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Chapter 1: Introduction to TIU

Purpose of Text Integration Utilities

The purpose of Text Integration Utilities (TIU) is to simplify the access and use of clinical documents for both clinical and administrative VAMC personnel, by standardizing the way clinical documents are managed. In connection with Authorization/Subscription Utility (ASU), a hospital can set up policies and practices for determining who is responsible or has the privilege for performing various actions on required VHA documents.

The initial release of Version 1.0 includes Discharge Summary and Progress Notes. Consult Reports was added with the release of Computerized Patient Record System (CPRS). TIU replaces and upgrades the previous versions of these VISTA packages. It has also been designed to meet the needs of other clinical applications that address document handling.

TIU allows you to continue to access Progress Notes and Discharge Summaries from OE/RR menus. The CPRS Graphical User Interface (GUI) allows point-and-click access to all Progress Notes, Discharge Summaries, and Consults TIU documents.

Benefits

a. Standardized and common user interface
Clinicians can go through the same program to enter, review, and sign discharge summaries, progress notes, and other clinical documents that may be set up locally for processing through TIU.

b. Integration
Clinicians and management can search for and retrieve clinical documents more efficiently because documents reside in a single location within the database. This is also a benefit for other uses such as Incomplete Record Tracking, quality management, results reporting, order checking, research, etc.

c. Data Capture Flexibility
TIU accepts document input from a variety of data capture methodologies. Those initially supported are transcription and direct entry. TIU allows upload of ASCII formatted documents into VISTA.
Benefits, cont’d

d. Links to Other Packages.
TIU interfaces, as appropriate, with such applications as Health Summary, Problem List, Patient Care Encounter/Visit Tracking, and Incomplete Record Tracking. Computerized Patient Record System (CPRS) further integrates VISTA packages and allows point and click switching between packages.

A new Health Summary component is available (through Patch GMTS*2.7*12), Selected Progress Notes, which allows selection of specific Progress Notes Titles for display on Health Summaries. The PN, DS, and CWAD components now extract data from TIU, rather than Progress Notes (GMRP), or Discharge Summary (GMRD). Care has been taken to assure that the formatting and content of the components have remained the same, except that the signature block information will now reflect the author's (and cosigner's) name and title at the time of signature, rather than displaying their current values at the time of output.

e. Improved management of Documents.
- TIU has a file structure called the Document Definition Hierarchy for defining elements and parameters of a document. It allows:
  - Inheritance of document characteristics, such as signing, cosigning, visit linkage, etc.
  - Site definition of document characteristics
  - Shared components
  - Ownership (personal or class) of document definitions
  - Boilerplate text functionality
  - Interdisciplinary Note functionality.
  - Embedded “Object” functionality which can extract data from other VISTA packages and insert it into boilerplate text

Recent Patches

Patch TIU*1*305 – Contingency Downtime Bookmark Progress Notes / Post-Signature Alerts
TIU*1.0*305 provides the following enhancements to VistA:

- Enables sites to add a progress note to the electronic record of all inpatients and outpatients who were seen during computer system downtime using the new option Contingency Downtime Bookmark Progress Notes [TIU DOWNTIME BOOKMARK PN] in the TIU Maintenance Menu [TIU IRM MAINTENANCE MENU]. The note must use a locally-approved title that has been mapped to the Veterans Health Administration (VHA) enterprise-standard COMPUTER DOWNTIME title. When creating the note, users can enter: the note title; whether the computer downtime was scheduled or unscheduled; outage start/end times; the author of the note; a date/time stamp to sequence the note in the note tree; clinics to which the outage applies; users to receive an email notification listing the patients affected and whether the note was successfully appended to each patient's record; an option to edit the TIU note text; and
an electronic signature to perform an administrative closure of the note to enter it into the medical record. The progress note states that a computer outage occurred, and alerts the user to search the patient's paper records for non-electronic documentation created during the outage. The set-up and note content should be coordinated with the Chief, Health Information Management at each site. Only one progress note is filed for any patient with multiple appointments (whether inpatient, outpatient, or both) at different clinics during the outage period.

The patch deletes a site’s existing text in the BOILERPLATE TEXT field (#3) in the TIU DOCUMENT DEFINITION file (#8925.1) and replaces it with new standard TIU note text. This new text can be modified by users when creating downtime bookmark progress notes. The installation history for the patch will capture the data from the BOILERPLATE TEXT field so that local OIT personnel can retrieve the previous boilerplate text, if needed. The installation history can be reviewed using the Install File Print [XPD PRINT INSTALL FILE] option under the KIDS UTILITIES sub-menu.

- Enables clinicians and providers to create progress notes that automatically generate a post-signature alert to designated recipients based on the progress note title. The new option Create Post-Signature Alerts [TIUFPC CREATE POST-SIGNATURE] in the Document Definitions (Manager) [TIUF DOCUMENT DEFINITION MGR] menu allows Clinical Application Coordinators (CACs) or other supervisors to define who is alerted when a specific progress note title is used. The note title to define is selected at the "Select TIU DOCUMENT DEFINITION NAME:" prompt. The option then enables entry of the recipients to be notified (individual, mail group, or team list), whether to alert the Primary Care Provider, whether to print a chart copy at the patient's location, and to optionally select an output device for printing at another location. The notification is made through VistA Kernel Alerts and is sent to recipients immediately upon a clinician's entry of an electronic signature for the note.

**Patch OR*3.0*420 – CPRS Lab Monitoring**

Patch OR*3.0*420 modifies the Pharmacy package in VistA to display the most recent associated lab results when a clinician is ordering medication using the CPRS Inpatient or Outpatient Medication Order dialogs. The lab results for the most recent lab test associated with an Orderable Item are displayed in the Information field in the Medication Order dialog after an Orderable Item is selected. When a dispense drug is chosen (by selecting a dosage in the order dialog), the lab test information is replaced by the National Standard Drug Information found in the MESSAGE (#101) field of the DRUG (#50) file.

A CAC or ADPAC must set the OR CPRS LAB DISPLAY ENABLED parameter to ON to activate this functionality at a site.

To optionally apply this functionality to Quick Orders, create a TIU OBJECT from routine ORWDPLM2 using the TIU Document Definitions option and then insert it into the comments field of the Quick Order. Upon selection of the Quick Order in CPRS, the monitored LAB results will appear on the Ordering screen.
The object method to insert into the TIU OBJECT is:
S X=$$SL^ORWDPLM2(DFN,
$$($G(X0)"":$P(X0,U),$G(NODE0)"":$P(NODE0,U),1:""),""\^TMP($J,""ORWDPLM2 "")")

The display is wrapped for ease of reading, but the object method must be entered as one single line.

Note: The TIU OBJECT method will work for generalized Quick Orders only (orders assigned to Order Menus). It is not currently implemented for personal Quick Orders.

Patch TIU*1*297 – TIU Unauthorized Abbreviation and Dictation Control
TIU*1*297 modifies the Text Integration Utilities (TIU) application. It introduces two new applications, TIU Unauthorized Abbreviation and TIU Dictation Control. It also contains a security privilege fix for TIU*1*296.

The TIU Unauthorized Abbreviation application searches and prevents misinterpretation of a patient's "CPRS – Progress Note" due to misuse of unauthorized abbreviation(s). See chapter 18, “Unauthorized Abbreviations.”

The TIU Dictation Control application introduces functionality to allow a facility to control TIU dictation privileges in CPRS. See section entitled “TIU Dictation Control” in chapter 3, “TIU for Clinicians.”

Patch TIU*1*291 – CWAD/Postings Auto-Demotion Setup
Patch TIU*1*291 introduces the new Crisis, Warnings, Allergies and/or Adverse Reactions, and Advance Directives (CWAD) notes auto-demotion functionality. CWAD is a section of CPRS used for posting progress notes, which are more important than standard level notes. These progress notes are made more easily available throughout CPRS. The postings dialog box can become full of CWAD notes, resulting in important notes from being easily distinguishable from less important notes. The requested enhancement is to demote previously designated notes from the CWAD postings to a regular note status based on various criteria, such as the passage of time or a newer note of a particular title being written which supersedes the existing CWAD note. This is accomplished by converting an existing Class III application to Class I.

Patch TIU*1*296 – TIU Text Alerts
Patch TIU*1*296 modifies the TIU application to send a TIU alert to the appropriate service provider(s) immediately after a staff member screens a patient and signs the associated note. The service provider(s) will be alerted prior to the note being co-signed by the licensed clinician responsible for reviewing and approving the note. Prior to this modification, TIU alerts were not sent to all service providers. This resulted in missed
opportunities to provide needed services for patients while the patients are on site, and forced staff to take time to contact patients and reschedule needed services.

This patch utilizes one new file (TIU TEXT EVENTS (#8925.71)) used to define the words or phrase that will be searched for in a TIU document (progress note, consult, etc.). If the words or phrase are found in the TIU document, then an alert is sent to the team(s) specified in the TIU TEXT EVENTS file.

A Text Event Edit [TIU TEXT EVENT EDIT] menu option was added to the TIU Maintenance Menu [TIU IRM MAINTENANCE MENU]. This option is used to set up a text event in the TIU TEXT EVENTS file.

Note: Any TIU document that is to be used to trigger these alerts must have the MUMPS code ‘D TASK^TIUTIUS(DA)’ entered in the POST-SIGNATURE CODE field (#4.9) in the TIU DOCUMENT DEFINITION file (#8925.1). This field can only be edited by IRM personnel.

TIU*1*263 – Changes for ICD-10
This patch is part of the Computerized Patient Records System CPRSv30 project. This project will modify the Computerized Patient Record System, Text Integration Utilities, Consults, Health Summary, Problem List, Clinical Reminders, and Order Entry/Results Reporting to meet the requirements proposed by the Dept. of Health and Human Services to adopt ICD-10 code set standards for Clinic Orders.

This patch makes all changes to TIU that are required to move from the ICD-9 coding version to ICD-10.

Changes Made to Accommodate ICD-10:

Progress Notes, VistA
- The TIU package will print and display ICD codes obtained from other VistA packages within a single Progress Notes that were captured at the time the data was entered, including:
  - ICD-9-CM diagnosis and procedure codes
  - ICD-10-CM diagnosis and ICD-10-PCS procedure codes
- The VistA TIU package will print and display ICD codes within a single progress note.

Progress Notes, CPRS
- The CPRS TIU application will print and display ICD-9 and ICD-10 diagnosis codes, procedure codes, obtained from other packages within Progress Notes at the time the data was entered.
- The CPRS TIU package will print and display ICD codes within a single progress note.

Discharge Summary
• The VistA TIU package will print and display ICD-9 and ICD-10 diagnosis and procedure codes and descriptions obtained from other VistA packages within Discharge Summaries that were captured at the time the data was entered.

Patient Data Objects
• Patient Data Object VA-WRIISC Active Problems will be modified to print and display ICD-10-CM diagnosis codes.

NOTE:
TIU Object VA-WRIISC ACTIVE PROBLEMS is the only nationally distributed TIU Object which includes Diagnoses/Problems.

Health Summary
• The VistA TIU package will print and display ICD-9 diagnosis codes obtained from other VistA packages within Health Summaries which display PN or DS.

Problem List
• TIU VistA protocols permitting users to link problems directly to a TIU Progress Note have been disabled. Note: This means that all problems linked directly to Progress Notes will predate this patch and will therefore be ICD-9 problems.

Patch TIU*1*279 – Create Missing Patient PRF TIU installs one new Progress Note Title into the TIU DOCUMENT DEFINITION file (8925.1) PATIENT RECORD FLAG CATEGORY I – MISSING PATIENT. The patch installation links the title to the existing document class, PATIENT RECORD FLAG CAT I. This title will be automatically linked to the MISSING PATIENT Patient Record Flag during the install of DG*5.3*869.

Patch TIU*1*275 – USH LEGAL SOLUTION installs one new Progress Note Title into the TIU DOCUMENT DEFINITION file (8925.1): PATIENT RECORD FLAG CATEGORY I – URGENT ADDRESS AS FEMALE. The patch installation links the title to the existing document class, PATIENT RECORD FLAG CAT I. This title will be automatically linked to the URGENT ADDRESS AS FEMALE Patient Record Flag during the install of DG*5.3*864.

Patch TIU*1*265 - PRF CAT I - HIGH RISK FOR SUICIDE supports the Improve Veteran Mental Health (IVMH) initiative, High Risk Mental Health (HRMH) -National Reminder & Flag.
This patch installs one new Title into the TIU DOCUMENT DEFINITION file (8925.1): PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE

PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE is used with the new Patient Record Flag.

Patch TIU*1*261 permits an authorized user to rescind an Advance Directive document by changing the title to RESCINDED ADVANCE DIRECTIVE.
Patch TIU*1*261 supports Imaging patch MAG*3.0*121, which provides the ability to watermark images "RESCINDED".

☞ Note: EXACT TITLE NAMES are REQUIRED
The title of the Advance Directive to be rescinded must be ADVANCE DIRECTIVE
The title it is changed to when it is being rescinded must be RESCINDED ADVANCE DIRECTIVE

Both LOCAL and National Standard titles must be as above. Variations on either title will cause the Change Title action to fail to watermark images as rescinded. These exact titles are required by policy. See the VHA HANDBOOK 1004.02 section on Advance Directives:
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2042

Patch TIU*1*159 implements the War-Related Illness and Injury Study Centers (WRIISC pronounced “risk”) note title and template. The associated note title is WRIISC ASSESSMENT NOTE. This note is described in the memo Description of WRIISC Programs and Associated Referral Process accompanying the patch. To get it to work properly a Clinical Coordinator authorized to edit shared templates must perform the following steps from the CPRS GUI:

1. Go to the Notes tab.
2. From the Options menu, select Edit Shared Templates.
3. In the Shared Templates pane highlight document Titles.
4. From the Tools menu select Import Template.
5. Select WRIISCASSESSMENT.TXML and press Open.
6. Highlight the WRIISC ASSESSMENT template.
7. In the Associated Title list box, select WRIISC ASSESSMENT NOTE.
8. Press OK.

Once these steps have been performed, the template and note title will work for all CPRS users. Further information about setting up shared templates is available in the Computerized Patient Record System (CPRS) User Guide in the section on Creating Personal Document Templates.
Chapter 2: Orientation

Manual organization

This manual is divided into four major sections:

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<th>Purpose</th>
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<td>II: Using TIU</td>
<td>Describes and demonstrates how to use the basic entry and reporting functions of TIU. This section is divided into sub-sections for the four major users of TIU: clinicians, MRTs, MIS Managers, and transcriptionists.</td>
</tr>
<tr>
<td>III: Managing TIU</td>
<td>Describes the options and tools available to coordinators and IRMS for assigning menus, setting parameters, and other management functions. Also includes Troubleshooting and Helpful Hints.</td>
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<tr>
<td>Glossary and Index</td>
<td>Definitions of terms and the index to the manual.</td>
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How each chapter is formatted

Each chapter generally follows the format of:
- Brief overview
- Description of process (step-by-step description of how to use functions, if appropriate)
- Examples

Online documentation: Intranet

Online Documentation for this product is available on the intranet at the following address:
http://www.va.gov/vdl/
This address takes you to the Clinical Products page, which has a listing of all the clinical software manuals. Click on the CPRS: Text Integration Utilities link and it will take you to the TIU Homepage.

Note: Remember to bookmark this site for future reference.
Special Instructions for the new VISTA Computer User

If you are unfamiliar with this package or other Veterans Health Information Systems and Technology Architecture (VISTA) software applications, we recommend that you study the DHCP User’s Guide to Computing. This orientation guide is a comprehensive handbook for first-time users of any VISTA application to help you become familiar with basic computer terms and the components of a computer. It is reproduced and distributed periodically by the Kernel Development Group. To request a copy, contact your local Information Resources Management Service (IRMS) staff.

Graphic Conventions Used in This Manual

<Enter>
The Enter or Return key. It is pressed after every response you enter or when you wish to bypass a prompt, accept a default (/i), or return to a previous action. In this manual, it is only included in examples when it might be unclear that such a keystroke must be entered.

Option examples
Menus and examples of computer dialogue that you see on the screen are shown in boxes:

Select Menu Option:

User responses
User responses are shown in boldface.

Select PATIENT NAME: TIUPATIENT,ONE

NOTE
The pointing finger with a NOTE is used to call your attention to something especially significant.

Example:

NOTE: You can respond to many prompts by typing the first few letters of a name, option, or action.

Select PATIENT NAME: TIUPATIENT,O      TIUPATIENT,ONE
TIU and VistA Conventions

^, ^^, ^^^

Enter the up-arrow (also known as a caret or circumflex) at a prompt to exit the current option, menu, sequence of prompts, or help. To get completely out of your current context and back to your original menu, you may need to enter two or three up-arrows. For example, when you’re reviewing a list of documents, one up-arrow takes you to the next document; you need to enter two up-arrows to get out of the option.

>>
TIU screens can contain more information to the right of the main screen display. To see this information, enter the > character. To return to the main screen, enter the < character.

NOTE: The arrow keys on the keypads of some keyboards can sometimes be used for navigation in List Manager applications, but this depends on the operating system. So if you get funny characters on your screen when you use those arrows, use the > and < symbols on the comma and period keys (the greater-than and less-than symbols).

Online Help ?, ??, ???
Online help is available by entering one, two, or three question marks at a prompt. One question mark elicits a brief statement of what information is appropriate for responding to the prompt; two question marks shows a list (and sometimes descriptions) of more actions; and three question marks provide more detailed help, including a list of possible answers, if appropriate.

Defaults (/) Defaults are responses provided to speed up your entry process. They are either the most common responses, the safest responses, or the previous response. Examples:

Most common: Enter the ending date: NOW//
Safest: Do you wish to delete the entire entry: NO//
Last entered Enter the Provider Name: TIU_PROVIDER,THREE//
TIU uses the List Manager utility which enables TIU (and other applications) to display a list of items in a screen format.

**Screen title**
The screen title changes according to what type of information List Manager is displaying (e.g., Progress Notes, Discharge Summary, etc.).

**Header area**
The header area is a “fixed” (non-scrollable) area that displays patient information.

**List area**
(scrolling region) This area scrolls if there are more items than will fit on one page. It displays a list of items, such as Unsigned Progress Notes, that you can take action on. If there’s more than one page of items, it’s listed in the upper right-hand corner of the screen (Page 1 of #).

**Message window**
This section displays a plus (+) sign, minus (-), or >> sign, or informational text (i.e., Enter ?? for more actions). If you enter a plus sign at the action prompt, List Manager “jumps” forward a page. If a minus sign is displayed and you enter it at the action prompt, List Manager “jumps” back a screen. The plus, minus, and > signs are only valid actions if they are displayed in the message window.
**List Manager Screen Display cont’d**

**Action area**
A list of actions display in this area of the screen. If you enter a double question mark (??) at the “Select Item(s)” prompt, you are shown a “hidden” list of additional actions that are available to use.

**Entering Actions**

The List Manager utility allows you to:
- browse through the list
- select items that need action
- take action against those items
- select other actions without leaving the option

Actions are entered by typing the name or abbreviation at the “Select Action” prompt.

**Shortcut:** Actions may also be preselected by typing the action abbreviation, then the number of the document on the list (Example: ED=1 will let you edit entry 1, Consult Report.

*Besides the actions specific to the option you are working in, List Manager provides generic actions applicable to any List Manager screen. Enter a double question mark (??) at the “Select Action” prompt for a list of all actions available. The abbreviation for each action is shown in brackets following the action name. These actions are described on the next page.*
List Manager Screen Display, cont’d

The following actions are available (enter ?? to see these):

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Next screen</td>
<td>Move to the next screen (may be shown as a default)</td>
</tr>
<tr>
<td>- Previous Screen</td>
<td>Move to the previous screen</td>
</tr>
<tr>
<td>FS First Screen</td>
<td>Move to the first screen</td>
</tr>
<tr>
<td>LS Last Screen</td>
<td>Move to the last screen</td>
</tr>
<tr>
<td>GO Go to Page</td>
<td>Move to any selected page in the list</td>
</tr>
<tr>
<td>RD Re Display Screen</td>
<td>Redisplay the current screen</td>
</tr>
<tr>
<td>DD Detailed Display</td>
<td></td>
</tr>
<tr>
<td>EC Edit Cosigner</td>
<td></td>
</tr>
<tr>
<td>ADPL Auto Display(On/Off)</td>
<td>Toggles the menu of actions to be displayed/not displayed automatically</td>
</tr>
<tr>
<td>CT Change Title</td>
<td>Allows you to change the Title of a note from, e.g., a CWAD note to a Nursing Note</td>
</tr>
<tr>
<td>CWAD CWAD Display</td>
<td>Displays details of any CWAD notes available</td>
</tr>
<tr>
<td>UP Up a Line</td>
<td>Move up one line</td>
</tr>
<tr>
<td>DN Down a Line</td>
<td>Move down one line</td>
</tr>
<tr>
<td>&gt; Shift View to Right</td>
<td>Move the screen to the right if the screen width is more than 80 characters</td>
</tr>
<tr>
<td>&lt; Shift View to Left</td>
<td>Move the screen to the left if the screen width is more than 80 characters</td>
</tr>
</tbody>
</table>

Generic (hidden) actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Next Screen</td>
<td>Move to the next screen (may be shown as a default)</td>
</tr>
<tr>
<td>Previous Screen</td>
<td>Move to the previous screen</td>
</tr>
<tr>
<td>Up a Line</td>
<td>Move up one line</td>
</tr>
<tr>
<td>Down a Line</td>
<td>Move down one line</td>
</tr>
<tr>
<td>Shift View to Right</td>
<td>Move the screen to the right if the screen width is more than 80 characters</td>
</tr>
<tr>
<td>Shift View to Left</td>
<td>Move the screen to the left if the screen width is more than 80 characters</td>
</tr>
<tr>
<td>First Screen</td>
<td>Move to the first screen</td>
</tr>
<tr>
<td>Last Screen</td>
<td>Move to the last screen</td>
</tr>
<tr>
<td>Go to Page</td>
<td>Move to any selected page in the list</td>
</tr>
<tr>
<td>Re Display Screen</td>
<td>Redisplay the current screen</td>
</tr>
<tr>
<td>Print Screen</td>
<td>Prints the header and the portion of the list currently displayed</td>
</tr>
<tr>
<td>Print List</td>
<td>Prints the list of entries currently displayed</td>
</tr>
<tr>
<td>Search List</td>
<td>Finds selected text in list of entries</td>
</tr>
<tr>
<td>Auto Display (On/Off) [ADPL]</td>
<td>Toggles the menu of actions to be displayed/not displayed automatically</td>
</tr>
<tr>
<td>Change Title</td>
<td>Allows you to change the Title of a note from, e.g., a CWAD note to a Nursing Note</td>
</tr>
<tr>
<td>CWAD Display</td>
<td>Displays details of any CWAD notes available</td>
</tr>
</tbody>
</table>
### List Manager Screen Display, cont’d

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Edit Cosigner [EC]</strong></td>
<td>Allows authorized users to modify the Expected Cosigner (Attending Physician for Discharge Summaries) of documents without having access to the text of the document. It is intended for Clinical Coordinators when they need to change the Expected Cosigner of a document whose Expected Cosigner cannot be otherwise changed because it is already signed. It permits the Expected Cosigner field to be edited for unsigned or uncosigned documents of type Progress Notes, Consults, Clinical Procedures, or Discharge Summaries. <strong>Note:</strong> Recent changes enforce limits on cosigning privileges. No provider may be a cosigner on Discharge Summaries if the provider requires a cosignature. To correct expected cosigners who were erroneously assigned before this restriction went into effect, perform a search on uncosigned notes, then use the (hidden) Edit Cosigner (EC) action to correct any problems.</td>
</tr>
<tr>
<td><strong>Quit [QU]</strong></td>
<td>Exits the screen (may be shown as a default)</td>
</tr>
</tbody>
</table>
Chapter 3: TIU for Clinicians

Progress Notes/Discharge Summary Menu

This is the main TIU menu for clinicians. It includes all of the options necessary for clinicians to manage their Progress Notes, Discharge Summaries, and other clinical documents which may be set up locally, either separately or in an integrated fashion. TIU also allows you to continue to access Progress Notes and Discharge Summaries through OE/RR menus. CPRS allows point and click access to all Progress Notes, Discharge Summaries, and Consults TIU documents.

The Progress Notes/Discharge Summary (TIU) menu also includes a Personal Preferences menu that allows clinicians to change their own parameters for viewing clinical documents.

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Progress Notes User Menu</td>
<td>This menu includes options for reviewing, entering, printing, and signing progress notes, either by individual patient or by multiple patients.</td>
</tr>
<tr>
<td>Discharge Summary User Menu</td>
<td>This menu includes options for reviewing, entering, printing, and signing discharge summaries, either by individual patient or by multiple patients.</td>
</tr>
<tr>
<td>Integrated Document Management</td>
<td>This menu allows clinicians to perform actions on progress notes, discharge summaries, and other clinical documents from a single menu For example, a clinician may want to bring up all his unsigned documents.</td>
</tr>
<tr>
<td>Personal Preferences</td>
<td></td>
</tr>
</tbody>
</table>
Using Progress Notes through CPRS

Clinicians enter and review Progress Notes through CPRS (Computerized Patient Record System) VistA and List Manager or through the CPRS GUI. Here we give an example of reviewing Notes through the List Manager version of CPRS. The GUI version has a different sequence of steps.

Example: Reviewing and signing Notes through CPRS

1. Select the Clinician Menu from your CPRS menu.

   OE     CPRS Clinician Menu
   RR     Results Reporting Menu
   AD     Add New Orders
   RO     Act On Existing Orders
   PP     Personal Preferences ...
Select Clinician Menu Option: OE  CPRS Clinician Menu

2. The Patient Selection screen is displayed. If you have a patient or team list defined, the patients are on this display.

   Ward 2B     Mar 17, 1997 17:07:09     Page: 1 of 1
Current patient: ** No patient selected **

   Patient Name           ID        DOB            Room-Bed
   1    TIUPATIENT,ONE   (3456)    Jan 01, 1951
   2    TIUPATIENT,THREE (1996)    Mar 05, 1949
   3    TIUPATIENT,FIVE  (3779)    Nov 19, 1991
   4    TIUPATIENT,SEVEN (3234)    Mar 03, 1966
   5    TIUPATIENT,TEN   (2432)    Apr 04, 1932
   6    TIUPATIENT,NINE  (2591)    Apr 25, 1931   9-B
   7    TIUPATIENT,ELEVEN (8910)   Jan 01, 1934   A-4
   8    TIUPATIENT,SEVEN (3243)    Apr 04, 1954
   9    TIUPATIENT,FOURTEEN (4723)  Oct 23, 1927   A-2

   Enter the number of the patient chart to be opened
   +   Next Screen   CG  Change List ...   FD  Find Patient
   -   Previous Screen  SV  Save as Default List  Q  Close
Select Patient: Close// 1  TIUPATIENT,ONE
Searching for the patient's chart ...

3. Select a patient by:
   • Entering a name from a list (if you have one defined and set as your default
   • Entering a patient’s name (or last initial + last 4 letters of SSN)
   • Entering FD (Find Patient), entering a ward or clinic name, then selecting a patient name from the list that appears.
Example: Reviewing Notes, cont’d

4. The “Cover Sheet” for the patient’s record is displayed. Select Chart Contents.

5. A new set of actions is displayed. These are the Contents or categories of the Patient Chart (also known as “Tabs.”) Select the Notes tab.
Example: Reviewing Notes, cont’d

6. The patient’s completed progress notes are displayed. This is the default set up through Personal Preferences. You can “change view” to see a different status, such as unsigned notes.

<table>
<thead>
<tr>
<th>Completed Progress Notes</th>
<th>Mar 17, 1997 17:10:56</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT,ONE 666-12-3456</td>
<td>2B JAN 1,1951 (46)</td>
<td>&lt;CW&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Title</th>
<th>Written</th>
<th>Sig Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>CRISIS NOTE</td>
<td>02/24/97 08:28 completed</td>
</tr>
<tr>
<td>2</td>
<td>CLINICAL WARNING</td>
<td>02/21/97 09:16 completed</td>
</tr>
<tr>
<td>3</td>
<td>General Note</td>
<td>01/24/97 14:18 completed</td>
</tr>
<tr>
<td>4</td>
<td>CLINICAL WARNING</td>
<td>01/15/97    completed</td>
</tr>
<tr>
<td>5</td>
<td>SOAP - GENERAL NOTE</td>
<td>12/04/96 14:39 completed</td>
</tr>
<tr>
<td>6</td>
<td>SOAP - GENERAL NOTE</td>
<td>12/04/96 11:32 completed</td>
</tr>
<tr>
<td>7</td>
<td>CRISIS NOTE</td>
<td>12/03/96 10:44 completed</td>
</tr>
<tr>
<td>8</td>
<td>SOAP - GENERAL NOTE</td>
<td>12/03/96 10:31 completed</td>
</tr>
<tr>
<td>9</td>
<td>SOAP - GENERAL NOTE</td>
<td>11/22/96 12:37 completed</td>
</tr>
</tbody>
</table>

Enter the numbers of the items you wish to act on. >>>

NW Write New Note CG Change List ... SP Select New Patient
+ Next Screen CC Chart Contents ... Q Close Patient Chart

Select: Chart Contents// CG CHANGE LIST

Select attribute(s) to change: S STATUS

Select Signature Status: completed//??

