST for this TIU DOCUMENT PARAMETERS)? No// **Y** (Yes)

Select FILING ERROR ALERT RECIPIENTS:

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: RESIDENT PHYSICIAN

 // **STUDENT**

 Are you adding 'STUDENT' as a new USERS REQUIRING COSIGNATURE (the 2ND for this TIU DOCUMENT PARAMETERS)? No// **Y** (Yes)

Select USERS REQUIRING COSIGNATURE: **<Enter>**

Now enter the DIVISIONAL parameters: **<Enter>**

Select DIVISION: SALT LAKE CITY 660

 Are you adding 'SALT LAKE CITY' as a new DIVISION (the 1ST for this TIU DOCUMENT PARAMETERS)? No// Y (Yes)

 CHART COPY PRINTER: LASER PRINTER ROOM LN11 12 PITCH \_LTA36:

 STAT CHART COPY PRINTER:

Select DIVISION:

***Example, cont’d***

Notice that we added User Class STUDENT to the USERS REQUIRING COSIGNATURE multiple as well as filling in other parameters.

☞ NOTE: We split this edit into two separate steps for clarity, but it is more efficient to edit all parameters for POSTOPERATIVE NOTE in a single step, assuming you know what values it previously inherited.

If, in the future, TIU Document Parameters are made independently heritable, then the extra parameters you add now will become redundant. You shouldn’t have to remove them.

**Stub Document Parameters**

It follows from what we said earlier about TIU Document Parameter inheritance that stub parameters are not harmless.

**Example:**  Suppose you enter the following:

Select TIU Parameters Menu Option: **Document Parameter Edit**

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **POSTOPERATIVE NOTE** TITLE

 ...OK? Yes// **<Enter>** (Yes)

DOCUMENT DEFINITION: POSTOPERATIVE NOTE//**<Enter>**

Now, suppose you delete all values for POSTOPERATIVE NOTE, (or if POSTOPERATIVE NOTE is new, suppose you don’t enter any values). Then, since POSTOPERATIVE NOTE still exists as a TIU Document Parameters entry, it overrides any values that it might have inherited from a higher document definition. To avoid this override, you must delete the Document Parameter entry POSTOPERATIVE NOTE itself, not just all of its values.

### Progress Notes Batch Print Locations

Use this option for entering hospital locations used for TIU PRINT PN OUTPT LOC and TIU PRINT PN WARD options. If locations are not entered in this file they will not be selectable from these options.

Select TIU Maintenance Menu Option: **1** TIU Parameters Menu

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **4** Progress Notes Batch Print Locations

Select Clinic or Ward: **TELEPHONE TRIAGE** - PSYCHIATRY

PROGRESS NOTES DEFAULT PRINTER: LASERJET 4SI// **<Enter>**

EXCLUDE FROM PN BATCH PRINT: **?**

 Set to '1' progress notes for this location will not be included

 in the progress notes outpatient batch print job [TIU PRINT PN

 BATCH].You would do this if you wanted to print the CHART copies

 of the notes for this location in the clinic and not in the file

 room.

 Choose from:

 1 YES

EXCLUDE FROM PN BATCH PRINT: **YES**

Select Clinic or Ward:**<Enter>**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **<Enter>**

1. DIVISION must be defined in file #8925.94 (TIU DIVISION PRINT PRINT PARAMETERS FILE).

2. The variable TIUDIV must be defined in the VARIABLE NAME multiple of the OPTION SCHEDULING FILE (#19.2). TIUDIV should be set to the IEN of the DIVISION in the MEDICAL CENTER DIVISION FILE (#40.8). This pointer value is also stored in the .01 field of the TIU DIVISION PRINT PARAMETERS FILE (#8925.94).

3. This option must find a valid date in field #1.01 of file #8925.94 to start looping on. If a valid date is not found, the option will terminate with this message.

4. To assist in troubleshooting, if no notes are found, the DATE/TIME field (#1.01) of file #8925.94 will not be re-set to the new value (which is NOW) when the option begins calculating.

### Division - Progress Notes Print Parameters

These parameters are used by the TIU PRINT PN BATCH INTERACTIVE and TIU PRINT PN BATCH SCHEDULED options. If your site wants a footer other than what is returned by $$SITE^ VASITE, the .02 field of the 1st entry in this file will be used. For example, Waco-Temple-Marlin can have the institution of their progress notes as “CENTRAL TEXAS HCF.” If there are no TIU Division Parameters and your site has an Integration Name, the Integration Name will be used.

Select TIU Maintenance Menu Option: **1** TIU Parameters Menu

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **5** Division - Progress Notes Print Params

Select Division for PNs Outpatient Batch Print: **?**

 Answer with TIU DIVISION PRINT PARAMETERS, or NUMBER:

 1 SALT LAKE CITY

 You may enter a new TIU DIVISION PRINT PARAMETERS, if you

 wish. Select the DIVISION these print parameters apply to.

 Answer with MEDICAL CENTER DIVISION NUM, or NAME:

 1 SALT LAKE CITY 660

Select Division for PNs Outpatient Batch Print: **YOUR HOSPITAL**

 ...OK? Yes// **<Enter>** (Yes)

LOCATION TO PRINT ON FOOTER: **??**

 The name of this division as it should appear in the footer

 of the progress notes and forms printed using the terminal

 outpatient sort. This is useful for sites that want

 digit something other than what the external value of

 this division returned by $$SITE^VASITE. For example, the

 Waco division of the Central Texas Health Care System may

 want Central Texas HCS- Waco to appear in the footer instead

 of WACO VAMC.

LOCATION TO PRINT ON FOOTER: **CENTRAL ANYWHERE**

PROGRESS NOTES BATCH PRINTER: **WARD LASERJET 4SI**

☞ NOTE: Patch TIU\*1\*45 corrected problems related to printing progress notes: as a result, the value of TIUDIV should be defined as the IEN of an entry in the TIU DIVISION PRINT PARAMETERS file (#8925.94).

#### Patch TIU\*1\*20

Patch 20 offers enhancements to allow the printing of chart copies (where permitted) from the review screen (e.g., the *All my unsigned documents* option), and to specify a single printer when multiple notes are signed consecutively from the review screen. It also adds two new document parameters to conditionally require a YES or NO response to the Classification questions for exposure to AO, IR, or EC, as they apply, and to ask for encounter data on ALL Outpatient visits (scheduled as well as stand-alone). It adds action type protocols to allow the entry/editing of encounter data on demand, from the clinician's review and browse screens. It eliminates a DEVICE NOT OPEN error when the user exits, rather than printing upon signature, and finally, it allows for the removal of additional signers, independent of the user's file access.

Following successful installation of this patch, you may wish to modify the two new document parameters FORCE RESPONSE ON SC and ASK DX/CPT ON ALL OP VISITS, for the PROGRESS NOTES CLASS. To make the changes, use the TIU DOCUMENT PARAMETER EDIT option as shown below:

Select TIU Parameters Menu Option: **TIU DOCUMENT PARAMETER EDIT** Document Parameter Edit action

Document Parameter Edit

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **PROGRESS NOTES** CLASS

 ...OK? Yes// **<Enter>** (Yes)

DOCUMENT DEFINITION: PROGRESS NOTES//  **<Enter>**

REQUIRE RELEASE: NO// <Enter>

REQUIRE MAS VERIFICATION: NO// **<Enter>**

REQUIRE AUTHOR TO SIGN: YES// **<Enter>**

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: YES// **<Enter>**

ALLOW CHART PRINT OUTSIDE MAS: YES// **<Enter>**

ALLOW >1 RECORDS PER VISIT: YES// **<Enter>**

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON NEW VISIT: **<Enter>**

FORCE RESPONSE ON SC: YES// **??**

 This parameter determines whether the user will be forced to enter a

 Yes or No response when asked to specify the Service Connection

 Classification of a Veteran, when creating a standalone visit (i.e.,

 AO, IR, or EC).

 Choose from:

 1 YES

 0 NO

FORCE RESPONSE ON SC: YES// **Y** YES

ASK DX/CPT ON ALL OP VISITS: YES// **??**

 Please indicate whether the Diagnosis and Procedural questions should

 be asked on Scheduled Appointments, in addition to Walk-ins and

 Telephone (i.e., Standalone) Encounters.

 Choose from:

 1 YES

 0 NO

ASK DX/CPT ON ALL OP VISITS: YES// **Y** YES

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS: CLERK,ONE// **<Enter>**

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: STUDENT// **<Enter>**

Now enter the DIVISIONAL parameters:

Select DIVISION: SALT LAKE CITY// **<Enter>**

 CHART COPY PRINTER: LASER// **<Enter>**

 STAT CHART COPY PRINTER: **<Enter>**

Select DIVISION: **<Enter>**

Press RETURN to continue... **<Enter>**

#### Patch TIU\*1\*23: EXEMPT PURGING OF PN ADDENDA

This patch resolves two problems with the application of the purge to TIU DOCUMENTS, by increasing the allowable number of days for retention to 7300 days (20 years), and by exempting addenda to Progress Notes from purge.

Following installation, you may wish to reset the Basic TIU Parameters, from the TIU IRM MAINTENANCE MENU OPTION, as shown in the example below:

Select TIU Maintenance Menu Option: **TIU Parameters Menu**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Select TIU Parameters Menu Option: **1** Basic TIU Parameters

First edit Division-wide parameters:

Select INSTITUTION: **SALT LAKE CITY**

ENABLE ELECTRONIC SIGNATURE: YES// **<Enter>**

ENABLE NOTIFICATIONS DATE: OCT 1,1996// **<Enter>**

GRACE PERIOD FOR SIGNATURE: 7// **<Enter>**

GRACE PERIOD FOR PURGE:**??**

 This is the number of days following transcription for which a

 document will be kept, prior to purge. Allowable range is from 90 to

 7300 days (20 years).

 NOTE: Progress Notes and their addenda are not subject to purge,

 regardless of this parameter. IF YOU WANT TO DISABLE PURGING

 ALTOGETHER, LEAVE THIS PARAMETER EMPTY (i.e., GRACE PERIOD FOR PURGE

 equal to NULL).

GRACE PERIOD FOR PURGE: **7300**

CHARACTERS PER LINE: 60// **<Enter>**

OPTIMIZE LIST BUILDING FOR: performance// **<Enter>**

SUPPRESS REVIEW NOTES PROMPT: **<Enter>**

ENABLE CHART COPY PROMPT: YES// **<Enter>**

BLANK CHARACTER STRING: @@@// **<Enter>**

Press RETURN to continue... **<Enter>**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

#### Patch TIU\*1\*29: FIX PROVIDER RECOGNITION PROBLEM

This patch resolves an issue identified by a number of sites, where providers entering notes were not being passed to PCE, because they had not been allocated to the ASU Class PROVIDER or any of its subclasses. It also provides a mechanism to assure that the PRIMARY PROVIDER is unambiguously identified when entering new standalone encounters through TIU.

To enter a default primary provider, follow the example below:

Select TIU Parameters Menu Option: **1** Basic TIU Parameters

First edit Division-wide parameters:

Select INSTITUTION: <Enter your institution>

ENABLE ELECTRONIC SIGNATURE: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

ENABLE NOTIFICATIONS DATE: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

GRACE PERIOD FOR SIGNATURE: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

GRACE PERIOD FOR PURGE: <YOUR SITE'S CURRENT VALUE>

CHARACTERS PER LINE: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

OPTIMIZE LIST BUILDING FOR: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

SUPPRESS REVIEW NOTES PROMPT: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

DEFAULT PRIMARY PROVIDER: **??**

 This parameter determines whether and how TIU should default the Primary

 Provider prompt, when a standalone encounter is being documented.

 Choose from:

 0 NONE, DON'T PROMPT [The person entering the note will not be

 displayed the Primary Provider Provider

 prompt at all. There will be no chance to

 edit the primary provider at the time of

 the note being entered. The author, if

 appropriate, will be automatically past

 to PCE. If the author is not a valid

 provider, no provider will pass to PCE.]

 1 DEFAULT, BY LOCATION [The person entering the note will be

 prompted for PRIMARY PROVIDER, with the

 default displayed being the default

 provider assigned to the location on

 the note. The default provider for a

 location can be established within the

 PIMS software.]

 2 AUTHOR (IF PROVIDER) [The person entering the note will be

 prompted for PRIMARY PROVIDER, with the

 default displayed being the author IF

 the author is a active provider. If the

 author is not a valid provider, then

 the prompt for primary provider is

 displayed with no default. The person

 entering the note has the ability to

 enter a valid provider at this time.

DEFAULT PRIMARY PROVIDER: **1** DEFAULT, BY LOCATION

ENABLE CHART COPY PROMPT: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

BLANK CHARACTER STRING: <YOUR SITE'S CURRENT VALUE>// **<Enter>**

Press RETURN to continue... **<Enter>**

#### Patch TIU\*1\*128: INCORRECT PATIENT ON UPLOAD

This patch corrects TIU documentation for uploading Operation Reports, and warns against using field numbers in upload setup for *any* type of document where field numbers are not specified in TIU upload documentation. Also, sites that upload Operation Reports are reminded that transcribed CASE NUMBERS *must* be accurate.

#### Patch TIU\*1\*129: UPLOADING OP REPORTS TO SURGERY: IMPROVE RELIABILITY

This patch introduces a check of the case number during upload. If information on the transcribed case number does not match the patient social security number and operation date information, an error is generated along with an alert. You may then edit the transcribed information before the note gets filed.

This patch may be used as an example for checks for other documents. If your facility uploads document into files other than the TIU Document File (#8925) or the Surgery File (#130), your site needs to write custom code using TIU\*1\*129 as an example.

#### Patch TIU\*1\*131: UPLOADING CONSULTS: IMPROVE RELIABILITY

This patch provides cross-checks, which eliminate the possibility of uploading a consult result for one patient and associating it with a consult request for a different patient. It corrects problems that arise when documents are uploaded as consult results, but with document titles from Progress Notes, and vice-versa. It solves problems which occur when a consult is uploaded erroneously without a consult request. In the process of solving these problems, the patch provides a new ability to change a document uploaded as a Consult to a Progress Note during the filing error resolution process.

It also restructures filing error resolution code routines, making it possible for custom code developers to write their own cross-checks. For guidance in writing custom file resolution code, see section **Applying the Upload Utility to New Document Types** of the *TIU Technical Manual*.

☞ NOTE: These corrections are not applied until the parameter UPLOAD FILING ERROR CODE is updated. The upload filing error code must be changed to D CNFIX^TIUCNFIX for Consults and to D PNFIX^TIUPNFIX for Progress Notes. See the sections on Modifying Upload Parameters.

## Uploading Surgery Reports into the Surgery File

Operation Reports are uploaded into the Surgery File (#130) for the Surgery Package. Setup of other reports for storage in other non-TIU files would be similar and subject to similar notes and warnings concerning field numbers and data consistency checks.

To set up this functionality in TIU, use VA FileMan, along with the TIUFA SORT DDEFS MGR option to set up OPERATION REPORTS for the upload utility:

1. First, use the VA FileMan Utility - Edit File option to add TIU as an APPLICATION GROUP to the SURGERY file (#130). This will allow the SURGERY file to pass the screen on the TARGET FILE field in file 8925.1:

> **D P^DII**

VA FileMan 21.0

Select OPTION: **U**TILITY FUNCTIONS

Select UTILITY OPTION: **EDIT** FILE

MODIFY WHAT FILE: PROTOCOL// **130** SURGERY (2 entries)

NAME: SURGERY// **<Enter>**

DESCRIPTION: **<Enter>**

Each entry in the SURGERY file contains information regarding a surgery

case made up of an operative procedure, or multiple operative procedures

for a patient. The file includes the information necessary for creating

the Nurses' Intraoperative Report, Operation Report, and Anesthesia Report

 Edit? NO// **<Enter>**

Select APPLICATION GROUP: **TIU**

 Are you adding 'TIU' as a new APPLICATION GROUP (the 1ST for this FILE)? **Y**

 (Yes)

Select APPLICATION GROUP: **<Enter>**

DEVELOPER: **<Enter>**

Select UTILITY OPTION: **<Enter>**

Select OPTION: **<Enter>**

> **h**

***Uploading Surgery Reports into the Surgery File, cont’d***

1. Next, use the TIUFA SORT DDEFS MGR option to create a new document definition for OPERATION REPORTS:

☞ NOTE: The Sort Option is used rather than the Create Document Definitions option because the new OPERATION REPORT title has to be an *orphan title* and is not created as part of the Document Definition hierarchy. E. g., it is not under class Progress Notes.

 1 TIU Parameters Menu ...

 2 Document Definitions (Manager) ...

 3 User Class Management ...

Select TIU Maintenance Menu Option: **2** Document Definitions (Manager)

 --- Manager Document Definition Menu ---

 1 Edit Document Definitions

 2 Sort Document Definitions

 3 Create Document Definitions

 4 Create Objects

Select Document Definitions (Manager) Option: **S**ort Document Definitions

Select Attribute: (T/O/S/U/P/A): Owner// **T** Type

Select TYPE: (CL/DC/TL/CO/O/N): **TL** TITLE

START WITH DOCMT DEF: FIRST// **<Enter>........................**

**Sort by TYPE** Jan 23, 1997 10:00:22 Page: 1 of 1

 Entries of Type TITLE

Name Type

1 ADDENDUM TL

2 ADMISSION ASSESSMENT TL

3 ADVANCE DIRECTIVE TL

4 ADVERSE REACTION/ALLERGY TL

5 CLINICAL WARNING TL

6 CRISIS TL

7 CRISIS NOTE TL

8 DISCHARGE SUMMARY TL

9 FINAL DISCHARGE NOTE TL

10 GENERAL NOTE TL

11 SOAP - GENERAL NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Find Boilerplate Text Name/Owner/PrintName...

 Change View... Detailed Display/Edit Delete

 Create Status... Copy

Select Action: Quit// **CR** Create

Enter Document Definition Name to add as New Entry: **OPERATION REPORT**

TYPE: (CL/DC/TL/CO/O): **TL** TITLE

Delete the Class Owner if you want a Personal Owner

CLASS OWNER: **CLPAC** CLINICAL COORDINATOR

STATUS: (I): INACTIVE// **<Enter>**

 Entry added

***Uploading Surgery Reports into the Surgery File, cont’d***

**Sort by TYPE** Jan 23, 1997 10:03:48 Page: 1 of 1

 Entries of Type TITLE

Name Type

1 ADDENDUM TL

2 ADMISSION ASSESSMENT TL

3 ADVANCE DIRECTIVE TL

4 ADVERSE REACTION/ALLERGY TL

5 CLINICAL WARNING TL

6 CRISIS TL

7 CRISIS NOTE TL

8 DISCHARGE SUMMARY TL

9 FINAL DISCHARGE NOTE TL

10 GENERAL NOTE TL

11 OPERATION REPORT TL

12 SOAP - GENERAL NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Find Boilerplate Text Name/Owner/PrintName...

 Change View... Detailed Display/Edit Delete

 Create Status... Copy

Select Action: Quit//

**3.** Now that we have created an orphan OPERATION REPORT title, we use option MODIFY UPLOAD PARAMETERS to set upload parameters and captions for the new title:

Select TIU Parameters Menu Option: **?**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select TIU Parameters Menu Option: **2** Modify Upload Parameters

First edit Institution-wide upload parameters:

Select INSTITUTION: **SALT LAKE CITY HCS**

ASCII UPLOAD SOURCE: remote computer// **<Enter>**

UPLOAD PROTOCOL: KERMIT// **<Enter>**

UPLOAD HEADER FORMAT: captioned// **<Enter>**

RECORD HEADER SIGNAL: $HDR// **<Enter>**

BEGIN REPORT TEXT SIGNAL: $TXT// **<Enter>**

RUN UPLOAD FILER IN FOREGROUND: YES//**<Enter>**

Now Select upload error alert recipients:

Be sure to set this to NO so that the upload process does not create new entries in the SURGERY FILE.

Select ALERT RECIPIENT: SCRIPTION,TWO// **<Enter>**

Now edit the DOCUMENT DEFINITION file:

DOCUMENT DEFINITION: **OPERATION REPORT** TITLE

ABBREVIATION: **OPR**

LAYGO ALLOWED: **NO**

UPLOAD TARGET FILE: **TIU DOCUMENT**

NAME: OPERATION REPORT                  ABBREVIATION: ORPT

  PRINT NAME: OPERATION REPORT          TYPE: TITLE

  CLASS OWNER: CLINICAL COORDINATOR     STATUS: ACTIVE

  NATIONAL STANDARD: YES                UPLOAD TARGET FILE: TIU DOCUMENT

  LAYGO ALLOWED: NO                     TARGET TEXT FIELD SUBSCRIPT: 2;TEXT

  OK TO DISTRIBUTE: YES                 SUPPRESS VISIT SELECTION: NO

  UPLOAD LOOK-UP METHOD: D LOOKUP^TIUPUTS

  UPLOAD POST-FILING CODE: D FOLLOWUP^TIUPUTS(+$G(TIUREC("#")))

  UPLOAD FILING ERROR CODE: D FIX^TIUPUTS

  PRINT METHOD: D ENTRY^SROESPR

  ON BROWSE EVENT: D GETOP^TIUSROI(.TIUY,TIUDA,"OP")

  VHA ENTERPRISE STANDARD TITLE: OPERATION REPORT

  MAP ATTEMPTED: JAN 18, 2007@13:45:20  MAP ATTEMPTED BY: CPRSCOORDINATOR, ONE

  TIMESTAMP: 59682,26539

CAPTION: PATIENT NAME                   ITEM NAME: PT NAME

  FIELD NUMBER: .02                     EXAMPLE ENTRY: CPRSPATIENT,ONE

  CLINICIAN MUST DICTATE: YES           REQUIRED FIELD?: NO

CAPTION: PATIENT SSN                    ITEM NAME: PT SSN

  FIELD NUMBER: .02                     LOOKUP LOCAL VARIABLE NAME: TIUSSN

  EXAMPLE ENTRY: 555-12-3445            CLINICIAN MUST DICTATE: YES

  REQUIRED FIELD?: YES                  TRANSFORM CODE: S X=$TR(X,"-/","")

CAPTION: DOCUMENT NUMBER                ITEM NAME: DOCUMENT NUMBER

  FIELD NUMBER: .001                    LOOKUP LOCAL VARIABLE NAME: TIUSDA

  EXAMPLE ENTRY: 134567                 CLINICIAN MUST DICTATE: YES

  REQUIRED FIELD?: NO

CAPTION: SURGICAL CASE                  ITEM NAME: SURGICAL CASE

  FIELD NUMBER: 1405                    LOOKUP LOCAL VARIABLE NAME: TIUSRCN

  EXAMPLE ENTRY: 143342                 CLINICIAN MUST DICTATE: YES

  REQUIRED FIELD?: NO                   TRANSFORM CODE: S X="S.`"\_X

CAPTION: OPERATION DATE                 ITEM NAME: OPERATION DATE

  FIELD NUMBER: .07                     LOOKUP LOCAL VARIABLE NAME: TIUODT

  EXAMPLE ENTRY: 04/29/2001             CLINICIAN MUST DICTATE: YES

  REQUIRED FIELD?: YES                  TRANSFORM CODE: S X=$$IDATE^TIULC(X)

CAPTION: DICTATED BY                    ITEM NAME: DICTATING SURGEON

  FIELD NUMBER: 1202                    EXAMPLE ENTRY: CPRSPROVIDER, TWO

  CLINICIAN MUST DICTATE: YES           REQUIRED FIELD?: YES

CAPTION: ATTENDING SURGEON              ITEM NAME: ATTENDING SURGEON

  FIELD NUMBER: 1209                    EXAMPLE ENTRY: CPRSPROVIDER, ONE

  CLINICIAN MUST DICTATE: YES           REQUIRED FIELD?: YES

CAPTION: URGENCY                        ITEM NAME: STAT or ROUTINE

  FIELD NUMBER: .09                     EXAMPLE ENTRY: PRIORITY

  CLINICIAN MUST DICTATE: YES           REQUIRED FIELD?: NO

CAPTION: DICTATION DATE                 ITEM NAME: DICTATION DATE

  FIELD NUMBER: 1307                    EXAMPLE ENTRY: 04/28/2001

  CLINICIAN MUST DICTATE: NO            REQUIRED FIELD?: YES

CAPTION: TRANSCRIBER                    ITEM NAME: TRANSCRIPTIONIST ID

  FIELD NUMBER: 1302                    EXAMPLE ENTRY: CPRSTRANSCRIPIONIST,ONE

  CLINICIAN MUST DICTATE: NO            REQUIRED FIELD?: NO

$HDR:                                   OPERATION REPORT

PATIENT NAME:                           CPRSPATIENT,ONE

PATIENT SSN:                            666-00-0000

DOCUMENT NUMBER:                        134567

SURGICAL CASE:                          143342

OPERATION DATE:                         04/29/2001

DICTATED BY:                            CPRPROVIDER,TWO

ATTENDING SURGEON:                      CPRSPROVIDER,ONE

URGENCY:                                PRIORITY

DICTATION DATE:                         04/28/2001

TRANSCRIPTIONIST:                       T1212

$TXT

  OPERATION REPORT Text

$END

☞ NOTE: Since the upload header definition has changed, transcribed files must change accordingly. Transcribed caption names must exactly match those in the header definition. For example, the caption SURGERY DATE/TIME must now read OPERATION DATE. The full patient SSN must be transcribed. Time (as well as date) may be included for OPERATION DATE if preferred, but time is not used in determining the correct surgery record, even if time is included.

##  Using the Upload Process for Other Reports

Applying the TIU upload utility to new document types requires some custom code. Each document type requires its own code for document lookup. For filing error resolution code document types can either have their own code or they can rely on the generic TIU filing error resolution process.

☞ NOTE: Do not use filing error resolution code written for a different document type. Document types may either rely on the generic TIU upload filing error resolution process or they may use their own custom upload filing error code. See the section Applying the Upload Utility to New Document Types in the *TIU Technical Manual* for guidelines on writing custom filing error resolution code.

All reports must have their own Lookup Method to perform cross-checks on transcribed data. Relying on generic TIU upload code to look up the correct target record on the basis of a single piece of transcribed data *is not adequate*. A single error in dictation or transcription of the header data can result in reports being filed in the wrong patient record. The lookup methods that have been provided with TIU perform double-checks on the upload header data in order to avoid filing in the wrong patient record and custom upload code must do the same.

☞ NOTE: Use lookup methods provided by TIU only for the document type they are intended for. If a lookup method has not been provided for a document type you want to upload, you should write your own lookup method. See the section Applying the Upload Utility to New Document Types in the *TIU Technical Manual* for guidelines on writing custom upload code.

# Document Definition Setup

The Document Definition Hierarchy provides the building blocks for TIU. As a kind of database or document management system, it is the structure that defines the characteristics of the actual progress notes, discharge summaries, consults, etc. This database structure enables documents (Titles) to share or inherit characteristics of the higher levels, class and document class, such as signature requirements and print characteristics.

**Document Definition Categories and Definitions**

|  |  |
| --- | --- |
| Name | Description  |
| Class  | A group of groups which may contain one or more CLASSES or DOCUMENT CLASSES. TIU exports a root Class, Clinical Documents, with the sub-classes Progress Notes and Discharge Summary. |
| Document Class | A grouping which contains TITLES. Examples of document classes are: Medical Notes, Nursing Notes, Surgery Notes,  |
| Title  | A single entity at the lowest level. Titles define the actual Progress Notes or Discharge Summaries that you write (e.g., Endocrinology Notes, OPC/Psychology, Primary Care Notes, Dr. Jones’ Discharge Summaries, etc.). |
| Boilerplate Text | A kind of template for common types of documents, which may be composed of either boilerplate text, predefined Objects, or a combination of the two, to allow quick creation of notes. |
| Component | An individually stored block of text that is predefined for a specific purpose, such as SOAP components (Subjective, Objective, Assessment, Plan). |
| Object | A pre-defined placeholder that allows patient-specific text to be inserted into a document when a user selects a TIU document, such as PATIENT AGE.  |



### Create your TIU Document Class/Title structure

An important feature of TIU is its improved searching and retrieving capabilities across documents. This is done by a meaningful grouping of Titles to facilitate sorting.

A new grouping in TIU, *document class*, groups Titles according to Service, product line, or whatever grouping system your site prefers.

Sit down with hospital staff from relevant services or product lines to create a paper list of these document classes before you enter them with this option.

***Important***

**Exported Document Classes**

The CWAD Titles have already been established as individual Document Classes in order for the CWAD alert system to work. The corresponding Titles are automatically placed under the appropriate Document Class.

The Historical Titles Document Class has also been provided. Most sites have many thousands of General Notes as well as SOAP - General Notes entered in their databases. These titles will not serve you well in TIU, as they don’t contribute to meaningful sorting. The Titles conversion routine automatically converts these Titles to the Historical Titles Document Class and make them inactive. All data is still fully accessible; you just won’t have numerous notes sorted in no particular category.

Addiction Severity Index (ASI), a patch from the Mental Health Package, automatically generates a simple, electronically signed Progress Note. ASI is exported as a Document Class and a Title.

###### Example of a Document Definition Hierarchy:

**Clinical Documents**

**CLASS**

Consults

Discharge Summary

**TITLES**

**DOCUMENT CLASSES**

**CLASSES**

Eye Clinic Nursing Notes

Cardiology Nursing Notes

ICU Nursing Notes

Dietitian Notes

Interdisciplinary Child Notes

Clinician Notes

Nursing Notes

Progress Notes

### Fine-tuning your initial Document Definition Hierarchy

After installing and converting Progress Notes, you’ll probably need to do some fine-tuning of the Document Hierarchy before you create any new Document Classes, Titles, or Boilerplate Text. Look at the report of Titles produced by the option,*TITLEs Sorted by Document Class- Report,* on the TIU Maintenance Menu, before proceeding.

##### Inactivating a Title

When the Titles are converted from Progress Notes File 121.2 to TIU 8925, titles that were inactive are still inactive in TIU; active titles are converted as active. To be able to fine-tune Titles (change any parameters or characteristics) you must “inactivate” them. Do this through the option *Edit Document Definition.*

**Example: Inactivating a Title**

When you use *Edit Document Definition,* you can “drill down” to the Title by using the action Expand/Collapse or you can use Jump to Document Def to “jump” directly to the Title you want.

**1.** Select *Edit Document Definitions* from your Document Definition Menu.

**2.** Select the action Expand/Collapse and then entry #4, Progress Notes.

 Shortcut: At any “Select Action” prompt, you can type the action abbreviation, then the = sign and the entry number (e.g., E=4).