Enter the signature status you would like to screen on
Choose from:
- amended
- completed
- deleted
- purged
- uncosigned
- unddictated
- unreleased
- unsigned
- untranscribed
- unverified

Select Signature Status: completed//UNSigned

Searching for the patient's chart ...
Example: Reviewing Notes, cont’d

7. The patient’s unsigned notes are displayed.

```
Unsigned Progress Notes  Mar 17, 1997 17:13:22  Page: 1 of 1
TIUPATIENT,ONE  666-12-3456  2B  JAN 1,1951 (46)  <CW>

<table>
<thead>
<tr>
<th>Title</th>
<th>Written</th>
<th>Sig Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addendum to CLINICAL WARNING</td>
<td>01/28/97</td>
<td>unsigned</td>
</tr>
</tbody>
</table>
```

Enter the numbers of the items you wish to act on. >>>
NW  Write New Note  CG  Change List ...  SP  Select New Patient
+   Next Screen       CC  Chart Contents ...  Q  Close Patient Chart

Select: Chart Contents//

Example: Writing a note

Select: Chart Contents// NW  Write New Note
Available note(s): 11/22/96 thru 02/24/97 (9)
Do you wish to review any of these notes? NO// YES

--- Select note(s) to review ---

Please specify a date range from which to select note(s):
List Notes Beginning: 11/22/96/ <Enter> (NOV 22, 1996)
Thru: 02/24/97/ <Enter> (FEB 24, 1997)

```
1   02/24/97 08:28  CRISIS NOTE                           Two TIUProvider
Adm: 09/21/95

2   02/21/97 09:16  CLINICAL WARNING                      Sixteen TIUProvider
   Adm: 09/21/95

3   01/24/97 14:18  General Note                          Three TIUProvider
   Adm: 09/21/95
   SUBJECT: TEST

4   01/15/97 00:00  CLINICAL WARNING                      One TIUProvider, MD
   Visit: 08/14/95

5   12/04/96 14:39  SOAP - GENERAL NOTE                   Three TIUProvider
   Adm: 09/21/95
```

Choose Notes: (1-5): <Enter>

Nothing selected.
Example: Writing a note, cont’d

Personal PROGRESS NOTES Title List for NINE TIUPROVIDER
1  Crisis Note
2  Advance Directive
3  Adverse Reactions
4  Other Title
TITLE: (1-4): 3  Adverse React/Allergy

Creating new progress note...
Patient Location:  2B
Date/time of Admission:  09/21/95 10:00
Date/time of Note:  NOW
Author of Note:  TIUPROVIER,NINE
...OK? YES// <Enter>

SUBJECT (OPTIONAL description):
Calling text editor, please wait...
1>TEST
2> <Enter>
EDIT Option:
Save changes? YES// <Enter>

Saving Adverse React/Allergy with changes...
Enter your Current Signature Code: XXX  SIGNATURE VERIFIED..
Print this note? No// YES
Do you want WORK copies or CHART copies? CHART//<Enter>
DEVICE: HOME// <Enter>  VAX

---------------------------------------------------------------------
TIUPATIENT,ONE  666-12-3456                                 Progress Notes
---------------------------------------------------------------------
NOTE DATED: 03/17/97 17:15    ADVERSE REACT/ALLERGY
ADMITTED: 09/21/95 10:00  2B
TEST

Signed by: /es/ NINE TIUPROVIDER
NINE TIUPROVIDER 03/17/97 17:15

Enter RETURN to continue or '^^' to exit: <Enter>

You may enter another Progress Note. Press RETURN to exit.
Select PATIENT NAME: <Enter>
TIU Dictation Control

TIU*1*297 added functionality to allow a facility to control TIU dictation privileges by division for TIU documents of any type (Op reports, DC Summaries, Consults, etc.). Authors should initiate a note stub with a unique ID number and dictation instructions. The unique ID number is generated by the system. It is normally not disclosed to the user. However, in this case, it is disclosed as part of the dictation instructions, for easy identification.

Sites may choose whether to use this functionality.

Dictation privileges are controlled by two new fields that were added to the TIU PARAMETERS File (#8925.99).

The two new fields added to the TIU PARAMETERS File (#8925.99) are:

- **ENABLE DICTATION CONTROL** (Field #.23), which can be answered **YES** to activate the patch functionality. An answer of **NO** or nothing disables the functionality.

- **DICTATION INSTRUCTIONS** (Field #6), a word processing field, which allows sites to enter site-specific dictation instructions. Within this field, sites may reference the variables TIUDA, TIUL5, and TIUINST by placing them between vertical bars, Example |TIUDA|. TIUDA will be the internal entry number of the current document, TIUL5 will be the last 5 digits of TIUDA and TIUINST will be the internal entry number of the INSTITUTION of the currently logged-in user. Kernel’s software-wide variables, defined in the kernel technical manual, and FileMan’s package-wide variables, defined in the FileMan technical manual, may be used as well.

These new fields may be modified by using the TIU BASIC PARAMETERS EDIT option.

Set the “Enable Dictation Control” Field (#23) to “Yes” to activate the functionality. Enter “BEGIN-DICTATION” in the first line of the text in the CPRS progress note to trigger replacement of the progress NOTE by the “Dictation Instruction” in Field (#6).

The patch also introduced a new routine, TIUDCT, modified existing routine, TIULP, and introduced a new security key, TIUDCT. The TIUDCT security key must be assigned to the CPRS users who are authorized to dictate TIU documents and transcription personnel such as the Facility Chief (HIM) and the Transcription Supervisor/Staff.

Template TIU BASIC PARAMETER EDIT INPUT TIU PARAMETERS File (#8925.99) was modified to allow a facility to control TIU dictation privileges, request dictating authors to initiate a note stub, and dictate a unique ID number with dictation instructions.

The TIU PARAMETERS file is based on the INSTITUTION File (#4). This functionality is enabled/disabled at the division level. Each division may have its own parameters, which can be controlled separately, allowing divisions to have different sets of TIU Dictation Instructions, provided the site’s divisions were set up as separate institutions.
New Service Request, NSR 20141003 – TIU Dictation Control, was resolved with this patch.

**Dictation Instructions Example:**

Enter **YES** to activate DICTATION CONTROL. Add site specific instructions for your site in the DICTATION INSTRUCTIONS field using your TIU BASIC PARAMETER EDIT option.

```
Select OPTION NAME: TIU BASIC PARAMETER EDIT Basic TIU Parameters
Basic TIU Parameters
First edit Division-wide parameters:

Select INSTITUTION: ?
   Answer with TIU PARAMETERS INSTITUTION
   Choose from:
     ALBANY
     TROY
     ZZ DUP WASHINGTON VAMC

   You may enter a new TIU PARAMETERS, if you wish
   Enter your Institution:
   Answer with INSTITUTION NAME
   Do you want the entire INSTITUTION List? N (No)
   Select INSTITUTION: ALBANY NY VAMC 500
   ...OK? Yes// (Yes)

ENABLE ELECTRONIC SIGNATURE: YES//
ENABLE NOTIFICATIONS DATE: JUN 13,1995//
GRACE PERIOD FOR SIGNATURE: 5//
FUTURE APPOINTMENT RANGE:
CHARACTERS PER LINE: 66//
OPTIMIZE LIST BUILDING FOR: performance//
SUPPRESS REVIEW NOTES PROMPT: NO//
DEFAULT PRIMARY PROVIDER: AUTHOR (IF PROVIDER) //
BLANK CHARACTER STRING: @@@//
START OF ADD SGNR ALERT PERIOD:
END OF ADD SGNR ALERT PERIOD:
LENGTH OF SIGNER ALERT PERIOD:
ENABLE DICTATION CONTROL: Y YES
DICTATION INSTRUCTIONS:
   No existing text
   Edit? NO// YES
```

This note can **ONLY** be dictated using the Site Name VA DICTATION SYSTEM. Begin dictation by stating "DICTATING PROGRESS NOTE #|TIUL5|." In house, dial 45354 or from outside VA, 555-1212. Enter your Dictation ID followed by the # key. Enter appropriate work type followed by the # key. Enter the patient's 9-digit SSN followed by the # key.

Press 2 to begin dictating.
   Wait for the record tone to end.

Press 2 again to pause anytime during dictation.
   You may pause up to 5 minutes.

If you do not press 2 to pause, the system will warn you of disconnect when no recording has taken place for over 60 seconds.

For STAT/Rush dictation, press 6 anytime during dictation then press 2 to reactivate dictation mode.

When you have completed dictating the report:
Press 5 to disconnect, or
Press 8 to dictate another report
To “rewind” in dictation mode:
Press 3 to rewind 10 seconds.
Press 7 for continuous rewind. Wait, press 3 to play back.
Press 77 to rewind to beginning of report.
To edit the last words dictated:
Press 3 or 73 to rewind to the last correct word.
Press 2 to STOP playback and START recording.

Type the words “BEGIN-DICTATION” on the first line in a CPRS progress note then click “Save Without Signature.”
The dictation number appears on the right side of the screen. Follow the instructions displayed in the body of the note.

**LOCAL TITLE: Discharge Summary**

**STANDARD TITLE: DISCHARGE SUMMARY**

- **Dict Date:** Feb 23, 2017 @ 10:48
- **Entry Date:** Mar 17, 2017 @ 09:05:38
- **Dictated By:** Resident, Physician
- **Attending:** Staff, Physician One
- **Urgency:** Routine
- **Status:** Undictated

This note can ONLY be DICTATED using the MILWAUKEE VA DICTATION SYSTEM.

---

Begin dictation by stating "DICTATING PROGRESS NOTE # 3590"

---

In house, Dial 1234
From outside VA, 555-1234

Press 2 to begin dictating. Wait for record tone to end.
Press 2 again to pause anytime during dictation. You may pause up to 5 minutes. If you do not press 2 to pause, the system will warn you of disconnect when no recording has taken place for over 60 seconds.

For SIAI/Rush dictation, press 6 anytime during dictation, then 2 to reactivate dictation mode.

When you are done dictating the report either:
- Press 5 to DISCONNECT
- Or
- Press 8 to DICTATE ANOTHER report

To "rewind" in dictation mode:
- Rewind 10 seconds - Press 3
- Continuous rewind - Press 7, wait, 3 to play back
- Rewind to beginning of report - Press 77

To edit the last words dictated:
- Press 3 or 73 to rewind to the last correct word
- Press 2 to STOP playback and START recording.

If transcription is NOT available by 24 hours, contact Transcription Dept at x4321.
Sites not having the following business rules must determine the need to create them through “USR CLASS MANAGEMENT MENU” as indicated below:

<table>
<thead>
<tr>
<th>DOCUMENT DEFINITION</th>
<th>STATUS</th>
<th>ACTION</th>
<th>By</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DOCUMENTS</strong> (CLASS)</td>
<td>UNDICTATED</td>
<td>VIEW</td>
<td>USER</td>
</tr>
<tr>
<td><strong>CLINICAL DOCUMENTS</strong> (CLASS)</td>
<td>UNDICTATED</td>
<td>EDIT RECORD</td>
<td></td>
</tr>
<tr>
<td><strong>TRANSCRIPTIONIST</strong> OPERATION REPORTS__ (DOCUMENT CLASS)</td>
<td>UNDICTATED</td>
<td>EDIT RECORD</td>
<td>USER</td>
</tr>
</tbody>
</table>

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
5  Manage Business Rules

Select User Class Management Option: 5 Manage Business Rules
Select SEARCH CATEGORY: DOCUMENT DEFINITION//

**Suggested Set-Up Example 1**

Select Action: Next Screen// AD Add Rule
Please Enter a New Business Rule:

Select DOCUMENT DEFINITION: CLINICAL DOCUMENTS CLASS (or the document or class appropriate for site)
DOCUMENT DEFINITION: CLINICAL DOCUMENTS//
STATUS: UNDICTATED
ACTION: VIEW
USER CLASS: USER (or class that contains all medical record user classes)
AND FLAG: USER ROLE:
DESCRIPTION:

**Suggested Set-Up Example 2**

Select Action: Next Screen// AD Add Rule
Please Enter a New Business Rule:

Select DOCUMENT DEFINITION: CLINICAL DOCUMENTS CLASS (or the document or class appropriate for site)
DOCUMENT DEFINITION: CLINICAL DOCUMENTS//
STATUS: UNDICTATED
ACTION: EDIT RECORD
USER CLASS: TRANSCRIPTIONIST (or the TIU USR class appropriate for site)
AND FLAG: USER ROLE:
DESCRIPTION:

**Suggested Set-Up Example 3**

Select Action: Next Screen// ADD Add Rule
Please Enter a New Business Rule:

Select DOCUMENT DEFINITION: OPERATION REPORTS DOCUMENT CLASS (or the document or class appropriate for site)
DOCUMENT DEFINITION: OPERATION REPORTS//
STATUS: UNDICTATED
ACTION: EDIT RECORD
USER CLASS: USER
AND FLAG: USER ROLE:
DESCRIPTION:
Select Search through CPRS

You can narrow your view to signed notes by author, unsigned notes, etc. You can also specify the date order your notes will appear in: ascending (oldest first) or descending (most recent first) order.

Caution: Avoid selecting too large a date range or too general a category, as big searches are very system-intensive. This means that not only might it slow down your work, but everyone else’s as well.

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychology Notes</td>
<td>TIUPROVIDER,ONE</td>
<td>04/08/97 15:49</td>
<td>compl</td>
</tr>
<tr>
<td>CRISIS NOTE</td>
<td>TIUPROVIDER,THR</td>
<td>04/08/97 00:00</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,NIN</td>
<td>04/07/97 16:28</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,NIN</td>
<td>04/03/97 19:31</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,NIN</td>
<td>03/17/97 17:15</td>
<td>compl</td>
</tr>
<tr>
<td>CRISIS NOTE</td>
<td>TIUPROVIDER,NIN</td>
<td>02/24/97 08:28</td>
<td>compl</td>
</tr>
</tbody>
</table>

Valid selections are:
- signed notes (all)
- unsigned notes
- uncosigned notes
- signed notes/author
- signed notes/dates

Select context: 1 // 4  AUTHOR
Select AUTHOR: TIUPROVIDER,TWO // <Enter>  
jg
Please Specify Sort Order: descending // ?
Select one of the following:
- A ascending (OLDEST FIRST)
- D descending (NEWEST FIRST)
Please Specify Sort Order: descending // A ascending (OLDEST FIRST)
Searching for the progress notes.

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRISIS NOTE</td>
<td>TIUPROVIDER,ONE</td>
<td>02/24/97 08:28</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,THR</td>
<td>03/17/97 17:15</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,NIN</td>
<td>04/03/97 19:31</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,NIN</td>
<td>04/07/97 16:05</td>
<td>compl</td>
</tr>
</tbody>
</table>
**Progress Notes Options**

Clinicians can review, enter, print, and sign progress notes, either by individual patient or by multiple patients, through TIU.

**NOTE:** When reviewing several notes sequentially, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

### Clinician's Progress Notes Menu

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry of Progress Note</td>
<td>This is the main option for entering a new progress note. You can also edit patient progress notes.</td>
</tr>
<tr>
<td>Review Progress Notes by Patient</td>
<td>This option allows you to review, edit, or sign a selected patient’s progress notes, by selected criteria.</td>
</tr>
<tr>
<td>Review Progress Notes</td>
<td>This option allows clinicians to get quickly to a patient’s list of notes, without preliminary prompts to select criteria for displaying notes.</td>
</tr>
<tr>
<td>All MY UNSIGNED Progress Notes</td>
<td>This option retrieves all your unsigned progress notes for review, edit, or signature.</td>
</tr>
<tr>
<td>Show Progress Notes Across Patients</td>
<td>This option allows you to search for and review progress notes by many different criteria: status, type, date range, and category. Caution: Avoid selecting too large a date range or too general a category, as big searches are very system-intensive. This means that not only might it slow down your work, but everyone else’s as well.</td>
</tr>
<tr>
<td>Progress Notes Print Options ...</td>
<td>The options on this menu support the printing of chart or work copies, by author, location, patient, or ward. These options are described in Chapter 8.</td>
</tr>
<tr>
<td>List Notes By Title</td>
<td>This option allows you to look up progress notes by title within a specified date range.</td>
</tr>
<tr>
<td>Search by Patient AND Title</td>
<td>This option allows you to search for and review progress notes by patient, as well as many other criteria: status, type, date range, and category.</td>
</tr>
<tr>
<td>Personal Preferences...</td>
<td>The two options on this menu let you customize the way TIU operates for you; that is, which prompts will appear, what lists you will see to select from, etc. You can also specify the way documents are displayed on your review screens, by patient, by author, by type, in chronological or reverse chronological order, etc.</td>
</tr>
</tbody>
</table>
Entry of Progress Note

This is the main option for entering a new progress note. You can also edit patient progress notes.

Example 1: Inpatient progress note

Steps to use option:

1. Select Entry of Progress Note from your Progress Notes Menu. If you have a patient list set up (through Personal Preferences), it is displayed here.

```
Loading Ward Patient List...
  2B ward list

1    TIUPATIENT,ONE   (3456) ~          8    TIUPATIENT, TWO   (3243) A-4
2    TIUPATIENT,NINE  (2591) ~          9    TIUPATIENT,EIGHT (3242) ~
3    TIUPATIENT,FOUR  (2384) ~          10   TIUPATIENT, TEN  (2432) A-2
4    TIUPATIENT,SEVEN (3234) ~          11   TIUPATIENT, TWELV (3213) A-1
5    TIUPATIENT,THREE (1996) ~          12   TIUPATIENT, FOUT (4723) ~
6    TIUPATIENT,FIVE  (3779) ~          13   TIUPATIENT, SIXTE (1321) A-3
7    TIUPATIENT,SIX   (2476) 9-B        14   TIUPATIENT, ELEVE (1414) ~
```

2. Type in a patient name or a number from the list. Demographic data and CWAD (Cautions, Warnings, Adverse Reactions, and Directives) notes are displayed. You are prompted to choose if you want to see any of the previous Progress Notes for this patient.

```
Select Patient(s): 7    TIUPATIENT, TWO 04-25-31  666043243P NO  MILITARY RETIREE
(6 notes)  W: 01/27/97 15:17  (addendum 02/08/97 17:19)
A: Known allergies
(1 note )  D: 03/26/97 13:02
Available notes: 11/11/96 thru 04/15/97 (27)
Do you wish to see any of these notes? NO//
```

This indicates that there are 27 notes for this patient.
Entry of Progress Note, cont’d

3. Select a Title. If you have a personal Progress Notes title list set up through Personal Preferences, that list is displayed for you to choose from. Enter a Subject, if desired, and the text of the Progress Note.

```
Choosing new Progress note...
Patient Location: 1A
Date/time of Admission: 05/30/97 10:43
Date/time of Note: NOW
Author of Note: TIUPROVIDER, NINE
...OK? YES/<Enter>
SUBJECT (OPTIONAL description): <Enter>
Calling text editor, please wait...
1>Mr. TIUPatient improving; renewed prescription.
2> <Enter>
EDIT Option:
Save changes? YES/<Enter>
Saving Adverse React/Allergy with changes...
```

4. Enter your electronic signature code. If you wish to print the note (either a Work or Chart copy), answer yes to the next prompt, and enter a printer device name.

```
Enter your Current Signature Code: XXX SIGNATURE VERIFIED.
Print this note? No// y YES
Do you want WORK copies or CHART copies? CHART// w WORK
DEVICE: HOME//<Enter> VAX
```

The note is printed. You are prompted to enter another note or to exit.

```
------------------------------------------------------------------------
TIUPATIENT, SEVEN 666-04-3234P                             Progress Notes
------------------------------------------------------------------------
NOTE DATED: 05/31/97 14:58    ADVERSE REACT/ALLERGY
ADMITTED: 05/30/97 10:43 1A
Mr. TIUPatient improving; renewed prescription.
   Signed by: /es/ NINE TIUPROVIDER
   NINE TIUPROVIDER 05/31/97 14:59
Enter RETURN to continue or '^' to exit:
You may enter another Progress Note. Press RETURN to exit.
Select PATIENT NAME: <Enter>
```
Example 2: Outpatient note

Outpatient notes require more information than inpatient notes, because every outpatient encounter must now be associated with a visit to get workload credit. Most Progress Notes automatically get the visit data from Checkout or a scanned Encounter Form.

Steps to use option:

1. Select Entry of Progress Note from your Progress Notes Menu.

2. Type in a patient name.

   Select Patient(s): TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456 YES
   SC VETERAN
   (1 note ) C: 11/19/96   (addendum 01/28/97 09:55)
   A: Known allergies

   For Patient TIUPATIENT,ONE

3. Type in a Progress Note Title. You can use an existing Title or create a new one. If you have created a personal document list through the Personal Preferences’ Document Management option, that list is displayed here.

   Personal PROGRESS NOTES Title List for THREE TIUPROVIDER
   1    Crisis Note
   2    Advance Directive
   3    Adverse Reactions
   4    Other Title
   TITLE: (1-4): 3      Adverse React/Allergy

4. Since this is a note for an outpatient, you may be prompted to select an existing visit or create a new visit to associate the progress note with. 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> FEB 24, 1997@09:00      DIABETES CLINIC
   2> SEP 05, 1996@10:00      CARDIOLOGY
   CHOOSE 1-2 or <N>EW VISIT
   <RETURN> TO CONTINUE
   OR ^^ TO QUIT: N

   Creating new progress note...
   Patient Location: NUR 1A
   Date/time of Visit:  02/24/97 14:29
   Date/time of Note: NOW
   Author of Note: TIUPROVIDER,THREE
   ...OK? YES/<Enter>
   SERVICE: MEDICINE// <Enter>  111
Entry of Progress Note, cont’d

5. Enter a subject for your note (optional).

SUBJECT (OPTIONAL description): ?
Enter a brief description (3-80 characters) of the contents of the document.
SUBJECT (OPTIONAL description): Blue Note

6. Type in the text of the note. If it’s a SOAP Note or there’s a boilerplate for this, you can fill in the blanks or edit existing text. You can use the FileMan text editor or full-screen editor. Sign the Note when you’re finished.

Calling text editor, please wait...
1>Follow-up visit to ensure compliance with regimen.
2><Enter>
EDIT Option: <Enter>
Save changes? YES/<Enter>
Saving General Note with changes...
Enter your Current Signature Code: [HIDDEN CODE] SIGNATURE VERIFIED..

7. Enter the Diagnosis associated with this Progress Note.

NOTE: To receive workload credit, VAMCs must now capture Provider, Diagnosis, and Procedure for all outpatient visits.

Please Indicate the Diagnoses for which the Patient was Seen:
1. Abdominal Pain
2. Abnormal EKG
3. Abrasion
4. Abscess
5. Adverse Drug Reaction
6. AIDS/ARC
7. Alcoholic, intoxication
8. Alcoholism, Chronic
9. Allergic Reaction
10. Anemia
ANGINA:
11. Stable
12. Unstable
13. Anorexia
14. Appendicitis, Acute
15. Arthralgia
ARTHRITIS
16. Osteo
17. Rheumatoid
18. Ascites
19. ASHD
20. OTHER Diagnosis
Select Diagnoses: (1-20): 9

NOTE: As of patch TIU*1*263, Changes for ICD-10, TIU VistA Manager Actions which include TIU selection of diagnoses will permit selection from appropriate ICD diagnoses depending on the Date of Visit. The dialogue confirming the selections will include the ICD coding system as well as the ICD code.
**Entry of Progress Note, cont’d**

8. Enter the Procedure associated with this Progress Note.

Please Indicate the Procedure(s) Performed:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Cardioversion</td>
</tr>
<tr>
<td>2</td>
<td>EKG</td>
</tr>
<tr>
<td>3</td>
<td>Pericardiocentesis</td>
</tr>
<tr>
<td>4</td>
<td>Thoracotomy</td>
</tr>
<tr>
<td>5</td>
<td>Abscess</td>
</tr>
<tr>
<td>6</td>
<td>Less than 2.5 cm</td>
</tr>
<tr>
<td>7</td>
<td>2.6 - 7.5 cm</td>
</tr>
<tr>
<td>8</td>
<td>Greater than 7.5 cm</td>
</tr>
<tr>
<td>9</td>
<td>Burns 1 * Local Treatment</td>
</tr>
<tr>
<td>10</td>
<td>Dressings Medium</td>
</tr>
<tr>
<td>11</td>
<td>Dressings Small</td>
</tr>
<tr>
<td>12</td>
<td>Transfusion</td>
</tr>
<tr>
<td>13</td>
<td>Venipuncture</td>
</tr>
<tr>
<td>14</td>
<td>Foley Catheter</td>
</tr>
<tr>
<td>15</td>
<td>Removal Impacted Cerumen</td>
</tr>
<tr>
<td>16</td>
<td>Anterior, Simple</td>
</tr>
<tr>
<td>17</td>
<td>Anterior, complex</td>
</tr>
<tr>
<td>18</td>
<td>Posterior</td>
</tr>
<tr>
<td>19</td>
<td>Foreign Body Removal</td>
</tr>
<tr>
<td>20</td>
<td>OTHER Procedure</td>
</tr>
</tbody>
</table>

Select Procedure: (1-20): **19**

You have indicated the following data apply to this visit:

**DIAGNOSES:**

(ICH-9-CM 995.3) Allergic Reaction << PRIMARY

**PROCEDURES:**

65205 Foreign Body Removal

...OK? YES// <Enter>

Posting Workload Credit...
8. If you wish, you can print the note now.

Print this note? No// y YES
Do you want WORK copies or CHART copies? CHART// work
DEVICE: HOME// <Enter> VAX

---------------------------------------------------------------------
TIUPATIENT,ONE  666-23-3456                            Progress Notes
---------------------------------------------------------------------
NOTE DATED: 02/24/97 08:30    ADVERSE REACT/ALLERGY
VISIT: 02/24/97 08:30 GENERAL MEDICINE
new tests

Signed by: /es/ THREE TIUPROVIDER
THREE TIUPROVIDER 02/24/97 08:30

Enter RETURN to continue or '^' to exit:
You may enter another CLINICAL DOCUMENT. Press RETURN to exit.
Select PATIENT NAME: <Enter>
Review Progress Notes by Patient

This option allows you to review, edit, or sign a selected patient’s progress notes.

Steps to use option:

1. Select Review Progress Notes by Patient from the Progress Notes menu, then enter the name of the patient.

   Select Progress Notes User Menu Option: 2  Review Progress Notes by Patient
   PATIENT NAME: TIUPATIENT,ONE TIUPATIENT,ONE  09-12-44  666233456

   ERAN
   (2 notes)  C: 05/28/96 12:37
   (2 notes)  W: 05/28/96 12:33
   A: Known allergies
   (2 notes)  D: 05/28/96 12:36

   Available notes: 02/17/95 thru 06/21/96 (31)

2. Enter the date range of notes you wish to review.

   Specify a date range from which to select notes:
   List notes Beginning: 12/01/96  (DEC 01, 1994)
   Thru: 05/01/96//<Enter>  (MAY 01, 1997)

3. From the selection displayed, choose the notes you wish to review.

   Choose notes: (1-8): 2

If the patient has Cautions, Warnings, Allergies, or Directives (CWAD), they are displayed here.
Review Progress Notes by Patient, cont’d

4. The note you selected is then displayed.

Opening Lipid Clinic record for review...
Browse Document  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid Clinic</td>
<td></td>
</tr>
</tbody>
</table>

TIUPATIENT,O  666-23-3456  Visit Date: 06/18/96@10:00

DATE OF NOTE: JUN 21, 1996@07:47:47  ENTRY DATE: JUN 21, 1996@07:47:47
AUTHOR: TIUPROVIDER,ONE  EXP COSIGNER:  
URGENCY:  STATUS: COMPLETED

SUBJECTIVE:  5 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for initial evaluation of his DYSLIPIDEMIA.

PMH:  
Significant negative medical history pertinent to the evaluation and treatment of DYSLIPIDEMIA:

FH:  

NOTE: The screen indicates that this is Page 1 of 4; press Enter after each screen to see all the pages of this note. When reviewing several notes, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

Browse Document  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>June 26, 1996 10:56:09</td>
<td>Page: 2 of 4</td>
</tr>
<tr>
<td>Lipid Clinic</td>
<td></td>
</tr>
</tbody>
</table>

TIUPATIENT,O  666-23-3456  Visit Date: 04/18/96@10:00

SH:  
MEDICATION HISTORY:  CURRENT MEDICATIONS

DIET:  
Counseled on AHA Step I diet today by NINE TIUPROVIDER.
See her evaluation.

ACTIVITY:  
OBJECTIVE:  HT: 70 (08/23/95 11:45)  WT: 207 (08/23/95 11:45)
**Review Progress Notes by Patient, cont’d**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT,O</td>
<td>666-23-3456</td>
<td>Visit Date: 04/18/96@10:00</td>
</tr>
<tr>
<td>TSH/T4: 1.7/1.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FBG: 200</td>
<td>HEMOGLOBIN A1C: 15.2</td>
<td></td>
</tr>
<tr>
<td>SGOT: 44</td>
<td>URIC ACID: 4.7</td>
<td></td>
</tr>
</tbody>
</table>

**ASSESSMENT:**
1. MALE with / without documented CAD
2. CV Risk factors:
3. Lipid pattern:

**PLAN:**
1. Implement recommendations to lower fat intake.
2. Repeat FBG and HBG A1C on:
3. Return to review lab on:

<table>
<thead>
<tr>
<th>Action</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find</td>
<td>Make Addendum</td>
</tr>
<tr>
<td>Print</td>
<td>Sign/Cosign</td>
</tr>
<tr>
<td>Edit</td>
<td>Copy</td>
</tr>
<tr>
<td>+</td>
<td>Next Screen</td>
</tr>
<tr>
<td>-</td>
<td>Prev Screen</td>
</tr>
<tr>
<td>??</td>
<td>More actions</td>
</tr>
</tbody>
</table>

Select Action: Next Screen// <Enter>

---

**5. You can then select an action to perform on the note.**

Select Action: Quit// m Make Addendum

Adding ADDENDUM

DATE/TIME OF NOTE: 10/25/96@11:21:// <Enter> (OCT 25, 1996@11:21:00)

AUTHOR OF NOTE: TIUPROVIDER,ELEVEN// <Enter> jg

Calling text editor, please wait...