**Edit Document Definitions** Jan 28, 1997 10:46:03 Page: 1 of 1

 **BASICS**

 **Name Type**

**1 CLINICAL DOCUMENTS CL**

2 +ADDENDUM DC

3 +DISCHARGE SUMMARY CL

4 +PROGRESS NOTES CL

 **?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Expand/Collapse Detailed Display/Edit Items:Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy

Select Action: Quit// **E=4**

***Inactivating a Title, cont’d***

1. Select E again, then the entry 10.

**Edit Document Definitions** Jan 28, 1997 10:53:52 Page: 1 of 2

 BASICS

+ Name Type

5 ADVANCE DIRECTIVE DC

6 ADVERSE REACTION/ALLERGY DC

7 CRISIS NOTE DC

8 CLINICAL WARNING DC

9 HISTORICAL TITLES DC

10 NURSING NOTES

 DC

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Expand/Collapse Detailed Display/Edit Items:Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy

Select Action: Next Screen// **E=10** Expand/Collapse

**4.** Select the Status action, enter Inactive at the Status prompt, then enter 11 at the Select Entry prompt..

**Edit Document Definitions** Jan 28, 1997 10:53:52 Page: 1 of 2

 BASICS

+ Name Type

10 NURSING NOTES DC

11 NURSING-PATIENT EDUCATION NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Expand/Collapse Detailed Display/Edit Items:Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy

Select Action: Next Screen// **ST** Status

Select STATUS: (A/I/T): **?**

Documents can be entered on ACTIVE Titles. Only the Owner can enter a

document on TEST Titles. Only INACTIVE Document Definitions can be edited.

Choose from: ACTIVE INACTIVE TEST

Select STATUS: (A/I/T): **I** INACTIVE

Selecting Entries for Status INACTIVE. Please select ONE entry. You will be prompted for another.

at the same time.

Select Entry: (10-11): **11**

Entry Inactivated!......

**5.** Once a Title is inactivated, you can edit the search title (Name), the abbreviation (acronym), the print Title, the boilerplate, and the owner (personal or User Class).

 NOTE: The Title must be re-activated for a clinician or others to write a Progress Note using this Title.

##  Creating and Editing Titles

A basic set of Document Definitions is exported with the TIU package. Patch #44 helps you begin to set up your Document hierarchy by converting the Progress Notes structure to TIU files. With the exported set of Titles, you have an adequate base for your users to begin writing notes and summaries. To refine and adapt the package to your site’s needs, follow the instructions in this section.

**Document Definition Options**

|  |  |  |
| --- | --- | --- |
| **Option****Text**  | **Option Name** | **Description** |
| Edit Document Definitions | TIUFH EDIT DDEFS  | This option lets you view and edit entries. Entries are presented in hierarchy order. Items of an entry are in sequence order, or if they have no sequence, in alphabetic order by menu text, and are indented below the entry. Since Objects don’t belong to the hierarchy, they can’t be viewed or edited using the Edit Options.  |
| Create Document Definitions | TIUFC CREATE DDEFS  | This option lets you create new entries of any type (Class, Document Class, Title, Component) except Object, placing them where they belong in the hierarchy. Although entries can be created using the Edit and Sort options, the Create option streamlines the process. This option present entries in hierarchy order, traversing ONE line of descent, starting with Clinical Documents at the top.The Create option permits you to view, edit, and create entries, but only from within the current line of descent. The Create Option doesn’t let you copy an entry. |
| Sort Document Definitions | TIUFA SORT DDEFS  | This option lets you select sort criteria. It then displays selected entries in alphabetic order by Name, rather than in hierarchy order. Depending on sort criteria, entries can include Objects. The Sort option lets you view and edit entries. |
| Create Objects | TIUFJ CREATE OBJECTS MGR | This option lets you create new objects or edit existing objects. First you select Start With and Go To values, and the existing Objects within those values are displayed in alphabetical order. |
| View Objects | TIUFJ VIEW OBJECTS CLIN | This option on the Clinician Document Definition menu lets you view objects by a selected date range, in alphabetical order. |

#### Creating new Document Classes and Titles

#### Title Conversion

All Titles converted to TIU are assigned to the Clinical Coordinator.

Titles that were active will be active in TIU. While editing, adding boilerplate, etc., an Active Title needs to be made Inactive. When you’re ready to start using it, change the status to Active, using the Edit Status action in the *Edit Document Definitions* option*.*

#### Hierarchy Levels

To create Document Classes or Titles, you need to move to the level of the hierarchy where that document class or title belongs.

###### Summary of creating a new Document Class

1. Select Next Level.
2. Select the number on the screen for Progress Notes class.
3. You then see only that level of the hierarchy on the screen, with Progress Notes bolded.
4. Select the action Class/Document Class to Create a Document Class.

######  To create a Title:

1. Select Next Level plus the number of the new Document Class you created.
2. The screen shows just that level of the hierarchy with the Document Class Name bolded.
3. Select the action Title to Create a Title.

See the examples on the following pages for more detailed instructions.

**Example 1: Using the *Create Document Definitions* option**

In this example, we create a Progress Note Document Class called Nursing Notes, then a Title called Nursing Patient Education Notes.

**1.** Select *Document Definitions* from your menu.

**2.** Select *Create Document Definitions*. A screen appears, similar to the one on the following page .

☞ NOTE: The Class CLINICAL DOCUMENTS is bolded to show that you’re at that level of the hierarchy.

**Create Document Definitions**  Oct 30, 1996 15:41:35 Page: 1 of 1

 BASICS

 Name Type

1 **CLINICAL DOCUMENTS**  CL

2 ADDENDUM DC

3 DISCHARGE SUMMARY CL

4 PROGRESS NOTES CL

 **New Users. Please enter ‘?NEW’ for Help>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Next Level// ?NEW

##### Help for new users:

The Create Option shows the Hierarchy, with CLINICAL DOCUMENTS at the top. When the option begins, Clinical Documents is bolded with its current items indented below it. You can create additional items under Clinical Documents if you so choose.

If you wish to create items under a LOWER entry, you must go down the hierarchy successive levels until the proper entry is bolded and THEN create your items under the bolded entry.

To go down a level, select action NEXT LEVEL and then select an entry.

To create an entry, select Class/DocumentClass, Title, or Component. Only one of these actions is selectable at a given time.(Actions enclosed in parentheses are not selectable.)

 Enter ? for Help

 Enter ?? for detailed help on actions including PRINTING

 Enter ??? for detailed help on display

Press RETURN to continue or ‘^’ or “^^” to exit:

***Example 1: Create Document Definitions, cont’d***

**3.** Press Enter to accept the default of Next Level, so that you can create the Nursing Notes as a Document Class under Progress Notes.

**Create Document Definitions**  Oct 30, 1996 15:41:35 Page: 1 of 1

NAME BASICS

 Name Type

1 **CLINICAL DOCUMENTS**  CL

2 ADDENDUM DC

3 DISCHARGE SUMMARY DC

4 PROGRESS NOTES CL

 **New Users. Please enter ‘?NEW’ for Help>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Next Level// **<Enter>** Next Level

### Create Document Definitions Action Descriptions

Actions are not selectable when they are enclosed in parentheses.

Class/Document Class

This action is selectable only when the highlighted entry is a Class. It lets you create a new Class or Document Class under the bolded entry.

Title

Create Title is selectable only when the bolded entry is a Document Class. This action lets you create a new Title under the bolded entry.

Component

This action is selectable only when the bolded entry is a Title. It lets you create a new Component under the bolded entry. A Title must be Inactive before Components can be created under it. Subcomponents are created by selecting the action Detailed Display at the parent Component, and Editing its Items. You can’t create Objects in *Create Document Definitions.* Use the option *Create Objects* or *Sort Document Definitions.*

##### Next Level

Your current position in the Hierarchy is marked by the bolded entry. This action lets you navigate down the Hierarchy by selecting an item under the highlighted entry.

 NOTE: Next Level differs from Expand/Collapse in that Next Level changes your position in the hierarchy and limits future expansion to items of that entry.

##### Restart

This action takes you back to the original display, with Clinical Documents bolded as the current position in the hierarchy.

***Example 1: Create Document Definitions action descriptions, cont’d***

##### Boilerplate Text

Applies to Titles and Components only. This action lets you display and edit the boilerplate text of an entry. If the entry is a Title, it also displays the boilerplate text of any Components. If you have the Manager menu, you don’t have to own the entry to edit its boilerplate text.

##### Detailed Display/Edit

Detailed Display lets you view and edit (if appropriate) details about the entry you select. This action differs from the Items action in that Detailed Display permits edit of all aspects of the entry, including Items, but Items looks at the entry ONLY as an Item under its parent and permits edit of Item characteristics ONLY. Editing is limited if the entry is National. Shared Components can be viewed through the *Edit Document Definitions* option but can be edited only via the *Sort* option.

##### Status

* Select Status Inactive, Test, or Active.
* Select an entry. (If selected Status is Active, you can select multiple entries.)
* If the entry is a Class or Document Class, Status is changed to the selected Status (Inactive, Test, or Active). If the selected Status is Inactive, descendants are also Inactivated.
* If the entry is a Title, the Status is changed and Component Statuses are automatically changed to the same Status. Exception: Shared Components don’t have a Status and are not changed.
* To change the status of an Object, use the action Basics under Detailed Display, since Detailed Display shows Titles with the object embedded.

##### Delete

Deletes the entry from the TIU Document Definition file 8925.1. An entry will first be deleted as an item wherever it is used as an item.

**Can delete if**: **Can’t delete if:**

 Inactive status Active Status

 Owner In Use by documents.

 National entry

 Shared Component

 Pointed to by Business Rule

If the entry is used or pointed to by an entry in another file (for example if an entry has a Business Rule which references it), it is the user’s responsibility to delete the entry which points to it (for example, the Business Rule) before deleting the entry.

***Example 1: Create Document Definition, cont’d***

Objects can be deleted only from the Detailed Display of the Object. This action deletes the Object from the file. Objects can only be deleted by the owner and only after deactivation. Object can’t be deleted if they are embedded in Boilerplate Text of any Titles.

1. Select the number of the Clinical Document you want to place your Document Class under.

Select CLINICAL DOCUMENT Item (Line 2-4): **4**

**5.** The following screen appears, displaying only Progress Notes Document Classes. *Note that Progress Notes is bolded, indicating that you are working at that level in the hierarchy.* Select Class/Document Class to create a new document class.

**Create Document Definitions** Oct 30, 1996 15:41:35 Page: 1 of 1

 BASICS

 Name Type

1 CLINICAL DOCUMENTS CL

2 **PROGRESS NOTES** CL

3 ADVANCE DIRECTIVE DC

4 ADVERSE REACTION/ALLERGY DC

5 CRISIS NOTE DC

6 CLINICAL WARNING DC

7 HISTORICAL TITLES DC

 **? Help > Scroll Right PS/PL Print Screen/List +/- >>>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Next Level// **Cl** Class/DocumentClass

**6.** Answer the following prompts:

Enter the Name of a new PROGRESS NOTES: **NURSING NOTES**

TYPE: (CL/DC): **DC** DOCUMENTCLASS

STATUS: (A/I): INACTIVE// **<Enter>**

CLASS OWNER: CLINICAL COORDINATOR Replace **<Enter>**

SEQUENCE: **6**

MENU TEXT: Nursing Notes// **<Enter>**

Entry Created

If you wish, you may enter another PROGRESS NOTES: **<Enter>**

***Example 1: Create Document Definition, cont’d***

**Explanations for the prompts above:**

##### CLASS OWNER

* A Class Owner is a User Class from the USR CLASS file (in ASU) whose members may edit the entry. An entry may have a Personal OR a Class Owner, but not both. The program doesn’t prompt for Class Owner if the entry has a Personal Owner.
* If the document is owned by a Class rather than by a Person, enter the name of the User Class whose members may edit the entry. If it’s owned by a Person, you won’t be prompted for Class Owner. If you want to change a Class Owner to a Personal Owner, delete the Class Owner by entering '@' at the Class Owner prompt. When Titles were converted from the old Progress Notes package, they were all given to the Class Owner, Clinical Coordinator. To enter a different Class Owner, enter the appropriate class after the //'s. If there are no //'s and the Replace...with editor is being used, enter ... to replace the whole class and then enter the appropriate class.
* Document Definition Ownership has nothing to do with who can USE the entry to enter a document. It determines responsibility for the Document Definition itself.
* An entry can be edited by its owner. (The Manager menu permits override of ownership so that ownership can be assigned to a clinician (anyone who has the Clinician Menu) who can then fill in boilerplate text, while the manager can still edit the entry, since there are many fields the clinician does not have access to.)

##### STATUS (A/I/T)

* Status provides a way of making Document Definitions “offline” to documents. Document Definitions need to be “offline” if they are new and not ready for use, if they are being edited, or if they are retired from further use.
* Documents can only be entered on ACTIVE Titles.
* Only the Owner can enter a document on TEST Titles.
* Only INACTIVE Document Definitions can be edited.

##### SEQUENCE

* Sequence, if entered, determines an item’s order under its parent. If items have no sequence, item order is alphabetic by Menu Text.
* Sequence must be between .01 and 999.

##### MNEMONIC

* Mnemonic is a number or abbreviation to select Classes/Document Classes from a menu. Enter the Sequence number, or 1-4 letters, or nothing if you don't want mnemonics.
* Mnemonic is usually numeric with the same value as the Sequence.

***Example 1: Create Document Definitions, cont’d***

##### MENU TEXT

* Answer must be 1-20 characters in length.
* Can't start with "All" or a space.
* Menu Text is the name users will see for Classes and Document Classes when selecting them from a 3-column Menu. Document Definitions are selected from 3-column menus when viewing documents across many patients and when viewing many kinds of documents at the same time (e.g. Progress Notes and Discharge Summaries).
* The program automatically sets the Menu Text to the first 20 characters of the Item’s Name when an entry is first added as an item.
* It doesn’t update Menu Text if the item name is later changed, since this would overwrite what a site may have carefully set up.
* Menu Text can affect item order under a parent since order is alphabetic by Menu Text if items don’t have sequence numbers.

**7.** The following screen appears. Only one item is listed, because there are no items (Titles) below it.

**Create Document Definitions** Oct 30, 1996 15:41:35 Page: 1 of 1

 BASICS

+ Name Type

4 NURSING NOTES DC

**? Help > Scroll Right PS/PL Print Screen/List +/- >>>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Next Level// **<Enter>**

***Example 1: Create Document Definition, cont’d***

**8.** Select Detailed Display/Edit to see the details of your new Document, and to add characteristics that you want to apply to all sub-documents (Document Classes or Titles) for this Document Class.

**Detailed Display** Oct 30, 1996 15:41:35 Page: 1 of 2

 Document Class NURSING NOTE

Basics Note: Inherited Values preceded by \*

 Name: NURSING NOTE

 Abbreviation:

 Print Name: NURSING NOTE

 Type: DOCUMENT CLASS

 IFN: 1086

 National

 Standard: NO

 Status: INACTIVE

 Owner: CLINICAL COORDINATOR

 In Use: NO

Suppress Visit

 Selection: NO

 Items

**+ ? Help +, - Next, Previous Screen PS/PL**

 Basics Technical Fields Find

 Items: Seq Mnem MenuTxt Upload Quit

 (Boilerplate Text) Try

Select Action: Next Screen// **<Enter>**

**Detailed Display** Oct 03, 1996 14:12:17 Page: 2 of 2

 Document Class NURSING NOTE

+

Item IFN Seq Mnem Menu Text

 NURSING NOTE 1087 RAN 4 Nursing Note

 Technical Fields Note: Inherited Values preceded by \*

 Entry Action:

 Exit Action:

 Edit Template: \* [TIU ENTER/EDIT PROGRESS NOTE]

 Print Method: \* D ENTRY^TIUPRPN

 Print Form Header: \* Progress Notes

 Print Form Number: \* Vice SF 509

 Print Group: \* 2

Visit Linkage Method: \* D ENPN^TIUVSIT(.TIU,.DFN,1)

 Validation Method: \* S TIUASK=$$CHEKPN^TIULD(.TIU,.TIUBY)

Allow Custom Headers: \* YES

**+ ? Help +, - Next, Previous Screen PS/PL**

 Basics Technical Fields Find

 Items: Seq Mnem MenuTxt Upload Quit

 (Boilerplate Text) Try

Select Action: Quit//

***Example 1: Create Document Definitions cont’d***

**9.** As you can see, you can define the print methods, form headers, templates, and other characteristics that can apply to many documents (Titles) within a Class or Document Class.

**10.** Quit out of Detailed Display, select Next Level and item 8. You can now start adding Titles to the Document Class you just created.

Select Document Definitions Option: **3** Create Document Definitions.

**Create Document Definitions** Oct 30, 1996 15:41:35 Page: 1 of 1

 BASICS

 Name Type

1 CLINICAL DOCUMENTS CL

2 **PROGRESS NOTES** CL

3 ADVANCE DIRECTIVE DC

4 ADVERSE REACTION/ALLERGY DC

5 CRISIS NOTE DC

6 CLINICAL WARNING DC

7 HISTORICAL TITLES DC

8 NURSING NOTES DC

**? Help > Scroll Right PS/PL Print Screen/List +/- >>>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Next Level// **<Enter>**

 Select PROGRESS NOTES Item (Line 3-8): **8**

**11.** When the next level is displayed, accept the default of Title.

**Create Document Definitions** Oct 30, 1996 15:49:15 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 **NURSING NOTES** DC

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Class/DocumentClass Next Level Detailed Display/Edit

 (Title) Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title// **<Enter>** Title

***Example 1: Create Document Definitions cont’d***

**12**. Answer the following prompts about the new Title.

 Enter the Name of a new NURSING NOTES: **Nursing-Patient Education Note**

CLASS OWNER: CLINICAL COORDINATOR Replace

STATUS: (I): INACTIVE// **<Enter>**

SEQUENCE: **1**

MENU TEXT: Nursing-pt Education Replace **<Enter>**

 Entry Created

 If you wish, you may enter another NURSING NOTES: **<Enter>**

**13.** You can create another Title or edit the one you just created.

**14.** If you decide to create another Title, enter the name of the new Title at the prompt above and answer the other prompts, similarly to the example above.

**15.** If you don’t create another Title and respond to the prompt with **<Enter>**, the screen re-displays, showing the new Title. At this point you can edit, delete, perform other actions, or quit.

**Create Docmt Definitions** Oct 30, 1996 15:49:15 Page: 1 of 1

 BASICS

+ Name Type

3 **NURSING NOTES** DC

4 NURSING - PT EDUCATION NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 Component Boilerplate Text Delete

Select Action: Title//

***Example 1: Create Document Definitions cont’d***

 **16.** If you scroll to the right (using the “>” symbol), you can see further characteristics of your document (Title).

**Create Document Definitions** Oct 30, 1996 15:49:15 Page: 1 of 1

 BASICS

+ Name Type IFN Natl Status Owner

4 NURSING - PT EDUCATION NOTE TL 1087 No I jg

 **<<< ? Help +, - Next, Previous Screen >>>**

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 Component Boilerplate Text Delete

Select Action: Title// **>**

**17.** Scrolling to the right again produces even more characteristics.

**Create Document Definitions** Oct 01, 1996 11:26 Page: 1 of 1

 BASICS

+ Name Type In Use Boil Print Name

4 NURSING - PATIENT EDUCATION NOTE TL No No NURSING-PT ED

 **<<< ? Help +, - Next, Previous Screen >>>**

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 Component Boilerplate Text Delete

Select Action: Title// **<Enter>**

**18**. Create boilerplate text (or copy Boilerplate text from other Titles) to add to the Title you have created. Use the Boilerplate Text action. See the next section, “Creating Boilerplate Text and Objects,” for examples.

☞ NOTE: After you’ve created a Title and edited it to fit your needs, you need to “activate” the Title. Use the action “Status” to do this.

**Example 2: Using the *Edit Document Definitions* option**

This option lets you view and edit entries. Entries are presented in hierarchy order. Items of an entry are in sequence order, or if they have no sequence, in alphabetic order by menu text, and are indented below the entry. In this example, we’ll edit some of the “Basics” of a Title. We’ll add an abbreviation and change the class owner to a personal owner.

1. Select *Edit Document Definitions* from your menu.
2. When the screen is displayed, select the action Expand/Collapse, then entry #4.

**Edit Document Definitions** Jan 28, 1997 10:46:03 Page: 1 of 1

 **BASICS**

 **Name Type**

**1 CLINICAL DOCUMENTS CL**

2 +ADDENDUM DC

3 +DISCHARGE SUMMARY CL

4 +PROGRESS NOTES CL

 **?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move...

Select Action: Quit// **E=4**

1. Select Expand/Collapse again, then entry 10.

**Edit Document Definitions**  Jan 28, 1997 10:53:52 Page: 1 of 2

 BASICS

+ Name Type

5 ADVANCE DIRECTIVE DC

6 ADVERSE REACTION/ALLERGY DC

7 CRISIS NOTE DC

8 CLINICAL WARNING DC

9 HISTORICAL TITLES DC

10 NURSING NOTES DC

**? Help > Scroll Right PS/PL Print Screen/List >>>**

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move...

Select Action: Next Screen//**Ex=10** Exp/Collapse Entry

***Example 2: Edit Document Definitions, cont’d***

**Edit Document Definitions**  Jan 28, 1997 10:53:52 Page: 1 of 2

 BASICS

+ Name Type

10 NURSING NOTES DC

11 NURSING-PATIENT EDUCATION NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move...

Select Action: Next Screen//

1. We now show the Detailed Display/Edit screen, to edit characteristics of the Nursing-Patient Education Note. Select Det for Detailed Display, then entry 11.

**Edit Document Definitions Jan 28, 1997 10:53:52 Page: 1 of 2**

 BASICS

+ Name Type

10 NURSING NOTES DC

11 NURSING-PATIENT EDUCATION NOTE TL

 **? Help > Scroll Right PS/PL Print Screen/List >>>**

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... CopyMove...

Select Action: Next Screen// **det=11** Detailed Display/Edit

**5.** The screen displays the basics and technical fields of the note,

**Detailed Display** Jan 28, 1997 10:53:52 Page: 1 of 2

 Title NURSING-PATIENT EDUCATION NOTE

Basics Note: Inherited Values preceded by \*

 Name: NURSING-PATIENT EDUCATION NOTE

 Abbreviation:

 Print Name: NURSING-PATIENT EDUCATION NOTE

 Type: TITLE

 IFN: 1231

 National

 Standard: NO

 Status: INACTIVE

 Owner:

 Class Owner: CLINICAL COORDINATOR

 In Use: NO

 Additional

 Signers: \* ALLOWED

 Suppress Visit

 Selection: \* NO

**+ ? Help +, - Next, Previous Screen**

 Basics Technical Fields Find

 Items: Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

Select Action: Next Screen// **<Enter>**

***Example 2: Edit Document Definitions*, *cont’d***

**Detailed Display** **Jan 28, 1997 10:53:52** Page: 2 of 2

 Title NURSING-PATIENT EDUCATION NOTE

Technical Fields Note: Inherited Values preceded by \*

 Entry Action:

 Exit Action:

 Edit Template: \* [TIU Enter/EDIT PROGRESS NOTE]

 Print Method: \* D ENTRY^TIUPRPN

 Print Form Header: \* Progress Notes

 Print Form Number: \* Vice SF 509

 Print Group: \* 2

Visit Linkage Method: \* D ENPN^TIUVSIT(.TIU,.DFN,1)

 Validation Method: \* S TIUASK=$$CHEKPN^TIULD(.TIU,.TIUBY)

 **? Help +, - Next, Previous Screen**

 Basics Technical Fields Find

 Items: Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

Select Action: Quit// **ba** Basics

**Edit Document Definitions Action Descriptions**

Only actions unique to the Edit option are described here.

Actions are not selectable when they are enclosed in parentheses.

##### Expand/Collapse Entry

This action expands or collapses the selected entry to display entry items or to collapse the entry hierarchy. Entries preceded by + have items and can be expanded.

##### Jump To Document Def

This action applies to the *Edit Document Definitions* option only. Select any Document Definition in the Clinical Document Hierarchy and the action expands the display to include the selected entry. You can’t jump to Orphans or Objects, since they don’t belong to the hierarchy. You can’t jump to Shared Components, since they may occur more than once in the hierarchy. This is a quick way to move down the hierarchy in one step.

##### Name/Owner/PrintName

This action is available only on the Edit Document Definitions screen. Allows you to edit Name, Owner, and Print Name.

##### Copy/Move

##### OVERVIEW

Copy/Move is a very powerful action and should be used with great care. It is accessible only through the Document Definitions (Manager) menu [TIUF DOCUMENT DEFINITION MGR]. Like other actions on the Manager menu, it disregards ownership. Users are expected to move only titles or documents for which they are responsible.

Under the action Copy/Move, you may choose MT to MOVE TITLE, MD to MOVE DOCUMENTS, C to COPY, or U to UPDATE DOCUMENTS:

* MT: A Title may be moved to a different Document Class when, for example, hospital services are reorganized. Documents defined by the title are then updated with the new PARENT DOCUMENT TYPE (field # .04).
* MD: ALL documents defined by a given title may be moved to another title, for example, when a little-used title is eliminated in favor of a broader title.
* C: Titles, components, and objects may be copied, for example, when jump-starting a new Document Definition by copying and then editing the copy. Title and component copies may be placed under the same parent as the original, placed under a new parent, or left as orphans.
* U: Documents defined by a particular title are updated with the correct PARENT DOCUMENT TYPE (field # .04).

***Action Descriptions****,* ***cont'd***

When Moving or Copying a title, be aware that changing positions in the hierarchy gives an entry NEW INHERITED behavior. Accordingly, some moves may not be appropriate. It is the user's responsibility to determine whether or not a given action is appropriate.

##### DETAILED DESCRIPTION

###### COPY:

The Copy action prompts for an entry to copy and a new entry name to copy into. This name must be different from the name of the entry being copied. The action then creates a new entry with the chosen name and copies the fields in the Document Definition File 8925.1 into the new entry.

Certain fields require more information on exactly how they are copied:

EMPTY FIELDS - If the original has empty fields, they are copied empty, NOT as inherited.

STATUS FIELD - If the original has a Status of Active or Test, the entry may be copied, but the copy has a Status of Inactive.

NATIONAL STANDARD FIELD - If the original is National Standard, the entry may be copied, but the copy is not National Standard.

SHARED FIELD - If a component is Shared, it may be copied but the copy is not Shared. If the component has subcomponents, new nonshared subcomponents are created and added to the copy.

ITEMS FIELD - If the original entry has items, the action prompts for item names to copy into, creates NEW entries for the items, and adds the NEW items to the copy.

SHARED ITEMS - If a Nonshared entry has a Shared item, the action does NOT copy the Shared item but merely adds the Shared item to the copy.

TITLES and COMPONENTS can be copied from the Edit Option or the SortOption.

If an entry is copied under the Edit option, you are asked which parent to add the copy to, and the copy is added as an item to this parent. If no parent is selected, the copy is left as an orphan.

***Action Descriptions****,* ***cont'd***

###### Copying an Entry to a New Parent:

* If you are copying a title, then the parent to which the copy is added must be in the hierarchy and must be a document class.
* If you are copying a component, then the parent to which the copy is added must be in the hierarchy and must be a title or a component. The parent must be inactive and may not be National Standard or Shared.
* If an entry is copied under the Sort option (not the Edit option), then the title or component copies are left as orphans.
* Although orphan titles or components will not appear in the Document Definition hierarchy, they can be still be added to a parent through both the Sort and the Edit options by selecting the action Items for the parent, then the action Add/Create, and then the orphan item.

###### Checking Copies:

Copy titles which have been given a new parent should be thoroughly checked before they are activated since their inherited behavior may have changed.

The check should include Document Definition attributes of the entry (including Upload characteristics), TIU Document Parameters, and Business Rules. Consider inherited as well as explicit values. Any other implicit behavior, local or national, that applies to the entry must also be checked.

Although there is no harm in copying a Title to ANY document class in the hierarchy as long as the copy is not activated (since the copy has no documents), there is no reason to expect that such copies will function at all, much less function properly. You should either ensure that they function properly in every way, or delete such copies from the Document Definition file.

Copy COMPONENTS that have been given a new parent should also be checked by thoroughly testing the parent title as above. The copy action leaves the parent title of the copy component inactive. It is the user's responsibility to test the new parent title and then reactivate it so it is available to users for entering documents.

 NOTE: Although the action Copy *could* be used to change the behavior of an entry (i.e. change the copy and inactivate the original), it is better to use the actions Edit or Move and not clutter up the file with inactive entries.

Most behavior can be edited even when the entry is In Use by documents. Titles can be moved even when they are In Use by documents.

###### Copying Objects:

OBJECTS are copied from the Sort Option or the Create Objects Option. Object Abbreviation and Print Name are not copied, since they must be different from those of the original. If you don't have programmer access, the Object Method is not copied since it is an M field. Objects should be thoroughly tested before being activated.

***Action Descriptions****,* ***cont'd***

###### Move Title:

The action Move Title is accessed from the Edit option only, since it involves only entries in the Document Definition hierarchy.

######  Move Title permits:

* Moving TITLES
* Moving between DOCUMENT CLASSES within the same class

######  Move Title does not permit:

* Moving CLASSES or DOCUMENT CLASSES
* Moving COMPONENTS

(The same effect can be achieved by deleting the component as an item from its parent, and adding it as an item to the new parent. This can be done even if the component is In Use.)

* Moving NATIONAL STANDARD titles
* Moving titles which are not in the DOCUMENT DEFINITION HIERARCHY
* Moving titles between CLASSES
* Moving faulty titles (known as faulty to the computer)
* Moving titles to faulty DOCUMENT CLASSES
* Moves which result in a faulty title

(For example, suppose the Title NURSE NOTE inherits its Print Method from

its document class NIGHT NURSE DOCUMENT CLASS. Suppose DAY NURSE DOCUMENT CLASS has no Print Method. (This is not a fault since the

titles under it could all have their own Print Methods.) If you move NURSE NOTE from NIGHT NURSE DOCUMENT CLASS to DAY NURSE DOCUMENT CLASS, then the title lacks a Print Method and becomes faulty. Documents using the title don't print. In this case, the title must first be given its own Print Method, and *then* moved.)

The above restrictions are intended to prevent moves between Document Classes with very different behavior. However, hierarchies vary, and some structures will still permit risky moves. For example, if Consults are under Progress Notes, you can move a nonconsult Title to the Document Class CONSULTS. This sort of move is *not* advised. Anyone contemplating such a move should carefully read the paragraphs below on the Consequences of Moves between Very Different Document Classes.