1>Should say 55 year old...

2><Enter>

EDIT Option: <Enter>

Saving Addendum with changes...

Addendum Released.

Enter your Current Signature Code: xxxxxxx (code hidden) SIGNATURE VERIFIED..

Press RETURN to continue...<Enter>
Review Progress Notes

This option allows clinicians to get immediately to a patient’s list of notes, without preliminary prompts for selection criteria. It’s particularly useful for when physicians are seeing patients in clinics and want to pull up their records quickly, as they are able to do with Progress Notes 2.5 (frequently accessed through OE/RR 2.5). Note that the actions below the black bar look more like OE/RR (and CPRS) actions than the ones you’ll see in other TIU options.

1. **Select Review Progress Notes from your Progress Notes or OE/RR menu,** whichever one you commonly use. Then enter the name of the patient you are seeing.

```
Select Progress Notes User Menu Option: 2b Review Progress Notes
Select PATIENT NAME: TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456
YES
SC VETERAN
(2 notes) C: 02/24/97 08:44
(1 note ) W: 02/21/97 09:19
A: Known allergies
(2 notes) D: 03/25/97 08:57
Searching for the progress notes.
```

2. **A screen with a list of notes for your patient is displayed.** Items with the plus symbol (+) have addenda. You can look at details of any of the notes shown (by selecting the Browse or Detailed Display action), create a new note, make an addendum, sign a note, or perform any of the other actions listed below (as well as hidden actions).

```
Progress Notes May 31, 1997 14:20:10 Page: 1 of 1
<CWAD> PROGRESS NOTES Last 15 note(s)
TIUPATIENT,O 666-23-3456 SEP 12,1944 (52)
Title Author Date/Time
1 Adverse React/Allergy TIUPROVIDER,FIV 05/27/97 00:00 compl
2 Adverse React/Allergy TIUPROVIDER,ONE 05/20/97 17:18 compl
3 CRISIS NOTE TIUPROVIDER,THR 05/20/97 17:01 compl
4 Adverse React/Allergy TIUPROVIDER,SEV 05/20/97 11:23 compl
5 GENERAL NOTE TIUPROVIDER,SEV 05/20/97 11:21 compl
6 CARDIOLOGY NOTE TIUPROVIDER,SEV 05/20/97 10:56 compl
7 Adverse React/Allergy TIUPROVIDER,FIV 04/21/97 16:02 compl
8 Adverse React/Allergy TIUPROVIDER,FIV 04/15/97 06:23 compl
9 CARDIOLOGY NOTE TIUPROVIDER,FIV 04/11/97 12:09 compl
10 CRISIS NOTE TIUPROVIDER,FIV 04/11/97 09:09 compl
```

+ Next Screen - Prev Screen ?? More Actions
NW New Note SS Select Search IN Interdiscipl'ry Note
B Browse RS Reset to All Signed EE Expand/Collapse Entry
PC Print Copy AD Make Addendum Q Quit
SP Select New Patient $ Complete Note(s)
Select Action: Quit// B BROWSE
Review Progress Notes, cont’d

3. If you select the action Browse, you can see more details of a note.

Select Action: Next Screen// b  Browse
Select Progress Note(s): (1-15): 1

Reviewing Item #1
Opening Adverse React/Allergy record for review...

Browse Document

May 31, 1997 14:29:07       Page: 1 of 1
Adverse React/Allergy

TIUPATIENT,O  666-23-3456  GENERAL MEDICINE  Visit Date: 04/18/96@10:00

DATE OF NOTE: MAY 27, 1997       ENTRY DATE: MAY 27, 1997@12:15:13
AUTHOR: TIUPROVIDER,ONE       EXP COSIGNER:
URGENCY:                            STATUS: COMPLETED

Another test...is the antibiotic working?

/es/ ONE TIUPROVIDER, MD
PGY2 Resident
Signed: 05/27/97 12:21

+ Next Screen  - Prev Screen  ?? More actions

Find                    Sign/Cosign               Link ...
Print                  Copy                   Encounter Edit
Edit                  Identify Signers           Interdiscipl'ry Note
Make Addendum           Delete                  Quit
Select Action: Quit//

NOTE: When reviewing several notes sequentially, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).
**Review Progress Notes, cont’d**

4. If you select the action Detailed Display, you can see even more details of a note. Enter DT for Detailed Display. Detailed Display is a “hidden action,” an action that appears when you enter two question marks.

Select Action: Next Screen// det  Detailed Display
Select Progress Note(s): (1-15): 1

Reviewing #1
Opening Adverse React/Allergy record for review........

```
Detailed Display
Adverse React/Allergy
TIUPATIENT,O  666-23-3456  Visit Date: 04/18/96@10:00

Source Information
Reference Date: MAY 27, 1997@10:44:19    Author: TIUPROVIDER,ONE
Entry Date: MAY 27, 1997@10:44:19    Entered By: jg
Expected Signer: TIUPROVIDER,EIGHT     Expected Cosigner: None
Urgency: None                         Document Status: COMPLETED
Line Count: 46                       TIU Document #: 1132
Division: ISC-SLC-A4                  VBC Line Count: 56.25
Subject: None

Associated Problem
No linked problems.

Edit Information
Edit Date: JAN 17, 1997@10:45:08    Edited By: TIUPROVIDER,EIGHT

Reassignment History
Document Never Reassigned.

+ Next Screen  - Prev Screen  ?? More actions
  Find                      Print                     Quit
Select Action: Next Screen// <Enter>
```

```
Detailed Display
Adverse React/Allergy
TIUPATIENT,O  666-23-3456  Visit Date: 04/18/96@10:00

+ Next Screen  - Prev Screen  ?? More actions
  Find                      Print                     Quit
Select Action: Next Screen// <Enter>
```

```
Signature Information
Signed Date: MAY 27, 1997@10:45:17    Signed By: TIUPROVIDER,ONE
Signature Mode: ELECTRONIC
Cosigned Date: None                     Cosigned By: None
Cosignature Mode: None

Document Body
Mr. TIUPATIENT'S allergies improved with medication.

06/08/97 ADDENDUM:
Improvement was temporary; patient relapsed after a few days.
SIXTEEN TIUPROVIDER

+ Next Screen  - Prev Screen  ?? More actions
  Find                      Print                     Quit
Select Action: Quit//
```
Review Progress Notes, cont’d

5. If you select the action Select Search, you can narrow your view to a specific context of notes: signed, unsigned, by author, or by a date or date range.

<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,N</td>
<td>05/27/97 00:00</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,N</td>
<td>05/20/97 17:18</td>
<td>compl</td>
</tr>
<tr>
<td>CRISIS NOTE</td>
<td>TIUPROVIDER,N</td>
<td>05/20/97 17:01</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,N</td>
<td>05/20/97 11:23</td>
<td>compl</td>
</tr>
<tr>
<td>GENERAL NOTE</td>
<td>TIUPROVIDER,N</td>
<td>05/20/97 11:21</td>
<td>compl</td>
</tr>
<tr>
<td>CARDIOLOGY NOTE</td>
<td>TIUPROVIDER,N</td>
<td>05/20/97 10:56</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,T</td>
<td>04/21/97 16:02</td>
<td>compl</td>
</tr>
<tr>
<td>Adverse React/Allergy</td>
<td>TIUPROVIDER,T</td>
<td>04/15/97 06:23</td>
<td>compl</td>
</tr>
<tr>
<td>CARDIOLOGY NOTE</td>
<td>TIUPROVIDER,T</td>
<td>04/11/97 12:09</td>
<td>compl</td>
</tr>
<tr>
<td>CRISIS NOTE</td>
<td>TIUPROVIDER,T</td>
<td>04/11/97 09:09</td>
<td>compl</td>
</tr>
</tbody>
</table>

Valid selections are:
1 - signed notes (all)  2 - unsigned notes  3 - uncosigned notes
4 - signed notes/author  5 - signed notes/dates

Select context: 1//2 UNSIGNED NOTES
All MY UNSIGNED Progress Notes

When you select this option, the program retrieves all your unsigned progress notes for review, edit, or signature.

Steps to use option:

1. Select All My Unsigned Progress Notes from the Clinician’s Progress Notes Menu.

2. The list is then displayed, from which you can choose any of the listed actions.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>By AUTHOR (TIUPROVIDER,ONE) or EXPECTED COSIGNER 2 documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Document</td>
<td>Ref Date</td>
</tr>
<tr>
<td>TIUPATIENT(D3456)</td>
<td>Psychology - Crisis</td>
<td>10/25/96</td>
</tr>
<tr>
<td>TIUPATIENT(D3456)</td>
<td>Addendum to Lipid Clinic</td>
<td>10/25/96</td>
</tr>
</tbody>
</table>

+ Next Screen - Prev Screen ?? More Actions >>>

Find Sign/Cosign Change View
Add Document Detailed Display Copy
Edit Browse Delete Document
Make Addendum Print Quit
Link ... Identify Signers
Select Action: Quit//s Sign/Cosign
Select Progress Note(s): (1-2): 1
Opening Psychology - Crisis record for review...

SIGN/COSIGN Oct 25, 1996 11:34:21 Page:1 of 1

TIUPATIENT,ONE 666-23-3456 2B Visit Date: 10/25/96@11:32

DATE OF NOTE: OCT 25, 1996@11:32:55 ENTRY DATE: OCT 25, 1996@11:32:55
AUTHOR: TIUPROVIDER,ONE EXP COSIGNER: 
URGENCY: 
STATUS: UNSIGNED

Six-month follow-up visit. Patient continues to improve; no change in treatment required.

+ Next Screen - Prev Screen ?? More Actions

Print No
Ready for Signature: NO//y Yes
Item #: 1 Added to signature list.
Enter your Current Signature Code: xxxxxxx (code hidden) SIGNATURE VERIFIED..
Show Progress Notes Across Patients

This option allows you to search for and review progress notes by many different criteria: status, type, date range, and category. By different combinations of these criteria, you can see almost any view of your progress notes you could want.

NOTE: Use caution in how broad your search is (date range, # of patients, etc.), because searches for a lot of documents can be very system-intensive, slowing down response time for everyone.

Steps to use option:

1. Select *Show Progress Notes Across Patients* from the Clinician’s Progress Notes Menu.

2. Select one of the following status(es) of progress notes:
   - undictated
   - untranscribed
   - unreleased
   - unverified
   - unsigned
   - uncosigned
   - completed
   - amended
   - retracted

3. Select one of the following Progress Note Types.
   - Advance Directive
   - Crisis Note
   - Clinical Warning
   - Historical Titles
   - Adv React/Allergy

4. Select one or more of the following search categories:
   - 1 All Categories
   - 2 Author
   - 3 Division
   - 4 Expected Cosigner
   - 5 Hospital Location
   - 6 Patient
   - 7 Problem
   - 8 Service
   - 9 Subject
   - 10 Title
   - 11 Transcriptionist
   - 12 Treating Specialty
   - 13 Visit

5. Select the range of dates to include.

6. The notes meeting the criteria you selected are displayed.
### Progress Notes Print Options

See Chapter 8 for examples and further descriptions of these options.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author– Print Progress Notes</td>
<td>This option produces chart or work copies of progress notes for an author for a selected date range.</td>
</tr>
<tr>
<td>Location– Print Progress Notes</td>
<td>This option prints chart or work copies of progress notes for all patients who were at a specific location when the notes were written. The patients whose progress notes are printed on this report may not still be at that location. If Chart is selected, each note will start on a new page.</td>
</tr>
<tr>
<td>Patient– Print Progress Notes</td>
<td>This option prints or displays progress notes for a selected patient by selected date range.</td>
</tr>
<tr>
<td>Ward– Print Progress Notes</td>
<td>This option allows you to print progress notes for all patients who are now on a ward for a selected date range. This option is only for ward locations. <strong>NOTE:</strong> This option only prints to a printer, not to your computer screen.</td>
</tr>
</tbody>
</table>
List Notes by Title

This option allows you to look up progress notes by title within a specified date range. You can then take any of the usual actions on these notes.

Steps to use option:

1. Select List Notes by Title from the Clinician’s Progress Notes Menu. Select the titles (one or more) of progress notes to search for.

2. Enter a beginning and ending date range to choose documents from. The selected documents are displayed.
List Notes by Title, cont’d

3. You may now choose an action such as Edit, Sign/Cosign, Make Addendum or Detailed Display.

4. A detailed display of the note you chose appears on your screen.
Search by Patient AND Title

This option allows you to search for and review progress notes by patient, as well as many other criteria: status, type, date range, and category. You can then take any of the usual actions on these notes.

Steps to use option:

1. Select the Search by Patient AND Title option from the Progress Notes User Menu.

2. Select a Patient.

3. Type in one or more Progress Note Titles to search for.

4. A list is displayed of all notes that meet the criteria you specified.
Progress Notes Statuses and Actions

Statuses

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amended *</td>
<td>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</td>
</tr>
<tr>
<td>Completed *</td>
<td>The document has acquired all necessary signatures and is legally authenticated.</td>
</tr>
<tr>
<td>deleted</td>
<td>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.</td>
</tr>
<tr>
<td>Retracted *</td>
<td>When a signed document is reassigned, amended, or deleted, a retracted copy of the original is kept for audit purposes.</td>
</tr>
<tr>
<td>Uncosigned *</td>
<td>The document is complete with the exception of cosignature (e.g., by a supervisor).</td>
</tr>
<tr>
<td>undictated</td>
<td>The document is required and a record has been created in anticipation of dictation and transcription, but the system has not yet been informed of its dictation.</td>
</tr>
<tr>
<td>unreleased</td>
<td>The document is in the process of being entered into the system, but has not yet been released by the originator (i.e., the person who entered the text directly online).</td>
</tr>
<tr>
<td>unsigned</td>
<td>The document is online in a draft state, but the author hasn’t signed.</td>
</tr>
<tr>
<td>untranscribed</td>
<td>The document is required and the system has been informed of its dictation, but the transcription hasn’t been entered or received by upload.</td>
</tr>
<tr>
<td>unverified</td>
<td>The document has been released or uploaded, but must be verified before the document may be displayed.</td>
</tr>
</tbody>
</table>

* As of TIU*1*234, documents of these statuses (i.e., signed documents) cannot be edited regardless of business rules.

NOTE:

+ = a report has addenda.
* = priority (STAT) document.
# Progress Note Actions

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find</td>
<td>Allows you to search a list of documents for a text string (word or partial word) from the current position to the end of the list.</td>
</tr>
<tr>
<td>Add Document</td>
<td>Allows you to add a new Progress Note.</td>
</tr>
<tr>
<td>New Note</td>
<td>Same as Add Document, used in CPRS contexts.</td>
</tr>
<tr>
<td>Edit</td>
<td>Allows authorized users to edit selected documents online.</td>
</tr>
<tr>
<td>Make Addendum</td>
<td>Allows authorized users to add addenda to selected documents online. Physicians will be prompted for their signatures upon exit.</td>
</tr>
<tr>
<td>Link</td>
<td>Allows you to link documents to either problems, visits, or other documents. Such associations permit a variety of clinically useful “views” of the online record.</td>
</tr>
<tr>
<td>Sign/Cosign</td>
<td>Allows clinicians to electronically sign selected discharge summaries or addenda. NOTE: Electronic signature carries the same legal ramifications that wet signature of a hard-copy discharge summary carries. You are advised to carefully review each discharge summary for content and accuracy before exercising this option.</td>
</tr>
<tr>
<td>Detailed Display</td>
<td>Displays the report type, patient, urgency, line count, VBC line count, author, attending physician, transcriptionist, and verifying clerk, and also admission, discharge, dictation, transcription, signature, and amendment dates.</td>
</tr>
<tr>
<td>Browse</td>
<td>Allows you to browse through Documents from the Review Screen, by scrolling sequentially through the selected documents and their addenda. You can search for a word or phrase, or print draft copies.</td>
</tr>
<tr>
<td>Print</td>
<td>Allows you to print copies of VAF 10-1000 for selected summaries.</td>
</tr>
<tr>
<td>Identify Signers</td>
<td>Allows authorized users to identify additional signers for a document.</td>
</tr>
<tr>
<td>Change View</td>
<td>Allows you to change the displayed reports to signature status, review screen, or dictation date range.</td>
</tr>
<tr>
<td>Copy</td>
<td>Allows authorized users to copy one or more documents to other patients and encounters. This is particularly useful when documenting group sessions, etc.</td>
</tr>
<tr>
<td>Delete Document</td>
<td>Allows the author to delete an unsigned document. In rare cases, a signed document can be deleted but a copy is kept as a retracted document.</td>
</tr>
<tr>
<td>Change Title</td>
<td>This action on the “hidden” list allows you to change a Title for a Progress Note (e.g., CWAD Notes) to another Title.</td>
</tr>
<tr>
<td>Quit</td>
<td>Allows you to quit the current menu level.</td>
</tr>
</tbody>
</table>
Interdisciplinary Notes

Interdisciplinary Notes are 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, attending) and continue with separate notes created and signed by other providers and attached to the original note.

To accomplish this, your facility must:

1. Set up note titles for the initiating note and the attachment notes—also called parent note and child notes.
2. Use version 15 of the CPRS Windows (GUI) interface or later.

The Text Integration Utilities (TIU) Implementation Guide contains a new appendix, Appendix C, that describes in detail the technical aspects of setting up Interdisciplinary Notes.

The rest of this section shows the actions Interdisciplinary Notes using Version 15 of the CPRS Windows interface.

The Parent Note

You start any interdisciplinary note with a parent note. A parent is a note title that includes an ASU (Authorization/Subscription Utility) rule allowing attachments. Your facility should have set up these titles with unique names that allow you to easily identify them.

Only certain members of your team should start Interdisciplinary Notes. To establish a parent note for a patient and a specific episode of care, all they do is create a note with the proper title, and sign it.

The Child Note(s)

*Continue an interdisciplinary note by attaching one or more child notes to the parent note. The intention is for each child note to be by a different provider involved in this episode of care. Again your facility has established a number of notes with unique titles to act as child notes.*
**Interdisciplinary Notes, cont’d**

Previously created note attachments are made to the parent node by dragging and dropping. (Dragging and dropping may be a new concept to you. To drag and drop:
1. Point the cursor at the child note.
2. Hold down the left mouse button.
3. Move the cursor over the parent note. A ghost of the child note title will follow the cursor.
4. Release the left mouse button.

The following dialog appears to confirm the attachment:
Interdisciplinary Notes, cont’d

Menu Actions

There are two Interdisciplinary Note specific menu commands in the CPRS Windows interface. They are:
- Add New Entry to ID Note
- Detach from ID Note

These commands become active (usable) when the correct kind of note is selected as in these illustrations:

In the first case, the parent note has been selected. In this case, you can add a new note to the Interdisciplinary Note without having to later attach it (via drag and drop).
In the second case, one of the child notes has been selected. In this case, you can detach this note from the parent.
Interdisciplinary Notes, cont’d

The Display

CPRS displays all notes in the Interdisciplinary Note reference date order unless one of the child notes is selected. In this case, CPRS displays the child note, then it displays all the notes in the Interdisciplinary Note reference date order; repeating the current note. In all other respects, the format of the display is the same as a regular note.
The display of unsigned notes depends upon the business rules in effect at your site. These rules may allow you to view the unsigned child notes of other providers in the context of an Interdisciplinary Note. This is up to your local authorities.

Meaning of Icons

In the CPRS Windows interface, notes are listed in a tree-structured arrangement. This is intended to graphically show a number of things:
1. Signed and Unsigned notes.
2. Notes with an addendum attached.
3. Interdisciplinary notes.
4. Regular notes.

The meaning of the various icons is:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>📄</td>
<td>A list of notes, either signed or unsigned.</td>
</tr>
<tr>
<td>📄 📄</td>
<td>An Interdisciplinary Note. The open folder indicates that all the children are listed.</td>
</tr>
<tr>
<td>📄</td>
<td>A child to an Interdisciplinary Note.</td>
</tr>
<tr>
<td>📄 📄</td>
<td>A regular note, or a child note that has not yet been attached to a parent.</td>
</tr>
<tr>
<td>📄 📄 📄</td>
<td>The plus sign indicates an addendum is present.</td>
</tr>
<tr>
<td>📄</td>
<td>An addendum</td>
</tr>
</tbody>
</table>
**Interdisciplinary Notes, cont’d**

In the List Manager interface, similar devices are used to indicate the type of note:

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Nothing)</td>
<td>A regular note, or a child note that has not yet been attached to a parent.</td>
</tr>
<tr>
<td>&lt;</td>
<td>An Interdisciplinary Note parent.</td>
</tr>
<tr>
<td>&gt;</td>
<td>An Interdisciplinary Note child.</td>
</tr>
<tr>
<td>+</td>
<td>An addendum is present.</td>
</tr>
<tr>
<td>+&lt;</td>
<td>An Interdisciplinary Note with one or more addendum present. The addenda may be in the child note(s).</td>
</tr>
<tr>
<td>+&gt;</td>
<td>An Interdisciplinary Note child with one or more addendum present.</td>
</tr>
</tbody>
</table>

**LM Considerations**

**CPRS**

Interdisciplinary Notes are not supported in the List Manager (LM) interface of CPRS with the following exception: Interdisciplinary Notes are viewed and printed just as other notes supported by TIU.

**TIU**

To access the full range of Interdisciplinary Notes features, use the Progress Note User Menu and choose exported option **2b, Review Progress Notes**.

The IN (Interdiscipl'ry Note) action is the universal action for operations on Interdisciplinary Notes. You should select a note before selecting this menu option. If the note selected is a parent note, it will prompt you to enter a child of this note. If the note selected is an unattached child note, it will prompt you to select the parent that goes with it.
In this example, a new child note is added to an existing parent note:

```
To ADD a new entry to an interdisciplinary note, please select the interdisciplinary note. 
To ATTACH an existing stand-alone note to an interdisciplinary note, please select the note you want to attach. 
Select Progress Note: (1-14): 4
Are you adding a new interdisciplinary entry to this note? YES// <Enter>
Adding a new interdisciplinary entry to ID PARENT REHAB TREATMENT PLAN
Please select a title for your entry:
TITLE: ??
Choose from:
ER NURSE NOTE TITLE
ER PHYSICIAN NOTE TITLE
OCCUPATIONAL THERAPY CHILD NOTE TITLE
REHAB CHILD DISCHARGE PLANNING NOTE TITLE
REHAB CHILD INITIAL ASSESSMENT NOTE TITLE
REHAB CHILD NURSE NOTE TITLE
REHAB CHILD PHARMACY NOTE TITLE
REHAB CHILD PHYSICAL THERAPY NOTE TITLE
REHAB CHILD PSYCHOLOGY NOTE TITLE

TITLE: REHAB CHILD PHYSICAL THERAPY NOTE TITLE

Enter/Edit PROGRESS NOTE...
Patient Location: PULMONARY CLINIC
Date/time of Visit: 02/08/01 08:26
Date/time of Note: NOW
Author of Note: TIUPROVIDER,TWENTY ONE
...OK? YES// <Enter>
Calling text editor, please wait...
1>The Pt is doing very well ...
2>
EDIT Option: <Enter>

Saving ID CHILD REHAB PHYSICAL THERAPY NOTE with changes...
```

Enter your Current Signature Code: ********
<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Date/Time</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>- ID PARENT NINE</td>
<td>TIUPROVIDER</td>
<td>02/14/01 08:15</td>
<td>compl</td>
</tr>
<tr>
<td></td>
<td>ID CHILD OCCUPATIONAL THER</td>
<td>TIUPROVIDER</td>
<td>02/14/01 08:16</td>
</tr>
<tr>
<td>3 ER NOTE</td>
<td>TIUPROVIDER</td>
<td>02/14/01 08:14</td>
<td>compl</td>
</tr>
<tr>
<td>4 - ID PARENT REHAB TREATMENT PL</td>
<td>TIUPROVIDER</td>
<td>02/08/01 08:26</td>
<td>compl</td>
</tr>
<tr>
<td>5</td>
<td>ID CHILD REHAB INITIAL A</td>
<td>TIUPROVIDER</td>
<td>02/08/01 13:29</td>
</tr>
<tr>
<td>6 + ID CHILD REHAB PSYCHOLOGY</td>
<td>TIUPROVIDER</td>
<td>02/09/01 09:13</td>
<td>compl</td>
</tr>
<tr>
<td>7 + ID CHILD REHAB PHYSICAL TH</td>
<td>TIUPROVIDER</td>
<td>02/14/01 16:02</td>
<td>compl</td>
</tr>
<tr>
<td>8 - ANGIOPLASTY NOTE</td>
<td>TIUPROVIDER</td>
<td>01/08/01 13:16</td>
<td>compl</td>
</tr>
<tr>
<td>9 + Addendum to ANGIOPLASTY NO</td>
<td>TIUPROVIDER</td>
<td>02/14/01 08:13</td>
<td>compl</td>
</tr>
<tr>
<td>10 ID CHILD ONE</td>
<td>TIUPROVIDER</td>
<td>01/08/01 13:14</td>
<td>compl</td>
</tr>
<tr>
<td>11 ID ANY CHILD NOTE</td>
<td>TIUPROVIDER</td>
<td>01/02/01 07:52</td>
<td>compl</td>
</tr>
<tr>
<td>12 SEVEN'S CHILD SIX</td>
<td>TIUPROVIDER</td>
<td>12/28/00 13:49</td>
<td>compl</td>
</tr>
<tr>
<td>13 SEVEN'S CHILD FIVE</td>
<td>TIUPROVIDER</td>
<td>12/28/00 13:48</td>
<td>compl</td>
</tr>
<tr>
<td>14 + SEVEN'S ID NOTE</td>
<td>TIUPROVIDER</td>
<td>12/28/00 13:31</td>
<td>compl</td>
</tr>
</tbody>
</table>

**Entry attached**

**Select Action:** Next Screen
Discharge Summary

Clinicians can review, enter, print, and sign discharge summaries, either by individual patient or by multiple patients.

Clinician’s Discharge Summary Menu

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient Discharge</td>
<td>This option allows you to review, edit, or sign a patient’s discharge summaries.</td>
</tr>
<tr>
<td>Summary</td>
<td></td>
</tr>
<tr>
<td>All MY UNSIGNED Discharge</td>
<td>This option shows you all unsigned discharge summaries for you to review, edit, or sign. You must have signing or cosigning privileges to sign or cosign, based on your document definition, user class status, and business rules governing these actions. See your Clinical Coordinator if you have any problems or questions.</td>
</tr>
<tr>
<td>Summaries</td>
<td></td>
</tr>
<tr>
<td>Multiple Patient Discharge</td>
<td>This option shows you discharge summaries for selected statuses, types, and categories, which you can then review, edit, and/or sign.</td>
</tr>
<tr>
<td>Summaries</td>
<td></td>
</tr>
</tbody>
</table>
## Individual Patient Discharge Summary

This option allows you to review, edit, or sign a patient’s discharge summaries.

**Steps to use option:**

1. Select *Individual Patient Discharge Summary* from your TIU menu, then select a patient.

   Select Discharge Summary User Menu Option: **Individual Patient Discharge Summary**

   Select PATIENT NAME: **TIUPATIENT,ONE 09-12-44 666233456 YES SC VETERAN**

   - (2 notes) C: 05/28/96 12:37
   - (2 notes) W: 05/28/96 12:33
   - A: Known allergies

   Available summaries: 02/12/96 thru 02/12/96 (1)

2. Enter a date range to select summaries from, then select a summary from the ones displayed. The selected summary is displayed. Then select an action.

Select Action: Quit // p Print

DEVICE: HOME //<Enter> VAX

---

### Available Summaries:

- **02/12/96 thru 02/12/96 (1)**

---

If the patient has any CWAD (Crisis, Warning, Allergies, and Directives) notes, they are displayed here.

---

**DIAGNOSIS:**

1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. Coronary artery disease.
4. Hypertension.

---

+ Find + Next Screen - Prev Screen ?? More actions

*Find* + Make Addendum + Identify Signers
*Print* + Sign/Cosign + Delete
*Edit* + Copy + Link ...

Select Action: Quit // p Print

DEVICE: HOME //<Enter> VAX
PATIENT NAME | AGE | SEX | RACE | SSN   | CLAIM NUMBER
TIUPATIENT,ONE | 51  | M   | MEXI | 666-23-3456 |

ADM DATE | DISC DATE | TYPE OF RELEASE | INP | ABS | WARD NO
JUL 22, 1991 | FEB 12, 1996 | REGULAR | 1666 | 0 | 1A

DIAGNOSIS:
1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. End stage renal disease on hemodialysis.
5. Congestive heart failure.
6. Hypertension.
7. Non insulin dependent diabetes mellitus.
8. Peripheral vascular disease, status post thrombectomies.

OPERATIONS/PROCEDURES:
1. MRI.
2. CT SCAN OF HEAD.

HISTORY OF PRESENT ILLNESS:
Patient is a 49-year-old, white male with past medical history of end stage renal disease, peripheral vascular disease, status post BKA, coronary artery disease, hypertension, non insulin dependent diabetes mellitus, diabetic retinopathy, congestive heart failure, status post CVA, status post thrombectomy admitted from Anytown VA after a fall from his wheelchair in the hospital. He had questionable short-lasting loss of consciousness but patient is not very sure what has happened. He denies headache, vomiting, vertigo.

ACTIVE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd, ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic 0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.
PHYSICAL EXAMINATION: Patient had stable vital signs, his blood pressure was 160/85, pulse 84, respiratory rate 20, temperature 98 degrees. Patient was alert, oriented times three, cooperative. His speech was fluent, understanding of spoken language was good. Attention span was good. He had moderate memory impairment, no apraxia noted. Cranial nerves patient was blind, pupils are not reactive to light, face was asymmetric, tongue and palate are mid line. Motor examination showed muscle tone and bulk without significant changes. Muscle strength in upper extremities 5/5 bilaterally, sensory examination revealed intact light touch, pinprick and vibratory sensation. Reflexes 1+ in upper extremities, coordination finger to nose test within normal limits bilaterally. Alternating movements without significant changes bilaterally. Neck was supple.

LABORATORY: Showed sodium level 135, potassium 4.6, chloride 96, CO2 26, BUN 39, creatinine 5.3, glucose level 138. White blood cell count was 7, hemoglobin 11, hematocrit 34, platelet count 77.

HOSPITAL COURSE: Patient was admitted after head trauma with multiple medical problems. His coumadin was held. Patient had cervical spine x-rays which showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this level, prominent spurs at this level as well as above and below. CT scan on admission showed a moderate amount of scalp thinning with subcutaneous air overlying the left frontal lobe. The basal cisterns are patent and there is no mid line shift or uncal herniation. Patient has also a remote left posterior border zone infarct with hydrocephalus ex vacuo of the left occipital horn, a rather large remote infarct in the inferior portion of the left cerebellar hemisphere. He had hemodialysis q.o.d. He restarted treatment with Coumadin. His last PT was 11.9, PTT 31. Patient refused before hemodialysis new blood tests. His condition remained stable.

DISCHARGE MEDICATIONS: Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Betoptic 0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

DISPOSITION/FOLLOW-UP: Recommend follow PT/PTT. Patient is on coumadin and CBC with differential because patient has chronic anemia and thrombocytopenia.

Patient will be transferred to Anytown VA in stable condition on 5/19/96.

WORK COPY =========== UNOFFICIAL - NOT FOR MEDICAL RECORD ========= DO NOT FILE

SIGNATURE PHYSICIAN/DENTIST
THREE TIUPROVIDER, MD
PGY2 Resident

SIGNATURE APPROVING PHYSICIAN/DENTIST
ONE TIUPROVIDER, MS
Medical Informaticist

================================ CONFIDENTIAL INFORMATION ===============================
All MY UNSIGNED Discharge Summaries

This option shows you all unsigned discharge summaries for you to review, edit, or sign. You must have signing or cosigning privileges to sign or cosign, based on your document definition, user class status, and business rules governing these actions. See your Clinical Coordinator if you have any problems or questions about electronic signature or cosigning.

Steps to use option:

1. Select All MY UNSIGNED Discharge Summaries from your TIU menu.

2. Your unsigned discharge summaries are displayed.

<table>
<thead>
<tr>
<th>Discharge Summaries</th>
<th>Jun 18, 1996 10:13:45</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>by AUTHOR (TIUPROVIDER,ONE) or EXPECTED COSIGNER</td>
<td>0 documents</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Document</td>
<td>Ref Date</td>
</tr>
<tr>
<td>TIUPATIENT,S(T4831)</td>
<td>Discharge Summary</td>
<td>03/15/96</td>
</tr>
</tbody>
</table>

3. Select an action such as Sign/Cosign if you are authorized to perform these.

NOTE: You can enter Cosign rather than Sign/Cosign if you want to cosign.
Multiple Patient Discharge Summaries

This option shows you discharge summaries for selected statuses, types, and categories, which you can then review, edit, and/or sign.

**Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select Multiple Patient Discharge Summaries from your TIU menu.

2. Select one or more of the following statuses:
   - untranscribed
   - unsigned
   - amended
   - unreleased
   - unverified
   - uncosigned
   - completed
   - purged
   - deleted

3. Select one of the following search categories:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All Categories</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>Author</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>Division</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Expected Cosigner</td>
<td>9</td>
</tr>
<tr>
<td>5</td>
<td>Hospital Location</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Transcriptionist</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Treating Specialty</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Visit</td>
<td></td>
</tr>
</tbody>
</table>

4. Enter a date range.

5. A list is displayed of the summaries that meet your specifications.

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>My UNSIGNED Disch Summaries</td>
<td>Jun 05, 1997 14:02:15</td>
<td>Page: 1 of 1</td>
<td></td>
</tr>
<tr>
<td>by AUTHOR (TIUPROVIDER,ONE) from 05/06/97 to 06/05/97</td>
<td>1 documents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Document</td>
<td>Ref Date</td>
<td>Status</td>
</tr>
<tr>
<td>+ TIUPATIENT,T(T2591) Discharge Summary</td>
<td>06/02/97</td>
<td>UNSIGNED</td>
<td></td>
</tr>
</tbody>
</table>

6. You can now take an appropriate action on one or all of the summaries.
Discharge Summary Statuses and Actions

Statuses

<table>
<thead>
<tr>
<th>Status</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amended *</td>
<td>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 Discharge Summary: CHIEF, MIS, CHIEF, HIM, PRIVACY ACT OFFICER.</td>
</tr>
<tr>
<td>Completed *</td>
<td>The document has acquired all necessary signatures and is legally authenticated.</td>
</tr>
<tr>
<td>deleted</td>
<td>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.</td>
</tr>
<tr>
<td>Retracted *</td>
<td>When a signed document is reassigned, amended, or deleted, a retracted copy of the original is kept for audit purposes.</td>
</tr>
<tr>
<td>uncosigned *</td>
<td>The document is complete with the exception of cosignature (i.e., by the supervisor).</td>
</tr>
<tr>
<td>undictated</td>
<td>The document is required and a record has been created in anticipation of dictation and transcription but the system has not yet been informed of its dictation.</td>
</tr>
<tr>
<td>unreleased</td>
<td>The document is in the process of being entered into the system but has not yet been released by the originator (i.e., the person who entered the text directly online).</td>
</tr>
<tr>
<td>unsigned</td>
<td>The document is online in a draft state but the author hasn’t signed.</td>
</tr>
<tr>
<td>untranscribed</td>
<td>The document is required and the system has been informed of its dictation but the transcription hasn’t been entered or received by upload.</td>
</tr>
<tr>
<td>unverified</td>
<td>The document has been released or uploaded but must be verified before the document may be displayed.</td>
</tr>
</tbody>
</table>

* As of TIU*1*234, documents of these statuses (i.e., signed documents) cannot be edited regardless of business rules.
### Actions

<table>
<thead>
<tr>
<th>Actions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Find</td>
<td>Sign/Cosign</td>
</tr>
<tr>
<td>Add Document</td>
<td>Change View</td>
</tr>
<tr>
<td>Edit</td>
<td>Description</td>
</tr>
<tr>
<td>Make Addendum</td>
<td>Copy</td>
</tr>
<tr>
<td>Link ...</td>
<td>Delete Document</td>
</tr>
<tr>
<td></td>
<td>Detailed Display</td>
</tr>
<tr>
<td></td>
<td>Copy</td>
</tr>
<tr>
<td></td>
<td>Edit</td>
</tr>
<tr>
<td></td>
<td>Find</td>
</tr>
<tr>
<td></td>
<td>Identify Signers</td>
</tr>
</tbody>
</table>

**Add Document**
Enter a new Document.

**Change View**
Allows you to modify the list of reports by signature status, review screen, and dictation date range without exiting the review screen.

**Copy**
Allows authorized users to duplicate the current document. This is especially useful when composing a note for a group of patients (e.g., therapy group) and rapid duplication to all members of the group is appropriate.

**Delete Document**
Allows the author to delete an unsigned document. In rare cases, a signed document can be deleted but a copy is kept as a retracted document.

**Detailed Display**
Displays the report type, patient, urgency, line count, VBC line count, author, attending physician, transcriptionist, and verifying clerk, in addition to the admission, discharge, dictation, transcription, signature and amendment dates, without showing the narrative report text.

**Edit**
Allows authorized users to edit the current document online. When electronic signature is enabled, physicians will be prompted for their signatures upon exit, thereby allowing doctors to review, edit, and sign as a one-step process.

**Find**
Allows you to search for a text string (word or partial word) from the current position in the summary through its end. Upon reaching the end of the document, you will be asked whether to continue the search from the beginning of the document through the origin of the search.

**Identify Signers**
Allows authorized users to identify additional users who are to be alerted for concurrence signature. These signers may enter an addendum if they do not concur with the content of the document, but they may not edit the document itself.

**Link**
Allows you to link documents to either problems, visits, or other documents. Such associations permit a variety of clinically useful “views” of the online record.

**Make Addendum**
Allows authorized users to add an addendum to the current document online. When electronic signature is enabled, physicians are prompted for their signatures upon exit, thereby allowing doctors to review, edit and sign as a one-step process.

**Print**
Allows you to print copies of selected documents on your corresponding VA Standard Forms to a specified device.

**Quit**
Allows you to quit the current menu level.

**Sign/Cosign**
Allows clinicians to electronically sign the current summary. NOTE: Electronic signature carries the same legal ramifications that wet signature of a hard-copy discharge summary carries. Carefully review each discharge summary for content and accuracy before exercising this option.
Integrated Document Management

The options on this menu allow clinicians to review, edit, or sign progress notes, discharge summaries, and any other documents set up at your site. This menu is especially useful for clinicians who wish to see an integrated view of documents, to be able to edit or sign many types in one session without changing applications.

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient Document</td>
<td>Allows you to interactively review, edit, or sign a designated clinical document for a designated patient.</td>
</tr>
<tr>
<td>All MY UNSIGNED Documents</td>
<td>Gets all unsigned documents for review, edit, and signature.</td>
</tr>
<tr>
<td>Multiple Patient Documents</td>
<td>Provides an integrated Review Screen of all TIU documents.</td>
</tr>
<tr>
<td>Enter/edit Document</td>
<td>Allows you to enter and edit clinical documents directly online.</td>
</tr>
<tr>
<td>ALL Documents requiring my Additional Signature</td>
<td>Prints a report showing all documents that require an additional signature.</td>
</tr>
</tbody>
</table>
**Individual Patient Document**

Use this option to review an individual document for a patient. You can then edit, sign, delete, or perform other actions, as appropriate, on the document.

**Steps to use option:**


2. Select a patient.

3. Enter a date range to display documents for. A list is displayed of that patient’s documents for the specified time period.

Please specify a date range from which to select documents:

<table>
<thead>
<tr>
<th>No.</th>
<th>Date</th>
<th>Time</th>
<th>Document</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/07/96</td>
<td>00:00</td>
<td>Diabetes Education</td>
<td>ONE TIUPROVIDER, MD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visit: 04/18/96</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>06/05/96</td>
<td>17:23</td>
<td>Lipid Clinic</td>
<td>THREE TIUPROVIDER,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visit: 04/18/96</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>06/05/96</td>
<td>11:10</td>
<td>Addendum to Lipid Clinic</td>
<td>THREE TIUPROVIDER,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visit: 04/24/96</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>05/28/96</td>
<td>12:37</td>
<td>Crisis Note</td>
<td>SEVEN TIUPROVIDER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visit: 02/20/96</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>05/28/96</td>
<td>12:37</td>
<td>Crisis Note</td>
<td>SEVEN TIUPROVIDER</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Visit: 02/20/96</td>
<td></td>
</tr>
</tbody>
</table>

4. Choose a document from the list.

Choose documents: (1-6): 1

Opening Diabetes Education record for review...
Provided Mr. TIUPatient with Diabetes diet pamphlet and explained areas he especially needed to be concerned about.

/es/ TIUPROVIDER,THREE MD
for TIUPROVER,SIX MS3
Medical Student III

5. Select one of the actions to perform on the document (e.g., edit, sign, make addendum).
All MY UNSIGNED Documents

When you choose this option from the Integrated Document Management Menu, all your unsigned documents are displayed to review, edit, or sign.

Steps to use option:

1. Select All MY UNSIGNED Documents from your Integrated Document Management menu on your TIU menu.

2. After all your unsigned documents are displayed, you can select an action such as add, edit, or sign/cosign, etc.

# MY UNSIGNED Documents #

<table>
<thead>
<tr>
<th>Patient</th>
<th>Document Type</th>
<th>Ref Date</th>
<th>Status</th>
<th>Complete</th>
<th>Auth</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC501050</td>
<td>ONE-PER-VISIT NOTE</td>
<td>12/18/02</td>
<td>com</td>
<td>12/24/02</td>
<td>TIUP</td>
</tr>
<tr>
<td>TB668832</td>
<td>Cardiology Note</td>
<td>09/23/02</td>
<td>uns</td>
<td></td>
<td>CPRS</td>
</tr>
<tr>
<td>FW120870</td>
<td>CARDIOLOGY CS CONSULT</td>
<td>11/11/01</td>
<td>uns</td>
<td></td>
<td>CPRS</td>
</tr>
<tr>
<td>- CPRSPATI</td>
<td>Discharge Summary</td>
<td>10/12/01</td>
<td>com</td>
<td>01/16/01</td>
<td>ARTP</td>
</tr>
<tr>
<td>+_CPRSPA</td>
<td>Addendum to Discharge Summ</td>
<td>02/09/01</td>
<td>comple</td>
<td>02/12/01</td>
<td>LUPR</td>
</tr>
</tbody>
</table>

Select Integrated Document Management Option: All MY UNSIGNED Documents
Searching for the documents.

Select Document(s): (1-5): 3-5
Opening Adverse React/Allergy record for review...

# SIGN/COSIGN #

DATE OF NOTE: MAY 20, 1997@10:51:18  ENTRY DATE: MAY 20, 1997@10:51:18
AUTHOR: TIUPROVIDER,ONE  EXP COSIGNER:  
URGENCY:  STATUS: UNSIGNED

MORE TESTS ORDERED

Ready for Signature: NO// y  Yes
Item #: 3 Added to signature list.
All MY UNSIGNED Documents, cont’d

Opening General Note record for review...

SIGN/COSIGN       Jun 06, 1997 12:04:59       Page: 1 of 1

General Note

TIUPATIENT,FIVE  666-04-3779P  2B
Visit Date: 05/28/96@15:58

DATE OF NOTE: APR 07, 1997@15:50:26  ENTRY DATE: APR 07, 1997@15:37:25

AUTHOR: TIUPROVIDER,ONE  EXP COSIGNER: 
URGENCY:    STATUS: UNSIGNED

general malaise

+ Next Screen  - Prev Screen ?? More actions

Print           No
Ready for Signature: NO// y  Yes
Item #: 4 Added to signature list.

Opening Adverse React/Allergy record for review...

SIGN/COSIGN       Jun 06, 1997 12:04:10       Page: 1 of 1

Adverse React/Allergy

TIUPATIENT,ONE  666-23-3456                     
Visit Date: 07/22/91@11:06

DATE OF NOTE: MAR 24, 1997@11:03:39  ENTRY DATE: MAR 24, 1997@11:03:39

AUTHOR: TIUPROVIDER,FIVE           EXP COSIGNER: 
URGENCY:                            STATUS: UNSIGNED


+ Next Screen  - Prev Screen ?? More actions

Print           No
Ready for Signature: NO// y  Yes
Item #: 5 Added to signature list.

Enter your Current Signature Code: XXX  SIGNATURE VERIFIED.....

MY UNSIGNED Documents       Jun 06, 1997 12:04:27       Page: 1 of 1

by AUTHOR (TIUPROVIDER,FIVE) or EXPECTED COSIGNER 5 documents

Patient   Document                    Ref Date    Status
1 + TIUPATIENT,FIVE (T3779) Discharge Summary 06/02/97 UNSIGNED
2 TIUPATIENT,ONE (T3456) Adverse React/Allergy 05/31/97 completed
3 TIUPATIENT,TWO (T3243) Adverse React/Allergy 05/20/97 completed
4 TIUPATIENT,FIVE (T3779) General Note       04/07/97 completed
5 TIUPATIENT,SIX (T3476) Adverse React/Allergy 03/24/97 completed

** Items 3, 4, 5 Signed. **

Find       Sign/Cosign       Change View
Add Document Detailed Display  Copy
Edit       Browse           Delete Document
Make Addendum Print            Quit
Link ... Identify Signers

Select Action: Quit//
Multiple Patient Documents

Use this option to see an integrated Review Screen of all TIU documents.

**Caution:** Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select *Multiple Patient Documents* from your Integrated Document Management menu on your TIU menu.

2. Select one or more of the following statuses.

   1. unddictated
   2. untranscribed
   3. unreleased
   4. unverified
   5. unsigned
   6. uncosigned
   7. completed
   8. amended
   9. purged
  10. deleted

   Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

3. Select a document type (from whatever you have set up at your site):

4. Select one of the following search categories

   Enter selection(s) by typing the name(s), number(s), or abbreviation(s).
Multiple Patient Documents, cont’d

5. Enter a date range.

Start Reference Date [Time]: T-7// T-60 (APR 01, 1997)
Ending Reference Date [Time]: NOW// <Enter> (MAY 31, 1997@15:42)
Searching for the documents.

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

<table>
<thead>
<tr>
<th>UNSIGNED Documents</th>
<th>Ref Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Document</td>
<td></td>
</tr>
<tr>
<td>Patient,ONE</td>
<td>Discharge Summary</td>
<td>06/02/97 unsigned</td>
</tr>
<tr>
<td>Patient,ONE</td>
<td>Adverse React/Allergy</td>
<td>05/31/97 unsigned</td>
</tr>
<tr>
<td>Patient,TWO</td>
<td>Adverse React/Allergy</td>
<td>05/20/97 unsigned</td>
</tr>
</tbody>
</table>

Select Action: Quit//
Enter/Edit Document

This option allows you to enter and edit clinical documents directly online.

**NOTE:** All documents for outpatients must be associated with a Visit or Admission in order to receive workload credit.

**NOTE:** Signed notes may not be edited even if there is a business rule allowing them to be. Hard code within TIU prevents editing of signed documents. The following categories are considered signed: Un-cosigned, completed, amended, and retracted.

**Steps to use option:**

1. Select *Enter/Edit Document* from your Integrated Document Management menu on your TIU menu and enter a patient name.

   Select Integrated Document Management Option: Enter/edit Document
   Select PATIENT NAME: TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456 YES
   SC VETERAN
   A: Known allergies

2. Select the Document type.

   Select TITLE: ??
   Choose from:
   - ADVANCE DIRECTIVE
   - ADVERSE REACTION/ALLERGY
   - CLINICAL WARNING
   - CRISIS NOTE
   - DISCHARGE SUMMARY

   Select TITLE: ADVERSE REACTION/ALLERGY

3. If the patient is an outpatient, choose the Visit (admission) from the list displayed that you wish to associate with the Adverse Reaction/Allergy note.

   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
   2> FEB 21, 1996@08:40
   3> FEB 20, 1996@10:00
   4> FEB 20, 1996@08:00

   CHOOSE 1-4 or <N>EW VISIT
   <RETURN> TO CONTINUE
   OR '^^' TO QUIT: 1

   All outpatient TIU data has to be associated with a visit. If a visit related to TIU documents already exists, you only need to confirm it; otherwise you’ll have to enter a new visit.
Enter/Edit Document 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,NINE
...OK? YES// <Enter>

SUBJECT (OPTIONAL description): <Enter>
Calling text editor, please wait...
1>Mr. TIUPatient's allergies improved with medication.
2>
EDIT Option: <Enter>
Save changes? YES// <Enter>

Saving Adverse React/Allergy with changes...
Enter your Current Signature Code: xxx SIGNATURE VERIFIED..
Print this note? No// <Enter> NO

You may enter another CLINICAL DOCUMENT. Press RETURN to exit.

Select PATIENT NAME: <Enter>
--- Clinician's Menu ---

1  Individual Patient Document
2  All MY UNSIGNED Documents
3  Multiple Patient Documents
4  Enter/edit Document

Select Integrated Document Management Option: <Enter>
Documents Requiring Additional Signature
A report is available that will give you all documents requiring your additional signature. This report is available from the Integrated Document Management Menu and the Progress Notes User Menu.

To run this report:
1. From a menu, select ALL Documents requiring my Additional Signature.
2. The following report is displayed:

   Select Integrated Document Management Option: ?
   1. Individual Patient Document
   2. All MY UNSIGNED Documents
   3. All MY UNDICTATED Documents
   4. Multiple Patient Documents
   5. Enter/edit Document
   6. ALL Documents requiring my Additional Signature

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

Select Integrated Document Management Option: 6 ALL Documents requiring my Additional Signature
Searching for the documents.

My Identified Signer Docs Feb 21, 2005@19:00:32 Page: 1 of 1

<table>
<thead>
<tr>
<th>ALL DOCUMENTS Requiring My Additional Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>1 CPRSPATIENT,S (C1050)</td>
</tr>
<tr>
<td>2 CPRSPATIENT,T (C6572)</td>
</tr>
<tr>
<td>3 CPRSPATIENT,T (C6572)</td>
</tr>
</tbody>
</table>

+ Next Screen - Prev Screen ?? More Actions >>>
   Edit              Browse                Expand/Collapse Entry
   Make Addendum     Print                  Encounter Edit
   Link ...          Identify Signers      Quit
   Sign/Cosign       Delete Document       
   Detailed Display  Interdiscipl'ry Note

Select Action:Quit//
Personal Preferences

The two options on this menu let you customize the way TIU operates for you; that is, which prompts will appear, what lists you will see to select from, etc. Thus, if you only work with Discharge Summaries or Progress Notes, or only a specific set within these categories, you can set your preferences so that only these documents appear on selection lists. You can also specify the way documents are displayed on your review screens: by patient, by author, by type, in chronological or reverse chronological order, etc.

If you require cosignatures on your documents (for example, because you’re a medical student, PA, or some other category that your site has designated as needing cosignature), you can designate your “Default Cosigner” and then this person will be the default when you’re prompted for the Expected Cosigner.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Preferences</td>
<td>Specify defaults that you want in TIU (e.g., Default Location, Sort Order, Display Menus, Patient Selection Preference, etc.)</td>
</tr>
<tr>
<td>Document List Management</td>
<td>Specify your “pick lists” for document selection when composing or editing documents.</td>
</tr>
</tbody>
</table>

Personal Preferences

Steps to use option:

1. Select **Personal Preferences** from your TIU menu.

```
Select Progress Notes/Discharge Summary [TIU] Option: Personal Preferences
  1   Personal Preferences
  2   Document List Management
Select Personal Preferences Option: 1  Personal Preferences
```

2. Select **Personal Preferences** from your Personal Preferences menu.
3. Answer the following prompts, as appropriate.

Select Personal Preferences Option: Personal Preferences
Enter/edit Personal Preferences for TIUPROVIDER,ONE OT
Are you adding 'TIUPROVIDER,ONE' as
a new TIU PERSONAL PREFERENCES (the 5TH)? y (Yes)
DEFAULT LOCATION: Cardiology Clinic
REVIEW SCREEN SORT FIELD: ?
Specify the attribute by which the document list should be sorted.
Choose from:
P patient
D document type
R reference date
S status
C completion date
A author
E expected cosigner
REVIEW SCREEN SORT FIELD: p patient
REVIEW SCREEN SORT ORDER: ?
Please specify the order in which you want the list sorted
Choose from:
A ascending
D descending
REVIEW SCREEN SORT ORDER: a ascending
DISPLAY MENUS: ?
Indicate whether menus (for document selection, etc.) should be displayed.
Choose from:
0 NO
1 YES
DISPLAY MENUS: 1 YES
PATIENT SELECTION PREFERENCE: ?
Please indicate your patient selection preference
Choose from:
S single
M multiple
PATIENT SELECTION PREFERENCE: m multiple
DEFAULT COSIGNER: ?
Indicate which person will usually cosign your Progress Notes.
Answer with NEW PERSON NAME, or INITIAL, or SSN, or NICK NAME, or DEA#, or VA#
Do you want the entire 66-Entry NEW PERSON List? N
DEFAULT COSIGNER: TIUPATIENT,TWO TIUPATIENT, TWO, CA PHYSICIAN
ASK 'Save changes?' AFTER EDIT: y YES
ASK SUBJECT FOR PROGRESS NOTES: YES// ??
Enter YES if you want to be prompted for a SUBJECT when entering or editing a Progress Note. Subject is a freetext, indexed field which may help you to find notes about a given topic, etc.
Choose from:
1 YES
0 NO
ASK SUBJECT FOR PROGRESS NOTES: YES// <Enter>
NUMBER OF NOTES ON REV SCREEN: ??
This determines the number of notes that will be included in your initial list when reviewing progress notes by patient.
Personal Preferences, cont’d

<table>
<thead>
<tr>
<th>NUMBER OF NOTES ON REV SCREEN: 5??</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type a Number between 15 and 100</td>
</tr>
<tr>
<td>NUMBER OF NOTES ON REV SCREEN: 15</td>
</tr>
<tr>
<td>SUPPRESS REVIEW NOTES PROMPT: ??</td>
</tr>
<tr>
<td>Allows user to specify whether to suppress the prompt to Review Existing Notes on entry of a Progress Note. YES will suppress the prompt, while NO, or no entry will allow the site's default setting to take precedence.</td>
</tr>
<tr>
<td>Choose from:</td>
</tr>
<tr>
<td>1      YES</td>
</tr>
<tr>
<td>0      NO</td>
</tr>
<tr>
<td>SUPPRESS REVIEW NOTES PROMPT: 0</td>
</tr>
<tr>
<td>Select DAY OF WEEK: Monday</td>
</tr>
<tr>
<td>Are you adding 'Monday' as a new DAY OF WEEK (the 1ST for this TIU PERSONAL PREFERENCES)? Y (Yes)</td>
</tr>
<tr>
<td>HOSPITAL LOCATION: GENERAL MEDICINE TIUPATIENT,TWO</td>
</tr>
<tr>
<td>Select DAY OF WEEK: &lt;Enter&gt;</td>
</tr>
<tr>
<td>1      Personal Preferences</td>
</tr>
<tr>
<td>2      Document List Management</td>
</tr>
</tbody>
</table>

Document List Management

This option allows you to specify which types (Titles) of documents you wish to choose from when asked to select from a given Class (e.g., Discharge Summary or Progress Notes). Then when you create a Progress Note, you will be prompted to select from the specified list of Titles, say, Lipid Clinic Note, History & Physical, Interservice Transfer Note, and Discharge Planning, in that order. This option also allows you to specify a default title for the selected Class.

Steps to use option:

1. Select Document List Management from your Personal Preferences Menu on your TIU menu.

<table>
<thead>
<tr>
<th>Select Personal Preferences Option: 2 Document List Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>--- Personal Document Lists ---</td>
</tr>
</tbody>
</table>

This option allows you to create and maintain lists of TITLES for any of the active CLASSES of documents supported by TIU at your site.

Explain Details? NO// y YES

When you use the option to enter a document belonging to a given class, you will be asked to select a TITLE belonging to that class.
Document List Management, cont’d

For any particular class, you may find that you only wish to choose from among a few highly specific titles (e.g., if you are a Pulmonologist entering a PROGRESS NOTE, you may wish to choose from a short list of three or four titles related to Pulmonary Function, or Pulmonary Disease).

Rather than presenting you with a list of hundreds of unrelated titles, TIU will present you with the list you name here.

In the event that you need to select a TITLE which doesn’t appear on your list, you will always be able to do so.

NOTE: If you expect to enter a single title, or would be unduly restricted by use of a short list, then we recommend that you bypass the creation of a list, and simply enter a DEFAULT TITLE for the class. This option will afford you the opportunity to do so.

2. Answer the following prompts, as appropriate.

Enter/edit Personal Document List for ONE TIUPROVIDER
Add a new Personal Document List? YES// <Enter>
CLASS: ?
Please select the parent group to which the document list belongs. You may only pick CLASSES of documents at this prompt.
Answer with TIU DOCUMENT DEFINITION NAME, or ABBREVIATION, or PRINT NAME
Do you want the entire TIU DOCUMENT DEFINITION List? y (Yes)
Choose from:
  DISCHARGE SUMMARY CLASS
  PROGRESS NOTES CLASS
CLASS: Progress Notes
Edit (L)ist, (D)efault TITLE, or (B)oth? BOTH// <Enter> both

When selecting from this PARENT CLASS, which TITLES would you like to be presented with initially?