Moving a title automatically inactivates it. Therefore, managers should move titles only during off-peak hours. After the title is inactivated and moved under a new Document Class, the MT action attempts to update the PARENT DOCUMENT TYPE field (#.04) for existing documents of the title. This may take awhile if there are many documents to update. (If certain documents were not updated, you must update them later, using the action Update Documents.) When the action is finished, the title is left INACTIVE.

***Action Descriptions****,* ***cont'd***

###### Checking the Title:

Since the title has changed position within the hierarchy, its behavior may have changed. It is the user's responsibility to thoroughly check its new behavior, and then to reactivate it so it is available for entering new documents.

The check should include Document Definition attributes of the entry (including Basic, Technical, and Upload fields), TIU Document Parameters, and Business Rules. Consider inherited as well as explicit values. Any other implicit behavior, local or national, that applies to the entry must also be checked.

It is possible that the Document Definition action TRY might state that an entry looks OK when it still does not function. For example, the action TRY may quit without continuing on to let you enter a trial document. In such a case, check the title's Document Definition Fields against a different title that DOES work. (The TRY action checks that fields *exist*, but does not check whether or not they function properly.)

###### Possible Consequences of Moves between Very Different Document Classes:

Some behaviors are explicit, being determined by parameters, Business Rules, etc. Others are implicit. For example, a Consult document is linked to a request when it is created, while a Progress Note document is not. These differences mean, for example, that one document may belong to a given cross-reference or have a certain field, while another lacks the field and is not in the cross-reference. Furthermore, the entry may have Business Rules, parameters, etc., which are not appropriate in its new position. It may also be lacking necessary ones.

Except for updating the PARENT DOCUMENT TYPE field (#.04) for documents of a title, the COPY/MOVE actions simply move the entry *as is*, making no attempt to ensure that it functions correctly in its new position. It is the user's responsibility to determine whether or not a move is reasonable, and to make all necessary changes to documents, Document Definitions, and rules/parameters.

This does NOT mean that all moves are dangerous. The more the difference in behavior and the greater the number of documents a title has, the greater the risk.

Moves may take awhile if a title has many documents. In the meantime, existing documents may not function properly, and users may not be able to enter given Titles.

On the other hand there should be little risk in moving, say, a Cardiology/Medicine Service Progress Note title from Document Class MEDICINE SERVICE to Document Class CARDIOLOGY.

***Action Descriptions****,* ***cont'd***

###### Move Documents:

Under this action, you select an old title and a new title. The action then attempts to move ALL the documents of the old title to the new title. After a document is moved, its Parent Document Type is updated if necessary. If some documents are not available for move/update, they can be moved later using the same action. The old title is then no longer In Use and can be deleted if desired.

The old title is inactivated while documents are moved, and left inactive. If you want it available for entering documents, you must reactivate it.

###### Move Documents does not permit:

* Moving documents from or to titles that have components
* Moving documents to a faulty title
* Moving documents between CLASSES
* Moving SELECTED documents (To move a particular document from one Title to another, use Hidden Action CT Change Title for that particular document.)

The behavior of documents is determined by their title. Therefore, moving documents from one title to another can affect their behavior. Users are responsible to make sure the behavior of the target title is appropriate *before* moving documents to it. Anyone contemplating a move between very different titles should carefully read the warnings under the action Move Title, above.

###### Update Documents:

This action is intended as a possible follow-up to Move Title. It will usually not be necessary since Move Title itself attempts to update documents defined by the moved title, giving them the correct new Parent Document Type. However, if a document is not available, then Move Title finishes, leaving that document with the old Parent Document Type.This may affect document behavior. It will cause CWADs to fail to generate alerts, and conversely will cause nonCWADs to generate CWAD alerts. It may have other consequences in the future. Update Documents is intended for this situation. It updates every document defined by a certain title to the correct Parent Document Type. It can be run multiple times if necessary and entails no risk.

**Detailed Display/Edit Action Descriptions**:

**Basics**

An entry’s Status must be Inactive in order to edit most basic attributes. Enter ??? to see more information about the Status. If you have the Manager menu, you don’t need to own an entry in order to edit it. Managers can edit Name, Abbreviation, Print Name, Type (if not In Use), Owner, Shared (for Components), Suppress Visit Selection, and Status.

**Items: Seq Mnem MenuTxt**

Item information (Mnemonic, Sequence, and Menu Text) is displayed for the selected entry. You may add, edit, or delete appropriate items if they are Inactive and have an Owner. You can view items of National entries, but only take limited actions on them. Items of Shared Components can be edited only via the Sort Option. Enter ??? to see Shared. Managers (persons with Manager menu) can edit items whether or not they own the parent entry.

**Boilerplate Text**

Boilerplate Text is the optional text a Document Definition may be given. It is displayed as the default, editable text of a TIU document when a TIU document is entered. Only Titles or Components may have Boilerplate Text, and only Inactive entries can be edited.

Managers (persons with Manager menu) can edit the boilerplate text of entries regardless of Ownership, except Shared Components.

**Technical Fields**

Technical fields are mainly M code (which requires Programmer access), although some are just very technical, requiring detailed knowledge of the utility. Many Technical Fields can be inherited from ancestor entries.

Technical fields include: Entry Action, Exit Action, Edit Template, Print Method, Print Form Header, Print Form Number, Print Group, Visit Linkage Method, Validation Method, and Allow Custom Form Headers, except for Objects, which have only one technical field: Object Method.

**Upload**

TIU permits documents to be dictated and then uploaded into TIU or into other files. Upload information can be set by this action for TIUF Classes, Document Classes, or Titles, and is heritable.

Although upload information is heritable, it is NOT displayed by the Document Definition Utility when it is inherited rather than belonging to the entry itself. To Detailed Display existing upload information, Detailed Display the entry where such information is set rather than lower entries. Do NOT set partial information at a lower level; if information is set at all at a lower level, it must be complete at that level.

Upload information includes basic characteristics such as the file/field which will store the text of the document, as well as header information for each fixed-field to be uploaded.

***Detailed Display/Edit Action Descriptions****,* ***cont'd***

**Try**

The TRY action is a way to test Boilerplate Text and any embedded Objects. TRY examines the selected entry for basic problems. If the entry is a Title and checks out OK, you can choose a patient and enter a document using the entry.

TRY doesn’t require any particular Status, since documents entered during the trial are deleted immediately after the trial. During the trial, objects function even if inactive in order to permit testing of objects. (Ordinarily, Object data isn’t retrieved unless the Object is active, so be sure to activate when ready for use.)

If TRY is selected from the Boilerplate Text Screen, TRY shows which objects are badly embedded and why. If the entry is okay, you can enter a trial document. When checking boilerplate text, TRY doesn’t check objects for ambiguity. Ambiguous objects are found by checking the OBJECT, not the entries the object is embedded in.

For Object, TRY checks the Object Name, Abbreviation, and Print Name to make sure they aren’t ambiguous so that the right Object is invoked when being used. TRY checks to see if the Object has an Object Method, but doesn’t check to see if the Object Method functions correctly.

For Classes, Document Classes, and Components, TRY just checks for basic completeness.

Since the document does show up on Unsigned lists during the time it is being edited, so it’s best to select test patients for creating and testing boilerplate text.

**Find**

This action finds text in a list of entries/information displayed. All pages of the current list/ information are searched except unexpanded entries in the Edit Document Definitions Option. Using the Find action can be a quick way to get to the right page.

**Quit**

Allows you to quit the current menu level.

**Example of Editing Basics**

Select Action: Next Screen// **BA** Basics

NAME: NURSING - PATIENT EDUCATION NOTE Replace...**<Enter>**

ABBREVIATION: **PE**

PRINT NAME: NURSING-PATIENT EDUCATION// **<Enter>**

TYPE: (CL/DC): DC// **<Enter>** DOCUMENT CLASS

CLASS OWNER: CLINICAL COORDINATOR Replace **C...** With **<Enter>** Replace **<Enter>**

PERSONAL OWNER: **TIUCAC,ONE** jg

SUPPRESS VISIT SELECTION: NO// **<Enter>**

STATUS: (A/I/T): ACTIVE// **<Enter>**

**Explanations for prompts in Edit Basics**

**NAME**

The name of a Document Definition entry (.01 field) must be between 3 and 60 characters long and may not begin with a punctuation character. Although names can be entered in any case, they are transformed to upper case before being stored. It functions as the Technical Name of the entry. Some sites have put KWIC cross-references on it to get, say, all Titles from a given Service. The .01 name differs from the Print Name, which appears in lists of documents and functions as the Title of the document. It also differs from Menu Text (1-20 characters), which is used when selecting documents from menus.

**ABBREVIATION**

Two to four letters. Abbreviation can be entered at the *Select Title* prompt when entering a document. Since all Titles with the given abbreviation will then be listed, Abbreviation can serve to group Titles.

**PRINT NAME**

1. Print Name is used in lists of documents and as the document Title in the Patient Chart. 3-60 Characters.

**TYPE: (CL/DC)**

1. Class or Document Class

**CLASS OWNER**

1. If the document is owned by a Class rather than by a Person, enter the name of the User Class whose members may edit the entry. If it’s owned by a Person, delete the Class Owner by entering '@' at the Class Owner prompt. When Titles were converted from the old Progress Notes package, they were all given to the Class Owner, Clinical Coordinator. To enter a different Class Owner, enter the appropriate class after the //'s. If there are no //'s and the Replace...with editor is being used, enter ... to replace the whole class and then enter the appropriate class.
2. Answer with USR CLASS NAME, or ABBREVIATION, or ACTIVE, or DISPLAY NAME.
3. Document Definition Ownership has nothing to do with who can USE the entry to enter a document. It determines responsibility for the Document Definition itself.
4. An entry can be *edited* by its owner. (The Manager menu permits override of ownership so that ownership can be assigned to a clinician (person with Clinician Menu) who can then fill in boilerplate text, while the manager can still edit the entry, since there are many fields the clinician doesn’t have access to.)
5. A Class Owner is a User Class from the USR CLASS file whose members may edit the entry. An entry may have a Personal OR a Class Owner, not both. The program doesn’t prompt for Class Owner if the entry has a Personal Owner.

***Explanations for prompts in Edit Basics, cont'd***

**SUPPRESS VISIT SELECTION**

1. Enter 1 for YES *only if* this is an administrative note which creates its own historical visit. You will NOT receive workload credit for such visits.
2. For most documents it is very important that the user entering a document select the appropriate visit to link the document with. However, certain administrative documents for outpatients have no particular visit that they should be linked with. For example, a clinician could have a chance encounter with a patient in the corridor and want to document the discussion, or a clinician could simply want to remind him/herself of something for a given patient.
3. Documents for such purposes can be set to automatically create their own historical visit when they are entered, so that the user is not asked to select a visit.

**STATUS: (A/I/T)**

1. A=Active, I=Inactive, T=Test
2. Documents can be entered on ACTIVE Titles.
3. Only the Owner can enter a document on TEST Titles.
4. Only INACTIVE Document Definitions can be edited.

##### Hidden Action Descriptions for all Document Definition options.

|  |  |
| --- | --- |
| **Action** | **Description** |
| **Next Screen** | Enter **+** to move down to the next screen of entries/information. . |
| **Previous Screen** | Enter the **-** character to move up to the previous screen of entries/ information.  |
| **Up One Line** | Enter UP to move up a line.  |
| **Down A Line** | Enter DN to move down a line.  |
| **Right** | Enter > to scroll to the right one column when >> shows on the message bar. Most screens display essential information which can only be seen by scrolling to the right. You can also enter >=5 for example, to scroll 5 characters to the right, or >=> to scroll to the rightmost position. |
| **Left** | Enter < to scroll left when << shows on the message bar. Enter < to scroll left to the next column or enter <=5 to scroll 5 characters to the left, or enter <=< to scroll to the leftmost column.  |
| **First Screen** | Enter FS to display the first screen of entries/information.  |
| **Last Screen** | Enter LS to display the last screen of entries/information.  |
| **Go To Page** | Enter GO to choose a page to go to. You can also enter GO=3, for example to go to page 3 in a single step.  |
| **Print**  | All document definition printing is done through the hidden actions, Print Screen and Print List. First locate the data to be printed so that it shows on the screen, and then select either PS or PL. To locate the appropriate data use the Edit, Sort, or Create option to list appropriate entries. *Edit Document Definitions* shows the hierarchy. *Sort Document Definitions* shows sorted document definitions including Orphans, Objects, and Shared Components. *Create* *Document Definitions* shows a particular line of descent of the hierarchy. *Create Objects* shows only Objects.To print information on a single given entry, 1) locate the entry in one of the above lists, 2) select Detailed Display or Edit Items, 3) select action PS or PL. |
| **Print Screen**  | Enter PS for Print Screen. It *only* prints what is currently visible on the screen, ignoring information that can be moved to horizontally or vertically (pages), so you should move left/right and up/down to the desired information before printing.  |
| **Print List** | Enter PL for Print List to print more than one visible screen of information. Print List prints the entire vertical list of entries/ information, including entries/information not currently visible but which are displayed when you move up or down. If the action is selected from the leftmost position of the screen, you’re asked whether to print ALL columns or only those columns visible on the current leftmost position of the screen. If you select the action after scrolling to the right, only the currently visible left/right columns are printed.  |
| **Find** | Finds text in list of entries/information displayed. The action searches all pages of list/information, but cannot 'see' the expansion for unexpanded entries in the Edit Document Definitions Option. Can be a quick way to get to the right page. |
| **Quit** | Quit takes you out of the current level of the hierarchy and back to the previous level or menu. |

#### Matrix of Actions allowed per Status and Ownership

**User**: For Document Definition, IRMS, Clinical Coordinators, or service managers authorized to maintain the Document Definition Hierarchy. Only programmers can create objects or edit Technical Fields.

**Owner**: Either Personal Owner or Class Owner; the person who creates or is assigned responsibility for the document definition being acted on. Items under the relevant type may have separate owners (that is, A may own the Document Class, but B could own a Title under the Document Class.

**Status**: A=Active, I=Inactive, T=Test

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type**  | **Status** | **User** | **Actions** | **Limitations** |
| **Class, Document Class** | A | Any  | 1. Edit Status, Owner
2. Add new items to Class  *(Class or Document Class),* or to Document Class (*Titles*).
 | Nat’l Standards can’t be edited.Must own the *items.* |
|  | I | Any | 1. Edit Basics and Upload Fields.
 |  |
|  | I | Owner | 1. Delete as entry from file.
 | Entry can’t be In Use. |
| **Title** | A, T | Any | 1. Edit Status and the Owner.
 |  |
|  | I | Any | 1. Add items (*components*).
2. Edit Basics and Boilerplate Text .
 | Only owners can add non-Shared Components. Item can’t already have a parent. |
|  | I | Owner | 1. Delete file entry.
 | If not In Use. |
| **Component**  | A,T | Any | 1. Edit the Owner.
 |  |
|  | I | Any | 1. Add new items (*components*).
2. Edit or delete its items.
3. Edit Basics and Boilerplate Text.
 | Users must own items. |
|  | I | Owner | 1. Delete entry from file.
 | If not In Use. |
| **Shared Component** | N/A | Any | 1. Add entry as an item to a Title or Component.
 |  |
|  |  | Owner | 1. Edit Basics and Boilerplate Text.
 | All parents must be Inactive. |
| **Object** |  | Any | 1. Embed Object in Boilerplate Text.
 |  |
|  | I | Any | 1. Edit Owner.
 | Component or Title must be Inactive.  |
|  | I | Owner | 1. Edit Object Basics and Technical Fields.
 | Only programmers can edit Technical Fields. |

##  Creating Boilerplate Text

*Boilerplate* *Text* is similar to a template or overprint. It includes commonly used headings, phrases, or forms, which can be completed by a clinician or other user. TIU provides the means for sites and individuals to create specific boilerplate documents for most of the commonly used progress notes, discharge summaries, or other clinical documents. Also, boilerplates can be copied and modified by individuals, departments, sites, or between sites.

*Objects* are names representing executable M-code, which may be “embedded” in the predefined boilerplate text of titles. This allows patient-specific text to be inserted into a document when a user selects a TIU document. The Object “PATIENT AGE” may be used to insert the value of the patient’s age at an arbitrary location within a document. To see a list of Objects available at your site, use the option *Create Objects.*

Boilerplate text documents may be composed of static text, Objects, or a combination of the two. Examples of static test are captions, complete sentences, or section headings for a SOAP note.

**Examples:**

**1.** The boilerplate text document “Dr. Jones’ Clinic Note” contains the following default text and Objects (the names between the “|” symbols):

The patient is a |PATIENT AGE| year old |PATIENT RACE|

|PATIENT SEX|, who presented to the |VISIT LOCATION| on

|VISIT DATE| with |CHIEF COMPLAINT|.

When Dr. Jones opens this boilerplate document in TIU, values are inserted to replace Objects.

The patient is a 55 year old white male, who presented to the Cardiology Clinic on October 27, 1996 with chest pains.

### Boilerplate Text

**2.** The Adverse Reaction/Allergies component of a discharge summary is an example of a more complex Object.

ADVERSE REACTION/ALLERGIES

|ALLERGIES/ADR|

The resulting text may look like this:

ALLERGIES/ADVERSE REACTION:

Milk, Amoxicillin

**General Information**

Boilerplate text may be added to any title.Boilerplate text is specific to that document definition and is not Shared.Boilerplate text may contain Objects.Components may also contain boilerplate text, with embedded Objects.

Objects must always have uppercase names, abbreviations, and print names. When embedding objects in boilerplate text, use any of these three (the Name, Abbreviation, or Print Name) enclosed by “|s.” Objects must always be embedded in uppercase. Objects must initially be written by programmers. (See a description of writing an object on page 67.) Once defined, Objects may be used any number of times within an unlimited number of different titles.

As sites develop their own Objects, they can be shared with other sites through a mailbox entitled TIU OBJECTS in SHOP,ALL (reached via FORUM).

 ☞ NOTE: Object routines used from SHOP,ALL are *not* supported by the Field Offices. Use at your own risk!

***Boilerplate Text***

Objects can have Inactive or Active Statuses. Only ACTIVE objects function. That is, if you enter a document on a Title with boilerplate text containing an inactive object, the object doesn’t do anything. You see the name of the object and an error message in place of the object data. Only ACTIVE objects should be embedded in boilerplate text, except when owners are creating or editing objects.

Only INACTIVE objects can be edited (and only by an owner). Only an owner can activate or inactivate an object. Active objects are assumed to be ready for use in any boilerplate text.

Since the owner is essentially the caretaker of the object for the entire site, the owner should consult with all who use it before editing it. An object can be tested by embedding it in the boilerplate text of a Title and selecting the action “Try” for the Title. It doesn’t need an Active status for this testing and shouldn’t have an Active status until testing is complete. Owners who inactivate objects for editing should make sure to reactivate them if they are being used.

##### Example of creating boilerplate text

1. At the title level in the hierarchy, select Detailed Display and the number of the document you want to add boilerplate text to.

**Create Docmt Definitions** Oct 01, 1996 11:26 Page: 1 of 1

 BASICS

+ Name Type In Use Boil Print Name

4 RADIOLOGY NURSING NOTE TL No No RADIOLOGY NURSING

 **<<< ? Help +, - Next, Previous Screen >>>**

 (Class/DocumentClass) Next Level Detailed Display

 Title Restart Status...

 Component Boilerplate Text Delete

Select Action: Create Title// **DET** Detailed Display

Select Entry: (4-4): **4**

 ***Creating Boilerplate Text cont’d***

**2.** The details of the document are displayed. Select BO for Boilerplate Text.

**Detailed Display** Oct 01, 1996 11:29:10 Page: 1 of 2

 Title RADIOLOGY NURSING NOTE

 Basics Note: Inherited Values preceded by \*

 Name: RADIOLOGY NURSING NOTE

 Abbreviation:

 Print Name: RADIOLOGY NURSING NOTE

 Type: TITLE

 IFN: 1087

 National

 Standard: NO

 Status: INACTIVE

 Owner: TIUCAC,ONE

 In Use: NO

 Additional

 Signers: \* ALLOWED

 Suppress Visit

 Selection: NO

 Items

**+ ? Help +, - Next, Previous Screen**

 Basics Technical Fields Find

 Items:Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

Select Action: Next Screen// **BO**

**3.** Your preferred screen editor is displayed (in this case, FileMan Text Editor). Type in the text, including objects, in your document boilerplate text:

 1> **NAME: |PATIENT NAME|**

 2> **DOB: |PATIENT DATE OF BIRTH|**

 3>

 4>**ALLERGIES: |ALLERGIES/ADR|**

 5>

 6> **LIPIDS: |BASELINE LIPIDS|**

EDIT Option: **<Enter>**

***Creating boilerplate text cont’d***

**4.** To see how this boilerplate text you created will work in a document, select the action *Try*.

**Detailed Display** Oct 01, 1996 15:42:01 Page: 2 of 3

 Title RADIOLOGY NURSING NOTE

+

No Items

 Boilerplate Text

 NAME: |PATIENT NAME|

 DOB: |PATIENT DATE OF BIRTH|

ALLERGIES: |ALLERGIES/ADR|

LIPIDS: |BASELINE LIPIDS|

 Technical Fields Note: Inherited Values preceded by \*

**+ ? Help +, - Next, Previous Screen**

 Basics Technical Fields Find

 Items:Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

Select Action: Next Screen// **TR Try**

1. The following text and prompts appear. The boilerplate text you created appears in the format of the text editor you use.

Entry Checks out OK. Checking Title on a document. You will not be permitted to sign the document, and the document will be deleted at the end of the check.

Be sure to select a TEST PATIENT since the document will show up on Unsigned lists while you are editing it.

Select Patient: **TIUPATIENT,ONE** 09-12-44 000000000 YES SC VETERAN

 (2 notes) C: 05/28/96 12:37 (addendum 08/12/96 16:04)

 A: Known allergies

This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// **<Enter>**

The following VISITS are available:

 1> APR 18, 1996@10:00 GENERAL MEDICINE

 2> FEB 21, 1996@08:40 PULMONARY CLINIC

CHOOSE 1-2 or <N>EW VISIT

<RETURN> TO CONTINUE

OR '^' TO QUIT: **1**

***Creating Boilerplate Text cont’d***

Creating new progress note...

 Patient Location: GENERAL MEDICINE

 Date/time of Visit: 04/18/96 10:00

 Date/time of Note: NOW

 Author of Note: TIUPROVIDER,ONE

 ...OK? YES// **<Enter>**

Calling text editor, please wait…

Gathering Allergy Data…

=[ WRAP ]==[ INSERT ]===< Patient: TIUPATIENT,ONE. >==[ <PF1>H=Help ]====

 NAME: TIUPATIENT,ONE.

 SEX: MALE

 DOB: SEP 12,1944

ALLERGIES: Amoxicillin, Aspirin, MILK

 LIPIDS: No data available

<======T=======T=======T=======T=======T=======T=======T=======T========

Saving Text……

<Nothing Entered, Radiology Nursing Note Deleted>

##### Example of editing boilerplate text

**1.** Select Detailed Display from your *Create Document Definition* option.

Select Action: Next Screen// DET Detailed Display

Select Entry: (50-63): 50

**Detailed Display** Oct 01, 1996 11:57:11 Page: 1 of 3

 Title RADIOLOGY NOTE

 Basics Note: Inherited Values preceded by \*

 Name: BP TEST

 Abbreviation:

 Print Name: BP TEST

 Type: TITLE

 IFN: 981

 National

 Standard: NO

 Status: ACTIVE

 Owner: TIUPROVIDER,ONE

 In Use: YES

 Additional

 Signers: \* ALLOWED

 Items

**+ ? Help +, - Next, Previous Screen**

 Basics Technical Fields Find

 Items:Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

Select Action: Next Screen// B Boilplt Txt

**2.** Select the *Boilerplate Text* action. Your preferred screen editor appears and the boilerplate text already created for this Title.

==[ WRAP ]==[ INSERT ]============< BP TEST >========[ <PF1>H=Help ]====

 NAME: |PATIENT NAME|

 SEX: |PATIENT SEX|

 DOB: |PATIENT DATE OF BIRTH|

ALLERGIES: |ALLERGIES/ADR|

LIPIDS: |BASELINE LIPIDS|

**3.** Just type in new text (including Objects) or edit existing text, according to the methods of the text editor you normally use in your work (in this case FileMan Screen Editor).

 **HT: |PATIENT HEIGHT|**

 **WT: |PATIENT WEIGHT|**

<====T=======T======T=======T=======T=======T=======T=======T=======T=>===

### Creating Objects

The Create Objects option may be assigned to any TIU manager, coordinator, or IRMS specialist, but only programmers can create Objects.

The Create Objects option lets you review current Objects and then perform various actions, such as Create, Copy, and Delete, depending on yours and the Object’s status. Only Inactive objects can be edited (and only by an owner). Only an owner can activate or inactivate an object. Active objects are assumed to be ready for use in any boilerplate text.

See the next section for an example of creating an Object.

 --- Manager Document Definition Menu ---

 1 Edit Document Definitions

 2 Sort Document Definitions

 3 Create Document Definitions

 4 Create Objects

You have PENDING ALERTS

 Enter "VA VIEW ALERTS to review alerts

Select Document Definitions (Manager) Option: 4 Create Objects

START WITH OBJECT: FIRST// **<Enter>**..........................................

...................

**Objects** Feb 28, 1997 09:52:16 Page: 1 of 3

 Objects

 Status

1 ACTIVE MEDICATIONS A

2 ALLERGIES/ADR A

3 BASELINE LIPIDS A

4 BLOOD PRESSURE A

5 CURRENT ADMISSION A

1. NOW A
2. PATIENT AGE A
3. PATIENT DATE OF BIRTH A

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Copy

 Change View Try Quit

 Create Owner

Select Action: Next Screen//

##  Creating an Object Example

 To create an object, you must be familiar with M code at least well enough to read and copy it.

In this example, we create a very simple object, test it, make it more realistic, and then re-test it. After that, we’ll present further issues to consider.

### A. Create a very simple Object.

 We’ll create an object called PATIENT RELIGION that inserts the patient’s religion into the text of a document.

1. Go into the option *Create Objects* and select the action Create:

Select TIU Maintenance Menu Option: **2** Document Definitions (Manager)

 --- Manager Document Definition Menu ---

 1 Edit Document Definitions

 2 Sort Document Definitions

 3 Create Document Definitions

 4 Create Objects

Select Document Definitions (Manager) Option: **4** Create Objects

START WITH OBJECT: FIRST// **<Enter>**.........................................

**Objects** Mar 09, 1997 16:10:12 Page: 1 of 3

 Objects

+ Status

1 ACTIVE MEDICATIONS A

2 ALLERGIES/ADR A

3 BASELINE LIPIDS A

4 BLOOD PRESSURE A

5 CURRENT ADMISSION A

6 FASTING BLOOD GLUCOSE A

7 HEMOGLOBIN A1C A

8 INR VALUE A

9 LABS ADMISSION ABNORMAL A

10 LABS ADMISSION ALL A

11 NOW A

12 PATIENT AGE A

13 PATIENT DATE OF BIRTH A

14 PATIENT DATE OF DEATH A

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Copy

 Change View Try Quit

 Create Owner

Select Action: Next Screen// **<Enter>**

***Creating an Object, cont’d***

**Objects** Mar 09, 1997 16:13:44 Page: 2 of 3

 Objects

+ Status

15 PATIENT HEIGHT A

16 PATIENT NAME A

17 PATIENT RACE A

18 PATIENT RELIGION A

19 PATIENT SEX A

20 PATIENT SSN A

21 PATIENT WEIGHT A

22 PROTHROMBIN TIME A

23 PROTHROMBIN TIME COLLECTED A

24 PULSE A

25 RESPIRATION A

26 SGOT A

27 TEMPERATURE A

28 TODAY'S DATE A

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Copy

 Change View Try Quit

 Create Owner

Select Action: Next Screen// **??**

1. Select the action Create.

**Objects** Mar 05, 1997 15:03:12 Page: 1 of 3

 Objects

 Status

1 ACTIVE MEDICATIONS A

2 ALLERGIES/ADR A

3 BASELINE LIPIDS A

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Copy

 Change View Try Quit

 Create Owner

Select Action: Next Screen// **CR** Create

1. Enter PATIENT RELIGION.
2. Delete the default owner CLINICAL COORDINATOR with an @ sign and enter your own name as the personal owner. This enables you to continue editing the object.

Enter Document Definition Name to add as New Entry: **PATIENT RELIGION**

CLASS OWNER: CLINICAL COORDINATOR Replace @

PERSONAL OWNER: TIUCOORDINATOR,ONE OT

 Entry added

1. The new object appears at the top of the list.
2. Scroll right (>) to see that you are the owner.
3. Select the action Detailed Display and select your new entry.

☞ NOTE: You can do this in one step by entering DET=(entry number):

**Objects** Mar 05, 1997 15:03:12 Page: 2 of 3

 Objects

 Status

18 PATIENT RELIGION I

19 PATIENT SEX A

1. PATIENT SSN A

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Copy

 Change View Try Quit

 Create Owner

Select Action: Next Screen// **DET=18** Detailed Display

1. The Detailed Display screen appears, showing your entry.
2. Select the action Technical Fields.

**Detailed Display** Mar 05, 1997 15:03:58 Page: 1 of 1

 Object PATIENT RELIGION

 **Basics**

 Name: PATIENT RELIGION

 Abbreviation:

 Print Name: PATIENT RELIGION

 Type: OBJECT

 IFN: 599

 National

 Standard: NO

 Status: INACTIVE

 Owner: TIUCOORDINATOR,ONE

 **Technical Fields**

 Object Method:

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Find Detailed Display Delete

Basics Technical Fields Find

 (Items: Seq Mnem MenuTxt) (Upload) Quit

 (Boilerplate Text) Try

Select Action: Quit// **TE** TECHNICAL FIELDS

1. Enter the object method: S X=”TESTING123”

OBJECT METHOD: S X=”TESTING123”

### B. Testing the Object

**☞** **NOTE**: **Be sure to thoroughly test the information inserted by the object as well as the functioning and format of the object. Incorrect information inserted into a document could compromise Patient Safety.**

Now that we have a new object, let’s try it out.