Select TITLE: PSYCHOLOGY - CRISIS
Select TITLE: PSYCHOLOGY - FAMILY THERAPY
Select TITLE: PSYCHOLOGY - NURSING NOTE
Select TITLE: NURSING NOTES - ENCOUNTER GROUP

Now, Specify the TITLE you'd like as your DEFAULT for PROGRESS NOTES

DEFAULT TITLE: ??
This determines what TITLE will be offered by default when selecting from a given parent class (e.g., when entering a PROGRESS NOTE, you may want the DEFAULT TITLE to be DIABETES EDUCATION, etc.).
### Document List Management, cont'd

<table>
<thead>
<tr>
<th>DEFAULT TITLE:</th>
<th>PSYCHOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PSYCHOLOGY - BEHAV MED</td>
</tr>
<tr>
<td>2</td>
<td>PSYCHOLOGY - BIOFEEDBACK</td>
</tr>
<tr>
<td>3</td>
<td>PSYCHOLOGY - CRISIS</td>
</tr>
<tr>
<td>4</td>
<td>PSYCHOLOGY - FAMILY THERAPY</td>
</tr>
<tr>
<td>5</td>
<td>PSYCHOLOGY - IP SATC</td>
</tr>
</tbody>
</table>

Type `'^' to stop, or choose 1-5: 3

Select PERSONAL DOCUMENT LIST Name: SUBSTANCE ABUSE

| 1 | SUBSTANCE ABUSE | TITLE |
| 2 | SUBSTANCE ABUSE COMMITTEE | TITLE |
| 3 | SUBSTANCE ABUSE TLC | TITLE |
| 4 | SUBSTANCE ABUSE TREATMENT CENTER CONSULT | TITLE |

Choose 1-4: 1

Are you adding 'SUBSTANCE ABUSE' as a new PERSONAL DOCUMENT LIST (the 1st for this TIU PERSONAL DOCUMENT TYPE LIST)? Y (Yes)

Sequence: 1

Display Name: SUBSTANCE ABUSE
Document Definitions (Clinician)

TIU uses a structure called Document Definitions to organize Progress Notes, Discharge Summaries, and other documents. It contains the Document Definition Hierarchy, which allows documents (Titles) to inherit characteristics of the higher levels, Class and Document Class, such as signature requirements and print characteristics. This structure creates the capability for better integration, shared use of boilerplate text, components, and objects, and a more manageable organization of documents. End users (clinical, administrative, and MIS staff) need not be aware of the hierarchy. They work at the Title level, with the actual documents.

The Document Definitions menu for Clinicians may be assigned to those clinicians who are interested in creating and editing boilerplate text or in viewing or editing Document Definition entries (Class, Document Class, or Title). You can also view available Objects that can be embedded in boilerplate text. See your Clinical Coordinator or the TIU Implementation Guide if you need further information about these options or descriptions of Document Definition concepts.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edit Document Definitions</td>
<td>This option allows you to 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/edited using the Edit Option.</td>
</tr>
<tr>
<td>Sort Document Definitions</td>
<td>The Sort option allows you to view and edit entries, by 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.</td>
</tr>
<tr>
<td>View Objects</td>
<td>The option displays Objects within selected Start With and Go To values in alphabetic order by Name.</td>
</tr>
</tbody>
</table>
Edit Document Definitions

This example shows you how to traverse the hierarchy to see details about a Title in Document Definitions, in this case, an Advance Directive. The first screen shows just the top level of document types. A + indicates that there are items under that document type. To see these, select Expand/Collapse, then enter the number of the document type to be expanded.

```
Select Document Definitions (Clinician) Option: 1 Edit Document Definitions

Select Document Definitions Apr 17, 1997 16:42:53 Page: 1 of 1

BASICS

Name                                                                 Type
1     CLINICAL DOCUMENTS                                               CL
2       +DISCHARGE SUMMARY                                             CL
3       +PROGRESS NOTES                                                CL
4       +ADDENDUM                                                      DC

?Help   >ScrollRight   PS/PL PrintScrn/List   +/-                  >>>
Expand/Collapse   Detailed Display          Quit
Jump to Document Def   Try
Boilerplate Text   Find
Select Action: Quit// e Expand/Collapse
Select Entry: (1-4): ....
```

```
Edit Document Definitions Apr 17, 1997 16:43:56 Page: 1 of 1

BASICS

Name                                                                 Type
1     CLINICAL DOCUMENTS                                               CL
2       +DISCHARGE SUMMARY                                             CL
3       PROGRESS NOTES                                                CL
4         +ADVANCE DIRECTIVE                                           DC
5         +ADVERSE REACTION/ALLERGY                                    DC
6         +CRISIS NOTE                                                 DC
7         +CLINICAL WARNING                                            DC
8         +HISTORICAL TITLES                                           DC
9         +ADDENDUM                                                    DC

?Help   >ScrollRight   PS/PL PrintScrn/List   +/-                  >>>
Expand/Collapse   Detailed Display          Quit
Jump to Document Def   Try
Boilerplate Text   Find
Select Action: Quit// Expand/Collapse=4

Shortcut:
Enter action, =, and the item number
```
**Edit Document Definitions, cont’d**

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL DOCUMENTS</td>
<td>CL</td>
</tr>
<tr>
<td>+DISCHARGE SUMMARY</td>
<td>CL</td>
</tr>
<tr>
<td>PROGRESS NOTES</td>
<td>CL</td>
</tr>
<tr>
<td>ADVANCE DIRECTIVE</td>
<td>DC</td>
</tr>
<tr>
<td>ADVANCE DIRECTIVE</td>
<td>TL</td>
</tr>
<tr>
<td>+ADVERSE REACTION/ALLERGY</td>
<td>DC</td>
</tr>
<tr>
<td>+CRISIS NOTE</td>
<td>DC</td>
</tr>
<tr>
<td>+CLINICAL WARNING</td>
<td>DC</td>
</tr>
<tr>
<td>+HISTORICAL TITLES</td>
<td>DC</td>
</tr>
<tr>
<td>+ADDENDUM</td>
<td>DC</td>
</tr>
</tbody>
</table>

|?Help  >ScrollRight  PS/PL PrintScrn/List  +/-  >>> |
|Expand/Collapse| Detailed Display| Quit |
|Jump to Document Def| Try |
|Boilerplate Text| Find |
|Select Action: Quit// DET| DETAILED DISPLAY |
|Select Entry: (1-11): 5|

**Detailed Display**

Non-Owner; View Only

Press RETURN to continue or '^^' or '^^' to exit: <Enter>

Title ADVANCE DIRECTIVE

Basics

Name: ADVANCE DIRECTIVE
Abbreviation: ADIR
Print Name: ADVANCE DIRECTIVE
Type: TITLE
National Standard: YES
Status: ACTIVE
Owner: CLINICAL COORDINATOR
In Use: YES

Items

Boilerplate Text

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

Try  Find  Quit

Select Action: Quit//
View Objects

This option displays Objects in alphabetical order by Name. You can print all available Objects from your site, or specific ones.

--- Clinician Document Definition Menu ---

Edit Document Definitions
Sort Document Definitions
View Objects

Select Document Definitions (Clinician) Option: 3 View Objects

START WITH OBJECT: FIRST// <Enter>.................................

<table>
<thead>
<tr>
<th>Objects</th>
<th>April 17, 1997 11:57:57</th>
<th>Page: 1 of 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td>Status</td>
</tr>
<tr>
<td>ACTIVE MEDICATIONS</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>ALLERGIES/ADR</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>BLOOD PRESSURE</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>CURRENT ADMISSION</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>NOW</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT AGE</td>
<td>I</td>
<td></td>
</tr>
<tr>
<td>PATIENT DATE OF BIRTH</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT DATE OF DEATH</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT HEIGHT</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT NAME</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT RACE</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT SEX</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT SSN</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PATIENT WEIGHT</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>PULSE</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>RESPIRATION</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>TEMPERATURE</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>TODAY'S DATE</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>VISIT DATE</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

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

Find    Detailed Display     Quit
Change View
Select Action: Next Screen//
TIU and Health Summary

A new Health Summary component is available (through Patch GMTS*2.7*12), *Selected Progress Notes*, which allows selection of specific Progress Notes Titles for display on Health Summaries. Patch GMTS*2.7*45, *Interdisciplinary Progress Notes*, expands this functionality to include Interdisciplinary Notes.

All Progress Notes, Discharge Summary, and CWAD components now extract data from TIU, rather than Progress Notes (GMRP), or Discharge Summary (GMRD).

Care has been taken to assure that the formatting and content of the components have remained the same, except that the signature block information will now reflect the author's (and cosigner's) name and title at the time of signature, rather than displaying their current values at the time of output.
Chapter 4: TIU for Medical Record Technicians

Medical Record Technicians in the MIS or HIMS of Medical Administration Service complete the tasks of assuring that all discharge summaries placed in a patient’s medical record have been verified for accuracy and completion. They are also responsible for assuring that a permanent chart copy has been placed in a patient’s medical record for each separate admission to the hospital.

MRT Menu

This is the main TIU menu for Medical Record Technicians (MRTs). It includes all of the options necessary for MRTs to review, edit, sign, and print documents, print reports on TIU documents, search for documents, and review upload filing events.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient Document</td>
<td>This option allows MRTs to review, edit, or sign patient Documents.</td>
</tr>
<tr>
<td>Multiple Patient Documents</td>
<td>Text Integration Utilities review screen of all types of TIU documents available for MRTs.</td>
</tr>
<tr>
<td>Review Upload Filing Events</td>
<td>This option allows MRTs to generate a list of all upload filing events (i.e., successes, filing errors, or missing field errors) by division, by status, by date range, and to print the corresponding error records or resolve the error (e.g., correct the Patient SSN or Admission date), and retry the filer.</td>
</tr>
<tr>
<td>Print Document Menu ...</td>
<td>This menu allows MAS personnel to print chart or work copies of discharge summaries, progress notes, or mixed Documents.</td>
</tr>
<tr>
<td>Released/Unverified Report</td>
<td>This report gives information on documents for a specified time period that have been released from transcription but still aren’t verified. This menu action can be eliminated if Transcription Release or MAS Verification parameters are not enabled.</td>
</tr>
<tr>
<td>Search for Selected Documents</td>
<td>Allows MRT’s to generate lists of selected documents by extended search criteria (e.g., status, search category, and reference date range). These can then be reviewed individually or by groups, verified, sent back to transcription, reassigned, or printed.</td>
</tr>
<tr>
<td>Unsigned/Uncosigned Report</td>
<td>Provides information on unsigned/uncosigned documents for one, multiple, or all divisions. The report can be either Summary or Full. The summary report lists the number of documents by the service or section of the author. The full report lists detailed document information (such as author, patient, patient SSN, etc.) by the service or section of the author.</td>
</tr>
<tr>
<td>Reassignment Document Report</td>
<td>Provides a list of reassigned notes based on date range.</td>
</tr>
<tr>
<td>Option</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Review unsigned additional signatures</td>
<td>Gives a list of documents that require additional signatures. Provides either a detailed report listing each document that requires an additional signature, or a summary report.</td>
</tr>
</tbody>
</table>

**Individual Patient Document**

Use this option to review, verify, print or other actions an MRT can perform on clinical documents for a selected patient.

*Steps to use option:*

1. Select **Individual Patient Document** from the TIU MRT menu, and then enter a patient name to view documents for.

**Select Text Integration Utilities (MRT) Option:**

Select PATIENT NAME: **TIUPATIENT,ONE**

TIUPATIENT,ONE  666-23-3456  1A  YES

SC VETERAN  
(2 notes)  W: 05/28/96 12:33
Available documents:  10/24/96 thru 10/28/96  (3)

Enter a date range, then choose a document from the list.

Please specify a date range from which to select documents:

List documents Beginning: 02/17/96// <Enter>  (FEB 17, 1992)
Thru: 10/28/96// <Enter>  (OCT 28, 1996)

1  10/28/96 17:11  BP TEST One TIU Provider, MD
Adm: 07/22/91  Dis: 02/12/96

2  10/25/96 11:32  Psychology - Crisis Four TIU Provider
Adm: 10/25/96

Choose documents:  (1-6): 1

If the patient has Cautions, Warnings, Allergies, or Directives (CWAD), they are displayed here. In this case, the patient has a Warning (W).
Individual Patient Document, cont’d

3. The selected document is displayed. You may press Enter to see the remaining two pages, or choose an action to perform.

TIUPATIENT, O  666-23-3456  1A  Visit Date: 07/22/91@11:06

DATE OF NOTE: OCT 28, 1996@17:11:51  ENTRY DATE: OCT 28, 1996@17:11:51
AUTHOR: TIUPROVIDER, ONE  EXP COSIGNER:  
URGENCY:  STATUS: COMPLETED

NAME: TIUPATIENT, ONE  
SEX: MALE  
DOB: SEP 12,1944  
ALLERGIES: Amoxicillin, Aspirin, MILK
LABS:  
WBC 8.7, RBC 5.1, HGB 16, HCT 47, MCV 91, MCH 29, MCHC 34, Plt 320

+ Next Screen  - Prev Screen  ?? More Actions  >>>

Find  Edit  Copy  
Verify/Unverify  Send Back  Print  
On Chart  Reassign  Quit

Select Action: Next Screen//

Multiple Patient Documents

Use this option to display TIU documents of selected types, which can then be individually or multiply reviewed, verified, sent back to transcription, reassigned, or printed.

+ Caution: Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone.

Steps to use option:

1. Select Multiple Patient Documents from your TIU menu.
Multiple Patient Documents, cont’d

2. Select one or more divisions.

Select division: ALL// ?
ENTER:
- Return for all divisions, or
- A division and return when all divisions have been selected--limit 20
  Imprecise selections will yield an additional prompt.
  (e.g. When a user enters 'A', all items beginning with 'A' are displayed.)
Answer with MEDICAL CENTER DIVISION NUM, or NAME, or FACILITY NUMBER, or
TREATING SPECIALTY
Choose from:
1  SALT LAKE OEX     660
2  ISC-SLC-A4     660HA
3  SALT LAKE CIOFO     660GC
Select division: ALL// <Enter>

3. Select one or more of the following statuses.

1  und dictated     6  uncosigned
2  untranscribed     7  completed
3  unreleased     8  amended
4  unverified     9  purged
5  unsigned     10  deleted
Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

Select Status: UNSIGNED// 4  UNVERIFIED

Multiple Patient Documents, cont’d

4. Select one of the following types (these may be different at your site):
Addendum
Discharge Summary
Progress Notes

Select Clinical Documents Type(s): All Addendum, Discharge Summary, Progress Notes

5. Enter a date range.

Start Entry Date [Time]: T-7// t-30 (May 02, 1997)
Ending Entry Date [Time]: NOW// <Enter> (JUN 02, 1997@14:31)
Searching for the documents............
6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document.

*Verify action example*

<table>
<thead>
<tr>
<th>UNVERIFIED Documents</th>
<th>Jun 02, 1997 14:31:12</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Document</td>
<td>Admitted</td>
</tr>
<tr>
<td>1 TIUPATIENT,ONE(T1255)</td>
<td>Adverse React/Allergy</td>
<td>05/03/97 05/31/97</td>
</tr>
<tr>
<td>2 TIUPATIENT,TWO(T3456)</td>
<td>ADVANCE DIRECTIVE</td>
<td>05/18/96</td>
</tr>
<tr>
<td>3 TIUPATIENT,FIV(T3456)</td>
<td>ADVANCE DIRECTIVE</td>
<td>08/14/95</td>
</tr>
<tr>
<td>4 + TIUPATIENT,(T1462)</td>
<td>Discharge Summary</td>
<td>05/04/92 05/31/97</td>
</tr>
<tr>
<td>5 + TIUPATIENT,F(T3456)</td>
<td>Discharge Summary</td>
<td>09/21/95</td>
</tr>
<tr>
<td>6 *+ TIUPATIENT,O(T3456)</td>
<td>Discharge Summary</td>
<td>07/22/91 05/12/97</td>
</tr>
</tbody>
</table>

* + Next Screen - Prev Screen ?? More Actions ***

* Verify/Unverify Link with Request Print
On Chart Send Back Interdiscipl'ry Note
Edit Detailed Display Change View
Reassign Browse Quit

Select Action: Quit//V Verify/Unverify
Select Document(s): (1-3): 4
Opening Discharge Summary record for review...

7. The selected document is displayed for you to verify.

*Verify Document*  

<table>
<thead>
<tr>
<th>TIUPATIENT,SEVEN 666-45-3234</th>
<th>Discharge Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adm: 05/04/92 Dis: 05/31/97</td>
<td></td>
</tr>
</tbody>
</table>

**DICT DATE: MAY 25, 1997**  
**ENTRY DATE: MAY 26, 1997@08:54:19**  
**DICTATED BY: TIUPROVIDER,THREE**  
**ATTENDING: TIUPROVIDER,ONE**  
**URGENCY: priority**  
**STATUS: UNVERIFIED**

*** Discharge Summary Has ADDENDA ***

**DIAGNOSIS:**
1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. End stage renal disease on hemodialysis.

* + Next Screen - Prev Screen ?? More Actions

Find Verify/Unverify
Print Quit

Select Action: Next Screen//V Verify/Unverify
Do you want to edit this Discharge Summary? NO// <Enter>
VERIFY this Discharge Summary? NO// Y YES
Discharge Summary VERIFIED
Chart copy queued.
Refreshing the list.
Review Upload Filing Events

Steps to use option:

1. Select Review Upload Filing Events from the TIU MRT menu.

   Select division displayed.

   Select division: ALL// SALT
   1   SALT LAKE CIOFO  660GC
   2   SALT LAKE OEX   660
   CHOOSE 1-2: 2  SALT LAKE OEX    660
   Select another division: <Enter>

   Note: This prompt is only displayed if you are at a multi-division medical center. In other words, if the MULTIDIVISION MED CENTER field of the MAS PARAMETERS file is set to YES.

3. Select the event type to be displayed.

   Select Event Type: FILING ERRORS// ?

   Enter a code from the list.
   Select one of the following:

   F   Filing Errors
   M   Missing Field Errors
   S   Successes
   A   All Events

   Select Event Type: FILING ERRORS// <Enter> Filing Errors

4. Select the Resolution Status (Unresolved Errors, Resolved Errors, or All Errors).

   Select Resolution Status: UNRESOLVED// ?

   Enter a code from the list.
   Select one of the following:

   U   Unresolved Errors
   R   Resolved Errors
   A   All Errors

   Select Resolution Status: UNRESOLVED// <Enter> Unresolved Errors
Review Upload Filing Events, cont’d

5. Enter the range of dates.

Start Event Date [Time]: T-30/* <Enter> (MAY 27, 1996)
Ending Event Date [Time]: NOW/* <Enter>
Searching for the events.....

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

<table>
<thead>
<tr>
<th>Filing Events</th>
<th>Jun 26, 1996 09:07:53</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESOLVED FILING EVENTS from 05/27/96 to 06/26/96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Document Type</td>
<td>Event Type</td>
<td>Event Date/time</td>
</tr>
<tr>
<td>DISCHARGE SUMMARY</td>
<td>Filing Error</td>
<td>06/06/96 13:29</td>
</tr>
<tr>
<td>FILING ERROR: STAT DISCHARGE SUMMARY</td>
<td>Record could not be found or created.</td>
<td></td>
</tr>
<tr>
<td>PROGRESS NOTES</td>
<td>Filing Error</td>
<td>06/06/96 14:39</td>
</tr>
</tbody>
</table>

Select Action: Next Screen// Display/Fix=1-2
Print Document Menu

This menu contains options that print chart or work copies of discharge summaries, progress notes, or mixed documents.

1  Discharge Summary Print
2  Progress Note Print
3  Clinical Document Print

Discharge Summary Print

Use this option to print chart or work copies of discharge summaries.

Steps to use this option:

1. Select Discharge Summary Print from the MIS Manager’s Print Document Menu.
2. Enter the name of the patient whose discharge summary you want to print.
3. Enter the range of dates from which to choose the discharge summary or summaries you want to print.

Choose summaries:  (1-1): 1
Do you want WORK copies or CHART copies? CHART// WORK
DEVICE: HOME// <Enter>  VAX
Discharge Summary Print Example

SALT LAKE CITY priority 06/27/96 08:45 Page: 1

PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
TIUPATIENT,ONE                |  51 |  M  | MEXI | 666-23-3456 |

ADM DATE   | DISC DATE   | TYPE OF RELEASE   | INP | ABS | WARD NO
JUL 22, 1991 | FEB 12, 1996 | REGULAR           |1666 |   0 | 1A

DICTATION DATE: JUN 09, 1996            TRANSCRIPTION DATE: JUN 12, 1996
TRANSCRIPTIONIST: bs

DIAGNOSIS:
1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. End stage renal disease on hemodialysis.
5. Congestive heart failure.
6. Hypertension.
7. Non insulin dependent diabetes mellitus.
8. Peripheral vascular disease, status post thrombectomies.
11. Chronic anemia.

OPERATIONS/PROCEDURES:
1. MRI.
2. CT SCAN OF HEAD.

HISTORY OF PRESENT ILLNESS:
Patient is a 49-year-old, white male with past medical history of end stage renal disease, peripheral vascular disease, status post BKA, coronary artery disease, hypertension, non insulin dependent diabetes mellitus, diabetic retinopathy, congestive heart failure, status post CVA, status post thrombectomy admitted from Anytown VA after a fall from his wheelchair in the hospital. He had questionable short lasting loss of consciousness but patient is not very sure what has happened. He denies headache, vomiting, vertigo. On admission patient had CT scan which showed a small area of parenchymal hemorrhage in the right temporal lobe which is most likely consistent with hemorrhagic contusion without mid line shift or incoordination.

ACTIVE MEDICATIONS: Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd, Ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic 0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.

PHYSICAL EXAMINATION: Patient had stable vital signs, his blood pressure was 160/85, pulse 84, respiratory rate 20, temperature 98 degrees. Patient was alert, oriented times three, cooperative. His speech was fluent, understanding of spoken language was good. Attention span was good. He had

Press RETURN to continue or '^' to exit: <Enter>
Discharge Summary Print Example cont’d

SALT LAKE CITY  priority      06/27/96 08:46      Page:  4

----------------------------------------------------------------------------
PATIENT NAME                  | AGE | SEX | RACE |     SSN     | CLAIM NUMBER
TIUPATIENT,ONE                |  51 |  M  | MEXI | 666-23-3456 |
----------------------------------------------------------------------------

moderate memory impairment, no apraxia noted. Cranial nerves patient was blind, pupils are not reactive to light, face was asymmetric, tongue and palate are mid line. Motor examination showed muscle tone and bulk without significant changes. Muscle strength in upper extremities 5/5 bilaterally, sensory examination revealed intact light touch, pinprick and vibratory sensation. Reflexes 1+ in upper extremities, coordination finger to nose test within normal limits bilaterally. Alternating movements without significant changes bilaterally. Neck was supple.

LABORATORY:  Showed sodium level 135, potassium 4.6, chloride 96, CO2 26, BUN 39, creatinine 5.3, glucose level 130. White blood cell count was 7, hemoglobin 11, hematocrit 34, platelet count 77.

HOSPITAL COURSE:  Patient was admitted after head trauma with multiple medical problems. His coumadin was held. Patient had cervical spine x-rays which showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this level, prominent spurs at this level as well as above and below. CT scan on admission showed a moderate amount of scalp thinning with subcutaneous air overlying the left frontal lobe. A small area of left parenchymal hemorrhage adjacent to the right petros bone in the temporal lobe which most likely represents a hemorrhagic contusion. Repeated CT scan on 5/13/94 didn’t show any progressive changes. Patient remained in stable condition. He had hemodialysis q.o.d. He restarted treatment with Coumadin. His last PT was 11.9, PTT 31. Patient refused before hemodialysis new blood tests. His condition remained stable.

DISCHARGE MEDICATIONS:  Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Betoptic 0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

DISPOSITION/FOLLOW-UP:
Recommend follow PT/PTT. Patient is on coumadin and CBC with differential because patient has chronic anemia and thrombocytopenia. Patient will be transferred to Anytown VA in stable condition on 5/19/94.

WORK COPY ========= UNOFFICIAL - NOT FOR MEDICAL RECORD ======== DO NOT FILE
SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST

TIUPROVIDER, ONE, MD            THREE TIUPROVIDER, MS
PGY2 Resident                   Medical Internist

========================================================================
D R A F T
JUN 26, 1996@17:36:02  ADDENDUM:
Routine visit today--no change to condition.

SIGNATURE PHYSICIAN/DENTIST             SIGNATURE APPROVING PHYSICIAN/DENTIST

Three TIUProvider, MD            Three TIUProvider, MD
Medical Internist                  Medical Internist
Progress Note Print

Use this option to print chart or work copies of progress notes.

Steps to use option:

1. Select Progress Note Print from the Print Document Menu.

2. Enter a patient name.

3. Enter the range of dates for progress notes you want to print.

4. Choose a note from those listed.

Select Print Document Menu Option: 2 Progress Note Print

Select PATIENT NAME: TIUPATIENT,ONE 09-12-44 666233456

YES

SC VETERAN

<table>
<thead>
<tr>
<th>Note</th>
<th>Date</th>
<th>Time</th>
<th>Description</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>05/28/96</td>
<td>12:37</td>
<td>C: known allergies</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>05/28/96</td>
<td>12:33</td>
<td>W:</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>05/28/96</td>
<td>12:36</td>
<td>D:</td>
<td></td>
</tr>
</tbody>
</table>

Available notes: 02/17/96 thru 06/21/96 (31)

Please specify a date range from which to select notes:

List notes Beginning: 02/17/96 // <Enter> (FEB 17, 1996)
Thru: 06/21/96 // <Enter> (JUN 21, 1996)

<table>
<thead>
<tr>
<th>Note</th>
<th>Date</th>
<th>Time</th>
<th>Description</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>06/21/96</td>
<td>11:40</td>
<td>Lipid Clinic</td>
<td>FIVE TIUPROVIDER</td>
</tr>
<tr>
<td>2</td>
<td>06/21/96</td>
<td>11:38</td>
<td>Social Work Service</td>
<td>FIVE TIUPROVIDER</td>
</tr>
<tr>
<td>3</td>
<td>06/07/96</td>
<td>00:00</td>
<td>Diabetes Education</td>
<td>ONE TIUPROVIDER MD</td>
</tr>
<tr>
<td>4</td>
<td>05/15/96</td>
<td>13:10</td>
<td>Addendum to Diabetes Education</td>
<td>SEVEN TIUPROVIDER MD</td>
</tr>
<tr>
<td>5</td>
<td>04/24/96</td>
<td>15:41</td>
<td>Lipid Clinic</td>
<td>THREE TIUPROVIDER</td>
</tr>
<tr>
<td>6</td>
<td>02/23/96</td>
<td>14:08</td>
<td>Diabetes Education</td>
<td>THREE TIUPROVIDER</td>
</tr>
</tbody>
</table>

Choose notes: (1-6): 3, 5

Do you want WORK copies or CHART copies? CHART// <Enter>

DEVICE: HOME// <Enter> VAX
Progress Notes Print Example

-----------------------------------------------------------------------------
TIUPATIENT,ONE  666-23-3456                                   Progress Notes
-----------------------------------------------------------------------------
NOTE DATED: 06/07/96 17:51 DIABETES EDUCATION
ADMITTED: 07/22/95 11:06 1A
SUBJECT: Routine diabetes education

Patient understanding good.

Signed by: /es/ Three TIUProvider, MD
Medical Internist 06/23/96 08:34
Analog Pager: 555-1213
Digital Pager: 555-1215

Cosigned by: /es/ TIUProvider, Three
06/23/96 08:34
Analog Pager: 555-1213
Digital Pager: 555-1215

-----------------------------------------------------------------------------
NOTE DATED: 04/24/96 08:00 ARTERIAL EVALUATION - LOWER EXTREMITY
VISIT: 04/17/92 08:00 FOURTEEN’S CLINIC
SUBJECT: Rule out embolus, lower extremity

AGE: 50
UNIT: General Medicine
REFERRING MD: Eight CPRSProvider
DIAGNOSIS: Rule out embolus

HISTORY: severe pedal edema, foot ulcers

OTHER: cyanosis
SYMPTOMS:
EXERTIONAL SYMPTOMS:
OTHER:

MEDICATIONS:

AUDIBLE DOPPLER SIGNAL   RIGHT  LEFT   DOPPLER WAVEFORM:   RIGHT  LEFT
COMMON FEMORAL            _____  _____   COMMON FEMORAL:      _____  _____
SUPERFICIAL FEMORAL       _____  _____   PRE-EXERCISE        _____  _____
POPITEAL                 _____  _____   POST-EXERCISE        _____  _____
POSTERIOR TIBIAL          _____  _____   OTHER               _____  _____
DORSALIS PEDIS            _____  _____

N=NORMAL     ABN=ABNORMAL    O=ABSENT    B=BIPHASIC

TRANSCUTANEOUS PO2 VALUES:

SUBCLAVICULAR           40   40
ABOVE KNEE              39   40
HIGH BK                 39   40
CALF                    37   39
ANKLE                   36   39
DORSUM OF FOOT          22   38
OTHER                   18   38

Enter RETURN to continue or ‘^’ to exit: <Enter>
**CONTINUED FROM PREVIOUS SCREEN **

40 = ADEQUATE FOR HEALING
39-30 = EQUIVOCAL FOR HEALING
29-0 = INADEQUATE FOR HEALING

SEGMENTAL SYSTOLIC BLOOD PRESSURE:

<table>
<thead>
<tr>
<th>Arm</th>
<th>Right</th>
<th>Index</th>
<th>Left</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH THIGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABOVE KNEE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BELOW KNEE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANKLE PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

EXERCISE RESPONSE:

MPH: 5 mph

MAXIMUM WALKING TIME: _10_ MIN _30_ SEC

SYMPTOMS: Pedal edema, cyanosis

MAXIMUM HEART RATE ACHIEVED:

<table>
<thead>
<tr>
<th>Time</th>
<th>Right Index</th>
<th>Left Index</th>
<th>Arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MINUTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

POST EXERCISE:

IMPRESSIONS:

Signed by: /es/ Three TIUProvider, MD
Medical Internist 04/24/96 14:19
Analog Pager: 555-1213
Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit: ^

1 Discharge Summary Print
2 Progress Note Print
3 Clinical Document Print

Select Print Document Menu Option: <Enter>
Clinical Document Print

Use this option to print chart or work copies of all clinical documents available through TIU.