1. Quit all the way out of Create Objects.
2. Go into the option *Create Document Definitions*:

--- Manager Document Definition Menu ---

 1 Edit Document Definitions

 2 Sort Document Definitions

 3 Create Document Definitions

 4 Create Objects

Select Document Definitions (Manager) Option: **3** Create Document Definitions

1. Find or create a title you wish to embed the new object in.
* If it’s active, make a copy rather than inactivating the original which takes it offline to users.
* Use an item under an active document class so that later you can change its status to “Test.”
* Use a Title under Progress Notes so that it inherits from Progress Notes.
* Make its status Inactive so you can edit it.
* Check it using the action Try to make sure it works properly before continuing this process (do a Detailed Display and select TRY).
1. We’ll use the Title DEMOGRAPHIC NOTE, under the Document Class DEMOGRAPHIC NOTE, under Progress Notes.
2. When you have your title, select the action Boilerplate Text and your title:

**Create Document Definitions** Mar 05, 1997 15:05:23 Page: 1 of 1

 BASICS

+ Name Type

 2 PROGRESS NOTES CL

 3 DEMOGRAPHIC NOTE DC

 4 DEMOGRAPHIC NOTE TL

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 (Class/DocumentClass) Next Level Detailed Display

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title// **BO=4**

 ***Testing the Object, cont’d***

1. The Boilerplate Text screen is displayed. At present, there is no text.
2. Select Boilerplate Text again, this time to edit it (rather than display it):

**Boilerplate Text** Mar 05, 1997 15:05:37 Page: 1 of 1

 Title DEMOGRAPHIC NOTE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Boilerplate Text Try Quit

 Status Find

Select Action: Quit// **B** Boilerplate Text

1. Your preferred editor appears. Type in the following:

======[WRAP]==[INSERT]=<DEMOGRAPHIC NOTE>===[<PF1>H=HELP]=========

Patient’s religious preference: |PATIENT RELIGION|. Patient’s home address: ……

=====T=====T=====T=====T=====T=====T=====T=====T=====T=====T

 ☞ NOTE: Be sure to spell the object name correctly; use upper case, and enclose it in vertical bars:

1. Exit out of the editor. The screen displays our new boilerplate text.
2. Select the action TRY:

***Testing the Object cont’d***

Saving text ...

**Boilerplate Text** Mar 05, 1997 15:05:37 Page: 1 of 1

 Title DEMOGRAPHIC NOTE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s religious preference: |PATIENT RELIGION|. Patient’s home address: …

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Boilerplate Text Try Quit

 Status Find

Select Action: Quit// **Try**

Entry Checks out OK for rudimentary completeness

1. The entry checks out OK.
2. Select a TEST patient. (Since it’s a title, you are given the opportunity to try it on a patient.)
3. Accept the defaults for location, etc.
4. You are presented with the boilerplate text, just as if you had entered a document Demographic Note on the patient:

Object |PATIENT RELIGION| is not active.

Press RETURN to continue or ‘^’ or ‘^^’ to exit: **<Enter>**

Checking Title on a document. You will not be permitted to sign the document, and the document will be deleted at the end of the check.

 Be sure to select a TEST PATIENT since the document will show up on Unsigned lists while you are editing it.

Select PATIENT NAME: **TIUPATIENT,ONE** 09-12-44 000000000 YES

 SC VETERAN

 (2 notes) C: 02/24/97 08:44

 (1 note ) W: 02/21/97 09:19

 A: Known allergies

Creating new progress note...

 Patient Location: UNKNOWN

 Date/time of Visit: 03/05/97 15:07

 Date/time of Note: NOW

 Author of Note: TIUPROVIDER,ONE

 ...OK? YES// **<Enter>**

Calling text editor, please wait…

 ======[WRAP]==[INSERT]=< >===[<PF1>H=HELP]===================

Patient’s religious preference: TESTING123. Patient’s home address: …

======T=====T=====T=====T=====T=====T=======T=======T=======T========T

 ***Testing the Object cont’d***

1. The trial document looks all right. The data we set X to is inserted in the text.

☞ NOTE: If there are errors in the object other than the status, you may receive any of the following messages:

Object |PATIENT RELIGION| cannot be found. User uppercase and use object’s exact name, print name, or abbreviation. Objects’ name/print name/abbreviation may have changed since this was embedded.

Object |PATIENT RELIGION| is not active.

Object |PATIENT RELIGION| lacks an object method.

Object |PATIENT RELIGION| is ambiguous. Can’t tell which object is intended.

Object split between lines, rest of line not checked.

The split line message refers to lines such as:

This is a test of Object |PATIENT

RELIGION|. Patient’s Home address: . . .

But none of these messages apply to us.

1. Exit the editor. The document is deleted:

Saving text ...

<NOTHING ENTERED. DEMOGRAPHIC NOTE DELETED>

### C. Making the Object More Realistic

Now that we have the basic idea, we’ll write an object method that actually gets the patient’s religion. We’ll imitate the PATIENT AGE object, which has the object method:

 S X=$$AGE^TIULO(DFN)

Note that, again, the object method sets the variable X. This time the object depends on the patient. The variable DFN is the internal entry number in the Patient File ^DPT. Its value is known to the system at the time a document is entered on a particular patient.

***Making the Object More Realistic, cont’d***

This object method calls the TIULO routine, exported with the TIU package, and sets X equal to the value of the function $$AGE^TIULO. That code looks like this:

TIULO ; SLC/JER - Embedded Objects ;9/28/95 16 :26

 ;;1.0;TEXT INTEGRATION UTILITIES;;Mar 05, 1997

AGE(DFN) ; Patient AGE

 I '$D(VADM(4)) D DEM^TIULO(DFN,.VADM)

 Q $S(VADM(4)]"":VADM(4),1:"AGE UNKNOWN")

 ;

DEM(DFN,VADM) ; Calls DEM^VADPT

 D DEM^VADPT

 Q

If the VADM array hasn’t been defined for subscript 4, the age subscript, the code calls module DEM, passing array VADM by reference. DEM calls the VADPT patient demographics utility, and passes patient demographics back. We can copy this and only need to understand that it puts demographic information for patient DFN in the VADM array as described in the VADPT utility.

Note that AGE is a function and quits with the value VADM(4) if VADM(4) has a value. Otherwise, it quits with the value “AGE UNKNOWN.”

*We’ll write similar code for religion.*

1. Quit out of the Manager Menu and get into programmer mode.
2. Write a similar function for religion. Looking up the VADPT utility, we find that patient religion is returned in VADM(9), so we have:

MYROUTIN ; HERE/ME - Embedded Objects ; 9/28/96 16:26

 ;

RELIG (DFN) ; Patient RELIGION

 I '$D(VADM(9)) D DEM^TIULO(DFN,.VADM)

 Q $S(VADM(9)]"":VADM(9),1:"Religious Preference UNKNOWN")

1. To test the code, set DFN to a known patient. (To find the DFN of a patient, do a Fileman Inquiry to the PATIENT file, enter the name of a patient, and enter R at the Include COMPUTED fields prompt to get the record number. Set DFN to this record number.).
2. Set X= $$RELIG^MYROUTIN(DFN).
3. WRITE !,X:

 W !,X

 OTHER

***Making the Object More Realistic, cont’d***

This patient’s religion is listed as “OTHER.”

1. When the code has been thoroughly tested on several different patients, including some who have no religion in the patient file, go back to the option Create Objects.
2. Select the action Detailed Display for object PATIENT RELIGION,
3. Select the action Technical Fields
4. Edit the object method to:

 S X=$$RELIG^MYROUTIN(DFN)

**Detailed Display** Mar 05, 1997 15:03:58 Page: 1 of 1

 Object PATIENT RELIGION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Basics**

 Name: PATIENT RELIGION

 Abbreviation:

 Print Name: PATIENT RELIGION

 Type: OBJECT

 IFN: 599

 National

 Standard: NO

 Status: INACTIVE

 Owner: TIUCOORDINATOR,ONE

Object Method: S X=$$RELIG^MYROUTIN(DFN)

Technical Fields

**+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 Basics Technical Fields Find

 Items: Seq Mnem MenuTxt Upload Quit

 Boilerplate Text Try

1. While we’re here, let’s go in, put in an abbreviation for the object, and namespace the print name. To do so, we select the action Basics:

Select Action: Quit// **BA** BASICS

NAME: Since objects are embedded by name, abbreviation, or print name, NOT by file number, your edit of name, abbreviation, or print name may affect which titles have the object embedded in them. You may want to note the list of titles NOW before it changes.

Press RETURN to continue or ‘^’ or ‘^^’ to exit: **<Enter>**

***Making the Object More Realistic, cont’d***

Since our object is new and we know it’s only in DEMOGRAPHIC NOTE, we’ll disregard the warning and enter a new Name and an abbreviation. We’ll keep the old print name and up-arrow out:

 NAME: DEM PATIENT RELIGION// **<Enter>**

 ABBREVIATION: **RELI**

 PRINT NAME: PATIENT RELIGION// **^**

**Detailed Display** Mar 05, 1997 15:03:58 Page: 1 of 1

 Object PATIENT RELIGION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Basics**

 Name: DEM PATIENT RELIGION

 Abbreviation: RELI

 Print Name: PATIENT RELIGION

 Type: OBJECT

 IFN: 599

 National

 Standard: NO

 Status: INACTIVE

 Owner: TIUCOORDINATOR,ONE

**Technical Fields**

 Object Method: S X=$$RELI^MYROUTIN (DFN)

Object is embedded in Title(s) Status Owner IFN

DEMOGRAPHIC I ME 567

 **? Help +, - Next, Previous Screen PS/PL**

 Basics Try Delete

 Technical Fields Find Quit

Select Action: Quit// **<Enter>**

### D. Testing the More Realistic Object

**☞ NOTE**: **Again, be sure to thoroughly test the information inserted by the object as well as the functioning and format of the object. Incorrect information inserted into a document could compromise Patient Safety**

When the Object Method, Name, Abbreviation, and Print Name are all as we wish, we again test the Object. Before trying our title DEMOGRAPHICS as we did before, we will try the object itself.

1. While still in the above Object Detailed Display screen, select the action TRY. We get the message:

Select Action: Quit// **T**

Entry checks out OK for rudimentary completeness

***Testing the More Realistic Object, cont’d***

This is an important step. If there were problems, we might have gotten any or all of the following messages:

Faulty Entry: No Object Method

Faulty Entry: Object Name finds multiple/wrong object(s)

Faulty Entry: Object Abbreviation finds multiple/wrong object(s)

Faulty Entry: Object Print Name finds multiple/wrong object(s)

The first message appears if the object has no Object Method. Unfortunately, this doesn’t tell us whether the Object Method functions correctly. It only tells us the entry has or doesn’t have an Object Method. We know it functions correctly because we tested the code.

We get one or more of the other messages if our object has a duplicate Name, Abbreviation, or Print Name with some other object. This would cause our object not to be found when that Name, Abbreviation, or Print Name is used in boilerplate text. We also get such a message if, for example, our object Abbreviation is the same as the Name of another object. In that case we would get the message:

Faulty entry: Object Abbreviation finds multiple/wrong object(s).

If this happens, our object might find and insert the WRONG object into boilerplate text. We must change the abbreviation so it doesn’t match the name, abbreviation, or print name for another object.

Once we have thoroughly tested the Object Method code, put in Name, Abbreviation, and Print Name as desired, and gotten a clean TRY when we tried the OBJECT, we can now try our title containing the object.

1. Quit out of *Create Objects*
2. Go into the option *Create Document Definitions*
3. Use the action Next Level to drill down to our title
4. Select the action Boilerplate Text
5. Select the title

**Create Document Definitions** Mar 05, 1997 15:05:23 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 DEMOGRAPHIC NOTE DC

4 DEMOGRAPHIC NOTE TL

**?Help >ScrollRight PS/PL PrintScrn/List +/- >>>**

 (Class/DocumentClass) Next Level Detailed Display

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title// **BO=4**

***Testing the More Realistic Object, cont’d***

1. The Boilerplate Text that we entered previously is displayed. We changed the name of the object, but we don’t need to make that update here since the Print Name is PATIENT RELIGION, and the Print Name will do just as well as the name.
2. Select the action Try.

**Boilerplate Text** Mar 05, 1997 15:05:37 Page: 1 of

 Title DEMOGRAPHIC NOTE

Patient’s religious preference: |PATIENT RELIGION|. Patient’s home address:…

**? Help +, - Next, Previous Screen PS/PL**

 Boilerplate Text Try Quit

 Status Find

Select Action: Quit// **Try**

1. Enter a test patient
2. Accept the defaults
3. The following text appears:

Object |PATIENT RELIGION| is not active.

 .

 .

Calling text editor, please wait…

================[WRAP]==[INSERT]=< >===[<PF1>H=HELP]===================

Patient’s religious preference: UNITARIAN; UNIVERSALIST. Patient’s home ad

======T======T======T======T======T======T=====T======T======T=======T

1. This allows you to check out the formatting of the boilerplate text when the object is being used.
2. In this case the line continues beyond 80 characters⎯we haven’t left enough room in the line for the object.
3. If there isn’t enough room for the object data, or it doesn’t print out in the right format, we change the Object Method and/or the Boilerplate text until it looks right.
4. Go into Boilerplate text and move the next sentence to the next line:

 ==============[WRAP]==[INSERT]=< >===[<PF1>H=HELP]===================

Patient’s religious preference |PATIENT RELIGION|.

Patient’s home address:…

=======T=======T=======T=======T=====T=====T=====T=====T=====T=====T=====

***Testing the More Realistic Object, cont’d***

1. Exit the editor.
2. In the Boilerplate screen, use the TRY action again:

======[WRAP]==[INSERT]=< >===[<PF1>H=HELP]===================

Patient’s religious preference: UNITARIAN; UNIVERSALIST.

Patient’s home address: …

=====T=====T=====T=====T=====T=====T=====T=====T=====T=====T

This time the formatting looks fine.

We have tested the Object Method code, TRIED the object, and TRIED a title with the object in it.

Everything looks good, so we proceed to activate the object.

### E. Activating the object:

1. Quit out of the Detailed Display screen.
2. In the Objects screen, select the Status action.
3. Select A for Active status:

**Detailed Display** Mar 05, 1997 15:03:58 Page: 1 of 1

 Object PATIENT RELIGION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Basics**

 Name: DEM PATIENT RELIGION

 Abbreviation: RELI

 Print Name: PATIENT RELIGION

 Type: OBJECT

 IFN: 599

 National

 Standard: NO

 Status: INACTIVE

 Owner: TIUCOORDINATOR,ONE

**Technical Fields**

 Object Method: S X=$$RELI^MYROUTIN (DFN)

**? Help +, - Next, Previous Screen PS/PL**

Basics Try Delete

Technical Fields Find Quit

Select Action: Quit// **BA** Basics

NAME: DEM PATIENT RELIGION// **<Enter>**

ABBREVIATION: RELI// **<Enter>**

PRINT NAME: PATIENT RELIGION// **<Enter>**

PERSONAL OWNER: ME// **<Enter>**

STATUS: (a/I): INACTIVE// **A** ACTIVE

***Activating the object***, ***cont’d***

Activating an object communicates to users that it is ready for embedding in boilerplate text. It also causes the object to execute its object method code rather than to write an inactive message when documents are entered on it through the regular options (as opposed to the action Try). If

the object TRY action had not been clean, we would not have been able to activate the object.

The Active object is now ready for entering documents. One last test, and we’ll be done.

To enter documents (rather than just TRY them), the title also must have a status of Active or Test.

1. Quit out of the option *Create Objects* and
2. Go into the option *Create Document Definitions*.
3. Edit the status of the test title to Test.
4. Check to make sure that you own it.
5. Quit out of the Document Definition menu
6. Go into the Clinician menu.
7. Select *Entry of Progress Note* from the Clinician’s Progress Notes Menu

--- Clinician's Progress Notes Menu ---

 1 Entry of Progress Note

 2 Review Progress Notes by Patient

 2b Review Progress Notes

 3 All MY UNSIGNED Progress Notes

 4 Show Progress Notes Across Patients

 5 Progress Notes Print Options ...

 6 List Notes By Title

 7 Search by Patient AND Title

 8 Personal Preferences ...

Select Progress Notes User Menu Option: **1** Entry of Progress Note

### F. Entering a Progress Note using the Object

1. Select a TEST PATIENT
2. Select the title:

Select PATIENT NAME: TIUPATIENT,ONE 09-12-44 000000000 YES

 SC VETERAN

 (2 notes) C: 02/24/97 08:44

 (1 note ) W: 02/21/97 09:19

 A: Known allergies

Available note(s): 11/07/96 thru 03/05/97 (23)

Do you wish to review any of these notes? NO// **<Enter>**

Personal PROGRESS NOTES Title List for ME

 1 CRISIS NOTE

 2 ADVANCE DIRECTIVE

 3 Other Title

TITLE: (1-3): 1// **3**

TITLE: CRISIS NOTE// **DEMOGRAPHICS NOTE** TITLE

Creating new progress note...

 Patient Location: 2B

 Date/time of Visit: 04/18/96 10:00

 Date/time of Note: NOW

 Author of Note: TIUCOORDINATOR,ONE

 ...OK? YES// **<Enter>**

Calling text editor, please wait...

=========[ WRAP ][ INSERT ]=< Patient: TIUPATIENT,ONE >[ <PF1>H=Help]=======

Patient’s religious preference: UNITARIAN; UNIVERSALIST.

Patient’s home address: …

T=======T=======T=======T=======T=======T=======T=======T=======T=======T

1. Exit your editor:

Saving text ...

No changes made...

1. Don’t sign it. You’ll want to delete it later since it’s a test note:

Enter your Current Signature Code: **<Enter>**

NOT SIGNED.

Press RETURN to continue... **<Enter>**

Print this note? No// **<Enter>** NO

You may enter another Progress Note. Press RETURN to exit.

Select PATIENT NAME: **<Enter>**

### G. Troubleshooting:

*If you have problems with this note:*

* Make sure its status is Active or Test.
* If its status is Test, make sure you own it.
* Make sure the embedded object PATIENT RELIGION has an active status.

### H. Using the Object

When the note works properly, the object is finished and available for any user with a Document Definition menu to embed it in boilerplate text. Unless you assign ownership to someone else, you are the site-wide caretaker for this object. Any questions or requests should be addressed to you.

### I. Further considerations.

***Using the option Sort Document Definitions to create Objects***

Once you are comfortable creating objects, it is actually easier to use the option *Sort Document Definitions* than the option *Create Objects*. To use the Sort option, select ALL, and select a narrow alphabetic range which includes both the object name and the name of a test title. Another possibility is to enter yourself as the Personal Owner. This assumes you are the personal owner of both the object and test title. *Sort Document Definitions* permits the object to be edited and tested (except for the code itself) without switching options.

###### Activating/Inactivating/Editing Objects

Objects must be inactive before they can be edited. Before inactivating an object that has already been used in boilerplate text, you should inactivate all Titles which use it. This takes those titles offline for entering documents. If a title containing an inactive object is not offline and someone enters a document on it, the object will not function and the user will see an “Object Inactive” error message where the object data should appear.

Objects can be tested using the Try action when they are inactive, but must be activated before they will function for the option *Entry of Progress Note*. So, when you have finished editing an object, be sure to reactivate it.

Objects should not be activated until they have been thoroughly tested both by TRYing the object and by TRYing a test title with the object embedded in its boilerplate text.

***Ownership of Objects***

When creating a new object, make yourself an owner, at least until you have finished testing it. Only the owner can edit an object, even with the Manager menu.

Persons with the Manager menu are permitted to edit the owner of objects they don’t own. This allows reassignment of object owner in those rare cases when reassignment is necessary. It should be done only by high-level managers. In general, users are expected to respect object ownership and edit only objects they own. If an object needs changing, contact its owner. When you own an object, you are caretaker of it for the entire site since it is available across the site for use in boilerplate text. Consult with all users before changing it.

***Naming Objects***

Although TIU doesn’t enforce any rules regarding which name of the object to embed in boilerplate text, sites may want to maintain the convention of embedding print name or abbreviation only, leaving the .01 name to be a longer, technical, namespaced name. Then Print Name must be long enough to be unique, but otherwise as short as possible for typing convenience. Abbreviation is 2 to 4 letters.

Objects must always have uppercase names, abbreviations, and print names. When embedding objects in boilerplate text, users may embed any of these three (name, abbreviation, print name) in boilerplate text, enclosed by an “|” on both sides. Objects must always be embedded in uppercase.

As for namespacing, sites will want to share ideas among themselves as to what works best. Some possibilities are by service or product, like the Document Definition Hierarchy, and/or by the site where the object originated. Sites can post objects to share on SHOP,ALL

***Creating more complex objects***

For ideas on creating more complex, longer objects, look at the object methods of some other exported objects. Look at the associated routines. Copy an exported object, put a break in the copy’s object method, embed the copy in a title and try the title.

**Action Descriptions**

Actions are not selectable when they are enclosed in parentheses.

 **FIND**

 Finds text in a list of entries/information displayed. The program

 searches all pages of list/information (except for unexpanded entries in

 the Edit Document Definitions Option). Can be a quick way to get to the

 right page. Enter F

 **CHANGE VIEW**

 Changes the view to a different list of Document Definitions.

 **CREATE**

 This action can be used to create either Objects or nonobject Document

 Definitions in TIU Document Definition file 8925.1. After it is created,

 a nonobject entry must be explicitly added as an Item to a parent in the

 hierarchy before it can be used. (The Create Document Definitions

 Option does this automatically.) File 8925.1 cannot have two entries of

 the same type with the same name.

 **DETAILED DISPLAY**

 Detailed Display displays the selected entry and permits edit if

 appropriate. Edit is limited if the entry is National. Shared Components

 can be VIEWED via the Edit Document Definitions Option but can be EDITED

 only via the Sort Option.

 The DETAILED DISPLAY action lets you edit all aspects of an entry,

 including Items. The Items action, in contrast, looks at the entry ONLY as

 an Item under its parent and permits edit of Item characteristics ONLY.

 Managers (anyone assigned the Manager menu) need not own the entry in

 order to edit it. You can edit Basics, Items, Boilerplate Text, Technical

 Fields and Upload Fields.

 **TRY**

 TRY examines the selected entry for basic problems.

 For titles and components with boilerplate text, this includes checking any

 Embedded objects to make sure the object is embedded correctly.

 If the entry is a title and checks out OK (or if its only problem is an inactive

 Object), you can test the boilerplate text by choosing a patient and entering

 A document using the entry. TRY doesn’t require any particular status for the

 Title, since documents entered during the trial function even if inactive, in

 Order to permit testing of objects. (Ordinarily, object data are not retrieved

 Unless the object is active, so be sure to activate the object when it’s ready

 For use.) Since the trial document shows up on Unsigned lists during the time

 It’s being edited, we recommend that you select *test patients only.*

 If TRY is selected from the Boilerplate Text Screen, TRY shows which

 objects are badly embedded and why. Checks include whether the object as

 written exists in the file, whether it is active, whether it is split

 between lines, and whether the object as written is ambiguous as to which

 object is intended. If the entry is OK, you can enter a trial document.

***Action Descriptions, cont’d***

 For objects, TRY checks the object Name, Abbreviation and Print Name to make

 sure they are not ambiguous. That is, it makes sure the utility can

 decide which object to invoke when given the Name, Abbreviation, or Print

 Name and that it does not get the wrong object. TRY checks that the

 object has an Object Method, but does NOT check that the Object Method

 functions correctly.

**OWNER**

 You can select multiple entries and edit Owner, Personal and/or Class. To

 change from Personal to Class Owner or vice versa, you must delete the

 unwanted entry before you are prompted for the other.

**COPY**

 Copy can be done from the *Edit Document Definitions* option or from the

 Sort option, but not from the *Create Document Definitions* option. Titles,

 Components, or Objects may be copied. Copy can be used to "jump start" new

 entries by copying an old entry and then editing it.

 Copy *could* be used to change the behavior of an entry (i.e. change the behavior

 of the copy and inactivate the original), but most behavior can be edited even

 when the entry is in use by documents. Edit is better than copy/inactivate since

 it does not clutter up the hierarchy with inactive entries.

 Copy can be used to "move" entries once they are in use by documents. (This is

 not a true "move", but is the only possibility once an entry has been used by

 documents. If the entry is not yet in use by documents, it is better to delete it

 as an item from the old parent, and add it to the new parent, a true move).

 The Copy action prompts for an entry to copy and a Name to copy into. This

 name must be different from the name of the entry being copied. The

 action then creates a new entry with the chosen name and copies the

 fields in the Document Definition File 8925.1 into the new entry. The

 copier is made the personal owner of the copy.

 If the copying is being done through the *Edit Document Definitions* option,

 the copy is then added as an item to the parent. If the copying is done

 through the *Sort Document Definitions* option, the copy is NOT added as an

 item to the parent. Since items must not be added to Active or Test

 Titles, components of Active or Test Titles can only be copied through the

 Sort option. Objects are copied from the Sort option or the Create Objects

 option.

 Several fields are NOT copied as is. If the original is a National Standard, the

 entry may be copied, but the copy is not National Standard. If the original is

 Shared, it may be copied but the copy is not Shared. The other exceptional field

 is the Items field. If the entry has items, the action prompts for item names to

 copy into, creates NEW entries for the items, and adds the NEW items to the copy.

 Exception to the Items field Exception: if a nonshared entry has a Shared

 item, the action does NOT copy the Shared item but merely adds the Shared

 item to the copy. If the entry being copied is itself a Shared component,

 the copy is not shared, and NEW items are added to the copy rather than

 reusing shared items.

***Action Descriptions, cont’d***

 If the copying is being done through the Edit Document Definitions option,

 the user is asked which parent to add the copy to, and the copy is added

 as an item to this parent. If the copy is a Title and the user has chosen

 a new parent rather than the same parent, the user is asked whether to

 activate the copy and inactivate the original.

 If the copying is done through the Sort Document Definitions option, the

 copy action does NOT add the copy to any parent. Such orphan copies can

 be added to any parent using action Items for the parent.

 Objects are copied from the Sort Option or the Create Objects Option.

**QUIT**

 Allows you to quit the current menu level.

### Exported Objects

ACTIVE MEDICATIONS

ALLERGIES/ADR

BLOOD PRESSURE

CURRENT ADMISSION

NOW

PATIENT AGE

PATIENT DATE OF BIRTH

PATIENT DATE OF DEATH

PATIENT HEIGHT

PATIENT NAME

PATIENT RACE

PATIENT SEX

PATIENT SSN

PATIENT WEIGHT

PULSE

RESPIRATION

TEMPERATURE

TODAY'S DATE

VISIT DATE

# Document Templates

Document templates let you quickly add commonly used text and TIU objects when writing or editing progress notes, completing consults, or writing discharge summaries.

The Template Editor, shown below, is used to set up personal, shared, and group templates. These types of templates are described in the following section.

**Personal templates**

Any user can create his or her own templates. You can copy and paste text into a template, type in new content, add TIU objects, or begin by copying a shared template and then modifying it as needed. Personal template and folder icons have a folded upper right corner.

**Shared templates**

Only members of the Clinical Coordinator ASU class can *create* shared templates. Shared templates are available to all users. Coordinators can copy and paste text into a template, type in new content, add TIU objects, or begin by copying a personal template and then modifying it as needed. In the tree view, shared template and folder icons do not have a folded corner.

☞ NOTE: When you install CPRS, a copy of all your existing boilerplate titles is placed in the inactive boilerplates folder under shared templates.

Clinical coordinators can arrange the boilerplate titles copied into the shared templates to be used as templates, use them to create new templates, or make them available to users by moving them out of the inactive folder. Users will not see the inactive folder or its contents unless you choose to make the folder active.

(To see the boilerplates folder, go into the templates editor, make sure Edit Shared Templates is checked, uncheck Hide Inactive under shared templates, and click the plus sign beside the shared icon.)

**Types of Templates**

When you create templates, you can go directly into the template editor, type in text, and add TIU objects, or if you are in a document and type in something you will use repeatedly, you simply select that text, right-click, select Create New Template, and the editor comes up with the selected text in the editing area.

***Shared templates, cont'd***

You can create individual templates, group templates, or folders.

*Templates* contain text and TIU objects that you can place in a document.

*Group templates* contain text and TIU objects and can also contain other templates. If you place a group template in a document, all text and objects in the group template and all the templates it contains (unless they are excluded from the group template) will be placed in the document. You can also expand the view of the group template and place the individual templates it contains in a document one at a time.

*Folders* are like folders or directories in a file system. They are used to group and organize templates. You cannot place a folder in a document. It is there to hold templates and help in navigating the template tree view. For example, you might create a folder called "radiology" for templates, group templates, and other folders relating to radiology.

**Arranging Templates for Ease of Use**

How you arrange your templates depends on your specific needs. However, it may be useful to group similar templates together. You can also use folders to group similar templates, making them easier to find. This organization will be similar to a good directory structure for your workstation. For example, you may want to place all of the pulmonary templates together rather than alphabetizing templates.

By placing those templates together that you will use, you will spend less time moving around the tree to find the template you need.

### Using Templates to Create Documents

Once you have created templates, adding them to a document is easy. When you create a new note, a Templates button (also called a "drawer") appears. When you click the button, it opens to show you the templates that are available. Group templates and folders have a plus next to them. Click the plus to expand the tree view and see the templates they contain. Click a minus sign to collapse the tree view, hiding the templates under that item.

When you find the object you want to place in a document, you can drag-and-drop it into the document, double-click it, or right-click and choose Insert Template. The text and objects will appear where the cursor was a few seconds later.

**Searching for Templates**

You can search for templates by the words in the template name. To search, right-click in the templates in the editor or in the templates "drawer" and choose Find Templates. A text field, Find button, and two find options check boxes appear. Enter the text you want to find and click Find.

### Creating Personal Document Templates

To create a personal document template, follow these steps:

1. On the Notes, Consults, or D/C Summ tab, bring up the Template Editor by selecting Options | Create New Template

-or-

To save specific text in a new note as a template, select the text, right-click on it, and select Copy into New Template.

2. In the Name field under Personal Template Properties, enter a name for the new template. Remember the template name requirements.

3. Click the template type: Template, Group Template, or Folder.

4. For Templates and Group Templates, enter the text and TIU objects (if desired) to create the content. You can enter content in these ways:

Copy and paste from other documents

 Type in text

 Insert TIU objects

 Copy a shared template

☞ NOTE: After you enter the content, you can right-click in the Template Boilerplate area to select spell check or Check Boilerplate for Errors, which looks for invalid TIU objects.

5. Find where you want to place the template in the tree view.

a. Click the plus sign next to an item to see the objects under it.

b. Drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)

6. To save the template, click Apply. To save and exit the editor, click OK.

### Editing Document Templates

You can change your personal templates and members of the Clinical Coordinator ASU class can change shared templates at any time.

To edit a document template, follow these steps:

1. Click the Notes, Consults, or D/C Summ tab.

2. Select Options | Edit Templates (Option | Edit Shard Templates to edit shared)

-or-

If the Templates drawer (Notes tab) is open, right-click in the drawer, and select Edit Templates.

3. Find the template you want to edit.

a. Click the plus sign next to an item to see the objects under it.

b. Click the template you want to edit.

4. Make any desired changes, like these:

* Type in more text.
* Add TIU objects.
* Change the template name.
* Move the template to a different location.
* Make the template inactive if you don't want it seen in the template drawer.
* If part of a group template, exclude it to make it not copy into a document when the group icon is dragged-and-dropped or double-clicked. Or, if excluded, you can click the check box to include it again.
* Change the template type (template, group template)

☞ NOTE: If you change from a template or group template to a folder, you will lose the text in the template.

5. To spell check or Check Boilerplate for Errors, right-click in the Boilerplate Template area and select the appropriate option.

6. When finished, click Apply to save or click OK to save and exit the editor.

### Creating Shared Document Templates

To create shared document templates, you must be a belong to the Clinical Coordinator ASU class. You can then create templates containing text and TIU objects that will be available to all users.

To create shared templates, follow these steps:

1. Click the Notes, Consults, or D/C Summary tab.

2. Select Options | Create New Shared Template to bring up the Template Editor.

A template called "New Template" is created under Shared Templates..

3. In the Name field under Shared Template Properties, enter a name for the new template. Remember the template name requirements.

4. Click the template type: Template, Group Template, or folder. If you choose Folder, skip to step 6.

5. For templates and Group Templates, enter the text and TIU objects (if desired) to create the content. you can enter content in these ways:

Copy and paste from other documents

* Type in text
* Insert TIU objects
* Copy one of your personal templates

☞ NOTE: After you enter the content, you can right-click in the Template Boilerplate area to select spell check or Check Boilerplate for Errors, which looks for invalid TIU objects.

6. Find where you want to place the template in the tree view.

a. Click the plus sign next to an item to see the objects under it.

b. Drag-and-drop the template where you want it in the tree. (Or use arrows below the personal templates tree view.)

7. To save the template, click Apply. To save and exit the editor, click OK.

☞ NOTE: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

### Copying Document Templates

Users can copy a shared template into their personal templates. Clinical Coordinators can copy personal templates into the shared templates also. In addition, you can also copy a template and paste it elsewhere in the same personal or shared tree (hierarchy).

Instructions for copying templates within a tree

To copy a shared template into personal, use these steps:

1. Click the Notes, Consults, or D/C Summ tab.

2. Select Options | Edit Templates

-or-

If the Templates "drawer" (Notes tab) is open, right-click in the drawer, and select Edit Templates.

3. Expand the personal template tree to show find where you will paste the shared template.

a. Click the plus sign next to an item to see the objects under it.

b. Continue until you find the right location.

c. Click the template under which you want the shared template.

4. Find the shared template you want to copy.

a. In the shared templates, click the plus sign next to items to see the objects under them.

b. Click the template you want to copy.

5. Click the arrow button between the trees, double-click the shared template, or drag-and-drop the shared template to the chosen location.

☞ NOTE: At this point, the template is still a shared template. Changes to the original shared template will appear in your version also, which may be desirable. But if you change your version in any way, it becomes a personal template, the icon will have a folded corner and changes to the original will not affect your version.

6. To save the template, click Apply. To save and exit the editor, click OK.

# User Class Setup

Automatic population of Provider Class

The option *Initialize Membership of User Classes*on the IRM Conversion Menu populates the Provider Class for operation of clinical applications, based on membership in the Provider File. (The option starts a routine called USRPROV.) You especially need to run this routine to implement Discharge Summary because you have to be a provider to sign a discharge summary. Since *all* holders of the provider key will be added to the ASU Provider Class, you need to review holders of the key before running the routine. It should be run only when first implementing ASU.

 **Required User Classes**

The following User Classes and sub-classes under Provider *must* be set up:

|  |  |
| --- | --- |
| **MIS** | **Provider** |
| Chief, MIS | Physician |
| Medical Record Technician | Nurse |
| Transcriptionist | Resident |
|  | Intern |
|  | Medical Student |
|  | Nurse Practitioner |
|  | Physician Assistant |

Other User Classes and sub-classes can be added later, as necessary. **Keep it simple.**

***Steps to set up User Classes***

1. Identify Medical Center staff who will be using Progress Notes and Discharge Summaries through TIU.

You can either work with the various Services or Product Line ADPACs or coordinators to provide names and roles, or you can work through VA FileMan to search the New Person File (or a combination).

If necessary, print the New Person file and look at titles. This is the long and complicated way to identify staff. Frequently different names are used for the same positions. We recommend working with the Services. Maybe they already have something online that is kept updated (especially for rotating medical students, interns, and residents) that can be used for ASU to keep it current.

To identify the users who should be allocated to the CHIEF, MIS and MEDICAL RECORD TECHNICIAN classes, get a list of MRTs and transcriptionists from the HIMS office.

2. Review the list of imported User Classes.

4. Decide how to categorize your list of staff by User Classes and sub-classes.

The Authorization/Subscription Utility (ASU) lets you define, populate, and retrieve information about User Classes (which can be defined hospital-wide or more narrowly for a specific service). It can be used across **V***IST***A** to replace and/or complement keys. You can link User Classes with TIU Document Definitions and document actions. CPRS actions such as ordering or signing can be linked with Document or Order type (e.g., Clinical Warning Note) and with User Classes (e.g., Provider Class). User Classes may be active or inactive.

The TIU/ASU installation automatically stuffs Clinical Coordinator as the CLASS OWNER for Progress Notes Titles.

**Initialize Membership of User Classes**

The option, *Initialize Membership of User Classes* [USR INITALIZE MEMBERSHIP] automatically populates the User Class Membership file (USRPROV) with the Provider User Class, based on membership in the Provider file. It should only be run when first implementing ASU. The option excludes terminated users and users whose names begin with “ZZ.”

**Keep it Simple**

We recommend that you start off by populating only the most essential User Classes (i.e., Provider; MRT; Chief, MIS; and Transcriptionist), and work with the exported classes and business rules. You may need to add a few people who weren’t in classes that were converted, or add a few classes/subclasses to match your hospital’s organization. As you gain experience using ASU, you may want to modify the class structure some.*Don’t make it more complicated or restrictive than necessary.*

#### User Class Management Menu

|  |  |  |
| --- | --- | --- |
| **Option**  | **Option Name** | **Description** |
| User Class Definition | USR CLASS DEFINITION | This option allows review, addition, editing, and removal of User Classes. |
| List Membership by User | USR LIST MEMBERSHIP BY USER  | This option allows review, addition, editing, and removal of individual members to and from User Classes. |
| List Membership by Class | USR LIST MEMBERSHIP BY CLASS | This option allows review, addition, editing, and removal of individual members to and from User Classes. |
| Manage Business Rules | USR BUSINESS RULE MANAGE-MENT | This option allows you to list the Business rules defined by ASU, and to add, edit, or delete them, as appropriate. |

##### Process for creating user classes:

1. Populate the Provider User Class with *Initialize Membership of User Classes*.
2. Edit and Define User Classes.
3. Add members to User Classes.
4. Modify (add or delete) User Classes and their members, as needed.

Detailed instructions are provided on the following pages.

### How to Set Up User Classes

## A. Populate the Provider Class

*Initialize Membership of User Classes*populates the User Class Membership file (USRPROV) with the Provider User Class, based on membership in the Provider file. It should be run ONCE when first implementing ASU.

Select TIU Menu Option: **IRM Conversion Menu**

 1. Convert Discharge Summaries [TIU DISCHARGE SUMMARY CONVERT]

 2. Convert Progress Notes Menu [TIIU PROGRESS NOTES CONVERT MENU]

 3. Initialize Membership of User Classes [USR INITIALIZE MEMBERSHIP]

Select TIU Conversion Menu Option: **3**  **Initialize Membership of User Classes**

## B. Edit and define user classes

1. Prepare a list of all users and their roles. Get the help of various clinical services or product line coordinators.
2. Make sure they’re in the New Person File (VA 200).
3. Look at the exported User Classes (use the option *User Class Definition* on the User Class Management Menu) to see which classes are available. Expand the classes to see sub-classes.
4. If you need new User Classes, you may create them with this option.
5. Determine who belongs in what category.
6. A user may belong to more than one category. Persons wearing several different hats can have more than one entry in the file. For example, Smith might be a dietitian also working toward a nursing degree. Smith could be entered twice, once as a Dietitian and once as a Student Nurse.
7. Since user class membership includes members of all subclasses, users should be made members of the most discrete class in a hierarchy of classes. For example, if Jones is a dentist, Jones should be entered into the Dentist class. Since Dentist is a subclass of the Provider class, Jones is then automatically a Provider, and will “inherit” any of the authorizations granted to Providers.

##### User Class Definition

This option allows you to review, add, edit, and remove User Classes. Follow the steps below to review current User Classes and to create new ones.

**1.** After you select the *User Class Definition* option, enter the User Class Status: Active, Inactive, or both.

User Class Definition

Select User Class Management Option: **1** User Class Definition

Select User Class Status: ACTIVE// **?**

 Active All User Classes

 Inactive

Enter selection(s) by typing the name(s), number(s), or abbreviation(s). **Active**

 Start With Class: FIRST// **Provider**

 Go To Class: LAST// **Provider**

Searching for the User Classes....

**2.** To see sub-classes of the classes shown on this screen, enter a class name at the prompt Start with Class: FIRST//. Then after the screen displays the class name, choose the action Expand/Collapse Tree. You will then see a screen of the hierarchy below the chosen class (e.g., physician).

**User Classes** Jan 31, 1997 13:41:40 Page: 1 of 1

 ACTIVE USER CLASSES 1 Classes

 Class Name Abbrev

1 Provider ... PROV Active

 **+ Next Screen - Prev Screen ?? More Actions**

 Find Expand/Collapse Tree Change View

 Create a Class List Members Quit

 Edit User Class

Select Action: Quit// **EX**

Expanding User Class Hierarchy.

 ***User Class Definition cont’d***

**User Classes** Jan 31, 1997 13:42:32 Page: 1 of 6

 ACTIVE USER CLASSES 1 Classes

 Class Name Abbrev

1 Provider PROV Active

 |-Nurse

 | |-Nurse Anesthetist

 | |-Nurse Clinical Specialist

 | |-Nurse Epidemiologist

 | |-Nurse Practitioner

 | |-Nursing Continuing Care

 | |-Nursing Supervisor

 | |-Head Nurse

 | |-Vascular Nurse

 | |-Research Nurse

 | |-Nurse - Licensed Practical

 | |\_Staff Nurse

 |-Physician Assistant

 |-Dentist

**+ + Next Screen - Prev Screen ?? More Actions**

 Find Expand/Collapse Tree Change View

 Create a Class List Members Quit

 Edit User Class

Select Action: Next Screen// **C** Create a Class

**3.** Select the action Create a Class and enter a new User Class or sub-Class name.

##### C. Add members to user classes

##### List Membership by User

This option lets you enter a user name and the program will identify what User Class he or she is in. You can then add, edit, or remove individual members to that class.

**1.** Select *List Membership by User* from the User Class Management menu, and then enter the name of a user.

Select User Class Management Option: **2** List Membership by User

Select USER: **TIUPROVIDER, ONE** OT

Searching for the User Classes.

###### List Membership by User, cont’d

1. A screen is displayed showing the User Class the designated user belongs to. Select the action Add, and enter other classes to which this user may belong.

**Current User Classes** Jan 18, 1996 13:48:53 Page: 1 of 1

 ONE PROVIDER 1 Class

 User Class Effective Expires

1 Staff Physician

 **+ Next Screen - Prev Screen ?? More Actions**

 Add Remove

 Edit Change View

Select Action: Quit// **Add**

##### D. Modify user classes and their members, as needed

##### List Membership by Class

This option lets you select a User Class to review members. You can then add, edit, or remove individual members to and from the Class.

**1.** Select *List Membership by Class* from the User Class Management menu, and then enter the name of a class.

Select User Class Management Option: 3 List Membership by Class

Select CLASS: **PHYSICIAN**

Searching for the User Classes.

***List Membership by User, cont’d***

1. A screen is displayed showing the User Class and current members in it. Select the action Add, and enter other names to this class. You can also schedule changes for rotating residents, interns, and medical students.

**User Class Members** Jan 18, 1996 13:51:09 Page: 1 of 1

 PHYSICIANs 6 Members

 Member Effective Expires

5 SEVEN DGPROVIDER

1 ELEVEN GMRCPROVIDER 06/01/95

2 FIFTY ORPROVIDER 11/02/95 01/01/99

6 FIVE SRPROVIDER

4 ONE TIUPROVIDER

3 NINE USRPROVIDER

 + Next Screen - Prev Screen ?? More Actions >>>

 Add Remove Change View

 Edit Schedule Changes

Select Action: Quit//

***Example: Adding MRTs and HIMS***

1. To identify the users who should be allocated to the CHIEF, HIMS and MEDICAL RECORD TECHNICIAN classes, get a list of MRTs and transcriptionists from the HIMS office.

Select TIU Maintenance Menu Option: **3** User Class Management

 --- User Class Management Menu ---

 1 User Class Definition

 2 List Membership by User

 3 List Membership by Class

 4 Edit Business Rules

 5 Manage Business Rules

Select User Class Management Option: **3** List Membership by Class

Select CLASS: **MRT** MEDICAL RECORDS TECHNICIAN

Searching for the User Classes.

**User Class Members** Jun 14, 1996 14:21:31 Page: 1 of 1

 MEDICAL RECORDS TECHNICIANs 0 Members Member Effective Expires

No MEDICAL RECORDS TECHNICIANs found

 **+ Next Screen - Prev Screen ?? More Actions >>>**

 Add Remove Change View

 Edit Schedule Changes Quit

Select Action: Quit// **AD** Add

Select MEMBER: **TIUTECHNICIAN,ONE** DCJ 274 MEDICAL RECORD TECHNICIAN

MEMBER: TIUTECHNICIAN,ONE// **<Enter>**

EFFECTIVE DATE: **T** (JUN 14, 1996)

EXPIRATION DATE: **<Enter>**

Rebuilding membership list.

**User Class Members** Jun 14, 1996 14:21:53 Page: 1 of 1

 MEDICAL RECORDS TECHNICIANs 1 Member

 Member Effective Expires

 ONE TIUTECHNICIAN 06/14/96

 **\*\* ONE** **TIUTECHNICIAN Added\*\* >>>**

Jun 14, 1996 14:21:53\_8

 Add Remove Change View

 Edit Schedule Changes Quit

Select Action: Quit// **A** Add

***Example: Adding MRTs and MIS, cont’d***

Select MEMBER: **TIUTECHNICIAN,TWO** TT 828 MEDICAL RECORD TECHNICIAN

MEMBER: **TIUTECHNICIAN,TWO** // **<Enter>**

EFFECTIVE DATE: **T** (JUN 14, 1996)

EXPIRATION DATE: **<Enter>**

Rebuilding membership list.

1. Add all MRTs on the list, then change view to add the Chief of MIS.

**User Class Members** Jun 14, 1996 14:24:11 Page: 1 of 1

 MEDICAL RECORDS TECHNICIANs 7 Members Member Effective Expires

1 ONE TIUTECHNICIAN 06/14/96

2 **TWO** **TIUTECHNICIAN** 06/14/96

3 THREE **TIUTECHNICIAN** 06/14/96

4 FOUR **TIUTECHNICIAN** 06/14/96

5 FIVE **TIUTECHNICIAN** . 06/14/96

6 SIX **TIUTECHNICIAN** 06/14/96

7 SEVEN **TIUTECHNICIAN** 06/14/96

 **\*\* SEVEN TIUTECHNICIAN Added \*\* >>>**

Jun 14, 1996 14:24:11\_8

 Add Remove Change View

 Edit Schedule Changes Quit

Select Action: Quit// **CH**  Change View

Select CLASS: **CHIEF**

 1 CHIEF

 2 CHIEF (ACTING)

 3 CHIEF OF STAFF

 4 CHIEF RESIDENT

 5 CHIEF TECHNOLOGIST

 6 CHIEF, ANESTHESIOLOGY SERVICE

 7 CHIEF, MEDICAL SERVICE

 8 CHIEF, HIMS

 9 CHIEF, PSYCHIATRY SERVICE

TYPE '^' TO STOP, OR

CHOOSE 1-9: **8**

Searching for the User Classes.

***Example: Adding MRTs and MIS, cont’d***

**User Class Members** Jun 14, 1996 14:24:24 Page: 1 of 1

 CHIEF, HIMS 0 Members Member Effective Expires

No CHIEF, HIMS found

 **+ Next Screen - Prev Screen ?? More Actions >>>**

 Add Remove Change View

 Edit Schedule Changes Quit

Select Action: Quit// **AD** Add

Select MEMBER: **TIUCHIEFHIMS,ONE** OT 364 CHIEF MIS

MEMBER: **TIUCHIEFHIMS,ONE**// **<Enter>**

EFFECTIVE DATE: **T** (JUN 14, 1996)

EXPIRATION DATE:

Rebuilding membership list.

###  Exported User Classes

ACTING ASSISTANT CHIEF

ACTING CHIEF

ADDICTION MEDICINE

ADJUDICATION OFFICER

ALLERGIST

ALLERGY & IMMUNOLOGY

ALLERGY & IMMUNOLOGY: CLINICAL & LABORATORY

ANCILLARY TESTING

ANESTHESIOLOGIST

ANESTHESIOLOGIST - CRITICAL CARE

ANESTHESIOLOGIST - PAIN MANAGEMENT

ASSISTANT CHIEF

ASSISTANT CHIEF OF STAFF

ASSOCIATE CHIEF OF STAFF

ATTENDING PHYSICIAN

AUDIOLOGIST

AUDIOVISUAL SPECIALIST

BODY IMAGING

CARDIOLOGIST

CAST TECHNICIAN

CHAPLAIN

CHIEF

CHIEF RESIDENT

CHIEF TECHNOLOGIST

CHIEF, ANESTHESIOLOGY SERVICE

CHIEF, MEDICAL SERVICE

CHIEF, MIS

CHIEF, PSYCHIATRY SERVICE

CHIEF, RESEARCH SERVICE

CHIEF, SURGICAL SERVICE

CLINICAL CLERK

CLINICAL COORDINATOR

CLINICAL DIETITIAN

CLINICAL INTERN

CLINICAL PHARMACIST

CLINICAL SERVICE CHIEF

CLINICAL SPECIALIST

CONSULT/LIAISON

CONSULTANT

COORDINATOR, OPERATING ROOM

COORDINATOR, QM/MIS

COUNSELOR

CYTOTECHNOLOGIST

DENTAL ASSISTANT

DENTAL INTERN

DENTAL RESIDENT

DENTIST

DERMATOLOGIST

***Exported User Classes cont’d***

DERMATOLOGIST: CLINICAL & LABORATORY

DERMATOLOGY FELLOW

DERMATOPATHOLOGIST

DIABETES STUDY NURSE

DIALYSIS TECHNICIAN

DIETETIC INTERN

DIETETIC TECHNICIAN STUDENT

DIETITIAN

DIETITIAN CLINICAL SPECIALIST

DISTINGUISHED PHYSICIAN

DRG COORDINATOR

ECHO TECHNICIAN

EDUCATION STAFF SPECIALIST

ELECTRON MICROSCOPIST

EMERGENCY MEDICINE PHYSICIAN

EMERGENCY SPORTS MEDICINE

EMG TECHNICIAN

ENDOCRINOLOGIST

EPIDEMIOLOGIST

EXERCISE PHYSIOLOGIST

FAMILY GERIATRICIAN

FAMILY PRACTICE PHYSICIAN

FAMILY SPORTS MEDICINE

FEE BASIS NURSE

FELLOW

GENERAL PRACTICE PHYSICIAN

GENERIC SCREENING NURSE

GERIATRICS, GENERAL PRACTITIONER

GRADUATE NURSE TECHNICIAN

GYNECOLOGIST

HEAD NURSE

HEALTH CARE TECHNICIANS

HEMATOLOGY & ONCOLOGY

HEMODIALYSIS TECHNICIAN

HISTOPATHOLOGY TECHNICIAN

HISTOTECHNOLOGIST

HIV/AIDS COORDINATOR

HOME CARE CLINICAL COORDINATOR

HOSPITAL EPIDEMIOLOGIST

HYGIENIST

IMAGE ASSISTANT

INDUSTRIAL HYGIENIST

INFECTION CONTROL NURSE

INFECTIOUS DISEASE FELLOW

INPATIENT PSYCHOLOGIST

INTERN

INTERN PHYSICIAN

INTERN: ALLOPATHIC

***Exported User Classes cont’d***

INTERN: OSTEOPATHIC

IV PHARMACIST

IV TECHNICIAN

JUNIOR ASSISTANT RESIDENT

JUNIOR RESIDENT

KINESIOTHERAPIST

LABORATORY PATHOLOGIST

LABORATORY PROGRAM ASSISTANT

LABORATORY TECHNICIAN

LEAD PHARMACIST

MEDICAL CLERK

MEDICAL CLERK SUPERVISOR

MEDICAL DATA CLERK

MEDICAL INFORMATION SECTION

MEDICAL INTERN

MEDICAL PROGRAM ASSISTANT

MEDICAL RECORD SUPERVISOR

MEDICAL RECORDS TECHNICIAN

MEDICAL STUDENT

MEDICAL STUDENT III

MEDICAL STUDENT IV

MEDICAL TECHNICIAN

MEDICAL TECHNOLOGIST

MEDICAL TECHNOLOGY STUDENT

MEDICAL TOXICOLOGIST

MIS FILE CLERK

NARCOTIC TECHNICIAN

NEUROLOGY PROGRAM CLERK

NEUROLOGY RESIDENT

NEUROLOGY TECHNICIAN

NUCLEAR CARDIOLOGY

NUCLEAR CARDIOLOGY DIRECTOR

NUCLEAR MEDICINE TECHNICIAN

NURSE

NURSE - STUDENT

NURSE ANESTHETIST

NURSE CLINICAL SPECIALIST

NURSE EPIDEMIOLOGIST

NURSE LICENSED PRACTICAL

NURSE PRACTITIONER

NURSING ASSISTANT

NURSING CLERK TYPIST

NURSING CONTINUING CARE

NURSING SUPERVISOR

NUTRITION CLINIC DIETITIAN

NUTRITION SUPPORT NURSE

OCCUPATIONAL THERAPIST

OCCUPATIONAL THERAPY ASSISTANT

OCCUPATIONAL THERAPY STUDENT

***Exported User Classes cont’d***

OCCURRENCE SCREENING

ONCOLOGY NURSE

OPC SCHEDULING SUPERVISOR

OPERATING ROOM COORDINATOR

OPERATING ROOM TECHNICIAN

OPHTHALMOLOGIST

OPTOMETRIST

ORAL SURGERY RESIDENT

ORTHOTIST/PROSTHETIST

OTOLARYNGOLOGY

OUTPATIENT CLINIC

OUTPATIENT CLINIC SUPERVISOR

OUTPATIENT PSYCHOLOGIST

OUTPATIENT RX SUPERVISOR

OUTPATIENT TECHNICIAN

PATHOLOGIST

PATHOLOGY RESIDENT

PEDIATRIC EMERGENCY PHYSICIAN

PHARMACIST

PHARMACY COORDINATOR

PHARMACY MEDICAL CLERK

PHARMACY STUDENT

PHARMACY SUPERVISOR

PHARMACY TECHNICIAN

PHARMACY TRAINEE

PHLEBOTOMIST

PHYSICAL THERAPIST

PHYSICAL THERAPY AID

PHYSICIAN

PHYSICIAN ASSISTANT

PHYSICIST

PODIATRIST

POST GRADUATE YEAR 1 RESIDENT

POST GRADUATE YEAR 2 RESIDENT

POST GRADUATE YEAR 3 RESIDENT

POST GRADUATE YEAR 4 RESIDENT

PRIVACY ACT OFFICER

PROCTOLOGIST

PROSTHETIC REPRESENTATIVE TRAINEE

PROSTHETICS

PROSTHETICS CLERK

PROSTHETICS REPRESENTATIVE

PROVIDER

PSYCHIATRIC RESEARCH ASSISTANT

PSYCHIATRIST

PSYCHIATRY CLERK

PSYCHIATRY PROGRAM ASSISTANT

PSYCHIATRY RESIDENT

PSYCHOLOGY CLINICAL ASSOCIATE

***Exported User Classes cont’d***

PSYCHOLOGY INTERN

PSYCHOLOGY PROGRAM CLERK

PSYCHOLOGY REHABILITATION TECHNICIAN

PSYCHOLOGY RESEARCH

PSYCHOLOGY VOCATIONAL REHAB SPEC

PULMONARY CHIEF

PULMONARY CLINICAL SPECIALIST

PULMONARY FELLOW

PULMONARY FUNCTION TECH

PULMONARY LAB SUPERVISOR

PULMONARY STAFF CHIEF OF STAFF

PULMONARY TECHNICIAN

RADIATION DIAGNOSTIC TECHNOLOGIST

RADIATION ONCOLOGIST

RADIATION THERAPY TECHNOLOGIST

RADIOGRAPHER

RADIOLOGIST

RADIOLOGY DIAGNOSTIC TECH

RADIOLOGY FILE ROOM SUPERVISOR

RADIOLOGY RESIDENT

RADIOLOGY TECHNICIAN

RADIOLOGY TRANSCRIPTIONIST

RECREATION THERAPIST

RECREATIONAL THERAPY ASSISTANT

REMOTE USER

RENAL FELLOW

RESEARCH NURSE

RESEARCH TECHNICIAN

RESEARCH TECHNOLOGIST

RESIDENT PHYSICIAN

RESPIRATORY THERAPIST

SECTION CHIEF

SENIOR ASSISTANT RESIDENT

SENIOR RESIDENT

SOCIAL WORK ASSOCIATE

SOCIAL WORK INTERN

SOCIAL WORK SECRETARY

SOCIAL WORKER

SOCIAL WORKER SUPERVISOR

SOLUTIONS TECHNICIAN

SPECIAL PROCEDURES

SPEECH PATHOLOGIST

SPEECH PATHOLOGY SECTION CHIEF

STAFF DENTIST

STAFF INTERNIST

STAFF NURSE

STAFF PATHOLOGIST

STAFF PHARMACIST

***Exported User Classes cont’d***

STAFF PHYSICIAN

STAFF PSYCHIATRIST

STAFF PSYCHOLOGIST

STAFF RADIOLOGIST

STAFF SOCIAL WORKER

STAFF SURGEON

STUDENT

STUDENT RADIOGRAPHER

SUB-INTERN

SUPERVISOR

SUPERVISOR, BLOOD BANK

SUPERVISOR, C&P UNIT

SUPERVISOR, EVENING LABS

SUPERVISOR, HEMATOLOGY LAB

SUPERVISOR, IMMUNOLOGY LAB

SUPERVISOR, MICROBIOLOGY LAB

SUPERVISOR, MIS

SUPERVISOR, PULMONARY FUNCTION LAB

SUPERVISOR, SPECIAL CHEM LAB

SUPERVISOR, STAT CHEM LAB

SUPERVISORY BIOCHEMIST

SUPERVISORY IMMUNOLOGIST

SUPERVISORY MICROBIOLOGIST

SUPERVISORY PHARMACIST

TRANSCRIPTIONIST

TUMOR REGISTRAR

UNIT COORDINATOR

UNIT NURSE

UNIT TEACHER

USER

VASCULAR NURSE

VETERINARIAN MEDICAL OFFICER

VOCATIONAL REHABILITATION SPECIALIST

## Define Business Rules

Business Rules in ASU authorize specific users or groups of users to perform specified actions on documents in particular statuses.

***Examples:***

1. A completed (CLASS) Clinical Document may be viewed by a User
2. An unsigned (CLASS) Clinical Document may be edited by a provider who is also the expected signer of the note
3. An unsigned (CLASS) Clinical Document may be deleted by Chief, MIS

A list of the Business Rules exported with TIU/ASU follows this section.

##### Manage Business Rules

This option allows you to display all the Business rules for a given Document Definition, User Class, or User Role. You can then add, edit, or delete Rules, as appropriate. (This option is also known as the ASU Rule Browser, because you can browse back and forth among existing Business Rules, by various criteria.)

##### Example 1: Adding a new Business Rule

1. In this example we’ll create a new Business Rule: “An UNCOSIGNED CLINICAL DOCUMENT may be SENT BACK by a PROVIDER who is also an EXPECTED COSIGNER.”

Select User Class Management Option: **5** Manage Business Rules

Select SEARCH CATEGORY: DOCUMENT DEFINITION// **??**

Choose from:

 DOCUMENT DEFINITION

 USER CLASS

 USER ROLE

Select SEARCH CATEGORY: DOCUMENT DEFINITION// **<Enter>**

Select DOCUMENT DEFINITION: **??**

Choose from:

 ADVANCE DIRECTIVE TITLE

 ADVANCE DIRECTIVE DOCUMENT CLASS

 ADVERSE REACTION/ALLERGY TITLE

 ADVERSE REACTION/ALLERGY DOCUMENT CLASS

 CLINICAL DOCUMENTS CLASS

 CLINICAL WARNING TITLE

 CLINICAL WARNING DOCUMENT CLASS

 CRISIS NOTE TITLE

 CRISIS NOTE DOCUMENT CLASS

 DISCHARGE SUMMARIES DOCUMENT CLASS

 DISCHARGE SUMMARY TITLE

 DISCHARGE SUMMARY CLASS

 PROGRESS NOTES CLASS

Select DOCUMENT DEFINITION: **Clinical Documents** (CLASS)

***Manage Business Rules, cont’d***

1. After you specify the search category and document definition, all rules for that definition are displayed.

**ASU Rule Browser** Jan 09, 1997 15:12:34 Page: 1 of 4

 List Business Rules by DOCUMENT 40 Rules

 for CLINICAL DOCUMENTS

 \_

1 An UNTRANSCRIBED CLINICAL DOCUMENT may be entered by A USER

2 An UNRELEASED CLINICAL DOCUMENT may be RELEASEED by AN TRANSCRIBER

3 An UNSIGNED CLINICAL DOCUMENT may be EDITED by AN AUTHOR/DICTATOR

4 An UNSIGNED CLINICAL DOCUMENT may be EDITED by AN EXPECTED SIGNER

5 An UNSIGNED CLINICAL DOCUMENT may be SIGNED by AN EXPECTED SIGNER

6 An UNSIGNED CLINICAL DOCUMENT may be SIGNED by A PROVIDER who is also

 AN EXPECTED COSIGNER

7 A COMPLETED CLINICAL DOCUMENT may be VIEWED by A USER

8 An UNRELEASED CLINICAL DOCUMENT may be EDITED by AN TRANSCRIBER

9 An UNRELEASED CLINICAL DOCUMENT may be EDITED by A TRANSCRIPTIONIST

10 An UNCOSIGNED CLINICAL DOCUMENT may be COSIGNED by AN EXPECTED

 COSIGNER

11 An UNSIGNED CLINICAL DOCUMENT may be SIGNED by A STUDENT who is also

 AN EXPECTED SIGNER

12 An UNSIGNED CLINICAL DOCUMENT may be EDITED by AN EXPECTED COSIGNER

+ + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Next Screen// **a** Add Rule

Please Enter a New Business Rule:

Select DOCUMENT DEFINITION: **??**

Choose from:

 ADVANCE DIRECTIVE TITLE

 ADVANCE DIRECTIVE DOCUMENT CLASS

 ADVERSE REACTION/ALLERGY TITLE

 ADVERSE REACTION/ALLERGY DOCUMENT CLASS

 BOIL MARCIE MN TITLE

 CLINICAL DOCUMENTS CLASS

 CLINICAL WARNING TITLE

 CLINICAL WARNING DOCUMENT CLASS

 CRISIS NOTE TITLE

 CRISIS NOTE DOCUMENT CLASS

 DISCHARGE SUMMARIES DOCUMENT CLASS

 DISCHARGE SUMMARY TITLE

 DISCHARGE SUMMARY CLASS

 MINN MARCIE DOCUMENT CLASS

 PROGRESS NOTES CLASS

 RNOTE DOCUMENT CLASS

Select DOCUMENT DEFINITION: **CLINICAL DOCUMENTS**

DOCUMENT DEFINITION: CLINICAL DOCUMENTS// **<Enter>**

STATUS: STATUS: **??**

 Choose from:

 AMENDED

 COMPLETED

 DELETED

***Manage Business Rules option, cont’d***

 PURGED

 UNCOSIGNED

 UNDICTATED

 UNRELEASED

 UNSIGNED

 UNTRANSCRIBED

 UNVERIFIED

STATUS: **UNCOSIGNED**

ACTION: **??**

 This is the action to be permitted for a given document definition

 and status.