Steps to use option:

1. Select Clinical Document Print from the Print Document Menu, and then enter a patient name.

   Select Print Document Menu Option: 3 Clinical Document Print
   Select PATIENT NAME: TIUPATIONE,ONE TIUPATIENT,ONE 09-12-44 666233456
   YES
   SC VETERAN
   (2 notes) C: 05/28/96 12:37
   (2 notes) W: 05/28/96 12:33
   A: Known allergies
   (2 notes) D: 05/28/96 12:36
   Available documents: 02/17/92 thru 06/21/96 (34)

2. Enter a date range that documents will be chosen from.

   Please specify a date range from which to select documents:
   List documents Beginning: 02/17/92// 6/1/96  (JUN 01, 1996)
   Thru: 06/21/96// 6/8/96  (JUN 08, 1996)
   1 06/07/96 00:00 Diabetes Education One TIUProvider, MD
     Visit: 04/18/96
   2 06/05/96 17:23 Lipid Clinic Three TIUProvider
     Visit: 04/18/96
   3 06/05/96 11:10 Addendum to Lipid Clinic Three TIUProvider
     Visit: 04/24/96

3. Choose the document or documents you would like printed, and whether you want work or chart copies.

   Choose documents: (1-3): 1-3
   Do you want WORK copies or CHART copies? CHART// <Enter>
   DEVICE: HOME// PRINTER
Clinical Document Print Example

4. The document(s) will then be printed at the device you specify.

-------------------------------------------------------------------------------
TIUPATIENT,ONE  666-23-3456                                   Progress Notes
-------------------------------------------------------------------------------
NOTE DATED: 06/07/96 00:00   DIABETES EDUCATION
VISIT: 04/18/96 10:00 GENERAL MEDICINE
Routine diabetes education given as follow-up to lipid clinic visit.

Signed by: /es/ One TIUProvider, MD
PGY2 Resident 06/07/96 10:22

NOTE DATED: 06/05/96 17:23   LIPID CLINIC
VISIT: 04/18/96 10:00 GENERAL MEDICINE
SUBJECTIVE:  51 year old MEXICAN AMERICAN MALE here for
initial evaluation of his DYSLIPIDEMIA.

PMH:

Significant negative medical history pertinent to the
evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION HISTORY:  CURRENT MEDICATIONS

DIET:  Counseled on AHA Step I diet today by Nine CPRSProvider.
See her evaluation.

ACTIVITY:

OBJECTIVE:  HT:  72 (08/23/95 11:45)   WT:  190 (08/23/95 11:45)

TSH/T4: /

FBG: 89        HEMOGLOBIN A1C:

SGOT:          URIC ACID:

ASSESSMENT:  1.   MALE with / without documented CAD
2.   CV Risk factors:
3.   Lipid pattern:

PLAN:  1.   Implement recommendations to lower fat intake.
2.   Repeat FBG and HBG A1C on:
3.   Return to review lab on:

Signed by: /es/ Three TIUProvider, MD
Internist  06/05/96 17:23
Analog Pager:  555-1213
Digital Pager:  555-1215

Enter RETURN to continue or '^^' to exit: <Enter>
Clinical Document Print Example cont’d

------------------------------------------------------------------------------
TIUPATIENT,ONE 666-23-3456                                             Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 04/24/96 15:41       LIPID CLINIC
VISIT: 04/24/96 15:40        DIABETIC EDUCATION-INDIV-MOD B
SUBJECTIVE: 51 year old MEXICAN AMERICAN MALE here for initial evaluation of his DYSLIPIDEMIA.

PMH:

Significant negative medical history pertinent to the evaluation and treatment of DYSLIPIDEMIA:

FH:
SH:

MEDICATION HISTORY: CURRENT MEDICATIONS

DIET: Counseled on AHA Step I diet today by NINE TIUPROVIDER. See her evaluation.

ACTIVITY:

OBJECTIVE: HT: 72 (08/23/95 11:45) WT: 190 (08/23/95 11:45)

TSH/T4: /

FBG: 89               HEMOGLOBIN A1C:

SGOT:                URIC ACID:

ASSESSMENT: 1. MALE with / without documented CAD
              2. CV Risk factors:
              3. Lipid pattern:

PLAN: 1. Implement recommendations to lower fat intake.
        2. Repeat FBG and HBG A1C on:
        3. Return to review lab on:

Signed by: /es/ Three TIUProvider, MD
Internist 04/24/96 15:41
Analog Pager: 555-1213
Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit: <Enter>

1 Discharge Summary Print
2 Progress Note Print
3 Clinical Document Print
Released/Unverified Report

Use this option to produce a list of released documents which haven’t been verified.

Steps to use option:

1. Select Released/Unverified Report from the MRT menu.

2. Enter the starting and ending divisions for the report.

3. Enter the starting day for the report.

4. Specify a printer. If necessary, set the margin width to 132.

Select Text Integration Utilities (MRT) Option: Released/Unverified Report

START WITH DIVISION: FIRST// 660
GO TO DIVISION: LAST//
START WITH RELEASE DATE/TIME: FIRST// <Enter>
DEVICE: PRINTER
MARGIN WIDTH IS NORMALLY AT LEAST 132 ARE YOU SURE? No// YES

Released/Unverified Report - ELY
OCT 15,1996  11:59 PAGE 1
PATIENT                         SSN         ADM DATE   DIS DATE
LINE
-----------------------------------------------
DICTATED BY      URGENCY   COUNT
TRANSCRIPTIONIST: DP
TIUPATIENT,THREE                666042591P  02/27/92   03/05/92
TIUPROVIDER,FOUR    routine   1         Discharg
--------
SUBTOTAL                     1

RELEASE DATE/TIME: JAN 10,1996
TRANSCRIPTIONIST: BS
TIUPATIENT,FOUR                  666123456   09/21/95
TIUPROVIDER,ONE    routine   72        Addendum
TIUPATIENT,FIVE                 666451462   05/04/92   05/31/96
TIUPROVIDER,ONE    priority  78        Addendum
--------
SUBTOTAL                     150

Discharge Summary Released/Unverified Report OCT 15,1996  11:59 PAGE 2
PATIENT                         SSN         ADM DATE   DIS DATE
LINE
-----------------------------------------------
DICTATED BY      URGENCY   COUNT
TRANSCRIPTIONIST: jg
TIUPATIENT,ONE                   666233456   07/22/91   02/12/96
TIUPROVIDER,THRE    routine   1         Discharg
--------
SUBTOTAL                     1

TOTAL                        152
Press RETURN to continue...<Enter>
Search for Selected Documents

Use this option to produce a list of selected documents by extended search criteria e.g., status, search category, and reference date range). These can then be reviewed, verified, sent back to transcription, reassigned, or printed.

Steps to use option:

1. Select Search for Selected Documents from the TIU MRT menu.

2. Select the status of documents you want displayed.

3. Select the document type you want displayed.

4. Select the search category you want displayed.
5. Enter the range of dates you want displayed.

Start Reference Date [Time]: T-7/<Enter> (MAY 26, 1997)
Ending Reference Date [Time]: NOW// <Enter> (JUN 02, 1997@15:46)
Searching for the documents...

6. The documents fitting the search criteria you selected are displayed. Choose an action to perform on the relevant documents.

<table>
<thead>
<tr>
<th>UNSIGNED Documents</th>
<th>Jun 02, 1997 15:46:28</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>by AUTHOR (TIUPROVIDER,ONE) from 05/26/97 to 06/02/97</td>
<td>2 documents</td>
<td></td>
</tr>
<tr>
<td>Patient</td>
<td>Document</td>
<td>Ref Date</td>
</tr>
<tr>
<td>1 TIUPATIENT,ONE(T3456)</td>
<td>Adverse React/Allergy</td>
<td>05/31/97</td>
</tr>
<tr>
<td>2 TIUPATIENT,FIV(T2591)</td>
<td>Adverse React/Allergy</td>
<td>05/31/97</td>
</tr>
</tbody>
</table>

UNSIGNED Documents
Jun 02, 1997 15:46:28
Page: 1 of 1
by AUTHOR (TIUPROVIDER,ONE) from 05/26/97 to 06/02/97
2 documents
Patient
Document
Ref Date
Status
1 TIUPATIENT,ONE(T3456)
Adverse React/Allergy
05/31/97
unsigned
2 TIUPATIENT,FIV(T2591)
Adverse React/Allergy
05/31/97
unsigned

+ Next Screen - Prev Screen ?? More Actions >>>
Find Reassign Print
Verify/Unverify Send Back Change View
On Chart Detailed Display Quit
Edit Browse
Select Action: Quit/

Unsigned/Uncosigned Report
Lists detailed document information such as author, patient, patient SSN, etc. for notes with no signature and/or cosignature. Optionally, a summary report can be generated showing the number of unsigned and uncosigned documents in each service.
In the following example, a summary report is generated for a selected division:

Select OPTION NAME: TIU UNSIGNED/UNCOSIGNED REPORT

Select division: ALL// SALT
1 SALT LAKE CIAFO 660GC
2 SALT LAKE OEX 660

CHOOSE 1-2: 1 SALT LAKE CIAFO 660GC

Please specify an Entry Date Range:

Start Entry Date: t-365 (JAN 28, 2003)
Ending Entry Date: t (JAN 28, 2004)

Select service: ALL// <Enter>

Select one of the following:
F FULL
S SUMMARY

Type of Report: S SUMMARY

DEVICE: HOME// <Enter> ANYWHERE

Unsigned and Uncosigned Documents Jan 28, 2003 thru Jan 28, 2004
PRINTED: for ELY
JAN 28, 2004@16:33

---------------------------------------------------------------------
Totals for Service: IRM--- UNSIGNED: 24 UNCOSIGNED: 0
Totals for Service: MEDICINE--- UNSIGNED: 112 UNCOSIGNED: 0
Totals for Service: OTHER--- UNSIGNED: 1 UNCOSIGNED: 0
Totals for Service: PHARMACY--- UNSIGNED: 6 UNCOSIGNED: 0
Totals for Service: SURGERY--- UNSIGNED: 1 UNCOSIGNED: 0
Totals for Service: UNKNOWN--- UNSIGNED: 2 UNCOSIGNED: 0
Totals for Division: ELY--- UNSIGNED: 146 UNCOSIGNED: 0

Enter RETURN to continue or '^' to exit:

☞ Note: A full Unsigned/Uncosigned Report requires a printer device capable of printing 132 columns.
Reassignment Document Report

The reassign action reassigns a note to a different patient, admission, or visit. Besides this, the reassign action may be used to promote an Addendum as an Original, swap the Addendum and the Original, or change a discharge summary to an Addendum.

This report provides a list of reassigned notes based on date range. In the following example TIU displays a report of reassigned documents over the past 6 months:

<table>
<thead>
<tr>
<th>DOCUMENT NAME</th>
<th>INITIAL PATIENT</th>
<th>FINAL PATIENT</th>
<th>REASSIGNMENT DATE/TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addendum</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 23, 1999@08:46:41</td>
</tr>
<tr>
<td>Addendum</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 23, 1999@08:46:42</td>
</tr>
<tr>
<td>Discharge Summa</td>
<td>TIUPATIENT,SEVEN</td>
<td>TIUPATIENT,SEVEN</td>
<td>Aug 25, 1999@11:51:47</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,NINE</td>
<td>Aug 25, 1999@14:40:10</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,EIGHT</td>
<td>Aug 25, 1999@16:03:24</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,EIGHT</td>
<td>Aug 25, 1999@16:16:32</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,EIGHT</td>
<td>Aug 25, 1999@16:36:05</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,EIGHT</td>
<td>Aug 25, 1999@16:36:06</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,FIVE</td>
<td>Aug 27, 1999@10:47:49</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,NINE</td>
<td>Aug 27, 1999@15:56:28</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 27, 1999@18:45:18</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 27, 1999@14:41:45</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 27, 1999@14:41:46</td>
</tr>
<tr>
<td>PULMONARY CS CO</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 31, 1999@14:29:07</td>
</tr>
<tr>
<td>Addendum</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 31, 1999@17:01:15</td>
</tr>
<tr>
<td>Addendum</td>
<td>TIUPATIENT,EIGHT</td>
<td>TIUPATIENT,SIX</td>
<td>Aug 31, 1999@17:01:16</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit:
Review Unsigned Additional Signatures
This option prints either a detailed or summary report of documents requiring additional signatures.

In the detailed report the patient name is abbreviated to the patient initials followed by the last six digits of the social security number to save space.

In the following example, a detailed report is run covering a four month period:

Select Text Integration Utilities (MRT) Option: 9  Review unsigned additional signatures
Select division: ALL//
Please specify an Entry Date Range:
Start Entry Date: t-90  (NOV 09, 2004)
Ending Entry Date: t  (FEB 07, 2005)
Select service: ALL//
Select one of the following:
F    FULL
S    SUMMARY
Type of Report: f    FULL
This report should be sent to a 132 Column Device
DEVICE: HOME//   ANYWHERE
Pending Additional Signature Documents for ELY on Feb 07, 2005@14:39:49
Oct 10, 2004 thru Feb 07, 2005@23:59:59
IDENT. SIGNER    PATIENT   STATUS  ENTRY DATE         DOCUMENT TITLE
DOCUMENT IEN
--------------------------------------------------------------------------------
SERVICE: MEDICINE
CPRSPROVIDER, E  EB111148   com    10/15/04@07:58:50  ACUTE PAIN NOTE 29303
CPRSPROVIDER, F  EH224567   com    11/26/04@14:39:48  SURGERY CS CONSULT 28002
CPRSPROVIDER, F  FC781990   com    11/30/04@07:39:31  CARDIOLOGY NOTE 29008
CPRSPROVIDER, N  FC781990   com    10/20/04@12:30:10  MEDICINE NOTE 29079
CPRSPROVIDER, O  SH345377   com    10/30/04@12:40:24  AB ID PARENT BARRY TEST
<table>
<thead>
<tr>
<th>CPRSPROVIDER, O</th>
<th>TH345377</th>
<th>com</th>
<th>12/30/04@12:40:24</th>
<th>AB ID PARENT BARRY TEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPRSPROVIDER, S</td>
<td>NC448661</td>
<td>com</td>
<td>12/20/04@13:08:40</td>
<td>PODIATRY CS CONSULTS</td>
</tr>
<tr>
<td>CPRSPROVIDER, T</td>
<td>OC324321</td>
<td>com</td>
<td>01/29/05@13:50:35</td>
<td>CRISIS NOTE</td>
</tr>
<tr>
<td>CPRSPROVIDER, T</td>
<td>OC668847</td>
<td>com</td>
<td>01/28/05@11:16:37</td>
<td>ACUTE PAIN NOTE</td>
</tr>
</tbody>
</table>

Totals for Service   MEDICINE:  9  
Totals for Division   ELY:       9  

Enter RETURN to continue or '^' to exit:
Chapter 5: TIU for MIS/HIMS Managers

The Medical Information Section (MIS), also called Health Information Management Section (HIMS), maintains and manages records of clinical documents, including copies of statistical reports, and chart or work copies of discharge summaries and progress notes.

MIS Manager’s Menu

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient Document</td>
<td>Allows you to review or print patient Clinical Documents.</td>
</tr>
<tr>
<td>Multiple Patient Documents</td>
<td>This option allows MIS Managers to see any of the available TIU documents on the Text Integration Utilities Review Screen.</td>
</tr>
<tr>
<td>Print Document Menu</td>
<td>This menu gives MAS personnel access to options which print CHART or WORK copies of discharge summaries, progress notes, or mixed Documents on demand.</td>
</tr>
<tr>
<td>Search for Selected Documents</td>
<td>Allows MIS Managers to generate a list of selected documents based on extended search criteria; e.g., STATUS, SEARCH CATEGORY, and REFERENCE DATE RANGE.</td>
</tr>
<tr>
<td>Statistical Reports</td>
<td>This menu allows you to view or print statistical reports for line counts and timeliness by Author, Transcriptionist, and Service.</td>
</tr>
<tr>
<td>Unsigned/Uncosigned Report</td>
<td>Provides information on unsigned and uncosigned documents for one, multiple, or all divisions. The report can be either Summary or Full. The summary report lists the number of documents by the service or section of the author. The full report lists detailed document information (such as author, patient, patient SSN, etc.) by the service or section of the author.</td>
</tr>
<tr>
<td>Missing Text Report</td>
<td>Reports which TIU Documents that do not have any report text, are missing the 0 node of the text node, or both cases. Documents may be of any type, including addenda but not notes with components or addenda attached to them.</td>
</tr>
<tr>
<td>Missing Text Cleanup</td>
<td>This is a utility for assisting with the cleanup of documents without report text. In some cases you may choose to correct documents manually, such as when the author is still available or when the document was originally an upload document.</td>
</tr>
<tr>
<td>Option</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UNKNOWN Addenda Cleanup</td>
<td>Gives a list of surgery addenda that are not connected to an Operations Report and provides options for reviewing, assistance in finding the parent, and attaching to the parent.</td>
</tr>
<tr>
<td>Missing Expected Cosigner Report</td>
<td>Provides a list of documents that have a status of “Uncosigned” where the “Expected Cosigner” field is null, 0 or -1.</td>
</tr>
<tr>
<td>Mark Document as ‘Signed by Surrogate’</td>
<td>Provides a way to mark a document as 'Signed by Surrogate'. This will set the .09 field of file 8925.7 to 1 - meaning that the signing for an Additional Signer was done by a surrogate of that Additional Signer.</td>
</tr>
<tr>
<td>Mismatched ID Notes</td>
<td>This option runs a routine that will report/fix mismatched interdisciplinary (ID) notes.</td>
</tr>
<tr>
<td>TIU 215 ANALYSIS</td>
<td>Surgery cases will be analyzed within a particular date range and information from Nurse Intraoperative Report (NIR) and/or Anesthesia reports will be compared to their corresponding TIU notes. If the information does not match, the case number will be recorded as one that needs to be reviewed.</td>
</tr>
<tr>
<td>Transcription Billing Verification Report</td>
<td>This report can be run by division and provides information on all transcriptionists or one or more selected transcriptionist. It reports based on an entered date range. Since the VBC Line Count is only calculated for transcribed reports, it does not report on any document transcribed before the line count patch was installed.</td>
</tr>
<tr>
<td>CWAD/Postings Auto Demotion Setup</td>
<td>This option on the menu allows Clinical Application Coordinators and/or site designated personnel to configure CWAD notes for auto demotion using the CWAD/Postings Auto-Demotion Setup.</td>
</tr>
</tbody>
</table>
Individual Patient Document

Use this option to review or print TIU documents for a patient.

Steps to use option:

1. Select **Individual Patient Document** from the MIS Manager Menu, and then enter the patient name.

   Select Text Integration Utilities (MIS Manager) Option: Individual Patient Document
   Select PATIENT NAME: TIUPATIENT,SEVEN TIUPATIENT,SEVEN 04-25-31 666042591P NO MILITARY RETIREE
   (2 notes) W: 09/16/96 15:12 (addendum 09/18/96 09:53) A: Known allergies
   Available documents: 08/11/95 thru 10/10/96 (131)

2. Select a date range for the documents you wish to review, and then choose one or more of the documents displayed.

   Please specify a date range from which to select documents:
   1 10/06/96 14:11 Addendum to Diabetes Education Three TIUProvider, Adm: 09/28/96
   2 10/05/96 13:56 Diabetes Education Six TIUProvider, Adm: 09/28/96
   Choose documents: (1-3): 2

3. The document(s) you chose is displayed. Choose an action to perform.

   TIUPATIENT,SEVEN 666-04-2591P 1A Visit Date: 09/28/96@15:58
   DATE OF NOTE: SEP 05, 1996@13:51:03 ENTRY DATE: SEP 05, 1996@13:51:03
   AUTHOR: TIUPROVIDER,SIX EXP COSIGNER: TIUPROVIDER,THREE
   URGENCY: STATUS: COMPLETED
   TEST DRUG EFFICACY.
   /es/ Six TIUProvider, MS3 /es/ Three TIUProvider, MD
   Medical Student III
   Signed: 10/05/96 13:51 Cosigned: 10/05/96 14:11
   + Next Screen - Prev Screen ?? More Actions >>
   Find On Chart Reassign
   Print Amend Send Back
   Edit Delete Quit
   Verify/Unverify
   Select Action: Quit//
Multiple Patient Documents

Use this option to display TIU documents of specified types, which can then be reviewed, verified, sent back to transcription, reassigned, or printed.

+ Caution: Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone. The example below would probably be too broad in a large hospital.

Steps to use option:

1. Select Multiple Patient Documents from the MIS Manager menu. Answer the prompts that follow.

   Select Text Integration Utilities (MIS MANAGER) Option: Multiple Patient Documents
   Select division: ALL//<Enter>
   Select Status: UNSIGNED//<Enter> Unsigned
   Select Clinical Documents Type(s): ? 1 Progress Notes 2 Discharge Summary 3 Addendum
   Enter selection(s) by typing the name(s), number(s), or abbreviation(s).
   Select Clinical Documents Type(s): 1-3 Addendum Discharge Summary Progress Notes
   Start Reference Date [Time]: T-7//t-15 (MAR 19, 1997)
   Ending Reference Date [Time]: NOW//<Enter> (APR 18, 1997@15:21)
   Searching for the documents.............

2. When the documents that fit the criteria you entered are displayed, choose an action and a document(s).

   UNSIGNED Documents Apr 18,1996 15:21:44 Page:1 of 1
   by ALL CATEGORIES from 03/19/96 to 04/18/96 15 documents
   Patient Document Admitted Disch'd
   1 TIUPATIENT,O (T8101) Nursing Note 04/15/96
   2 TIUPATIENT,T (T2760) Addendum 03/22/96
   3 TIUPATIENT,T (T2760) Addendum 03/22/96
   4 TIUPATIENT,F (T6641) Ambul/Outp Care 04/18/96
   5 TIUPATIENT,F (T6641) General Note 04/18/96
   6 TIUPATIENT,F (T6641) Diabetes Ed 03/20/96
   7 TIUPATIENT,S (T0482) Diabetes Edu 03/25/96
   8 TIUPATIENT,S (T0482) Addendum 03/25/96

   + Next Screen - Prev Screen ?? More Actions >>>
   Verify/Unverify Link with Request Print
   On Chart Send Back Interdiscipl'ry Note
   Edit Detailed Display Change View
   Reassign Browse QuitSelect
   Action: Quit//ON CHART

These may differ at your site.
Print Document Menu

This menu contains options which print chart or work copies of discharge summaries, progress notes, or mixed documents.

<table>
<thead>
<tr>
<th></th>
<th>1 Discharge Summary Print</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Progress Note Print</td>
</tr>
<tr>
<td></td>
<td>3 Clinical Document Print</td>
</tr>
</tbody>
</table>

Discharge Summary Print

Use this option to print chart or work copies of discharge summaries.

Steps to use this option:

1. Select **Discharge Summary Print** from the MIS Manager’s Print Document Menu.

2. Enter the name of the patient whose discharge summary you want to print.

3. Enter the range of dates to choose the discharge summary or summaries you want to print.

   Please specify a date range from which to select summaries:
   
   List summaries Beginning: 02/12/96// **<Enter>** (FEB 12, 1996)  
   Thru: 02/12/96// **<Enter>**

   1 02/12/96 13:56 Discharge Summary One TIUProvider, MD  
   Adm: 07/22/91  Dis: 02/12/96

   Choose summaries: (1-1): 1  
   Do you want WORK copies or CHART copies? CHART// **WORK**  
   DEVICE: HOME// **<Enter>** VAX
# Discharge Summary Print Example

**SALT LAKE CITY**

**priority**

**06/27/96 08:45**

**Page: 1**

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>SSN</th>
<th>CLAIM NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT.ONE</td>
<td>51</td>
<td>M</td>
<td>MEXI</td>
<td>666-23-3456</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADM DATE</th>
<th>DISC DATE</th>
<th>TYPE OF RELEASE</th>
<th>INP</th>
<th>ABS</th>
<th>WARD NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>JUL 22, 1991</td>
<td>FEB 12, 1996</td>
<td>REGULAR</td>
<td>1666</td>
<td>0</td>
<td>1A</td>
</tr>
</tbody>
</table>

**DICTATION DATE: JUN 09, 1996**

**TRANSCRIPTION DATE: JUN 12, 1996**

**TRANSCRIPTIONIST: bs**

**DIAGNOSIS:**

1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. End stage renal disease on hemodialysis.
5. Congestive heart failure.
6. Hypertension.
7. Non insulin dependent diabetes mellitus.
8. Peripheral vascular disease, status post thrombectomies.
11. Chronic anemia.

**OPERATIONS/PROCEDURES:**

1. MRI.
2. CT SCAN OF HEAD.

**HISTORY OF PRESENT ILLNESS:**

Patient is a 49-year-old, white male with past medical history of end stage renal disease, peripheral vascular disease, status post BKA, coronary artery disease, hypertension, non insulin dependent diabetes mellitus, diabetic retinopathy, congestive heart failure, status post CVA, status post thrombectomy admitted from Anytown VA after a fall from his wheelchair in the hospital. He had questionable short lasting loss of consciousness but patient is not very sure what has happened. He denies headache, vomiting, vertigo. On admission patient had CT scan which showed a small area of parenchymal hemorrhage in the right temporal lobe which is most likely consistent with hemorrhagic contusion without mid line shift or incoordination.

**ACTIVE MEDICATIONS:** Isordil 20 mgs p.o. t.i.d., Coumadin 2.5 mgs p.o. qd, ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d. with food, Betoptic 0.5% ophthalmologic solution gtt OU b.i.d., Nephrocaps 1 tablet p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Compazine 10 mgs p.o. t.i.d. prn nausea, Tylenol 650 mgs p.o. q4 hours prn.

Patient is on hemodialysis, no known drug allergies.

**PHYSICAL EXAMINATION:** Patient had stable vital signs, his blood pressure was 160/85, pulse 84, respiratory rate 20, temperature 98 degrees. Patient was alert, oriented times three, cooperative. His speech was fluent, understanding of spoken language was good. Attention span was good. He had

Press RETURN to continue or ‘^’ to exit: <Enter>
**Discharge Summary Print Example cont’d**

---

**SALT LAKE CITY** priority 06/27/96 08:46 Page: 4

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>SSN</th>
<th>CLAIM NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT,ONE</td>
<td>51</td>
<td>M</td>
<td>MEXI</td>
<td>666-23-3456</td>
<td></td>
</tr>
</tbody>
</table>

---

Mild memory impairment, no apraxia noted. Cranial nerves patient was blind, pupils are not reactive to light, face was asymmetric, tongue and palate are mid line. Motor examination showed muscle tone and bulk without significant changes. Muscle strength in upper extremities 5/5 bilaterally, sensory examination revealed intact light touch, pinprick and vibratory sensation. Reflexes 1+ in upper extremities, coordination finger to nose test within normal limits bilaterally. Alternating movements without significant changes bilaterally. Neck was supple.

**LABORATORY:** Showed sodium level 135, potassium 4.6, chloride 96, CO2 26, BUN 39, creatinine 5.3, glucose level 138. White blood cell count was 7, hemoglobin 11, hematocrit 34, platelet count 77.

**HOSPITAL COURSE:** Patient was admitted after head trauma with multiple medical problems. His coumadin was held. Patient had cervical spine x-rays which showed definite narrowing of C5, C6 interspace, slight retrolisthesis at this level, prominent spurs at this level as well as above and below. CT scan on admission showed a moderate amount of scalp thinning with subcutaneous air overlying the left frontal lobe. A small area of left parenchymal hemorrhage adjacent to the right petros bone in the temporal lobe which most likely represents a hemorrhagic contusion. Repeated CT scan on 5/13/94 didn’t show any progressive changes. Patient remained in stable condition. He had hemodialysis q.o.d. He restarted treatment with Coumadin. His last PT was 11.9, PTT 31. Patient refused before hemodialysis new blood tests. His condition remained stable.

**DISCHARGE MEDICATIONS:** Isordil 20 mgs p.o. t.i.d., Ferrous sulfate 325 mgs p.o. b.i.d., Ativan 0.5 mgs p.o. b.i.d., Lactulose 15 ccs p.o. b.i.d., Calcium carbonate 650 mgs p.o. b.i.d., Compazine 10 mgs p.o. t.i.d., prn nausea, Betoptic 0.5% OU b.i.d., Nephrocaps 1 p.o. qd, Pilocarpine 4% solution 1 gtt OU b.i.d., Coumadin 2.5 mgs p.o. qd, Tylenol 650 mgs p.o. q6 hours prn pain.

**DISPOSITION/FOLLOW-UP:**
Recommend follow PT/PTT. Patient is on coumadin and CBC with differential because patient has chronic anemia and thrombocytopenia. Patient will be transferred to Anytown VA in stable condition on 5/19/94.