Choose from:

 AMENDMENT

 COPY RECORD

 COSIGNATURE

 DELETE RECORD

 DICTATION

 EDIT DOCUMENT DEFINITION

 EDIT RECORD

 ENTRY

 MAKE ADDENDUM

 PRINT RECORD

 RELEASE FROM TRANSCRIPTION

 SEND BACK

 SIGNATURE

 VERIFICATION

 VIEW

ACTION: **SEND BACK**

USER CLASS: **PROVIDER**

AND FLAG: ??

This field allows the ADPAC to indicate whether the conditions specified by User Class and User Role should be logically "AND'ed," or logically "OR'ed," as they will be unless otherwise specified. i.e., if you want to specify that an unsigned discharge summary may be signed by a user, where:

 User Class = Provider AND User Role = Author,

 then you'll want to set this field to AND.

 Choose from:

 & AND

 ! OR

AND FLAG: **&** AND

USER ROLE: **??**

This identifies the role of the user with respect to the document in question (e.g., Author/Dictator, Expected Signer, Expected Cosigner,

Attending Physician, etc.).

Choose from:

 ADDITIONAL SIGNER

 ATTENDING PHYSICIAN

 AUTHOR/DICTATOR

 EXPECTED COSIGNER

 EXPECTED SIGNER

 SURROGATE

 TRANSCRIBER

***Manage Business Rules option cont’d***

USER ROLE: **EXPECTED COSIGNER**

DESCRIPTION:

 1> **<Enter>**

**ASU Rule Browser** Jan 09, 1997 17:35:52 Page: 1 of 1

 List Business Rules by DOCUMENT 2 Rules

 for CLINICAL DOCUMENTS

1 An UNTRANSCRIBED CLINICAL DOCUMENT may be ENTERED by A NURSE

2 An UNCOSIGNED CLINICAL DOCUMENT may be SENT BACK by a PROVIDER

 who is also an EXPECTED COSIGNER

 **\*\* Item 2 Added \*\***

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit//

##### Example 2: Manage Business Rules

In this example, we view business rules by User Class with Nursing Supervisor. We’ll delete one rule and edit another.

1. Choose *Manage Business Rules* from the User Class Management menu. Then select User Class for the search category and Nursing Supervisor for the user class.

Select User Class Management Option: 5 Manage Business Rules

Select SEARCH CATEGORY: DOCUMENT// **USER CLASS**

Select USER CLASS: **NURSING**

 1 NURSING ASSISTANT

 2 NURSING CLERK TYPIST

 3 NURSING CONTINUING CARE

 4 NURSING SUPERVISOR

CHOOSE 1-4: **4** NURSING SUPERVISOR

**2.** The current rules for the Nurse Supervisor User Class are displayed.

ASU Rule Browser Jan 09, 2008@11:15:02 Page: 1 of 1

 List Business Rules by USER CLASS 2 Rules

 for NURSING SUPERVISOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 An UNTRANSCRIBED (DOCUMENT CLASS) NURSE'S NOTE may BE EDITED by a NURSING

 SUPERVISOR

2 An UNSIGNED (DOCUMENT CLASS) NURSE'S NOTE may BE EDITED by a NURSING

 SUPERVISOR

 + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit// **D** Delete Rule

1. Select the number of the Business Rule you want to delete. When you get the confirmation message about deleting the rule, respond Yes to the prompt “Do you want to delete the rule?”

Select Business Rule(s): (1-2): **2**

Deleting #2

Removing the rule:

An UNSIGNED (DOCUMENT CLASS) NURSE'S NOTE may BE EDITED by a NURSING

SUPERVISOR

Do you want to delete the rule? NO// **Y**

Deleting Business Rule.

***Manage Business Rules, cont’d***

1. When the screen is displayed again, the rule is not there, and the center message bar indicates which item was deleted.

ASU Rule Browser Jan 09, 2008@11:15:21 Page: 1 of 1

 List Business Rules by USER CLASS 1 Rule

 for NURSING SUPERVISOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 An UNTRANSCRIBED (DOCUMENT CLASS) NURSE'S NOTE may BE EDITED by a NURSING

 SUPERVISOR

 \*\* Item 2 deleted \*\*

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit//

**5.** Select the Edit Rule action.

ASU Rule Browser Jan 09, 2008@11:15:21 Page: 1 of 1

 List Business Rules by USER CLASS 1 Rule

 for NURSING SUPERVISOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 An UNTRANSCRIBED (DOCUMENT CLASS) NURSE'S NOTE may BE EDITED by a NURSING

 SUPERVISOR

 \*\* Item 2 deleted \*\*

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit// **E** Edit Rule

1. Then accept the defaults or enter a new rule component.

Editing #1

DOCUMENT DEFINITION: NURSE'S NOTES// **<Enter>**

STATUS: UNTRANSCRIBED// **<Enter>**

ACTION: EDIT RECORD// **ENTRY**

USER CLASS: NURSING SUPERVISOR// **NURSE**

 1 NURSE

 2 NURSE ANESTHETIST

 3 NURSE CLINICAL SPECIALIST

 4 NURSE EPIDEMIOLOGIST

 5 NURSE LICENSED PRACTICAL

Press <RETURN> to see more, '^' to exit this list, OR

CHOOSE 1-5: **1** NURSE

AND FLAG: **<Enter>**

USER ROLE: **<Enter>**

DESCRIPTION:

 No existing text

 Edit? NO// **<Enter>**

Refreshing the list.

***Manage Business Rules, cont’d***

1. The screen is redisplayed with current rules for this User Class. Note that the edited rule isn’t displayed. That’s because the User Class was changed, so you need to Change View to the new User Class, Nurse.

ASU Rule Browser Jan 09, 2008@11:31:28 Page: 1 of 1

 List Business Rules by USER CLASS 0 Rules

 for NURSING SUPERVISOR

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No Business Rules currently exist for USER CLASS NURSING SUPERVISOR

 + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit// **C** CHANGE VIEW

1. After you respond to prompts for User Class and enter Nurse, the screen redisplays with current rules for this User Class.

Select SEARCH CATEGORY: DOCUMENT DEFINITION// user class

Select USER CLASS: nurse

 1 NURSE

 2 NURSE ANESTHETIST

 3 NURSE CLINICAL SPECIALIST

 4 NURSE EPIDEMIOLOGIST

 5 NURSE LICENSED PRACTICAL

Press <RETURN> to see more, '^' to exit this list, OR

CHOOSE 1-5: 1 NURSE

ASU Rule Browser Jan 09, 2008@11:16:05 Page: 1 of 1

 List Business Rules by USER CLASS 2 Rules

 for NURSE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1 A COMPLETED (DOCUMENT CLASS) NURSE'S NOTE may BE VIEWED by a NURSE

2 An UNTRANSCRIBED (DOCUMENT CLASS) NURSE'S NOTE may BE ENTERED by a NURSE

 + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Quit//

**Business Rule Statuses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Status** | **Symbol** | **Sequence** | **Description** |
| Amended \* | a | 45 | The document has been completed and a privacy act issue has required its amendment. By design, only the following user classes are allowed to amend a note:* CHIEF, MIS
* CHIEF, HIM
* PRIVACY ACT OFFICER
 |
| Completed \* | c | 35 | The document has acquired all necessary signatures and is legally authenticated. |
| Deleted | d | 47 | Status DELETED is no longer operable. Before status RETRACTED was introduced deleting a document removed the text of the document leaving a stub with status DELETED. |
| Retracted \* | r | 40 | When a signed document is reassigned, amended, or deleted, a retracted copy of the original is kept for audit purposes.  |
| Uncosigned \* | u | 30 | The document is complete, with the exception of cosignature by the attending physician. |
| Undictated | d | 5 | The document is required and a record has been created in anticipation of dictation and transcription, but the system hasn’t been informed of its dictation. |
| Unreleased | r | 15 | The document is in the process of being entered into the system, but hasn’t been released by the originator (i.e., the person who entered the text online). |
| Unsigned | $ | 25 | The document is online in a draft state, but the author's signature hasn’t yet been obtained. |
| Untranscribed | t | 10 | The document is required, and the system has been informed of its dictation, but the transcription hasn’t yet been entered or received by upload. |
| Unverified | v | 20 | The document has been released or uploaded, but an intervening verification step must be completed before the document is displayed. |

* As of TIU\*1\*234, documents of these statuses (i.e., signed documents) cannot be edited regardless of business rules.

## Inheritance for Business Rules

Business Rules may have one or both of the following hierarchical attributes:

1. Document Definition
2. User Class

Sometimes a rule contains a User role but no User Class, and, therefore, only has one hierarchical attribute.

Business Rules are inherited along both of these attribute lines.

***Inheritance along the Document Definition line***

Rules defined for a given Document Definition are inherited by all Document Definitions below the given one. For example, the following rule is inherited by all Titles since all Titles descend from CLINICAL DOCUMENTS:

A COMPLETED (CLASS) CLINICAL DOCUMENT may be VIEWED by a USER

In other words, all completed Titles may be viewed by a User.

**Overriding Business Rule inheritance:**

This Document Definition inheritance can be overridden by setting rules at lower levels of the Document Definition hierarchy.

**Example 1:**

Rule #1 below is overridden by rule #2, because Document Class NURSE NOTE is under Class CLINICAL DOCUMENTS in the Document Definition hierarchy and both rules have the same Status and Action.

1. An UNTRANSCRIBED (CLASS) CLINICAL DOCUMENT may be ENTERED by a USER

2. An UNTRANSCRIBED (DOCUMENT CLASS) NURSE NOTE may be ENTERED by a NURSE

**Example 2:**

Rule #1 below is overridden by rule #2 because Document Class NURSE NOTE is under Class CLINICAL DOCUMENTS and both rules have the same Status and Action.

1. An UNSIGNED (CLASS) CLINICAL DOCUMENT may be VIEWED by an AUTHOR/DICTATOR

2. An UNSIGNED (DOCUMENT CLASS) NURSE NOTE may be VIEWED by a CHIEF, MIS

 If both of these rules exist, and an Author/Dictator should be able to view an Unsigned (Document Class) NURSE NOTE, then the following rule must be added:

An UNSIGNED (DOCUMENT CLASS) NURSE NOTE may be VIEWED by an AUTHOR/DICTATOR

☞ NOTE: Document Definition override permits Clinical Coordinators to modify the behavior of documents for which they are responsible (e.g., NURSE NOTE), without affecting the behavior of other documents.

***Inheritance along the User Class line***

Rules defined for a given User Class are inherited by all User Classes below the given one. For example, the following rule applies to all users since all User Classes descend from the User Class USER.

A COMPLETED (CLASS) CLINICAL DOCUMENT may be VIEWED by a USER

Putting the two lines of inheritance together, this rule (if it has not been overridden) means that all completed Titles may be viewed by all users.

Although rules are INHERITED through User Class as well as through the Document Definition hierarchy, inheritance is *not* overridden by the User Class hierarchy.

In fact, if two rules have the same status, the same action, and the same Document Definition, but one rule has a User Class that descends from the User Class of the other rule, then the rule for the more explicit User Class is redundant. It does NOT override the more general rule.

For example, rule #1 below is *not* overridden by rule #2.

1. An UNSIGNED (DOCUMENT CLASS) NURSE NOTE may be VIEWED by a MEDICAL INFORMATION SECTION

2. An UNSIGNED (DOCUMENT CLASS) NURSE NOTE may be VIEWED by a CHIEF, MIS

Instead, the second rule is redundant in the presence of the first rule. It could be eliminated with no effect.

If a site has only rule #2 and wishes to expand those that can view NURSE NOTE from Chief, MIS to the Medical Information Section, they could simply add rule #1. However, it would be more efficient (fewer rules) to simply change the class CHIEF, MIS to MEDICAL INFORMATION SECTION in the second rule.

☞ NOTE: The reason there is no inheritance override for User Classes is that the responsibility for User Classes is not divided up the way it is for Document Definitions. For example, the Nursing Clinical Coordinator is responsible for Nursing Note behavior for ALL User Classes, but is *not* responsible for all TIU documents, only for Nurse Notes.

***Inheritance and Addenda***

Business Rules cannot be set for Addenda, since Addenda inherit their behavior from their parents.

## Exported Business Rules

The exported business rules are meant as a guide and aid to local sites. They were crafted to give sensible permissions to appropriate health care workers. Local sites may modify these to satisfy local requirements. They are given here as a reference in case you wish to return to original settings.

### Clinical Documents

ASU Rule Browser Jun 20, 1997 16:33:39 Page: 1 of 5

 List Business Rules by DOCUMENT DEFINITION 64 Rules

 for CLASS **CLINICAL DOCUMENTS**

-------------------------------------------------------------------------------

1 An UNTRANSCRIBED (CLASS) CLINICAL DOCUMENT may be ENTERED by A USER

2 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be RELEASED by A TRANSCRIBER

3 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by An AUTHOR/DICTATOR

4 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by An EXPECTED SIGNER

5 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be SIGNED by An EXPECTED SIGNER

6 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be SIGNED by A PROVIDER who is

 also An EXPECTED COSIGNER

7 A COMPLETED (CLASS) CLINICAL DOCUMENT may be VIEWED by A USER

8 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be EDITED by A TRANSCRIBER

9 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be EDITED by A TRANSCRIPTIONIST

10 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be COSIGNED by An EXPECTED

 COSIGNER

11 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be SIGNED by A STUDENT who is

 also An EXPECTED SIGNER

12 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by An EXPECTED COSIGNER

13 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by An EXPECTED COSIGNER

14 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

15 An UNDICTATED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

16 An UNTRANSCRIBED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

17 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

18 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

19 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

20 A COMPLETED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

21 An AMENDED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

22 A COMPLETED (CLASS) CLINICAL DOCUMENT may be PRINTED by A USER

23 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be VIEWED by An EXPECTED COSIGNER

24 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by A CLINICAL SERVICE CHIEF

25 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be EDITED by A CLINICAL SERVICE

 CHIEF

26 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be SIGNED by An ADDITIONAL SIGNER

27 A COMPLETED (CLASS) CLINICAL DOCUMENT may be SIGNED by An ADDITIONAL SIGNER

28 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be SIGNED by An ADDITIONAL

 SIGNER

29 An AMENDED (CLASS) CLINICAL DOCUMENT may be VIEWED by A USER

30 An AMENDED (CLASS) CLINICAL DOCUMENT may be PRINTED by A USER

31 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be COPIED by An AUTHOR/DICTATOR

32 A COMPLETED (CLASS) CLINICAL DOCUMENT may be COPIED by A USER

33 A DELETED (CLASS) CLINICAL DOCUMENT may be DELETED by A CLINICAL

 COORDINATOR

34 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be SENT BACK by A MEDICAL

 INFORMATION SECTION

35 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be SENT BACK by A MEDICAL

 INFORMATION SECTION

36 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be VIEWED by An EXPECTED

 COSIGNER

37 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be VIEWED by A CLINICAL SERVICE CHIEF

***Exported Business Rules****,* ***cont’d***

38 A COMPLETED (CLASS) CLINICAL DOCUMENT may be AMENDED by A CHIEF, MIS

39 A COMPLETED (CLASS) CLINICAL DOCUMENT may be ADDENDED by A USER

40 An AMENDED (CLASS) CLINICAL DOCUMENT may be ADDENDED by A USER

41 A DELETED (CLASS) CLINICAL DOCUMENT may be VIEWED by A USER

42 A DELETED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

43 A PURGED (CLASS) CLINICAL DOCUMENT may be DELETED by A CHIEF, MIS

44 A PURGED (CLASS) CLINICAL DOCUMENT may be VIEWED by A USER

45 An UNTRANSCRIBED (CLASS) CLINICAL DOCUMENT may be VIEWED by A CHIEF, MIS

46 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be VIEWED by A CHIEF, MIS

47 An UNDICTATED (CLASS) CLINICAL DOCUMENT may be VIEWED by A USER

48 A COMPLETED (CLASS) CLINICAL DOCUMENT may HAVE SIGNERS IDENTIFIED by An AUTHOR/DICTATOR

49 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may HAVE SIGNERS IDENTIFIED by

 An AUTHOR/DICTATOR

50 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may HAVE SIGNERS IDENTIFIED by An EXPECTED COSIGNER

51 A COMPLETED (CLASS) CLINICAL DOCUMENT may HAVE SIGNERS IDENTIFIED by An EXPECTED COSIGNER

52 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be REASSIGNED by A MEDICAL

 INFORMATION SECTION

53 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be REASSIGNED by An

 AUTHOR/DICTATOR

54 An UNSIGNED (CLASS) CLINICAL DOCUMENT may be HAVE ITS TITLE CHANGED by An

 AUTHOR/DICTATOR

55 A COMPLETED (CLASS) CLINICAL DOCUMENT may be HAVE ITS TITLE CHANGED by A

 CHIEF, MIS

56 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be HAVE ITS TITLE CHANGED by An EXPECTED COSIGNER

57 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may be HAVE ITS TITLE CHANGED by A

 CLINICAL SERVICE CHIEF

58 A COMPLETED (CLASS) CLINICAL DOCUMENT may be REASSIGNED by A CHIEF, MIS

59 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be VIEWED by A MEDICAL

 INFORMATION SECTION

60 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be VERIFIED by A MEDICAL

 INFORMATION SECTION

61 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be EDITED by A MEDICAL

 INFORMATION SECTION

62 An UNVERIFIED (CLASS) CLINICAL DOCUMENT may be PRINTED by A MEDICAL

 INFORMATION SECTION

63 An UNRELEASED (CLASS) CLINICAL DOCUMENT may be VIEWED by A TRANSCRIBER

1. An UNRELEASED (CLASS) CLINICAL DOCUMENT may be VIEWED by A TRANSCRIPTIONIST

65 An UNSIGNED (CLASS) CLINICAL DOCUMENT may BE LINKED with a request by an

 AUTHOR/DICTATOR

66 An UNCOSIGNED (CLASS) CLINICAL DOCUMENT may BE LINKED with a request by an

 EXPECTED COSIGNER

67 A COMPLETED (CLASS) CLINICAL DOCUMENT may BE LINKED with a request by a

 CHIEF, MIS

68 An UNSIGNED (CLASS) CLINICAL DOCUMENT may BE LINKED with a request by a

 MEDICAL RECORDS TECHNICIAN

69 An UNSIGNED (CLASS) CLINICAL DOCUMENT may BE VIEWED by an AUTHOR/DICTATOR

***Exported Business Rules****,* ***cont’d***

### Progress Notes

 List Business Rules by DOCUMENT DEFINITION 23 Rules

 for CLASS **PROGRESS NOTES**

-------------------------------------------------------------------------------

1 A COMPLETED (CLASS) PROGRESS NOTE may be VIEWED by A USER

2 An UNSIGNED (CLASS) PROGRESS NOTE may be EDITED by A STUDENT who is also An AUTHOR/DICTATOR

3 An UNSIGNED (CLASS) PROGRESS NOTE may be DELETED by An AUTHOR/DICTATOR

4 An UNSIGNED (CLASS) PROGRESS NOTE may be VIEWED by An AUTHOR/DICTATOR

5 An UNCOSIGNED (CLASS) PROGRESS NOTE may be VIEWED by An AUTHOR/DICTATOR

6 An UNCOSIGNED (CLASS) PROGRESS NOTE may be VIEWED by An EXPECTED COSIGNER

7 An UNSIGNED (CLASS) PROGRESS NOTE may be PRINTED by An AUTHOR/DICTATOR

8 An UNCOSIGNED (CLASS) PROGRESS NOTE may be PRINTED by An AUTHOR/DICTATOR

9 An UNCOSIGNED (CLASS) PROGRESS NOTE may be EDITED by An EXPECTED COSIGNER

10 An UNSIGNED (CLASS) PROGRESS NOTE may be EDITED by An AUTHOR/DICTATOR

11 An UNCOSIGNED (CLASS) PROGRESS NOTE may be PRINTED by An EXPECTED COSIGNER

12 An UNSIGNED (CLASS) PROGRESS NOTE may be SIGNED by An AUTHOR/DICTATOR

13 An UNCOSIGNED (CLASS) PROGRESS NOTE may be COSIGNED by An EXPECTED COSIGNER

14 An UNSIGNED (CLASS) PROGRESS NOTE may be VIEWED by A CHIEF, MIS

15 An UNSIGNED (CLASS) PROGRESS NOTE may be DELETED by A CHIEF, MIS

16 An UNCOSIGNED (CLASS) PROGRESS NOTE may be VIEWED by A CHIEF, MIS

17 An UNCOSIGNED (CLASS) PROGRESS NOTE may be DELETED by A CHIEF, MIS

18 An UNSIGNED (CLASS) PROGRESS NOTE may be EDITED by An EXPECTED COSIGNER

19 An UNSIGNED (CLASS) PROGRESS NOTE may be VIEWED by An EXPECTED COSIGNER

20 An UNSIGNED (CLASS) PROGRESS NOTE may be EDITED by A CLINICAL SERVICE CHIEF

21 An UNSIGNED (CLASS) PROGRESS NOTE may be VIEWED by A CLINICAL SERVICE CHIEF

22 An UNSIGNED (CLASS) PROGRESS NOTE may be SIGNED by A CLINICAL SERVICE CHIEF

23 An UNSIGNED (CLASS) PROGRESS NOTE may be SIGNED by An EXPECTED COSIGNER

### Discharge Summary

 List Business Rules by DOCUMENT DEFINITION 17 Rules

 for CLASS **DISCHARGE SUMMARY**

-------------------------------------------------------------------------------

1 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be EDITED by A PROVIDER who is

 also An EXPECTED COSIGNER

2 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be SIGNED by A PROVIDER who is

 also An ATTENDING PHYSICIAN

3 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be COSIGNED by A PROVIDER who

 is also An EXPECTED COSIGNER

4 An UNVERIFIED (CLASS) DISCHARGE SUMMARY may be VIEWED by A MEDICAL

 INFORMATION SECTION

5 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be EDITED by A PROVIDER who is

 also An EXPECTED COSIGNER

6 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be SIGNED by A CLINICAL SERVICE

 CHIEF

7 An UNVERIFIED (CLASS) DISCHARGE SUMMARY may be VERIFIED by A MEDICAL

 INFORMATION SECTION

8 An UNVERIFIED (CLASS) DISCHARGE SUMMARY may be EDITED by A MEDICAL

 INFORMATION SECTION

9 An UNVERIFIED (CLASS) DISCHARGE SUMMARY may be PRINTED by A MEDICAL

 INFORMATION SECTION

10 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be VIEWED by A USER

11 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be PRINTED by A USER

12 An UNSIGNED (CLASS) DISCHARGE SUMMARY may be ADDENDED by A USER

13 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be ADDENDED by A USER

14 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be VIEWED by A USER

15 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be COSIGNED by A CLINICAL

 SERVICE CHIEF

16 An UNCOSIGNED (CLASS) DISCHARGE SUMMARY may be EDITED by A CLINICAL SERVICE CHIEF

1. An UNSIGNED (CLASS) DISCHARGE SUMMARY may be SIGNED by An EXPECTED SIGNER

### Patient Record Flag Cat I

 List Business Rules by DOCUMENT DEFINITION 1 Rule

 for DOCUMENT CLASS PATIENT RECORD FLAG CAT I

-------------------------------------------------------------------------------

1 An UNTRANSCRIBED (DOCUMENT CLASS) PATIENT RECORD FLAG CAT I may BE ENTERED

 by a DGPF PATIENT RECORD FLAGS MGR

***Exported Business Rules****,* ***cont’d***

### LR Anatomic Pathology

Rules for LR Laboratory Reports are set at the Document Class level for LR Anatomic Pathology. These rules *prevent* various actions on these documents ensuring that the documents are managed from the Anatomic Pathology menu only.

Unlike those exported for Clinical Documents, Progress Notes, and Discharge Summary, the business rules exported for LR Laboratory Reports must not be changed locally. The Anatomic Pathology Package will not work properly if these business rules are changed.

Patch USR\*1\*23 included the following nine business rules in support of Anatomic Pathology (AP).

An UNTRANSCRIBED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE ENTERED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE PRINTED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE DELETED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE AMENDED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE ADDENDED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE REASSIGNED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE COPIED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE ITS TITLE CHANGED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE SIGNERS IDENTIFIED by a LR ANATOMIC PATH EMPTY CLASS

☞ Note: USR\*1\*31 directed medical centers to change these rules to refer to CHIEF, MIS or CHIEF, HIM rather than the LR ANATOMIC PATHOLOGY EMPTY CLASS. The VA Office of Inspector General (OIG) determined that these rules are not in harmony with VHA Handbook 1907.1 and other VHA policies. See the section [USR\*1\*31 Impact on Business Rules](#USR_31_a) in this manual for further details.

USR\*1\*31 Impact on Business Rules

The ASU patch USR\*1\*31 directed medical centers to do the following three measures with respect to the business rules:

1. Change LR ANATOMIC PATHOLOGY EMPTY CLASS references in business rules to either CHIEF, MIS or CHIEF, HIM.
2. Remove references to the PURGED status in business rules.
3. Limit privileges to delete status DELETED documents in business rules.

All of these modifications can be accomplished with the TIU MAINTENANCE MENU, User Class Management option.

The persistence of these rules is not in harmony with current VHA directives such as VHA Handbook 1907.1 and was commented on during an Office of Inspector General (OIG) inspection. While removal of business rules referring to the PURGED status may seem cosmetic because the PURGED status has never been supported by VistA, OIG feels that it is still improper to leave these rules in place. Similarly, the use of the LR ANATOMIC PATHOLOGY EMPTY CLASS in rules about the modification of LR Anatomic Pathology documents also goes against a directive of VHA Handbook 1907.1 in that only the Privacy Officer or the Chief HIM may modify a signed document; hence any business rule stating otherwise is contrary to directives (even if the USR class involved is an empty class).

Complete directions for accomplishing these three tasks are given in the patch. An abridged version of these directions is given here:

### EMPTY CLASS and the LR Anatomic Pathology Rules

Rules were created when the following option, exported by TIU\*1\*137, was run after patch installation:

 Create DDEFS, Rules for Anat Path [TIU137 DDEFS & RULES, ANATPATH]

The rules concern documents completed in the Lab Anatomic Pathology package and automatically entered into the TIU DOCUMENT FILE. Any necessary changes to these documents must be made through Lab, not TIU.

Although these rules may look like they PERMITTED actions, they actually prohibited actions since the User Class LR ANATOMIC PATH EMPTY CLASS does not have any members (unless someone has been entered by mistake into that class). However, someone COULD be entered by mistake into that class, and the OIG has stated that these rules must be changed.

The rules as installed by TIU\*1\*137 are:

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE AMENDED by

a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE ITS

TITLE CHANGED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE COPIED by

a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE DELETED by

a LR ANATOMIC PATH EMPTY CLASS

An UNTRANSCRIBED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE

ENTERED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE

SIGNERS IDENTIFIED by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE ADDENDED

by a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE PRINTED by

a LR ANATOMIC PATH EMPTY CLASS

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE REASSIGNED

by a LR ANATOMIC PATH EMPTY CLASS

The User Class in these 9 exported rules must be changed to:

 CHIEF, MIS [or CHIEF, HIM if your site has that class instead]

As of patch TIU\*1\*234, this first rule should be deleted by each medical center.

Your changed rules should look like this:

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE AMENDED by

a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE ITS

TITLE CHANGED by a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE COPIED by

a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE DELETED by

a CHIEF, MIS [or CHIEF, HIM]

An UNTRANSCRIBED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE

ENTERED by a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may HAVE

SIGNERS IDENTIFIED by a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE ADDENDED

by a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE PRINTED by

a CHIEF, MIS [or CHIEF, HIM]

A COMPLETED (DOCUMENT CLASS) LR ANATOMIC PATHOLOGY may BE REASSIGNED

by a CHIEF, MIS [or CHIEF, HIM]

To make these changes you must have access to the TIU MAINTENANCE MENU, User Class Management option. Use Search Category DOCUMENT DEFINITION under option Manage Business Rules, and select LR ANATOMIC PATHOLOGY (the Document Class). Then EDIT each rule, changing the User Class as described above.

☞ Warning Do NOT DELETE these rules for LR ANATOMIC PATHOLOGY!

#### Why LR ANATOMIC PATH rules MUST NOT BE DELETED

These rules prohibit permissions regarding these actions from being inherited from TIU Document Class CLINICAL DOCUMENTS. If these rules were deleted, incorrect permissions would be inherited from CLASS CLINICAL DOCUMENTS. These rules (with a changed User Class) MUST CONTINUE TO EXIST as Business Rules to avoid this unwanted inheritance.

### Obsolete PURGED Status

Sites must DELETE Rules Referencing Obsolete Status PURGED.