**WORK COPY ========= UNOFFICIAL - NOT FOR MEDICAL RECORD ========= DO NOT FILE**

**SIGNATURE PHYSICIAN/DENTIST**

One TIUProvider, MD
PGY2 Resident

**SIGNATURE APPROVING PHYSICIAN/DENTIST**

Three TIUProvider, MS
Medical Internist

---

**JUN 26, 1996@17:36:02 ADDENDUM:**
Routine visit today--no change to condition.

**SIGNATURE PHYSICIAN/DENTIST**

Three TIUProvider, MD
Medical Internist
Progress Note Print

Use this option to print chart or work copies of progress notes.

Steps to use option:

1. Select Progress Note Print from the Print Document Menu.

2. Enter a patient name.

   Select Print Document Menu Option: 2 Progress Note Print
   Select PATIENT NAME: TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456
   YES
   SC VETERAN
   (2 notes) C: 05/28/96 12:37
   (2 notes) W: 05/28/96 12:33
   A: Known allergies
   (2 notes) D: 05/28/96 12:36
   Available notes: 02/17/96 thru 06/21/96 (31)

3. Enter the range of dates for progress notes you want to print.

4. Choose a note from those listed.

   Please specify a date range from which to select notes:
   List notes Beginning: 02/17/96// <Enter> (FEB 17, 1996)
   Thru: 06/21/96// <Enter> (JUN 21, 1996)

   1 06/21/96 11:40 Lipid Clinic Visit: 02/21/96 Three TIUProvider,
   2 06/21/96 11:38 Social Work Service Visit: 04/18/96 Three TIUProvider,
   3 06/07/96 00:00 Diabetes Education Visit: 04/18/96 One TIUProvider, MD
   4 05/15/96 13:10 Addendum to Diabetes Education Visit: 02/21/96 Seven TIUProvider
   5 04/24/96 15:41 Lipid Clinic Visit: 04/24/96 Three TIUProvider,
   6 02/23/96 14:08 Diabetes Education Visit: 02/21/96 Three TIUProvider,

   Choose notes: (1-6): 3, 5
   Do you want WORK copies or CHART copies? CHART// <Enter>
   DEVICE: HOME// <Enter> VAX
Progress Notes Print Example

------------------------------------------------------------------------------
TIUPATIENT,ONE  666-23-3456                                        Progress Notes
------------------------------------------------------------------------------
NOTE DATED: 06/07/96 17:51    DIABETES EDUCATION
ADMITTED: 07/22/95 11:06 1A
SUBJECT: Routine diabetes education

Patient understanding good.

Signed by: /es/ One TIUProvider, MD
Medical Internist 06/23/96 08:34
Analog Pager:  555-1213
Digital Pager:  555-1215

Cosigned by: /es/ TIUProvider, Six
06/23/96 08:34
Analog Pager:  555-1213
Digital Pager:  555-1215

------------------------------------------------------------------------------
NOTE DATED: 04/24/96 08:00    ARTERIAL EVALUATION - LOWER EXTREMITY
VISIT: 04/17/92 08:00 FOURTEEN’S CLINIC
SUBJECT: Rule out embolus, lower extremity

AGE: 50
UNIT: General Medicine
REFERRING MD: Six TIUProvider
DIAGNOSIS: Rule out embolus

HISTORY: severe pedal edema, foot ulcers

OTHER: cyanosis

SYMPTOMS:

RESTING SYMPTOMS:

EXERTATIONAL SYMPTOMS:

LESIONS:

MEDICATIONS:

RECORDED
AUDIBLE DOPPLER SIGNAL

RIGHT     LEFT

DOPPLER WAVEFORM:

RIGHT     LEFT

COMMON FEMORAL

SUPERFICIAL FEMORAL

POPLITEAL

POSTERIOR TIBIAL

DORSALIS PEDIS

N=NORMAL   ABN=ABNORMAL    O=ABSENT    B=BIPHASIC

TRANSCUTANEOUS PO2 VALUES:

RIGHT     LEFT

SUBCLAVICULAR

ABOVE KNEE

HIGH BK

Calf

ANKLE

DORSUM OF FOOT

OTHER

Enter RETURN to continue or '^' to exit: <Enter>
**CONTINUED FROM PREVIOUS SCREEN **

** ADEQUATE FOR HEALING 
39-30 = EQUIVOCAL FOR HEALING 
29-0 = INADEQUATE FOR HEALING 

<table>
<thead>
<tr>
<th>SEGMENTAL SYSTOLIC BLOOD PRESSURE:</th>
<th>RIGHT</th>
<th>INDEX</th>
<th>LEFT</th>
<th>INDEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIGH THIGH</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABOVE KNEE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BELOW KNEE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANKLE PT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** EXERCISE RESPONSE:**

MPH: 5 mph 

MAXIMUM WALKING TIME: 10 MIN 30 SEC 

SYMPTOMS: Pedal edema, cyanosis 

** MAXIMUM HEART RATE ACHIEVED:**

<table>
<thead>
<tr>
<th>TIME</th>
<th>RIGHT INDEX</th>
<th>LEFT INDEX</th>
<th>ARM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 MINUTE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 MINUTES</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** POST EXERCISE:**

** IMPRESSIONS:**

Signed by: /es/ Three TIUProvider, MD 
Medical Internist 04/24/96 14:19 
Analog Pager: 555-1213 
Digital Pager: 555-1215 

Enter RETURN to continue or '^' to exit: ^ 

1 Discharge Summary Print 
2 Progress Note Print 
3 Clinical Document Print 

Select Print Document Menu Option: <Enter>
Clinical Document Print

Use this option to print chart or work copies of all clinical documents available through TIU.

Steps to use option:

1. Select *Clinical Document Print* from the Print Document Menu, and then enter a patient name.

   Select Print Document Menu Option: 3 Clinical Document Print
   Select PATIENT NAME: TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456
   YES
   SC VETERAN
       (2 notes) C: 05/28/96 12:37
       (2 notes) W: 05/28/96 12:33
       A: Known allergies
       (2 notes) D: 05/28/96 12:36
   Available documents: 02/17/92 thru 06/21/96 (34)

2. Enter a date range that documents will be chosen from.

   Please specify a date range from which to select documents:
   List documents Beginning: 02/17/92/ 6/1/96 (JUN 01, 1996)
   Thru: 06/21/96/ 6/8/96 (JUN 08, 1996)
   1 06/07/96 00:00 Diabetes Education One TIUProvider,
   Visit: 04/18/96
   2 06/05/96 17:23 Lipid Clinic Three TIUProvider,
   Visit: 04/18/96
   3 06/05/96 11:10 Addendum to Lipid Clinic Three TIUProvider,
   Visit: 04/24/96

Choose the document or documents you would like printed, and whether you want work or chart copies.

Choose documents: (1-3): 1-3
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// PRINTER

4. The document(s) will then be printed at the device you specify.
Search for Selected Documents

Use this option to generate a list of selected documents based on extended search criteria (e.g., status, search category, and reference date range).

Steps to use option:

1. Select Search for Selected Documents from the MIS Manager Menu.

2. Select the status of the documents you want to view (completed, unsigned, amended, etc.).

3. Select the type of documents you want to view (progress notes, discharge summary, etc.).

4. To make your search more specific, select one or more categories for the documents you want to view:

   All Categories  Patient  Title
   Author  Problem  Transcriptionist
   Division  Expected Cosigner  Service
   Treating Specialty  Hospital Location  Subject
   Visit

5. To limit the search even further, specify a time period for the documents you want to view:

   Start Reference Date [Time]: T-7//T-30
   Ending Reference Date [Time]: NOW//<Enter>
   Searching for the documents....
Search for Selected Documents, cont’d

6. After the documents are displayed, you can choose one of the actions listed below (amend, browse, delete, etc.) to perform on one or more of the documents.

UNVERIFIED Documents

<table>
<thead>
<tr>
<th>Patient</th>
<th>Document</th>
<th>Ref Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 TIUPATIENT (T3456)</td>
<td>Addendum to Discharge Summary</td>
<td>06/05/97</td>
<td>unverified</td>
</tr>
<tr>
<td>2 TIUPATIENT (T3456)</td>
<td>Addendum to Discharge Summary</td>
<td>06/05/97</td>
<td>unverified</td>
</tr>
<tr>
<td>3 TIUPATIENT (T3456)</td>
<td>Addendum to Discharge Summary</td>
<td>06/04/97</td>
<td>unverified</td>
</tr>
<tr>
<td>4+ TIUPATIENT (T3456)</td>
<td>Discharge Summary</td>
<td>05/25/97</td>
<td>unverified</td>
</tr>
</tbody>
</table>

Find Delete Document Browse
On Chart Reassign Print
Edit Send Back Change View
Verify/Unverify Detailed Display Quit
Amend Document

Select Action: Quit// v=3 Verify/Unverify

Opening Addendum record for review...

Verify Document

TIUPATIENT,ONE 666-12-3456 2B Visit Date: 09/21/95@10:00

DICT DATE: JUN 04, 1997 ENTRY DATE: JUN 05, 1997@16:10:02
DICTATED BY: TIUPROVIDER,ONE ATTENDING: TIUPROVIDER,THREE
URGENCY: routine STATUS: UNVERIFIED

DIAGNOSIS:
1. Status post head trauma with brain contusion.
2. Status post cerebrovascular accident.
3. End stage renal disease on hemodialysis.
5. Congestive heart failure.
6. Hypertension.
7. Non insulin dependent diabetes mellitus.

Do you want to edit this Discharge Summary? NO// <Enter>

VERIFY this Discharge Summary? NO// y YES

Discharge Summary VERIFIED.
Refreshing the list.
Correcting Documents that are Entered in Error

Reassigning signed documents is restricted to the “Chief, MIS User Class.” This includes notes that are awaiting a co-signature. If the document is completely unsigned, users who are Author/Dictator or users with proper authorization may reassign it.

Besides reassigning a note to a different patient, admission, or visit, the reassign action may be used to promote an Addendum as an Original, swap the Addendum and the Original, change a discharge summary to an Addendum.

The basic reassign process includes the following steps:

1. **Electronic signature challenge.** If the document is already signed, TIU asks for the electronic signature of the Chief of MIS.
2. **Retract.** If the document is moved to a different patient, TIU retracts the document.
3. **Re-edit original visit.** If necessary, the PCE information is updated for the original visit.
4. **Edit destination visit.** If necessary, PCE information is collected or revised for the new visit.
5. **Sign.** The original provider needs to sign the document. If the document was moved to a different patient, TIU removes the original signature.

In the following example, an unsigned note is transferred from one patient to another:

```
Select OPTION NAME: TIU MAIN MENU MGR  Text Integration Utilities (MIS Manager)
                     --- MIS Managers Menu ---
   1  Individual Patient Document
   2  Multiple Patient Documents
   3  Print Document Menu ...
   4  Search for Selected Documents
   5  Statistical Reports ...
   6  Unsigned/Uncosigned Report
   7  Missing Text Report
   8  Missing Text Cleanup
   9  Signed/unsigned PN report and update
  10  UNKNOWN Addenda Cleanup
  11  Missing Expected Cosigner Report
  11  Missing Expected Cosigner Report
  12  Mark Document as 'Signed by Surrogate'
  13  Mismatched ID Notes
  14  TIU 215 ANALYSIS ...
  15  Transcription Billing Verification Report
    ...16  CWAD/Postings Auto-Demotion Setup

Select Text Integration Utilities (MIS Manager) Option: 1  Individual Patient Document
Select PATIENT NAME: TIUPATIENT,E
   1  TIUPATIENT,ELEVEN        4-2-44    666568765     YES     NON-SERVICE
   2  TIUPATIENT,TWENTY        4-1-48    666090934     NO     NON-SERVICE
CONNEC TED THIS IS A TEST
   2  TIUPATIENT,TWENTY        4-1-48    666090934     NO     NON-SERVICE
CONNEC TED

CHOOSE 1-4: 2  TIUPATIENT,TWENTY        4-1-48    666090934     NO     NON-SERVICE
```
Correcting Documents that are Entered in Error cont’d

Please specify a date range from which to select documents:
Thru: 01/19/2001// <Enter>  (JAN 19, 2001)

1 01/19/2001 10:27  Infection Control                     TIUPROVIDER,O
   Visit: 01/26/1999
2 12/30/2000 16:00  + Discharge Summary                   TIUPROVIDER,T
3 11/01/2000 14:00  Discharge Summary                     TIUPROVIDER,T
   Adm: 04/19/2000  Dis: 11/01/2000
4 04/24/2000 00:00  Discharge Summary                     TIUPROVIDER,T

Choose one or more documents:  (1-4):1

Browse Document               Jan 19, 2001 10:33:50      Page:    1 of    1◄
Infection Control
TIUPATIENT,N  666-09-2591  AUDIOLOGY AND SPE Visit Date: 01/26/1999 17:50◄
DATE OF NOTE: JAN 19,2001@10:27:57   ENTRY DATE: JAN 19,2001@10:27:58
AUTHOR: TIUPROVIDER,SEVEN        EXP COSIGNER:
URGENCY:                            STATUS: UNSIGNED
Pt is very sick...

Are you sure you want to REASSIGN this Infection Control? NO// Y  YES

Please choose the correct PATIENT and CARE EPISODE:

Select PATIENT NAME:  TIUPATIENT,N
1  TIUPATIENT,N  1-1-65    666344321     YES     SC VETERAN
   *SENSITIVE*  *SENSITIVE*  NO     EMPLOYEE
   IS A TEST   THIS IS A TEST
2  TIUPATIENT,N  1-1-65    666344321     YES     SC VETERAN
   IS A TEST   THIS IS A TEST
CHOOSE 1-2:  2  TIUPATIENT,N  1-1-65    666344321     YES     SC VETERAN
   THIS IS A TEST
   IS A TEST
   THIS IS A TEST
   IS A TEST

(1 note )  W: 09/15/98 08:29
   A: Known allergies
   Enrollment Priority: GROUP 1    Category: IN PROCESS   End Date:
This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT// <Enter>
The following SCHEDULED VISITS are available:

1> AUG 20, 1999@08:00                         NINE CLINIC
2> JUL 30, 1999@09:00                         NINE CLINIC
3> JUL 29, 1999@09:15                         NINE CLINIC
4> JUN 03, 1999@13:00                         NINE CLINIC
5> JUL 22, 1997@09:00  INPATIENT APPOINTMENT SIX CLINIC

CHOOSE 1-5, or
<U>NSCHEDULED VISITS, <F>UTURE VISITS, or <N>EW VISIT
<RETURN> TO CONTINUE
OR '^' TO QUIT: 2 JUL 30 1999@09:00

Enter/Edit PROGRESS NOTE...
Patient Location:  NINE CLINIC
Date/time of Visit:  07/30/99 09:00
Date/time of Note:  01/19/01 10:27
Author of Note:  TIUPROVIDER,SEVEN

...OK? YES//
AUTHOR/DICTATOR: TIUPROVIDER,SEVEN//

Infection Control Reassigned.
Press RETURN to continue...

Select PATIENT NAME:
Rescinding Advance Directives

Patch TIU*1*261 supports Imaging patch MAG*3.0*121. The two patches are being released in a combined release, with TIU*1*261 requiring MAG*3.0*121. Patch MAG*3.0*121 provides the ability to watermark images "RESCINDED".

Patch TIU*1*261 permits an authorized user to rescind an Advance Directive document by changing the title to RESCINDED ADVANCE DIRECTIVE.

MAG*3.0*121 takes it from there and watermarks any linked images "RESCINDED".

NOTE: Exact title names are required

Exact title names are required. The title of the Advance Directive to be rescinded must be ADVANCE DIRECTIVE

The title it is changed to when it is being rescinded must be RESCINDED ADVANCE DIRECTIVE

Both LOCAL and National Standard titles must be as above. Variations on either title will cause the Change Title action to fail to watermark images as rescinded. These exact titles are required by policy. See the VHA HANDBOOK 1004.02 section on Advance Directives: http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2042

Example

<table>
<thead>
<tr>
<th>Select OPTION NAME: TIU MAIN MENU MGR</th>
<th>Text Integration Utilities (MIS Manager) menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select Text Integration Utilities (MIS Manager) Option: 1 Individual Patient Document</td>
<td></td>
</tr>
<tr>
<td>Select PATIENT NAME: CPRSPATIENT, TWO</td>
<td></td>
</tr>
<tr>
<td>(1 notes)</td>
<td>D: 12/20/2002 09:07</td>
</tr>
<tr>
<td>Enrollment Priority: GROUP 3</td>
<td>Category: IN PROCESS</td>
</tr>
</tbody>
</table>

Available documents: 12/17/1998 thru 01/10/2012 (231)

Please specify a date range from which to select documents:


1 01/10/2012 11:44 ADVANCE DIRECTIVE CPRSPROVIDER,ONE Adm: 12/20/2002 Dis:

One document found within date range...

Opening ADVANCE DIRECTIVE record for review...
<table>
<thead>
<tr>
<th>Browse Document</th>
<th>Jan 10, 2012@11:52:57</th>
<th>Page: 1 of 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVANCE DIRECTIVE</td>
<td>CPRSPATIENT,TWO 666-54-8668 1A(1&amp;2)</td>
<td>Adm: 12/20/2002 Dis:</td>
</tr>
<tr>
<td>STANDARD TITLE: ADVANCE DIRECTIVE</td>
<td>DATE OF NOTE: JAN 10, 2012@11:44:13 ENTRY DATE: JAN 10, 2012@11:44:13</td>
<td>AUTHOR: CPRSPROVIDER,ONE EXP COSIGNER:</td>
</tr>
</tbody>
</table>

The title of this note will be changed to RESCINDED ADVANCE DIRECTIVE and linked images will be watermarked 'RESCINDED'. OK? NO// YES Title changed; Image queued for watermarking. Press RETURN to continue...
Creating Post-Signature Alerts Based on Progress Note Title

The Create Post-Signature Alerts [TIUFPC CREATE POST-SIGNATURE] option in the Document Definitions (Manager) [TIUF DOCUMENT DEFINITION MGR] menu allows clinicians and providers to create progress notes that automatically generate a notification (alert) to designated recipients based on the progress note title. This enables immediate communication of time-sensitive patient information to designated individuals or groups. These alerts are specific to each VA Medical Center.

To create or edit a Post-Signature Alert:

1. Select the Create Post-Signature Alerts [TIUFPC CREATE POST-SIGNATURE] option in the Document Definitions (Manager) [TIUF DOCUMENT DEFINITION MGR] menu.

2. At the "Select TIU DOCUMENT DEFINITION NAME" prompt, enter the progress note title that will generate the alert. Typing “???” and then pressing Enter provides a list of titles already available in VistA.

   If an alert is already associated with this title, then the existing Post-Signature code is displayed—continue to Step 3. If there is no existing alert associated with the title, skip to Step 4.

3. If an alert is already associated with the selected title, then the Post-Signature code is displayed and the "Do you want to change the Code? (YES or NO)? NO// " prompt is displayed.

   Enter “YES” if you wish to change the code, and then complete the remaining steps in this procedure. Enter "NO" to retain the current code. The "Enter <RETURN> for another TIU Document Definition Name or '^' to exit" prompt displays and you have the option to enter another title (returning you to Step 2) or exit "Enter Post-Signature Code for Alert."
4. At the "Choose RECIPIENTS to receive the alert (N/I/G/T) or '^' to exit" prompt, select the recipients who will receive the alert every time this note title is used. Choosing I, G, or T enables you to define which individual(s) or group(s) will receive the alert.

   - **N/A** – Select if you do not want to specify an Individual User, Mailgroup, or Team List to receive the alert.
   - **Individual User** – A single defined person will receive the alert.
   - **Mailgroup** – An established mailgroup will receive the alert.
   - **Team List** – An established team list will receive the alert.

**NOTE:** Do not use mailgroup or team list names containing special characters other than parentheses "( )" or asterisks "*". Use of other special characters might result in an alert not being received by the intended recipients.

5. At the "Choose an alert ROUTINE from the above listing:" prompt, set the alert routine to run when this title is used.
• N/A – Use when no conditional alert is needed; the alert will be sent only to the recipients designated in Step 4.

**NOTE:** If you select N/A both here and in Step 4, then you will be provided with an option to delete the Post-Signature code associated with this title (including pre-existing code) or to cancel this code change (which retains any pre-existing code).

• PCP – Sends the alert to the Primary Care Provider designated for each patient.

• AUTOPRT – Use to auto-print to the printer designated as the chart copy print device at the patient's location.

6. The “DEVICE NAME (Optional) for Paper Alert:” prompt displays if either PCP or AUTOPRT was selected in the previous step. This is an option to generate a printout containing the patient's name and the progress note title, which is useful to notify clinicians who are not at their computer when the note is entered. Pressing Enter sends the printout to a default printer.

**NOTE:** Do not use device names containing special characters other than parentheses "( )" or asterisks "*". Use of other special characters might result in an alert not being received by the intended recipients.

7. The code that will be generated based on your selections is displayed for confirmation. Type YES to accept the code. Type NO to return to the initial Create Post-Signature Alert screen—this will discard your previously entered selections.
The progress note title with the defined parameters to create an alert is now available. When a user creates and signs a new progress note using this title, the designated recipients will receive an alert.
**Statistical Reports**

Use this menu to produce statistical reports for line counts and timeliness by Author, Transcriptionist, or Service.

**NOTE:** These reports are designed for a margin width of 132.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSCRIPTIONIST Line Count Statistics</td>
<td>This option allows generation of statistical reports of line counts and timeliness data by transcriptionist (or the person who entered the document).</td>
</tr>
<tr>
<td>SERVICE Line Count Statistics</td>
<td>This option allows generation of statistical reports of line counts and timeliness data by SERVICE (e.g., Medical Service, Surgical Service, Psychiatry Service, etc.).</td>
</tr>
<tr>
<td>AUTHOR Line Count Statistics</td>
<td>This option allows generation of statistical reports of line counts and timeliness data by AUTHOR (or Dictating practitioner).</td>
</tr>
</tbody>
</table>
**TRANSCRIPTIONIST Line Count Statistics**

<table>
<thead>
<tr>
<th>Transcriber</th>
<th>Line Count</th>
<th>Ref Date</th>
<th>Patient</th>
<th>Disch-Dict</th>
<th>Dict-Transcr</th>
<th>Transcr-Sign</th>
<th>Sign-Cosign</th>
</tr>
</thead>
<tbody>
<tr>
<td>BS</td>
<td>0</td>
<td>JUN 19,1996</td>
<td>TIUPATIENT,SEVEN</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>73</td>
<td>JUN 11,1996</td>
<td>TIUPATIENT,FIVE</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>78</td>
<td>MAY 31,1996</td>
<td>TIUPATIENT,SEVEN</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>72</td>
<td>MAR 25,1996</td>
<td>TIUPATIENT,EIGHT</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>78</td>
<td>MAR 24,1996</td>
<td>TIUPATIENT,NINE</td>
<td>-1</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>73</td>
<td>MAR 23,1996</td>
<td>TIUPATIENT,ELEVE</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>73</td>
<td>FEB 12,1996</td>
<td>TIUPATIENT,ONE</td>
<td>84</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>80</td>
<td>FEB 8,1995</td>
<td>TIUPATIENT,TWELV</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharg</td>
<td>96</td>
<td>FEB 8,1995</td>
<td>TIUPATIENT,ELEVE</td>
<td>0</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

SUBTOTAL 623
SUBCOUNT 9
SUBMEAN 69.22

DP 1 JAN 1996 TIUPATIENT,FIVE 1004 0 0 0

SUBTOTAL 1
SUBCOUNT 1
SUBMEAN 1.00

SBW 0 MAY 25,1996 TIUPATIENT,SEVEN 1

SUBTOTAL 0
SUBCOUNT 0
SUBMEAN 1.00

Jg 0 FEB 12,1996 TIUPATIENT,ONE 97 0

SUBTOTAL 97
SUBCOUNT 1
SUBMEAN 97.00

TOTAL 624
COUNT 1191
MEAN 52.00
### DISCHARGE SUMMARY Line Count Statistics by AUTHOR - ISC-SLC-A4

**AUTHOR:**

<table>
<thead>
<tr>
<th>Author</th>
<th>Count</th>
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<th>Patient</th>
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<th>Transcr-Sign</th>
<th>Sign-Cosign</th>
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## DISCHARGE SUMMARY Line Count Statistics by SERVICE - ISC-SLC-A4

### MEDICINE

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<th>Disch-Dict</th>
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<th>Transcr-Sign</th>
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</table>
Unsigned/Uncosigned Report

Lists detailed document information such as author, patient, patient SSN, etc. for notes with no signature and/or cosignature. Optionally, a summary report can be generated showing the number of unsigned and uncosigned documents in each service.

In the following example, a summary report is generated for all divisions:

Select Text Integration Utilities (MIS Manager) Option: 6 Unsigned/Uncosigned Report
Select division: ALL// <Enter>

Please specify an Entry Date Range:

  Start Entry Date: T-180  (AUG 08, 2003)
  Ending Entry Date: T  (FEB 04, 2004)

Select service: ALL// <Enter>

  Select one of the following:
    F        FULL
    S        SUMMARY

Type of Report: S  SUMMARY

DEVICE: HOME// <Enter> ANYWHERE

Unsigned and Uncosigned Documents Aug 08, 2003 thru Feb 04, 2004
PRINTED: FEB 04, 2004@09:16

================================================================================
Totals for Service: IRM--- UNSIGNED: 1  UNCOSIGNED: 0
Totals for Division: SALT LAKE CITY HCS--- UNSIGNED: 1  UNCOSIGNED: 0

Enter RETURN to continue or '^' to exit:
Missing Text Report

This report lists TIU Documents that do not have any report text, are missing the 0 node of the text node, or both cases. The report results have the following categories:

**Missing Text Only.** This means the note has a 0 TEXT node, but no text (and this can be fine depending on the status of the document, such as und dictated).

**Missing 0 Node Only.** This means the note has text but no 0 TEXT node.

**Missing 0 node & Text.** This means the note doesn't have a 0 TEXT node or text.

This cause of this condition is unknown and has only been reported from a few sites. Nevertheless, this report should be run by all sights. If any missing text documents are found, refer to the discussion under Missing Text Cleanup below for guidance.

The report can be run as often as needed to track the occurrences of documents without text and missing the 0 text node. It is advised to run the report on a regular interval (once per week or month) to track an increase or decrease of reported documents missing text or the 0 text node.

A delimited form of the report can be provided for users who want to put the report into a spreadsheet program.