We are aware of the following rules referencing Status PURGED:

A PURGED (CLASS) CLINICAL DOCUMENT may BE DELETED by a CHIEF, MIS

A PURGED (CLASS) CLINICAL DOCUMENT may BE VIEWED by a USER

To delete these rules referencing Status PURGED you must have access to the TIU MAINTENANCE MENU, User Class Management option. Use Search Category DOCUMENT DEFINITION, select Document Definition CLINICAL DOCUMENT, select action FIND, and find 'PURGED'. Then delete each rule referencing Status PURGED.

Although these rules are not in effect since no document has status PURGED, please clean them up to avoid misunderstanding.

### Documents of Status DELETED

There should only be one business rule in your system that allows deletion of DELETED notes. That is:

A DELETED (CLASS) CLINICAL DOCUMENT may BE DELETED by a CHIEF, MIS [or CHIEF, HIM]

Some medical centers may have other rules such as:

A DELETED (CLASS) CLINICAL DOCUMENT may BE DELETED by a Clinical Coordinator

This allows too much access to this function. You must delete all except the first rule listed here.

The DELETE action performs differently in different situations:

1. In the case of an unsigned document, the document is removed from the filing system.
2. In early versions of TIU, deleting a signed note would remove the text and mark the note as DELETED. This was unsatisfactory and has since been changed. Today, in the case of a signed document, DELETE only removes the document from the general view. It is still in the filing system with the status of RETRACTED. This status allows examination of the document in cases where a patient’s record needs to be closely scrutinized, such as in a court proceeding.
3. In the case of a document already marked with the status of DELETED, the DELETE action changes the status to RETRACTED.

The only reason to delete a signed document is to correct some sort of error, such as one introduced by the test version of some software. VHA regulations such as VHA Handbook 1907.1 require that the privilege of determining when an error has occurred and the right to correct such an error be limited to a high level position such as the Chief of MIS or the Chief of HIM.

### TIU\*1\*234 Impact on Business Rules

First, patch 234 prevents the text of signed documents from being edited. This change overrides business rules for editing signed documents. In the past some sites had business rules permitting edit by expected cosigners of uncosigned documents. This practice is forbidden by current policy.

Second, it prohibits all users except PRIVACY ACT OFFICER, CHIEF, MIS, CHIEF HIM from AMENDING documents. (Note that alternates to these positions may be designated with these roles for computer purposes.) The amending process is an important feature of TIU to keep the medical record accurate. It keeps an audit trail and allows a paper trail of everything that has been done.

☞ Note: These two changes are required by the Office of the Inspector General and by HIMS. The prohibitions function regardless of business rules and apply in both VISTA and the CPRS GUI.

Because of these first two changes all sites should delete the following categories of rules. This will avoid confusion over what actions are allowed:

1. All rules that refer to the action AMEND.
2. All rules allowing edit of signed documents.

Third, this patch adds Clinical Procedures (CP) to the types of documents

whose Expected Cosigners can be changed using VISTA option EDIT COSIGNER

(EC), which was sent out in TIU\*1\*220.

# Glossary

**ASU** Authorization/Subscription Utility, a utility that allows sites to associate users with user classes, allowing them to specify the level of authorization needed to sign, order, or perform other actions on specific document definitions and orderables.

**Action** A functional process that a clinician or clerk uses in the TIU computer program. “Edit,” “Create,” and “Find” are examples of actions. Actions used in List Manager applications are also known as protocols.

**Boilerplate Text** A pre-defined Progress Notes or Discharge Summary template containing standard text, with blanks to fill in for specific data about a patient.

**Business Rule** Business Rules in ASU authorize specific users or groups of users to perform specified actions on documents in particular statuses. A set of business rules is exported with TIU/ASU; sites can edit or add to these.

**Class** Classes are groups of groups which hold documents.

 For example, Progress Notes is a Class with many Document Classes (kinds of progress notes) under it.

 Classes may themselves be subdivided into Classes and/or may go straight to Document Class if no further subdivisions are desired. Besides grouping documents, Classes also store behavior which is then inherited by lower level entries.

**Clinician** A doctor or other provider in the medical center who is authorized to provide patient care.

**Component** Components are “sections” or “pieces” of documents, such as Subjective, Objective, Assessment, and Plan in a SOAP Progress

***Glossary cont’d***

**Discharge Summary** A discharge summary is a formal synopsis of a patient’s medical care during a single hospitalization. It includes the pertinent diagnostic and therapeutic tests and procedures as well as the conclusions generated by those tests. A discharge summary is prepared for all discharges and transfers from a VA medical center or domiciliary or from nursing home care. The automated Discharge Summary module of TIU provides an efficient and immediate mechanism for clinicians to capture transcribed patient discharge summaries online, where they’re available for review, signing, adding addendum, etc.

**Document Class** Document Classes group documents. Document Class is the lowest level of class, and has Titles as items under it.

**Document Definition** TheDocument Definition utility provides the building blocks for TIU, by organizing types of documents into a hierarchy structure. This structure allows documents (Titles) to inherit characteristics (such as signature requirements and print characteristics) of the higher levels, Class and Document Class.

HIMS A common abbreviation/synonym used at VA facilities for Health Information Management Section of Medical Administration Service. May also be called MIS for the Medical Information Section.

**IRT** Incomplete Record Tracking, a **V***IST***A** application that can interface with TIU to track incomplete discharge summaries and progress notes.

***Glossary cont’d***

**MIS** Common abbreviation/synonym used at VA site facilities for the Medical Information Section of Medical Administration Service. May be called HIMS (Health Information Management Section).

**MIS Manager** Manager of the Medical Information Section of Medical Administration Service at the site facility who has ultimate responsibility to see that MRTs complete their duties.

**MRT** Medical Record Technician in the Medical Information Section or HIMS of Medical Administration Service who completes the tasks of assuring that all discharge summaries placed in a patient’s medical record have been verified for accuracy and completion and that a permanent chart copy has been placed in a patient’s medical record for each separate admission to the hospital.

**Object** Objects are placeholders which may be embedded in the predefined boilerplate text of Titles. An example of an “Object” is “PATIENT AGE.” Objects are typed into the boilerplate text of a Title, enclosed by '|'s. If a Title has the boilerplate text:

 Patient is a healthy |PATIENT AGE| year old male

 then a user who enters such a note for a 56 year old patient would be presented with the text:

 Patient is a healthy 56 year old male

**Progress Notes** The Progress Notes module of TIU is used by health care givers to enter and sign online patient progress notes and by transcriptionists to enter notes to be signed by caregivers at a later date. Caregivers may review progress notes online or print progress notes in chart format for filing in the patient’s record.

**TIU** Text Integration Utilities, a **V***IST***A** product for handling text applications.

***Glossary cont’d***

**Title** Titles are definitions for documents. They store the behavior of the documents that use them.

**User Class** User Classes are the basic component of ASU (Authorization/ Subscription Utility). The User Class file contains the different categories of users within a hospital. ASU allows sites to designate who is authorized to do what.

# Appendix A: User Class Membership Expiration Date for Users Requiring Co-signature (patch TIU\*1.0\*95)

☞ WARNING: In some cases, users may gain inappropriate privileges when their user class membership expires. In particular, users who require co-signature may be able to complete documents without co-signature when their membership in that user class expires.

This is how it happens:

TIU/ASU software automatically regards all users as members of the exported root class USER. Sites often assign users to additional classes. Generally this provides the user with additional privileges. However, some user class assignments impose **RESTRICTIONS.**

This is the case with classes entered for the TIU DOCUMENT DEFINITION parameter USERS REQUIRING COSIGNATURE. Here, user classes such as STUDENT impose a co-signature requirement on class members: When a student signs a document, the student is required to enter an expected cosigner, and the document is not complete until it is cosigned.

The problem occurs when such a membership expires, while the user remains a student, requiring co-signature. **When the membership expires, the user’s restrictions are removed, and if the student still has an account and menu access, they can enter and complete notes without requiring a co-signature.**

For example:

* Suppose the following is defined in ASU:
	+ A user is a member of the STUDENT user class with an EFFECTIVE DATE of January 1, 2001 and EXPIRATION DATE of June 30, 2001. There are no additional user class definitions for the user.
* And suppose the following parameter is defined in TIU:
	+ STUDENTs require co-signature upon writing a new PROGRESS NOTE.

Then,

* From January 1, 2001 through midnight June 30, 2001 the user requires co-signature upon writing a new PROGRESS NOTE. This is appropriate.
* If the user remains active (not terminated, etc.), their functional privileges only include those defined for the USER user class as of July 1, 2001. This user class does not require co-signature upon writing a new PROGRESS NOTE, thus effectively increasing privileges for the user. **If in fact the user is still a student and still requires co-signature, then this is NOT appropriate**.

The following actions are recommended to ensure that users who require co-signature are not inadvertently permitted to complete notes without co-signature:

* Look up USERS REQUIRING COSIGNATURE for each TIU DOCUMENT PARAMETERS file entry at your site to determine which classes require co-signature.
* Review all active (current **V***IST***A**) members of each of these user classes, noting expiration date if it exists.

A FileMan print/search from the USR CLASS MEMBERSHIP file could be used to provide a list of class memberships. See below for an example related to the STUDENT user class.

* Determine the appropriateness of these user class assignments.
* Modify user class assignments as necessary. Modification may include one or more of the following:
	+ Terminate User Account
	+ Remove TIU and/or CPRS GUI option(s) from user
	+ Delete the EXPIRATION DATE for the user class membership
	+ Edit the EXPIRATION DATE to future date
	+ If the user has “graduated”, you may want to assign a new user class.

*Example of FileMan print:*

Or earliest date known.

Select VA FileMan Option: **Print File Entries**

OUTPUT FROM WHAT FILE: USR CLASS MEMBERSHIP// **<Enter>**

SORT BY: NUMBER// **'@EXPIRATION DATE**

START WITH EXPIRATION DATE: FIRST// **1/1/80**

GO TO EXPIRATION DATE: LAST// **T-1**

 WITHIN EXPIRATION DATE, SORT BY: **'@USER CLASS**

Or choose another date range to determine current active users.

 START WITH USER CLASS: FIRST// **STUDENT**

 GO TO USER CLASS: LAST// **STUDENT**

 WITHIN USER CLASS, SORT BY: **MEMBER:**

 NEW PERSON FIELD: **'@LAST SIGN-ON DATE/TIME**

 START WITH LAST SIGN-ON DATE/TIME: FIRST// **T-30**

 GO TO LAST SIGN-ON DATE/TIME: LAST// **<Enter>**

 WITHIN LAST SIGN-ON DATE/TIME, SORT BY: **MEMBER**

 START WITH MEMBER: FIRST//**<Enter>**

You could also print the NEW PERSON field TERMINATION DATE.

 WITHIN MEMBER, SORT BY: **<Enter>**

STORE IN 'SORT' TEMPLATE: **<Enter>**

FIRST PRINT FIELD: **MEMBER**

THEN PRINT FIELD: **EXPIRATION DATE**

THEN PRINT FIELD: **MEMBER:**

 THEN PRINT NEW PERSON FIELD: **LAST SIGN-ON DATE/TIME**

 THEN PRINT NEW PERSON FIELD: **<Enter>**

 THEN PRINT FIELD: **<Enter>**

Heading (S/C): USR CLASS MEMBERSHIP LIST Replace USR With STUDENT USR

 Replace

 **STUDENT USR CLASS MEMBERSHIP LIST**

STORE PRINT LOGIC IN TEMPLATE: **<Enter>**

START AT PAGE: 1// **<Enter>**

DEVICE: **<Enter>**

STUDENT USR CLASS MEMBERSHIP LIST FEB 13,2001 (Today) PAGE 1

 EXPIRATION LAST SIGN-ON

MEMBER DATE DATE/TIME

--------------------------------------------------------------------------

USERA,A JAN 20,2001 JAN 18,2001 11:11

USERB,B JUN 1,2000 FEB 6,2001 12:38

USERC,C FEB 28,2001 FEB 13,2001 09:05

USERD,D FEB 12,2001 FEB 13,2001 08:55

Comments:

* USERA: This user last signed into **V***IST***A** on Jan 18,2001 and today is Feb 13,2001. It appears this user is no longer working at the site. Take the necessary steps to verify this, and if so, ensure their account is terminated. If not, see below.
* USERB & USERD: These users have recently signed into **V***IST***A**, and their STUDENT class assignment expired – for one user, months ago; for the other, a day ago.
* If they are still STUDENTs, **they now have the ability to complete notes without co-signature, which is not appropriate**. You should either delete the EXPIRATION DATE or edit it to a more accurate date in the future.
* If they are no longer STUDENTs, but have become, say, RESIDENTS, and no longer require co-signature, then the student expiration date does not pose a problem. You may want to verify they have the appropriate new class membership so that they enjoy all privileges of their new class.

* USERC: This user has recently signed into **V***IST***A**, and their STUDENT user class membership will expire in several weeks.
	+ If the student will no longer be working at the site as of that date, plan to terminate their access.
	+ If the user may still be working at the site as of that date, and will still be a student, you should either delete the EXPIRATION DATE or edit it to a more accurate date in the future.
	+ If the user will still be working at the site as of that date, but will no longer be a student, and will no longer require co-signature, the expiration date does not pose a problem. However, you may want to set up the appropriate new class membership to begin upon expiration of the student membership, so that they enjoy all privileges of their new class.

# Appendix b: Interdisciplinary Notes Setup Guide

Interdisciplinary Notes is a new feature of Text Integration Utilities (TIU) for expressing notes from different care givers as a single episode of care. They always start with a single note by the initial contact person (e.g., triage nurse, case manager, attending) and continue with separate notes created and attached to the original note.

To accomplish this, your facility must set up new document definitions and user classes within TIU. An Interdisciplinary Note consists of a parent title note and one or more child title notes. A parent title note (parent note) is a single note by the initial contact person. A child title note (child note) is a single entry note attached to the parent note.

The behavior of parent and child notes is different and mutually exclusive. Your users must be able to identify which note titles can act as parents for their particular service area, and which can be attached to those notes.

You may want to put limits as to which users have the ability to create Interdisciplinary Note entries. In addition, provisions should be made for select users to have the ability to perform correction to Interdisciplinary Notes.

## Titles

☞ NOTE: Decide on a nomenclature, with the consensus from stakeholders, prior to implementation and remain consistent throughout the facility.

It is likely that several service areas at your medical center are interested in Interdisciplinary Notes. Choose one of these service area and one particular note to implement. Then meet with the clinical staff to plan the note structure.

Consider the following title scheme:

       REHAB Parent Treatment Plan

   REHAB Child Initial Assessment Note

   REHAB Child Nurse Note

   REHAB Child Physical Therapy Note

   REHAB Child Occupational Therapy Note

   REHAB Child Pharmacy Note

   REHAB Child Psychology Note

   REHAB Child Discharge Planning Note

Notice that each note has “Parent” or “Child” as part of its title.

Consider the following list of parent titles:

 ER Cover Note

 ER ID Parent Note

 Rehab IDP Note

 Rehab Routing Note

 Same-day Surgery Team Note

 End-of-Life Team Note

 Pain Clinic IN Parent Note

 Mental Health Team Note

 Discharge Planning Cover Note

In each case, the underlined word or phrase would be reserved for only parent note titles. Clinicians responsible for starting an Interdisciplinary Note should be aware of which note titles are potential parent note titles.

Similarly, you should use an indicator to differentiate child note titles. Clinicians responsible for adding to Interdisciplinary notes should be aware of which note titles are potential child note titles.

Next, plan a note structure for the service area you have selected to initially implement Interdisciplinary Notes. Write the planned titles down and discuss them with stakeholders. Once you have a consensus, enter the titles into the TIU document definition hierarchy.

1. Create a parent title under an existing document class.
2. Create a document class for the child titles.
3. Enter the child titles under the child titles document class.

In our example the parent title looks like this:

Create Document Definitions Apr 12, 2001@10:27:55 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 REHAB SERVICE DC

4 REHAB PARENT TREATMENT PLAN TL

 ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title//

There are seven (7) child titles in the Interdisciplinary Note we are implementing. The child Document Class and its members look like this:

Create Document Definitions Apr 12, 2001@10:27:55 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 INTERDISC CHILD DOCUMENT DC

4 REHAB CHILD DISCHARGE PLANNING NOTE TL

5 REHAB CHILD INITIAL ASSESSMENT NOTE TL

6 REHAB CHILD NURSE NOTE TL

7 REHAB CHILD OCCUPATIONAL THERAPY NOTE TL

8 REHAB CHILD PHARMACY NOTE TL

9 REHAB CHILD PHYSICAL THERAPY NOTE TL

10 REHAB CHILD PSYCHOLOGY NOTE TL

 ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title//

## User Classes

Consider the users who are going to create and/or attach Interdisciplinary note entries. It would be advantageous to limit which users can perform these actions. In our example, we created an Authorization/Subscription Utility (ASU) user class called REHAB TEAM MEMBER.

If it is conducive to your working environment, we recommend that you set up user classes by the treatment teams using Interdisciplinary notes.

Also, consider who is going to make corrections to Interdisciplinary notes. In our examples, the person with the ASU User Class of CHIEF, MIS is designated to perform this duty.

### Parent Business Rules

BE GIVEN AN ID ATTACHMENT (entered as ATTACH ID ENTRY) is a new ASU action that permits the designated title note entry to receive child notes, thus creating an Interdisciplinary Note entry.

A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a REHAB TEAM MEMBER

This is the minimum rule necessary for establishing REHAB Parent Treatment Plan title as an interdisciplinary parent title.

If you are not able to establish a user class of REHAB TEAM MEMBER, then the rule should be stated as follows:

A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a USER

You may also want to add the following rule:

An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a REHAB TEAM MEMBER

Uncosigned is the lowest status that can act as a parent note. The software will not allow a child note to be attached to a parent note unless the parent note is at least in the uncosigned status.

All these rules are symmetrical—they apply equally to attaching and detaching child notes. (In list manager, the Interdisciplinary Notes (IN) action is also symmetrical—it will either attach or detach a note depending on the circumstances.) Any user who is authorized (via ASU business rules) to attach a note, is also authorized to detach that note.

### Parent Business Rules for Managers

You should echo each of these rules for the user class CHIEF, MIS, thus allowing the Chief of MIS (or designee) to perform corrective actions on Interdisciplinary Note entries.

The business rules for the user class CHIEF, MIS should look like this:

A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a CHIEF, MIS

An AMENDED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a CHIEF, MIS

An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by a CHIEF, MIS

In addition to the CHIEF, MIS user class having the ability to correct Interdisciplinary Note entries, consideration should be given to creating a user class for the management on Interdisciplinary Notes entries. You might call this class IN MANAGEMENT TEAM. This user class would consist of users who are intimately involved in the planning, implementation, and maintenance of Interdisciplinary notes. If you do set up such a user class, then add the following rules:

A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by an IN MANAGEMENT TEAM

An AMENDED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by an IN MANAGEMENT TEAM

An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID ATTACHMENT by an IN MANAGEMENT TEAM

### Child Business Rules

BE ATTACHED is a new ASU action (entered as ATTACH TO ID NOTE) that permits a child note entry to be attached to a parent entry.

For this user class, we initially created one business rule:

A COMPLETED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a COMPLETER

COMPLETER is a user role exported with USR\*1\*15 to support the creation of an Interdisciplinary Note. It indicates the user, either signer or cosigner, who is responsible for changing the status of the note to COMPLETED.

This rule is mandatory for all child note titles. Upon selecting a designated parent entry, a user may directly create a child note entry. However, if the above business rule does not exist, the user will not see the complete list of available titles designated as child entry titles.

In addition to the mandatory rule shown above, you should also include the following rules:

An UNCOSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a EXPECTED COSIGNER

A UNCOSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a AUTHOR/DICTATOR

An COMPLETED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by an AUTHOR/DICTATOR

☞ NOTE: The appropriate business rules must be created for each combination of note status and user role.

### Unsigned Child Notes

In general, if users are going to attach a pre-existing note, you probably want them to sign it first. However, circumstances may exist in your medical center where you want to permit users to attach pre-existing notes without signature.

If an Interdisciplinary Note entry contains an unsigned child entry, then the Interdisciplinary entry (parent title) displays as an unsigned entry in the tree view, although the individual unsigned note contents are not visible to the user.

Even without an ASU business rule permitting unsigned documents to be attached to an Interdisciplinary note, it is possible to have an unsigned child attached to an Interdisciplinary Note. This happens as follows:

1. In the CPRS GUI Notes tab, select a parent title.
2. Select the menu action Add New Entry to ID Note.
3. Select a title and start writing the note.
4. The process is interrupted and the note is saved without a signature.

A similar scenario is possible in TIU List Manager (LM).

The unsigned child note is visible in the tree structure display, but whether clinicians other than the author can view the contents of this note is dependent on your local business rules.

The software allows an unsigned note to stay attached to its parent entry, thus facilitating retrieval of the note entry. Upon returning to complete the note entry, the author (or as designee) finds the entry within its designated Interdisciplinary Note entry. Furthermore, if a member of the Interdisciplinary Notes Management Team has a need to retrieve unsigned child notes, it is clear what episode of care the note references.

### Child Business Rules for Managers

All the business rules for children document titles should be echoed with the CHIEF, MIS as the user class:

A COMPLETED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a CHIEF, MIS

An AMENDED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a CHIEF, MIS

An UNCOSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a CHIEF, MIS

An UNSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a CHIEF, MIS

In our example, we have created a user class of highly involved stakeholders to monitor Interdisciplinary Notes. This class is called the IN MANAGEMENT TEAM. We have included the following rules for the team:

A COMPLETED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by an IN MANAGEMENT TEAM

An AMENDED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by an IN MANAGEMENT TEAM

An UNCOSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by an IN MANAGEMENT TEAM

An UNSIGNED (TITLE) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by an IN MANAGEMENT TEAM

### TIU Parameters

There are two new document parameters for parent note titles:

ORDER ID ENTRIES BY TITLE

SEND ALERTS ON NEW ID ENTRY

The ORDER ID ENTRIES BY TITLE parameter manages the order in which child notes are listed (and printed) within the Interdisciplinary note. If set to YES, instead of listing the child notes in date order (the default), CPRS and TIU will list child notes in alphabetical order by note title. In effect, child notes are then grouped by title.

The SEND ALERTS ON NEW ID ENTRY parameter provides a mechanism to alert the originator of a parent note whenever a child note is attached to the parent note. If set to YES, then an alert is sent every time a new child note is attached to the parent note. This allows the originator to review additions to the interdisciplinary note.

NO is the default setting for both parameters.

If a title is entered as a new parameter to set one of these to YES, *TIU resets all the parameters associated with the note title*. To preserve the previous values, you must look them up, make note of them, and set them accordingly when you set the new parameters. The following worksheet is provided to assist you when doing this: (Entries in parentheses are recommended values.)

|  |
| --- |
| Parameters: Access the following menu:TIU IRM Maintenance Menu [TIU IRM MAINTENANCE MENU] TIU Parameters Menu [TIU SET-UP MENU]Document Parameter Edit [TIU DOCUMENT PARAMETER EDIT] |
| Select DOCUMENT DEFINITION: **(title)** |
| REQUIRE RELEASE:  |
| REQUIRE MAS VERIFICATION:  |
| REQUIRE AUTHOR TO SIGN: **(YES)**  |
| ROUTINE PRINT EVENT(S):  |
| STAT PRINT EVENT(S):  |
| MANUAL PRINT AFTER ENTRY:  |
| ALLOW CHART PRINT OUTSIDE MAS:  |
| ALLOW >1 RECORDS PER VISIT:  **(YES)**  |
| ENABLE IRT INTERFACE:  |
| SUPPRESS DX/CPT ON ENTRY:  **(NO)**  |
| FORCE RESPONSE TO EXPOSURES:  |
| ASK DX/CPT ON ALL OPT VISITS:  |
| SEND ALERTS ON ADDENDA:  |
| **ORDER ID ENTRIES BY TITLE:**  |
| **SEND ALERTS ON NEW ID ENTRY:**  |
| EDITOR SET-UP CODE:  |
| If document is to be uploaded, specify Filing Alert Recipients:Select FILING ERROR ALERT RECIPIENTS:  |
| Now enter the USER CLASSES for which cosignature will be required:Select USERS REQUIRING COSIGNATURE:  |
| Now enter the DIVISIONAL parameters:Select DIVISION: |
| CHART COPY PRINTER:  |
| STAT CHART COPY PRINTER: |

### Example Interdisciplinary Note

##### 1. Example of the parent title hierarchy:

Create Document Definitions Apr 12, 2001@10:27:55 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 REHAB SERVICE DC

4 REHAB PARENT TREATMENT PLAN TL

 ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title//

##### 2. The business rules for the parent title of our Interdisciplinary Note:

ASU Rule Browser Apr 12, 2001@10:46:59 Page: 1 of 2

 List Business Rules by DOCUMENT DEFINITION 9 Rules

 for TITLE REHAB PARENT TREATMENT PLAN

 \_

1 A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by a REHAB TEAM MEMBER

2 An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by a REHAB TEAM MEMBER

3 A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by a CHIEF, MIS

4 An AMENDED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by a CHIEF, MIS

5 An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by a CHIEF, MIS

6 A COMPLETED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by an IN MANAGEMENT TEAM

7 An AMENDED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by an IN MANAGEMENT TEAM

8 An UNCOSIGNED (TITLE) REHAB PARENT TREATMENT PLAN may BE GIVEN AN ID

 ATTACHMENT by an IN MANAGEMENT TEAM

+ + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Next Screen//

##### 3. Example of the document class Interdisc Child Document (which is in turn under the class Progress Notes):

Create Document Definitions Apr 12, 2001@10:27:55 Page: 1 of 1

 BASICS

+ Name Type

2 PROGRESS NOTES CL

3 INTERDISC CHILD DOCUMENT DC

4 REHAB CHILD DISCHARGE PLANNING NOTE TL

5 REHAB CHILD INITIAL ASSESSMENT NOTE TL

6 REHAB CHILD NURSE NOTE TL

7 REHAB CHILD OCCUPATIONAL THERAPY NOTE TL

8 REHAB CHILD PHARMACY NOTE TL

9 REHAB CHILD PHYSICAL THERAPY NOTE TL

10 REHAB CHILD PSYCHOLOGY NOTE TL

 ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 (Class/DocumentClass) Next Level Detailed Display/Edit

 Title Restart Status...

 (Component) Boilerplate Text Delete

Select Action: Title//

##### 4. The list of business rules to support the example child titles within the Document Class of Interdisc Child:

ASU Rule Browser Apr 12, 2001@12:48:02 Page: 1 of 2

 List Business Rules by DOCUMENT DEFINITION 13 Rules

 for DOCUMENT CLASS INTERDISC CHILD DOCUMENT

 \_

1 A COMPLETED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by a COMPLETER

2 An UNCOSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by a AUTHOR/DICTATOR

3 An UNCOSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by an EXPECTED COSIGNER

4 A COMPLETED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by an AUTHOR/DICTATOR

5 A COMPLETED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by a CHIEF, MIS

6 An AMENDED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED to

 an ID note by a CHIEF, MIS

7 An UNCOSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by a CHIEF, MIS

8 An UNSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by a CHIEF, MIS

9 A COMPLETED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by an IN MANAGEMENT TEAM

10 An AMENDED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED to

 an ID note by an IN MANAGEMENT TEAM

11 An UNCOSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by an IN MANAGEMENT TEAM

12 An UNSIGNED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED

 to an ID note by an IN MANAGEMENT TEAM

+ + Next Screen - Prev Screen ?? More Actions

 Find Edit Rule Change View

 Add Rule Delete Rule Quit

Select Action: Next Screen//

##### 5. Parameter settings:

In our example, we decided to send alerts to the signer (and cosigner) when a user attaches a child note to our parent note. In the display below we enter the parameter settings for our Document Definition:

Select TIU Parameters Menu Option: **?**

 1 Basic TIU Parameters

 2 Modify Upload Parameters

 3 Document Parameter Edit

 4 Progress Notes Batch Print Locations

 5 Division - Progress Notes Print Params

Enter ?? for more options, ??? for brief descriptions, ?OPTION for help text.

Select TIU Parameters Menu Option: **3** Document Parameter Edit

First edit Institution-wide parameters:

Select DOCUMENT DEFINITION: **REHAB PARENT** TREATMENT PLAN TITLE

 Are you adding 'REHAB PARENT TREATMENT PLAN' as

 a new TIU DOCUMENT PARAMETERS (the 34TH)? No// **Y** (Yes)

DOCUMENT DEFINITION: REHAB PARENT TREATMENT PLAN// **<Enter>**

REQUIRE RELEASE: **<Enter>**

REQUIRE MAS VERIFICATION: **<Enter>**

REQUIRE AUTHOR TO SIGN: **Y** YES

ROUTINE PRINT EVENT(S): **<Enter>**

STAT PRINT EVENT(S): **<Enter>**

MANUAL PRINT AFTER ENTRY: **<Enter>**

ALLOW CHART PRINT OUTSIDE MAS: **<Enter>**

ALLOW >1 RECORDS PER VISIT: **Y** YES

ENABLE IRT INTERFACE: **<Enter>**

SUPPRESS DX/CPT ON ENTRY: n NO

FORCE RESPONSE TO EXPOSURES: **<Enter>**

ASK DX/CPT ON ALL OPT VISITS: **<Enter>**

SEND ALERTS ON ADDENDA: **<Enter>**

ORDER ID ENTRIES BY TITLE: **<Enter>**

SEND ALERTS ON NEW ID ENTRY: **Y** YES

EDITOR SET-UP CODE: **<Enter>**

If document is to be uploaded, specify Filing Alert Recipients:

Select FILING ERROR ALERT RECIPIENTS: **<Enter>**

Now enter the USER CLASSES for which cosignature will be required:

Select USERS REQUIRING COSIGNATURE: **<Enter>**

Now enter the DIVISIONAL parameters:

Select DIVISION: **<Enter>**

Select TIU Parameters Menu Option:

#### Summary of Examples

For the example Interdisciplinary Note, one (1) parent title and seven (7) child titles were created. A new Document Class was created for the child titles. Two new user classes, one for REHAB team members and one for Interdisciplinary Notes managing stakeholders were defined in the ASU options. Business rules were created to allow all team members the authority to attach appropriate child notes to the appropriate parent note. In addition, business rules were created to give both the Chief of MIS and our managing stakeholders the authority to manage corrections to Interdisciplinary Note entries.

## Additional Considerations

#### Mandatory Business Rule

There is a certain amount of flexibility in business rules, but this one child rule is mandatory:

A COMPLETED (DOCUMENT CLASS) INTERDISC CHILD DOCUMENT may BE ATTACHED to an ID note by a COMPLETER

This rule enables TIU to properly list Interdisciplinary Note titles when creating a child note. Any child title with this business rule missing is excluded from lists of available child titles.

#### Detach Privileges

All the business rules, and the IN action in List Manager, are symmetrical with respect to Attach and Detach. Any user with the ability to attach a child note to a parent note, also has the ability to detach that child note from that parent note. Generally speaking, authors, signers, and cosigners can detach the notes they attached to a parent document.

#### Why not a single Document Class?

In our example, we pointedly did not include our parent title within the Interdisc Child Document document class. The Parent rule and child rule cannot work at the same hierarchal level. The two rules are contradictory.

In the event, through inheritance or some other mechanism, both the parent rule and child rule apply to the same title, TIU gives the parent rule precedence. Therefore, do not include child titles in a Document Class and then write parent rules for the Document Class. Write parent rules only for parent titles or create a separate parent Document Class.

#### Why not use USER?

In this guide, Interdisciplinary Notes are restricted to a well-defined group of users. If the user class USER was substituted in the business rules for every instance of the REHAB Team Member user class, there would be less business rules for the Clinical Application Coordinator (or designee) to create for the implementation of Interdisciplinary Notes.

However, it is *not* recommended to create Interdisciplinary Note business rules for the user class USER. This approach would greatly increase the possible occurrences of attaching a child note to the incorrect parent entry. Once a note is attached to a parent, it disappears from the All Notes list and is represented by the parent title. Retrieval of a misdirected child entry would have to be accomplished via the search options available in TIU. Business rules for a specific user class, such as REHAB Team Member user class, enhance the ability to attach child notes to a specific parent title entry.

#### Child Rules for Class Progress Notes

Writing the child rules for class Progress Notes is a tempting idea. You would never have to type the child rule again. Plus, you would not have to differentiate child titles with some reserved word, because every title, except the parent titles, would be a child title.

This approach is not recommended, as it would allow any title to be attached as an Interdisciplinary child entry. In addition, it would be difficult to find unattached Interdisciplinary children because there is no way of knowing if a particular note should be attached to an Interdisciplinary Note entry, or designated as an individual progress note.

If you do write child rules for class Progress Notes, consider making a Document Class for each related group of Interdisciplinary children. Then if it turns out that your titles should behave the same as most Progress Notes, you can rewrite rules for that particular Document Class as needed.

This will not prevent other Progress Notes from being attached, but it will make it simpler to search for unattached notes. Simply pull up a list of notes for the specific Document Class.

#### Use of Existing Titles (Not Recommended)

Prior to the Interdisciplinary Note functionality released with patch TIU\*1\*100, often existing titles would be coupled with multiple addendum to mimic an Interdisciplinary Note entry. It is recommended these titles not be used as Interdisciplinary Note titles.

The use of these titles for Interdisciplinary notes would be accomplished in the following two ways:

* **Changing an existing title.** If an existing title has its name changed to reflect a new Interdisciplinary title, then every previous incident where that the title was used will now reflect the new title name. In this case a note that was written 5 years ago will have its title changed to the current title name.
* **Creating Interdisciplinary Note rules for existing titles.** Use of existing titles in this way is not recommended. You will have titles that did not have Interdisciplinary note capability in the past and now will be able to receive a note entry or be attached to a note entry. A reviewer might ask, “You linked this title this year, why did you not do it last year?” Possibly concluding that the entry from a year ago was incomplete.

We recommend inactivating existing titles for which a similar Interdisciplinary Title is being created. This requires the creation and activation of new Interdisciplinary Note titles.

# Appendix c: Clinical Procedures Setup Guide

The setup information in this Appendix is dependent upon the site having Clinical Procedures Version 1.0 already installed on the VistA system.

Clinical Procedures (CP) primarily functions as a conduit for passing patient results, using HL7 messaging, between vendors of clinical information systems (CIS) and the VistA hospital information system. A Clinical Procedures document in TIU is the reporting mechanism for clinicians to use when documenting clinical findings and impressions for Clinical Procedure reports generated by a vendor device.

For example, a physician orders a clinical procedure using the Consults tab of the CPRS GUI. After the procedure is performed the technician, using the CPUser GUI, creates a new CP Transaction. This CP Transaction is the link between the TIU document, the Procedure ordered, the instrument results, and any applicable images. The transaction is then submitted to VistA for the interpreting provider to provide the interpretation and electronically sign. The instrument report and any additional images are stored in the Imaging server and linked to the TIU Document.

A new User Role called INTERPRETER is created by USR\*1.0\*19. The interpreter is usually the “IST” provider, (Cardiolog*ist*, Pulmonolog*ist*, etc). Only a user identified as an INTERPRETER is allowed to complete Clinical Procedures. When a clinical procedure is ready for interpretation, a notification is sent to the users defined as UPDATE USERS for the consult service associated with the procedure ordered. The interpreting provider selects the clinical procedure request, which now contains partial results. At this point the interpreting provider may also view any attached images. Using the Consult action Complete/Update, the interpreter completes the procedure by editing and signing the note.

During the completion process, the clinician is prompted to enter the new fields PROCEDURE SUMMARY CODE and PROCEDURE DATE/TIME in addition to any encounter information usually entered. Upon signature, an alert is sent to the ordering provider notifying him or her that the clinical procedure is complete.

### Related Manuals

This manual covers information needed to implement Clinical Procedures on the TIU package. Information covering other aspects of the Clinical Procedures package may be found in the most recent edition of the following manuals:

*Clinical Procedures Implementation Guide*

*Clinical Procedures Installation Guide*

*Clinical Procedures Technical Manual*

*Clinical Procedures User Manual*

*CPRS User Manual*

*Consult/Request Tracking User Manual*

*Text Integration Utilities (TIU) User Manual*

### Relation of TIU, Consults and Clinical Procedures

To implement Clinical Procedures, your facility must set up new document definitions for the new Clinical Procedures Class within TIU. You also must map CP Definitions (procedures) to the Consults Procedures File (#123.3) using the Setup Procedures [GMRC PROCEDURE SETUP] option of the Consults Management Menu.

As before, Procedures are ordered on the Consults tab of CPRS. However, instead of picking a consult document title when the consult procedure is completed, a note title from the Clinical Procedures Class is assigned by the CPUser GUI application. When the consulting provider (INTERPRETER) takes the action to complete the consults from the Consults tab of CPRS, an empty note already exists and is associated with the consult.

This appendix provides information on how to set up note titles of the class Clinical Procedures. The *Consult/Request Tracking Technical Manual* provides information on mapping CP Definition file (702.01) with the Consults Procedures File (#123.3).

## TIU/Clinical Procedures Setup

This appendix takes you through the following steps to set up the new Clinical Procedures Class in TIU **after** you have installed the TIU Enhancement for Clinical Procedures patch, TIU\*1\*109 and Clinical Procedures V. 1.0:

1. Verify the upload header is appropriately defined for Clinical Procedures.
2. Construct a new document definition sub-tree for Clinical Procedures.
3. Define a set of document parameters for the new Clinical Procedures Class.
4. Define business rules for the new Clinical Procedures Class and discuss role of Interpreter.

The Clinical Procedures Class in TIU can be set up but will not be fully utilized until after you have installed patches OR\*3\*131, GMRC\*3\*17, and Clinical Procedures V1.0. You should also have CPRS GUI V. 1.0.18.8 (or higher) running.

#### Step 1 Verify Clinical Procedures Class Upload Header

The upload header for the Clinical Procedures Class is automatically set-up when the TIU Enhancement for Clinical Procedures patch is installed.

To verify the upload header is appropriately defined for the Clinical Procedures Class use the Help for Upload Utility option [TIU UPLOAD HELP], as follows:

Select OPTION NAME: **TIU UPLOAD HELP** Help for Upload Utility

Help for Upload Utility

Select DOCUMENT DEFINITION: CLINICAL PROCEDURES// CLASS

$HDR: CLINICAL PROCEDURES

TITLE: GENERAL PROCEDURE

SSN: 555-12-1234

VISIT/EVENT DATE: 5/15/2001@08:15

AUTHOR: TIUPROVIDER,ONE

DATE/TIME OF DICTATION: 5/16/2001@09:25

LOCATION: MEDICAL-CONSULT 6200

EXPECTED COSIGNER: TIUPROVIDER,SEVEN

CONSULT REQUEST NUMBER: 1455

TIU DOCUMENT NUMBER: 543

PROCEDURE SUMMARY CODE: Normal

DATE/TIME PERFORMED: 5/15/2001@08:00

$TXT

 CLINICAL PROCEDURES Text

\*\*\* File should be ASCII with width no greater than 80 columns.

\*\*\* Use "@@@" for "BLANKS" (word or phrase in dictation that isn't understood).

>

Use the Edit Document Definitions [TIUFH EDIT DDEFS MGR] option of the Document Definitions (Manager) [TIUF DOCUMENT DEFINITION MGR] menu to change fields that are in error, or as an alternate way to check the download options.

Select Document Definitions (Manager) Option: 1 Edit Document Definitions

Edit Document Definitions Nov 07, 2001@12:16:58 Page: 1 of 1

 BASICS

 Name Type

1 CLINICAL DOCUMENTS CL

2 +DISCHARGE SUMMARY CL

3 +PROGRESS NOTES CL

4 +ADDENDUM DC

5 +CLINICAL PROCEDURES CL

6 +TIU KONNECTION DC

 ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move

Select Action: Quit// **DET** Detailed Display/Edit

From the Detailed Display/Edit screen most properties of the Clinical Procedures Class may be changed, including Edit Upload values:

Detailed Display Nov 07, 2001@14:50:49 Page: 1 of 11

 Class CLINICAL PROCEDURES

 Basics Note: Values preceded by \* have been inherited .

 Name: CLINICAL PROCEDURES

 Abbreviation: CP

 Print Name: Clinical Procedures

 Type: CLASS

 IFN: 142

 National

 Standard: YES

 Status: ACTIVE

 Owner: CLINICAL COORDINATOR

 In Use: YES

 Suppress Visit

 Selection: NO

 Items (By Sequence if they have it, otherwise alphabetically by Menu Text)

+ ? Help +, - Next, Previous Screen PS/PL

 (Basics) (Technical Fields) Find

 Items: Seq Mnem MenuTxt Edit Upload Quit

 (Boilerplate Text) Try

Select Action: Next Screen// **ED** Edit Upload

UPLOAD TARGET FILE: TIU DOCUMENT//**<Enter>**

LAYGO ALLOWED: YES//**<Enter>**

Select TARGET TEXT FIELD: REPORT TEXT//**<Enter>**

Editing Captioned ASCII Record Header

Select CAPTION: DATE/TIME PERFORMED//**<Enter>**

 CAPTION: DATE/TIME PERFORMED//**<Enter>**

 ITEM NAME: DATE/TIME PERFORMED//**<Enter>**

 FIELD NUMBER: 70202//**<Enter>**

 LOOKUP LOCAL VARIABLE NAME: TIUDTP//**<Enter>**

 EXAMPLE ENTRY: 5/15/2001@08:00//**<Enter>**

 CLINICIAN MUST DICTATE: YES//**<Enter>**

 REQUIRED FIELD?: NO//**<Enter>**

Select CAPTION: **<Enter>**

#### Step 2 Construct Clinical Procedures Class Document Sub-Tree

Use the Create Document Definitions option [TIUFC CREATE DDEFS MGR], under the IRM Maintenance Menu option [TIU IRM MAINTENANCE MENU], to construct a new document definition sub-tree for Clinical Procedures that looks something like this:

Edit Document Definitions Nov 07, 2001@15:36:06 Page: 1 of 2

 BASICS

 Name Type

1 CLINICAL DOCUMENTS CL

2 +DISCHARGE SUMMARY CL

3 +PROGRESS NOTES CL

4 +ADDENDUM DC

5 CLINICAL PROCEDURES CL

6 +GENERAL PROCEDURES DC

7 CARDIOLOGY DC

8 PULMONARY FUNCTION TEST TL

9 EKG TL

10 GASTROENTEROLOGY DC

11 ENDOSCOPY TL

12 COLONOSCOPY TL

13 +PODIATRY DC

14 +ONCOLOGY DC

+ ?Help >ScrollRight PS/PL PrintScrn/List +/- >>>

 Expand/Collapse Detailed Display/Edit Items: Seq Mnem MenuTxt

 Jump to Document Def Status... Delete

 Boilerplate Text Name/Owner/PrintName... Copy/Move

Select Action: Next Screen//

The above example suggests a Service oriented set of Document Classes with one or more titles under each. Just like Progress Notes, these can include boilerplate text, with embedded objects. It will probably take some time, with substantial cooperation between your Clinical Coordinator, IRMS, and the Consulting Services, to develop a complete set of Document Definitions for Clinical Procedures at your site.

☞ NOTE: There may be titles already created under the Consults Class/Document Class that are used for Medicine. These titles cannot be moved. We recommend that the Clinical Coordinators name new titles under the Clinical Procedures Class differently so that there is not confusion between old and new titles. (Hint: Begin each new title with the initials CP).

#### Step 3 Define Clinical Procedures Class Document Parameters

To define a set of document parameters for the new Clinical Procedures Class use the Document Parameter Edit option [TIU DOCUMENT PARAMETER EDIT]. In the table that follows, entries in parentheses are the recommended values:

|  |
| --- |
| Parameters: Access the following menu:TIU IRM Maintenance Menu [TIU IRM MAINTENANCE MENU] TIU Parameters Menu [TIU SET-UP MENU]Document Parameter Edit [TIU DOCUMENT PARAMETER EDIT] |
| Select DOCUMENT DEFINITION: **CLINICAL PROCEDURES CLASS**  |
| REQUIRE RELEASE: **(NO)** |
| REQUIRE MAS VERIFICATION: **(NO)**  |
| **\*REQUIRE AUTHOR TO SIGN:** **(YES)**  |
| ROUTINE PRINT EVENT(S):  |
| STAT PRINT EVENT(S):  |
| MANUAL PRINT AFTER ENTRY: **(NO)**  |
| ALLOW CHART PRINT OUTSIDE MAS: **(YES)** |
| \***ALLOW >1 RECORDS PER VISIT:** **(YES)**  |
| ENABLE IRT INTERFACE:  |
| **\*SUPPRESS DX/CPT ON ENTRY:** **(NO)**  |
| FORCE RESPONSE TO EXPOSURES:  |
| **\*ASK DX/CPT ON ALL OPT VISITS:** **(YES)** |
| SEND ALERTS ON ADDENDA:  |
| ORDER ID ENTRIES BY TITLE:  |
| SEND ALERTS ON NEW ID ENTRY:  |
| EDITOR SET-UP CODE:  |
| If document is to be uploaded, specify Filing Alert Recipients:Select FILING ERROR ALERT RECIPIENTS: <identify local recipients as appropriate>  |
| Now enter the USER CLASSES for which cosignature will be required:Select USERS REQUIRING COSIGNATURE: <identify local recipients as appropriate> |
| Now enter the DIVISIONAL parameters:Select DIVISION: |
| CHART COPY PRINTER:  |
| STAT CHART COPY PRINTER: |

**Note:** At a minimum parameters marked with an asterisk ‘**\***’ must be set. If a response is not entered for a particular parameter the default value is ‘No’.

#### Step 4 Define Clinical Procedures Business Rules

This section describes the suggested business rules that are recommended for Clinical Procedures. This section also describes the role of the Interpreter.

## Business Rules

Included here is a list of recommended business rules for the Clinical Procedures Class. Use the Manage Business Rules option [USR BUSINESS RULE MANAGEMENT] on the User Class Management Menu [USR CLASS MANAGEMENT MENU] should be used in the Authorization/Subscription Package to Add the following rules:

☞ NOTE: Since business rules are inherited from the Clinical Documents Class, you should first check to see if equivalent rules are already present at the Clinical Documents level. If so, there is no need to put them in the Clinical Procedures level of the hierarchy.

**Suggested Business Rules for CLINICAL PROCEDURES Class**

|  |  |
| --- | --- |
| 1 | A COMPLETED (CLASS) CLINICAL PROCEDURE may BE VIEWED by A USER |
| 2 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE EDITED by A STUDENT who is also An AUTHOR/DICTATOR |
| 3 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE DELETED by An AUTHOR/DICTATOR |
| 4 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by An AUTHOR/DICTATOR |
| 5 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by An AUTHOR/DICTATOR |
| 6 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by An EXPECTED COSIGNER |
| 7 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE PRINTED by An AUTHOR/DICTATOR |
| 8 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE PRINTED by An AUTHOR/DICTATOR |
| 9 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE EDITED by An EXPECTED COSIGNER |
| 10 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE EDITED by An AUTHOR/DICTATOR |

|  |  |
| --- | --- |
| 11 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE PRINTED by An EXPECTED COSIGNER |
| 12 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE SIGNED by An AUTHOR/DICTATOR |
| 13 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE COSIGNED by An EXPECTED COSIGNER |
| 14 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by A CHIEF, MIS |
| 15 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE DELETED by A CHIEF, MIS |
| 16 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by A CHIEF, MIS |
| 17 | An UNCOSIGNED (CLASS) CLINICAL PROCEDURE may BE DELETED by A CHIEF, MIS |
| 18 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE EDITED by An EXPECTED COSIGNER |
| 19 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by An EXPECTED COSIGNER |
| 20 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE EDITED by A CLINICAL SERVICE CHIEF |
| 21 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE VIEWED by A CLINICAL SERVICE CHIEF |
| 22 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE SIGNED by A CLINICAL SERVICE CHIEF |
| 23 | An UNSIGNED (CLASS) CLINICAL PROCEDURE may BE SIGNED by An EXPECTED COSIGNER |
| 24 | An UNDICTATED (CLASS) CLINICAL PROCEDURE may BE EDITED by An INTERPRETER  |
| 25 | An UNDICTATED (CLASS) CLINICAL PROCEDURE may BE VIEWED by An INTERPRETER  |
| 26 | An UNDICTATED (CLASS) CLINICAL PROCEDURE may BE DELETED by A CHIEF, MIS |

Business Rule Note(s):

1. Since linking can be inherited by the Clinical Documents Class, following business rule should not be needed at the Clinical Procedure Class level:
	1. A COMPLETED (CLASS) CLINICAL PROCEDURE may be LINKED by A CHIEF, MIS

The comparable rule:

* 1. A COMPLETED (CLASS) CLINICAL DOCUMENT may be LINKED by A CHIEF, MIS

should already exist at the Clinical Documents Class level. If it does not, then we strenuously recommend that you include one or the other of these rules.

## Role of the Interpreter

INTERPRETER is a user role exported with USR\*1\*19 to support the Clinical Procedures Class. The role of the Interpreter is to interpret the results of a clinical procedure. Users who are authorized to interpret the results of a clinical procedure are sent a notification when an instrument report and/or images for a CP request are available for interpretation.

Business rules are used to determine what actions an interpreter can perform on a document of a specified class, but the interpreters themselves are defined by the Consults application. These individuals are ‘clinical update users’ for a given consult service. They include individuals indicated by the following fields in the Request Services file (#123.5):

* SERVICE INDIVIDUAL TO NOTIFY
* SERVICE TEAM(S) TO NOTIFY
* UPDATE USERS W/O NOTIFICATIONS
* UPDATE TEAMS W/O NOTIFICATIONS
* UPDATE USER CLASSES W/O NOTIFS

These fields are set by the Set up Consult Services [GMRC SETUP REQUEST SERVICES] option of the of the Consults Management menu [GMRC MGR].

The following fragment of a screen shot shows the five fields that define an Interpreter to the system:

Select Consult Management Option: **SS**  Set up Consult Services

Select Service/Specialty:**CARDIOLOGY**

SERVICE NAME: CARDIOLOGY// **<Enter>**

. . .

**SERVICE INDIVIDUAL TO NOTIFY: CONSULTSPROVIDER, ONE// <Enter>**

**Select SERVICE TEAM TO NOTIFY: consultteam// <Enter>**

Select NOTIFICATION BY PT LOCATION: 2AS// **<Enter>**

 NOTIFICATION BY PT LOCATION: 2AS// **<Enter>**

 INDIVIDUAL TO NOTIFY: CONSULTSCOORDINATOR,ONE// **<Enter>**

 TEAM TO NOTIFY: **<Enter>**

Select NOTIFICATION BY PT LOCATION: **<Enter>**

**Select UPDATE USERS W/O NOTIFICATIONS: CONSULTSPROVIDER,TWO// <Enter>**

**Select UPDATE TEAMS W/O NOTIFICATIONS: <Enter>**

**Select UPDATE USER CLASS W/O NOTIFS: <Enter>**

. . .

The software finds the interpreter by following the RELATED SERVICES in the Consults Procedure file. This field is set by the Setup Procedures [GMRC PROCEDURE SETUP] option of the Consults Management menu [GMRC MGR].

# Appendix d: Patient Record Flags

Patches TIU\*1\*165 TIU\*1\*265 and USR\*1\*24 support the Patient Record Flags (PRF) project. Additional information on the PRF program is available in VHA Directive 2003-048, dated August 28, 2003 AND VHA Directive 2010-053, titled: *National Patient Record Flags* and on the PRF training web page at <http://vaww.vistau.med.va.gov/vistau/prf/>. Also see National Patient Record Flag High Risk for Suicide Memorandum, dated October 17, 2012.

Patient Record Flags are warnings placed on a patient’s chart to improve employee safety and the efficient delivery of health care. Each advisory or flag includes a narrative that describes the reason for the flag and may include suggested actions for users to take when they encounter the patient. It is this narrative which is displayed as a warning when users look up a flagged patient.

Flags are placed by a select group of authorized individuals using the new PRF software. In addition to placing the flag, authorized users must write a Progress Note for each flag that clinically justifies placing the flag on a patient’s record.

### National and Local Flags

Patient Record Flags are divided into types: the most critical flags—called Category I Patient Record Flags—are national and transmitted to all facilities, ensuring that these flags are universally available during patient look up.

The Office of Information creates and distributes definitions for Category I PRF through national patches. Currently, the only Category I Patient Record Flags are a Behavioral flag regarding violent or potentially violent patients and the High Risk for Suicide Category 1flag. A Wandering Patient Flag is in national development.

Category II flags are local. Each site creates and maintains its own set of local flags that are not transmitted to other sites. However, the purpose of Category II flags is similar to Category I—to provide important patient information that may affect the safety of staff or other patients or patient treatment. For example, a site could create a Category II Research Flag or a Category II Infectious Disease Flag. Like Category I flags, Category II flags require a Progress Note to document the reason for placing a flag on the patient’s record.

### Documenting PRF

Each Patient Record Flag must have an associated Progress Note that clinically justifies putting the flag on a patient’s record. It might also contain references to supporting documentation. The *PRF Best Practices* document, available on the PRF Training Materials web page (<http://vaww.vistau.med.va.gov/vistau/prf/TrainingMaterials.htm>), contains an example note.

Currently, the only Category I Patient Record Flags are a Behavioral flag regarding violent or potentially violent patients and the High Risk for Suicide Category 1flag. The Progress Note title for documenting the Behavioral flag is Patient Record Flag Category I. This title must be reserved for documenting the initial assignment or the continuation or discontinuation after review of Category I flags. With the High Risk for Suicide Category 1 flag, a new title was distributed, PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. These titles should not be used for other purposes. To write a note for this title, the user must belong to the DGPF PATIENT RECORD FLAG MGR user class. Each site is responsible for populating this user class.

To help sites that will be creating local Category II flags, four partially customizable Progress Note titles have been created:

* PATIENT RECORD FLAG CATEGORY II – RISK, FALL
* PATIENT RECORD FLAG CATEGORY II – RISK, WANDERING
* PATIENT RECORD FLAG CATEGORY II – RESEARCH STUDY
* PATIENT RECORD FLAG CATEGORY II – INFECTIOUS DISEASE

These titles must be reserved for documenting the assignment and/or review of their respective Category II flags. They should not be used for other purposes.

### Category I Implementation

After patches TIU\*1\*165 and TI\*1\*265 ARE installed and option TIU165 DDEFS & RULES, PRF is run, there is still additional work to do. To implement Category I Patient Record Flags the following additional steps need to be taken:

1. Evaluate Business Rules
2. Populate User Class DGPF PATIENT RECORD FLAGS MGR
3. Convert Existing Risk of Violence Flags

Then you need to consider Category II flags.

#### Evaluate Business Rules

This patch exports one Business Rule for Category I flag notes, limiting the ENTRY of notes documenting Category I flags. These notes inherit other Business Rules from class Progress Notes and class Clinical Documents. Review the Business Rules that these notes inherit for appropriateness and completeness. Add new Business Rules for document class PATIENT RECORD FLAG CAT I if needed. If necessary, add new Business Rules for the title in that document class, as well.

Do not, however, override the exported rule which limits ENTRY of Category I Patient Record Flag notes. You should also be cautious about adding rules that limit viewing because this will shut down Remote Data View for these notes.

#### Populate the New User Class

*After* appropriate Business Rules are in place, and *after* those who will be assigning Category I flags and documenting them in the Patient Record have been fully trained, populate User Class DGPF PATIENT RECORD FLAGS MGR. Users in user class DGPF PATIENT RECORD FLAGS MGR should then be able to enter notes entitled PATIENT RECORD FLAG CATEGORY I to document Category I flags. The user class is what protects this document class from unauthorized note writing, so only include people who are high-level enough to write Category I notes.

#### Convert Existing Risk of Violence Flags

The Category I Behavioral Patient Record Flag is intended to replace all existing warnings on the risk of violence. Therefore, all existing violence warnings *including any that may exist in CWAD notes*, must be evaluated for entry as Category I Patient Record Flags. All employees at your site who are involved in the conversion process should be familiar with the contents of the *PRF Conversion Document* available on the PRF Training Materials web page (<http://vaww.vistau.med.va.gov/vistau/PRF/TrainingMaterials.htm>).

As a flag is entered into the new system, it must be documented for the patient record by writing a note of title PATIENT RECORD FLAG CATEGORY I.

#### Convert High Risk for Suicide Flag

This flag was distributed with the High Risk Mental Health Patient – Reminder and Flag in May 2013. Sites were informed that they shouldn’t run the conversion until notified by the Office of Mental Health Services to run the Convert Local HRMHP PRF to National option - Process mode. Sites were instructed to add names to a mailgroup and to link a progress note title to the national flag. The title is named PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE.

When the Convert Local HRMHP PRF to National option is run in the processing mode, the actual processing and auto-creation of the national PRFs from the local PRFs will take place and messages will be sent out to summarize the process results. The local PRF for the patient will be inactivated. **Note**: Category I PRFs that are auto-created from this option will not have a Progress Note related to them.

The Process Mode can be re-run as needed if a patient had an error that is resolved. Each time the process mode is run the active local PRFs that are found will be processed.

Select OPTION NAME: **DGPF LOCAL TO NATIONAL CONVERT** Convert Local HRMH PRF to National action

This option can be run in a report only mode which will provide a report

of what actions the local-to-national processing will perform. Enter 'R'

to run the Report Only mode, or 'P' to begin the local-to-national PRF

processing.

 Select one of the following:

 R Report Only

 P Process Local-to-National

Select which mode to run: R// **P** Process Local-to-National

...SORRY, JUST A MOMENT PLEASE...

 >> Results have been sent to the 'DGPF CLINICAL HR FLAG' mail group

The process to generate the new national (category I) PRFs from the local (category II) PRFs consists of determining whether a national PRF can be created from existing, active, local PRFs for suicide prevention.

### Consider Category II flags

All existing patient warning systems, including COTS products and class III software (but not including CWAD), are intended to be replaced by the new PRF system. Therefore, all non-violence flags in systems other than CWAD must be evaluated for entry as Category II Patient Record Flags (or CWAD). If a flag is entered as a Category II PRF, then a note of the appropriate title must be entered.

If a site has existing flags to convert to Category II flags, or if a site simply wishes to use Category II flags to create new kinds of warnings, the site will need to set up Category II flags. Refer to VHA Directive 2003-048, dated August 28, 2003, titled *National Patient Record Flags* on the importance of limiting flags so they do not lose their salience.

After determining what flags a site wants or needs and creating flag definitions, the site needs to consider what titles to use to document those flags. The site should begin by evaluating the titles exported for this purpose. The exported titles are:

* PATIENT RECORD FLAG CATEGORY II – RISK, FALL
* PATIENT RECORD FLAG CATEGORY II – RISK, WANDERING
* PATIENT RECORD FLAG CATEGORY II – RESEARCH STUDY
* PATIENT RECORD FLAG CATEGORY II – INFECTIOUS DISEASE

If a site wishes, the site may alter the last part (the part following "PATIENT RECORD FLAG CATEGORY II - ") of the exported Category II titles. In view of future plans to standardize TIU titles, changing these is not recommended unless there is a compelling reason for the change. If exported titles are not adequate for new Category II flags which the site has created, new titles may be created, following the existing pattern. They must begin, "PATIENT RECORD FLAG CATEGORY II - ".

Any new Category II titles must be created under document class PATIENT RECORD FLAGS CAT II. Initially, give these title the status of TEST. This permits you to write business rules while preventing users from writing notes. (The four exported titles are also initially set to TEST by the option that creates them.)

##### Review Existing Business Rules for Category II Flags

Before activating Category II titles, review existing Business Rules which these Category II titles inherit from Progress Notes and Clinical Documents. Add new Business Rules for document class PATIENT RECORD FLAG CAT II or for individual Category II titles, if needed. If necessary, new User Classes may be created for Category II titles.

##### Update from TEST to ACTIVE

After the Category II titles have been tested, Business Rules have been reviewed, and staff have been trained in the use of Category II flags, the status of those exported and new Category II titles which are to be used should be updated from TEST to ACTIVE. This will enable people besides owners of the titles to enter notes on them.

☞ Note: If you do not plan to use certain of the exported titles, then do not update the status to ACTIVE. This will prevent the entry of notes to these unused titles.

#### Convert Existing Warnings to Category II Flags

The existing warnings that must be converted include all warnings in:

1. COTS products.
2. Class III warning software.

You are not required to convert CWAD warnings (except for the violence warnings that are covered under Category I). However, if you prefer Category II warnings over CWAD, then you may convert CWADs as well.

If a flag is entered as a Category II PRF, then a note of the appropriate title must be entered.

See *PRF Conversion Document* available on the PRF Training Materials web page (<http://vaww.vistau.med.va.gov/vistau/PRF/TrainingMaterials.htm>) for a more detailed discussion on the clinical aspects of converting Category II flags.

### Reviewing Flags

Flags must be reviewed at regular intervals. When a flag is reviewed and continued, a note of the corresponding title must be entered to justify the continuation. If a flag is discontinued, a note of the corresponding title must be entered to justify the discontinuation.

Since flags are generated by the Patient Record Flags software, not by the presence of notes of a certain title, it is not necessary to change the title or status of the original note when a flag is discontinued. Instead, the flag is inactivated in the PRF software and the discontinuation is documented in a note of the corresponding title.

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