In the following example a report is generated starting June 1, 2004:

```
Select Text Integration Utilities (MIS Manager) Option: ?

1   Individual Patient Document
2   Multiple Patient Documents
3   Print Document Menu ...  
4   Search for Selected Documents
5   Statistical Reports ...
6   Unsigned/Uncosigned Report
7   Missing Text Report
8   Missing Text Cleanup
9   Signed/unsigned PN report and update
10  UNKNOWN Addenda Cleanup
11  Missing Expected Cosigner Report

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

Select Text Integration Utilities (MIS Manager) Option: 7   Missing Text Report

START WITH REFERENCE DATE:  Jan 01, 2003//jun 1, 2004  (JUN 01, 2004)
                 GO TO REFERENCE DATE:  Mar 04, 2005// <Enter> (MAR 04, 2005)

Would you like a delimited report? NO// <Enter>

DEVICE: HOME// <Enter>  ANYWHERE
Searching...

Date range searched:  Jun 01, 2004 - Mar 04, 2005
 # of Records:
                              Searched  1074
               Missing Text Only   1
               Missing 0 Node Only  0
               Missing 0 node & Text 4
                              ----
Total              5
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<td>H&amp;P GENERAL MEDICINE</td>
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<td>H&amp;P GENERAL MEDICINE</td>
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<td>CPRSPROVIDER, FIVE</td>
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<td>Jun 04, 2004@14:02</td>
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Press RETURN to continue...:
Missing Text Cleanup

Note:

The TIU MISSING TEXT REPORT should be run prior to running the cleanup. Refer to the documentation on the previous page for TIU MISSING TEXT REPORT for cause and frequency to run that report.

This is a utility designed to help clean up TIU documents with no text. Before using this utility, a number of other things should be tried. They are:

- NO TEXT in DOCUMENT body with no attached addendum or image, document may or may not have the "TEXT" 0 node as indicated by the report. Delete or retract the document (based upon status); no disclaimer is needed.

- If the "TEXT" 0 node is missing as indicated by the report and the document has text:
  - For direct entry documents, contact author to make an addendum to the note and add the missing information. Sites may determine the allowable timeframe to permit the author entering the addendum with the missing information. If the author is no longer at the site or the timeframe has passed, the HIMS Manager or designee should enter an addendum with the following disclaimer:

    "DISCLAIMER: This completed document contains missing text that was electronically deleted in error"

  - For uploaded documents, contact the transcription company to re-upload if possible or contact the author to make an addendum to the note and add the missing information.

The cleanup utility retracts documents within a date range that meet certain criteria. The criteria are:

- Document may be of any type, including ADDENDUM with a STATUS of UNCOSIGNED/COMPLETED/AMENDED
- Document must fall within user entered date range
- Document must NOT have the "TEXT" 0 node
- Document must NOT have any TEXT
- Document must NOT have any addenda ("DAD" cross-reference)
- Document must NOT have any components ("ADI" cross-reference)

An informational alert is sent once the cleanup process is finished.

In the following example, the cleanup process is run for documents in a one month period:

Select Text Integration Utilities (MIS Manager) Option: ?

1  Individual Patient Document
Multiple Patient Documents
Print Document Menu ...
Search for Selected Documents
Statistical Reports ...
Unsigned/Uncosigned Report
Missing Text Report
Missing Text Cleanup
Signed/unsigned PN report and update
UNKNOWN Addenda Cleanup
Missing Expected Cosigner Report

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

Select Text Integration Utilities (MIS Manager) Option: 8  Missing Text Cleanup

START WITH REFERENCE DATE:  Jan 01, 2003//jun1, 2004 (JUN 01, 2004)
GO TO REFERENCE DATE:  Mar 04, 2005//jull, 2004 (JUL 01, 2004)
Requested Start Time: NOW//  (MAR 04, 2005@16:02:37)
Your task # is:  165564

Press RETURN to continue...:
UNKNOWN Addenda Cleanup

Prior to the release of TIU*1*187 it was possible to leave surgery addenda unconnected to their associated operation report. The UNKNOWN addenda Cleanup menu option is provided in TIU*1*173 to assist in cleaning up these unattached addenda.

In the following example an unknown addenda is attached to a surgery case:

--- MIS Managers Menu ---

1 Individual Patient Document
2 Multiple Patient Documents
3 Print Document Menu ...
4 Search for Selected Documents
5 Statistical Reports ...
6 Unsigned/Uncosigned Report
7 Missing Text Report
8 Missing Text Cleanup
9 Signed/unsigned PN report and update
10 UNKNOWN Addenda Cleanup
11 Missing Expected Cosigner Report
12 Mark Document as 'Signed by Surrogate'
13 Mismatched ID Notes
14 TIU 215 ANALYSIS ...
15 Transcription Billing Verification Report
16 CWAD/Postings Auto-Demotion Setup

Select Text Integration Utilities (MIS Manager) Option: 9  UNKNOWN Addenda Cleanup

START WITH REFERENCE DATE:  Jan 01, 2003// <Enter> (JAN 01, 2003)
GO TO REFERENCE DATE:  Apr 04, 2005// <Enter> (APR 04, 2005)

Searching for the documents..
TIU/Surgery Cleanup          Apr 04, 2005@08:48:53       Page:    1 of    1
UNKNOWN ADDENDA from Jan 01, 2003 to Apr 04, 2005

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You may select more than one document by using #-# or #,# notation.

The parent document may be outside the original date range.
Searching for the documents...

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</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2182</td>
<td>09/20/04</td>
<td>RETRACTED</td>
<td>#89</td>
</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2192</td>
<td>09/28/04</td>
<td>RETRACTED</td>
<td>#90</td>
</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2195</td>
<td>09/29/04</td>
<td>COMPLETED</td>
<td>#89</td>
</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2237</td>
<td>10/14/04</td>
<td>RETRACTED</td>
<td>#90</td>
</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2284</td>
<td>01/20/05</td>
<td>UNVERIFIED</td>
<td>#90</td>
</tr>
<tr>
<td>CPRSPATIENT,T (C5525)</td>
<td>2292</td>
<td>01/28/05</td>
<td>UNDICTATED</td>
<td>#109</td>
</tr>
</tbody>
</table>

Enter ?? for more actions

<table>
<thead>
<tr>
<th>Browse</th>
<th>Change View</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detailed Display</td>
<td>Attach to Parent</td>
</tr>
</tbody>
</table>

Select Item(s): Quit// 4
Select Action: Attach to Parent// <Enter>

Attach the following UNKNOWN Addenda:

<table>
<thead>
<tr>
<th>TIU</th>
<th>Doc No.</th>
<th>Patient</th>
<th>Entry DT/Time</th>
<th>Status</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2238</td>
<td>CPRSPATIENT,T (C5525)</td>
<td>10/14/04@11:56:14</td>
<td>UNSIGNED</td>
<td>None</td>
</tr>
</tbody>
</table>

to the following OPERATION REPORT?

<table>
<thead>
<tr>
<th>TIU</th>
<th>Doc No.</th>
<th>Patient</th>
<th>Entry DT/Time</th>
<th>Status</th>
<th>Case No.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2195</td>
<td>CPRSPATIENT,T (C5525)</td>
<td>09/29/04@08:18:39</td>
<td>COMPLETED</td>
<td>#89</td>
</tr>
</tbody>
</table>

Do you wish to begin attaching? NO// Y YES

Attaching #2238 to #2195 ... success!

Press <RETURN> to continue

⚠️ Note: Be sure to verify any addenda before attaching to a parent document. Many addenda are duplicates of the original Operation Report and may be deleted once they are verified as UNSIGNED copies.

Only one document may be selected as the potential parent to the previously selected addenda.

Users may NOT attach addenda to a parent OPERATION REPORT with a different patient or an OPERATION REPORT whose ENTRY DATE/TIME falls after the addenda.
Once a parent document has been selected, a confirmation screen will display the selected addenda and parent information and prompt the user to begin attaching the documents.

After the utility attempts to associate the addenda with a parent Operation Report the user will be returned to the initial List Manager display with successful associations being listed under the "Parent" column showing the TIU Document number of the parent that has been assigned. These documents will no longer appear once the current session is closed or a new search is initiated via the CHANGE VIEW option.

**Missing Expected Cosigner Report**

List detailed document information for notes that have a status of “uncosigned” where the expected cosigner field is either null, 0 or -1. Users will have a choice of 3 different report formats: an 80 column standard report, a 132 column extended report and a “^” delimited report for use in exporting the data to Excel. The 80 column report will include Patient Name (initials and last 4 of SSN), Entry Date/Time, Author, Title, and the Note IEN. The 132 column report and the “^” delimited report will include Patient Name (initials and last 4 of SSN), Entry Date/Time, Author, Title, Author’s Service/Section, Author’s Job Title and the Note IEN. In either case if the document is an Addendum then the parent’s Document Type, Entry Date/Time and Expected Cosigner will also be displayed. The cause of the problem is being fixed in CPRS patch OR*3.0*215. Users should review the notes displayed on this report to determine who should be the expected cosigner and then enter the expected cosigner. Once a note is signed the software doesn't permit editing so they will need to use FileMan. The author of the note may need to be contacted to determine who should be the expected cosigner.

In addition this report may be setup in Taskman to be run nightly. The entry point for this is NITE^TIU189. This task will look for notes missing an expected cosigner and send an email to the mail group TIU MIS ALERTS. This email will include Patient Name (initials and last 4 of SSN), Entry Date/Time, Author, Title, Author’s Service/Section, Author’s Job Title, Note IEN and if the note is an addendum the parent’s Document Type, Entry Date/Time and Expected Cosigner.

**Example 80 column report:**

```
Select Text Integration Utilities (MIS Manager) Option: 11  Missing Expected Cosigner Report

START WITH REFERENCE DATE:  Jan 01, 2003//1/1/2005  (JAN 01, 2005)
GO TO REFERENCE DATE:  Jun 28, 2005//  (JUN 28, 2005)
DEVICE: HOME//   TCP

NOTES WITH 'UNCOSIGNED' STATUS THAT DON'T HAVE AN EXPECTED COSIGNER

<table>
<thead>
<tr>
<th>Patient</th>
<th>Entry Date/Time</th>
<th>Title</th>
<th>Author</th>
<th>Note IEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX1234</td>
<td>JUN 28, 200509:24:44</td>
<td>UROLOGY NO SHOW</td>
<td>TIUAUTHOR,ONE</td>
<td>4957352</td>
</tr>
</tbody>
</table>
```
Example 132 column report:

Select Text Integration Utilities (MIS Manager) Option: 11 Missing Expected Cosigner Report

START WITH REFERENCE DATE: Jan 01, 2003//1/1/2005  (JAN 01, 2005)
GO TO REFERENCE DATE: Jun 28, 2005//  (JUN 28, 2005)
DEVICE: HOME//   TCP

NOTES WITH 'UNCOSIGNED' STATUS THAT DON'T HAVE AN EXPECTED COSIGNER

<table>
<thead>
<tr>
<th>Patient Entry Date/Time</th>
<th>Title</th>
<th>Author</th>
<th>Service/Section</th>
<th>Job Title</th>
<th>Note IEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>XXX1234 JUN 28, 2005@09:36:20</td>
<td>Addendum</td>
<td>TIUAUTHOR,ONE</td>
<td>CHIEF OF STAFF</td>
<td>SUPERVISOR, PHYS</td>
<td>~4957352</td>
</tr>
<tr>
<td>XXX1235 JUN 28, 2005@09:36:20</td>
<td>Addendum</td>
<td>TIUAUTHOR,THREE</td>
<td>CHIEF OF STAFF</td>
<td>SUPERVISOR, PHYS</td>
<td>~4957355</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit:

Example "^" delimited report (lines are truncated for this example):

Select Text Integration Utilities (MIS Manager) Option: 11 Missing Expected Cosigner Report

START WITH REFERENCE DATE: Jan 01, 2003//1/1/2005  (JAN 01, 2005)
GO TO REFERENCE DATE: Jun 28, 2005//  (JUN 28, 2005)
DEVICE: HOME//   TCP

Patient Name^Entry Date/Time^Title^Author^Service/Section^Job Title^Note IEN ...
XXX1234^JUN 28, 2005@09:24^UROLOGY NO SHOW^TIUPROVIDER,ONE^PHYSICIAN^SUPERV...
YYY5678^JUL 01, 2005@19:14^PROGRESS NOTE^TIUPROVIDER,TWO^NURSE^SUPERIVOR^84...

Example email message:

Subj: MISSING EXPECTED COSIGNER  [#440685] 02/08/06@13:14  11 lines
From: XXXX  In 'IN' basket.   Page 1

PATIENT: ABC1234
ENTRY DATE/TIME: JAN 10, 2006@15:34:21
NOTE TITLE: Addendum
AUTHOR: TIUAUTHOR,ONE
AUTHOR'S SERVICE/SECTION: CHIEF OF STAFF
AUTHOR'S TITLE: SUPERVISOR, PHYSICAL MEDICINE
NOTE IEN: '1234567
PARENT DOCUMENT TYPE: ANESTHESIA POST OP NOTE
PARENT DOCUMENT ENTRY DATE: JAN 09, 2006@16:25:47
PARENT DOCUMENT COSIGNER:

Enter message action (in IN basket):
Mark Documents ‘Signed by Surrogate’

This option allows documents needing an Additional Signer, where the additional signature was signed by a surrogate of the Additional Signer, to be marked as “Signed By Surrogate.” This should not be needed for documents signed after patch TIU*1.0*199 is installed.

Example:

Select OPTION NAME: TIU MAIN MENU MGR       Text Integration Utilities (MIS Manager)

--- MIS Managers Menu ---

1      Individual Patient Document
2      Multiple Patient Documents
3      Print Document Menu ...
4      Search for Selected Documents
5      Statistical Reports ...
6      Unsigned/Uncosigned Report
7      Missing Text Report
8      Missing Text Cleanup
9      Signed/unsigned PN report and update
10     UNKNOWN Addenda Cleanup
11     Missing Expected Cosigner Report
12     Mark Document as 'Signed by Surrogate'
13     Mismatched ID Notes
14     TIU 215 ANALYSIS ...
15     Transcription Billing Verification Report
16     CWAD/Postings Auto-Demotion Setup

Select Text Integration Utilities (MIS Manager) Option: 12  Mark Document as 'Signed by Surrogate'

Select ADDITIONAL SIGNER: TIUHEALTHTECHNICIAN, ONE OTT    116     HEALTH TECHNICIAN


SEQ  PATIENT                   DOCUMENT TYPE              REFERENCE DATE
---  -------                   -------------              --------------
1    CPRSPATIENT,FOUR (C1234)  DOMICILIARY CARE SECTION   MAR 12, 1998@09:52:21

ENTER SEQUENCE # TO MARK AS 'SIGNED BY SURROGATE', 'NEW' FOR A NEW SEARCH, OR '^' TO QUIT:
Mismatched ID Notes

The option TIU MISMATCHED ID NOTES is under the TIU MAIN MENU MGR, and it runs a routine that will report/fix mismatched interdisciplinary (ID) notes. There are cases where a child ID note points to a parent ID note and that parent ID note is for a different patient. There are also cases where the GDAD cross reference links a child ID note to a parent ID note when in fact the child does not point to the parent. In these cases, the situation will be reported/fixed. If it is found that there is a child ID note pointing to a parent that may not be an ID note, this will be reported but not fixed.

When this report is run in Report Only mode the report looks like the first example. When this report is run in Report and Fix mode the report looks like the second example.

When this report is run in either Report Only mode or in Report and Fix mode an email will be sent to the PSI-06-030 mail group on Forum. This email will contain ONLY the site, the date, the report mode and the result totals. No patient data of any kind is sent. The purpose of this is to track the extent of this problem. Note that the emails do not report the count of: CHILD ID NOTES POINTING TO A PARENT THAT MAY NOT BE AN ID NOTE.

Example of Report Only mode:

<table>
<thead>
<tr>
<th>CHILD DOCUMENT</th>
<th>PARENT DOCUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient: TIUPATIENT,ONE (P1234)</td>
<td>TIUPATIENT, TWO (P5678)</td>
</tr>
<tr>
<td>Title: INTERDISCIPLINARY PATIENT EDUCATI PM&amp;R KT</td>
<td></td>
</tr>
<tr>
<td>Entry DT: JAN 21, 1998@15:28:27</td>
<td>FEB 01, 1996@14:16:10</td>
</tr>
<tr>
<td>Author: TIUAUTHOR,ONE</td>
<td>TIUAUTHOR,ONE</td>
</tr>
<tr>
<td>Note IEN: 345678</td>
<td>123456</td>
</tr>
</tbody>
</table>

**NOTE: THIS IS AN INFORMATIONAL LIST FOR INVESTIGATION. NOTHING WILL BE FIXED**

<table>
<thead>
<tr>
<th>CHILD ID NOTES POINTING TO A NON-EXISTENT PARENT ID NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient: TIUPATIENT,THREE (P9876)</td>
</tr>
<tr>
<td>Title: CARDIAC REHAB DAILY</td>
</tr>
<tr>
<td>Entry DT: APR 28, 2003@07:43:49</td>
</tr>
<tr>
<td>Author: TIUAUTHOR, TWO</td>
</tr>
<tr>
<td>Child IEN: 3300852</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CHILD ID NOTES POINTING TO A PARENT THAT MAY NOT BE AN ID NOTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient: TIUPATIENT,FOUR (J0222)</td>
</tr>
<tr>
<td>Parent Title: OPERATION REPORT-IEN: 1734321</td>
</tr>
<tr>
<td>Parent Entry DT: FEB 03, 2006@12:43:49</td>
</tr>
<tr>
<td>Parent Author: TIUAUTHOR,THREE</td>
</tr>
<tr>
<td>Child Title: NURSE INTRAOPERATIVE REPORT-IEN: 1734320</td>
</tr>
</tbody>
</table>

| Patient: TIUPATIENT,FOUR (J0222) | |
| Parent Title: TELEPHONE CONTACT-IEN: 1734512 | |
| Parent Entry DT: JUN 26, 2006@10:42:25 | |
| Parent Author: TIUAUTHOR, FOUR | |
| Child Title: ECU ADL SELF CARE PERFORMANCE SUMMARY-IEN: 1734511 | |

TOTAL COUNTS FOR MISMATCHED ID NOTES
### Example of Report and Fix mode:

#### MISMATCHED INTERDISCIPLINARY NOTES

<table>
<thead>
<tr>
<th>CHILD DOCUMENT</th>
<th>PARENT DOCUMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient: TIUPATIENT,ONE (P1234)</td>
<td>TIUPATIENT, TWO (P5678)</td>
</tr>
<tr>
<td>Title: INTERDISCIPLINARY PATIENT EDUCATI</td>
<td>PM&amp;R KT</td>
</tr>
<tr>
<td>Entry DT: JAN 21, 1998@15:28:27</td>
<td>FEB 01, 1996@14:16:10</td>
</tr>
<tr>
<td>Author: TIUAUTHOR, ONE</td>
<td>TIUAUTHOR, ONE</td>
</tr>
<tr>
<td>Note IEN: 345678</td>
<td>123456</td>
</tr>
<tr>
<td>... Removed pointer from child to parent.</td>
<td></td>
</tr>
</tbody>
</table>

| Patient: TIUPATIENT,THREE (P4321)       | TIUPATIENT, FOUR (P8746)                 |
| Title: PRIME CARE CLINIC                 | PATIENT/FAMILY EDUCATION DOC             |
| Entry DT: FEB 04, 2003@10:33:48         |                                         |
| Author: TIUAUTHOR, TWO                  |                                         |
| Note IEN: 3100784                        | 3000597                                  |
| ... Child note did not point to parent. GDAD cross reference removed | |

#### CHILD ID NOTES POINTING TO A NON-EXISTENT PARENT ID NOTE

| Patient: TIUPATIENT,FIVE (P2233)        |                                         |
| Title: OTP DOSING NOTE                   |                                         |
| Entry DT: APR 28, 2003@07:54:47          |                                         |
| Author: TIUAUTHOR,THREE                  |                                         |
| Child IEN: 3300864                       |                                         |
| Parent IEN: 3200349                      |                                         |
| ... Child note did not point to parent. GDAD cross reference removed. | |

| Patient: TIUPATIENT,SIX (P4567)         |                                         |
| Title: PM&R PT DISCHARGE                 |                                         |
| Entry DT: JAN 29, 2004@15:26:57          |                                         |
| Author: TIUAUTHOR,FOUR                   |                                         |
| Child IEN: 4000224                       |                                         |
| Parent IEN: 4000522                      |                                         |
| ..... Removed pointer from child to parent removed. | |

#### CHILD ID NOTES POINTING TO A PARENT THAT MAY NOT BE AN ID NOTE

**NOTE: THIS IS AN INFORMATIONAL LIST FOR INVESTIGATION. NOTHING WILL BE FIXED**

| Patient: TIUPATIENT,SEVEN (J0202)       |                                         |
| Parent Title: OPERATION REPORT-IEN: 1834321 |                                         |
| Parent Entry DT: FEB 03, 2006@12:43:49     |                                         |
| Parent Author: TIUAUTHOR,FIVE             |                                         |
| Child Title: NURSE INTRAOPERATIVE REPORT-IEN: 1784320 | |

| Patient: TIUPATIENT,EIGHT (P2539)        |                                         |
| Parent Title: TELEPHONE CONTACT-IEN: 1734552 |                                         |
| Parent Entry DT: JUN 26, 2006@10:42:25     |                                         |
| Parent Author: TIUAUTHOR,SIX               |                                         |
| Child Title: ECU ADL SELF CARE PERFORMANCE SUMMARY-IEN: 1734555 | |

### TOTAL COUNTS FOR MISMATCHED ID NOTES

---
1173 CROSS REFERENCES CHECKED
2 MISS MATCHED NOTE(S) FOUND
2 NON EXISTENT PARENT NOTE(S)
2 PARENT MAY NOT BE AN ID NOTE

1 POINTER(S) FIXED FOR MISMATCHED NOTES
1 XREF(S) FIXED FOR MISMATCHED NOTES
1 POINTER(S) FIXED FOR MISSING NOTES
1 XREF(S) FIXED FOR MISSING NOTES

**Example of email sent to G.PSI-06-030 in report only mode:**

<table>
<thead>
<tr>
<th>Site Number</th>
<th>Site Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AUG 31, 2006@15:24:09</td>
</tr>
</tbody>
</table>

1173 CROSS REFERENCES CHECKED
9 MISMATCHED NOTE(S) FOUND
7 NON EXISTENT PARENT NOTE(S)

MODE - REPORT ONLY

**Example of email sent to G.PSI-06-030 in report and fix mode:**

<table>
<thead>
<tr>
<th>Site Number</th>
<th>Site Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AUG 31, 2006@15:24:09</td>
</tr>
</tbody>
</table>

1173 CROSS REFERENCES CHECKED
9 MISMATCHEDNOTE(S) FOUND
7 NON EXISTENT PARENT NOTE(S)

MODE - REPORT AND FIX
5 POINTER(S) FIXED FOR MISMATCHED NOTES
4 XREF(S) FIXED FOR MISMATCHED NOTES
3 POINTER(S) FIXED FOR MISSING NOTES
4 XREF(S) FIXED FOR MISSING NOTES
TIU 215 ANALYSIS

A problem has been found with VistA patch TIU*1.0*215, released June 28, 2007. One of the intents of this patch was to only allow editing/amending etc. from the Surgery package to keep the Surgery file (#130) and TIU files in sync. This was for the Nurse Intraoperative Report (NIR) and the Anesthesia Report only. However, if surgery personnel made changes to a surgery case using one of the case editors such as OSS Operation (Short Screen) [SROMEN-OUT], they were asked if they wanted to create an addendum. After installation of TIU*1.0*215, the addendum was not created for viewing via the Surgery Tab in CPRS, however, the data was being updated in the Surgery application files.

A new option, TIU 215 ANALYSIS, is set up with installation of patch TIU*1.0*231 and is being added as sequence 14 to the TIU MAIN MENU MGR option.

<table>
<thead>
<tr>
<th>TIU MAIN MENU MGR</th>
<th>Text Integration Utilities (MIS Manager)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIU 215 ANALYSIS ...</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>ANALYZE POTENTIAL SURGERY TIU PROBLEMS</td>
</tr>
<tr>
<td>V</td>
<td>VIEW SINGLE SURGERY CASE USING CASE #</td>
</tr>
<tr>
<td>T</td>
<td>SEND ANALYSIS OUTPUT TO TEXT FILE</td>
</tr>
</tbody>
</table>

**Option A - Analyze Potential Surgery TIU Problems:**
Allows for the analysis process (which was run during the installation of this patch) to be run again. Surgery cases will be analyzed within a particular date range and the information from NIR and/or Anesthesia reports will be compared to their corresponding TIU notes. If the information does not match, the case number will be recorded as one that needs to be reviewed. The information generated by this option should be printed, either by cutting and pasting the results into a text file, or you can simply print the MM that was generated during installation. It can be used to identify which TIU records have addenda and which do not. This is extremely important as how a comparison is handled depends directly on if the TIU record has addenda. It can also be used as a checklist, to make sure that every record in question is examined.

**Option V - View the Contents of a Surgery Case Using Case #:**
Views the content of a Surgery Case file (#130). NIR data will be displayed followed by the Anesthesia data.

**Option T - Send Output To Text File:**
Sends output to a Host text file on your production account's server. This will be very useful for sites that have a large number of cases to review. Microsoft Word can then be used to compare the text files, which is extremely helpful because discrepancies are automatically highlighted, thus expediting the comparison process.
Option T Overview:
Option T will send data from both Surgery and TIU to respective output files. First, the user is prompted for a path to send output files to which should look something like this: USER$:<directory name>. You may need to coordinate with your local IRM VistA system administrator to determine exactly what the path should be. The user is then prompted for three filenames; one for Surgery output, one for TIU output, and one for associated TIU addenda. If the path and/or filenames are invalid you will be prompted to enter them again.

Option T will use the same analysis technique as Option A does. Instead of just listing cases that need review, it will write the contents of the associated reports to text files. For each case, what is on record in Surgery will be written to one file, and what is on record in TIU will be written to another file. Also, if there are any associated TIU addenda with the case, these addendums will be written to a separate file. Multiple cases will be written to a single file, with the user pre-defining the maximum limit. When this limit is encountered, a new set of output files will be created. For instance, if there are a total of 50 cases found with possible discrepancies, and the user sets a maximum of 25 cases per file, then 2 Surgery output files will be created, two TIU output files, and x number of addenda output files. Note: The number of Surgery and TIU files will always be the same; the number of addenda files may not. This is due to the fact not every Surgery case will have an associated TIU addenda). Let's say the names "Surgery", "TIU", and "ADDENDA" are used for the output filenames. You would then have: Surgery1.txt, Surgery2.txt, TIU1.txt, TIU2.txt, and ADDENDA1.txt (and possibly ADDENDA2.txt), each with 25 cases per file.

**********IMPORTANT***********IMPORTANT***********IMPORTANT***********IMPORTANT***********IMPORTANT***********IMPORTANT***********IMPORTANT

NOTE!!!! The host files created in option T contains Patient Information and should only be sent to a server within the system boundary of the VA. The directory must be password protected. If you are going to download to a pc and use the Microsoft Word Compare feature for analysis, it must be a VA approved encrypted PC. Both the host files and the files downloaded to the pc must be destroyed by an approved means when analysis/correction is complete. When the files are destroyed the systems manager, official, or the ISO should be notified they have been destroyed.

**********IMPORTANT***********IMPORTANT***********IMPORTANT***********IMPORTANT

CORRECTION PROCESS
The following manual fix process is provided by the Surgery Enterprise Product Support(EPS) personnel:

The Surgery ADPAC should review the reports. Health Information Management (HIM) personnel should also be involved in this process. If the programmer feels comfortable in restoring the data in the Surgery package to what it was originally, then the programmer can, with the help of the Surgery ADPAC do it, but we would encourage the site to enter a Surgery Remedy ticket, and we will step the site through the process.
The programmer would edit the fields in the Surgery Case file (#130) that should be restored to their original data using FileMan enter/edit.

For the NIR, once the cases that need fixing are restored to their original data set (see examples one and two), one of the circulating nurses listed in the case, with the assistance of the Surgery ADPAC, should use the Surgery package to put the changes back into the cases and sign the addenda (see Options used to reenter the data in Surgery).

Similarly for the Anesthesia Report, once the cases that need fixing are restored to their original data set (see examples one and two), the anesthetist with the assistance of the Surgery ADPAC, should use the Surgery package to put the changes back into the cases and sign the addenda (see Options used to reenter the data in Surgery).

**Example ONE using FileMan:**

**Step One:**

```plaintext
Select OPTION: 1 ENTER OR EDIT FILE ENTRIES
INPUT TO WHAT FILE: SURGERY//
EDIT WHICH FIELD: ALL// ANESTHESIA TECHNIQUE (multiple)
   EDIT WHICH ANESTHESIA TECHNIQUE SUB-FIELD: ALL//
THEN EDIT FIELD:

Select SURGERY PATIENT: `30536 TIUPATIENT, FOUR 08-18-07 TOE
X-XX-XX XXXXXXXX YES SC VETERAN GJ

Select ANESTHESIA TECHNIQUE: GENERAL// @
SURE YOU WANT TO DELETE THE ENTIRE 'G' ANESTHESIA TECHNIQUE? Y (Yes)
Select ANESTHESIA TECHNIQUE:
```

**Step Two:**

THEN IN SURGERY ADD THE GENERAL ANESTHESIA TECHNIQUE BACK IN USING ONE OF THE SURGERY OPTIONS LISTED IN THE SECTION "OPTIONS USED TO RE-ENTER DATA IN SURGERY".

**Example TWO using FileMan:**

TIU HAS "CLEAN" FOR WOUND CLASSIFICATION BUT SURGERY HAS "CONTAMINATED"

**STEP ONE:**

```plaintext
Select OPTION: 1 ENTER OR EDIT FILE ENTRIES
INPUT TO WHAT FILE: SURGERY//
EDIT WHICH FIELD: ALL// WOUND CLASSIFICATION
THEN EDIT FIELD:

Select SURGERY PATIENT: `30506 TIUPATIENT, TWO 12-31-06 BAD FINGER
X-XX-XX XXXXXXXX YES SC VETERAN GJ

WOUND CLASSIFICATION: CONTAMINATED// CLEAN 1 CLEAN
```
STEP TWO:

NOW REENTER 'CONTAMINATED' IN SURGERY USING ONE OF THE OPTIONS USED TO RE-ENTER DATA INTO SURGERY AND IT WILL GENERATE AN ADDENDUM FORTIU

***Options used to reenter the data in Surgery.***

<table>
<thead>
<tr>
<th>NIR REPORT</th>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>OSS Operation (Short Screen)</td>
<td>Other Scrubbed Assistant</td>
</tr>
<tr>
<td>NR Nurse Intraoperative Report</td>
<td>Comments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ANESTHESIA REPORT</th>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR Anesthesia Report</td>
<td>O.R. Circulating Nurse</td>
</tr>
<tr>
<td>PAC Enter PAC(U) Information</td>
<td>Educational Status</td>
</tr>
<tr>
<td>M Medications (Enter/Edit)</td>
<td>O.R. Scrub Nurse</td>
</tr>
</tbody>
</table>

For those sites that use the Anesthesia Report, the following list of fields create an addendum to the NIR.

<table>
<thead>
<tr>
<th>Sub-file</th>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Scrubbed Assistant(s)</td>
<td>Other Scrubbed Assistant</td>
</tr>
<tr>
<td>Other Scrubbed Assistant(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>O.R. Circulating Nurse(s)</td>
<td>O.R. Circulating Nurse</td>
</tr>
<tr>
<td>O.R. Circulating Nurse(s)</td>
<td>Educational Status</td>
</tr>
<tr>
<td>O.R. Scrub Nurse(s)</td>
<td>O.R. Scrub Nurse</td>
</tr>
<tr>
<td>O.R. Scrub Nurse(s)</td>
<td>Educational Status</td>
</tr>
<tr>
<td>Other Persons in O.R.</td>
<td>Other Person in O.R</td>
</tr>
<tr>
<td>Other Persons in O.R.</td>
<td>Title/Organization</td>
</tr>
<tr>
<td>Position(s)</td>
<td>Position</td>
</tr>
<tr>
<td>Position(s)</td>
<td>Placed</td>
</tr>
<tr>
<td>Restraints and Position Aids</td>
<td>Restraint/Position Aid</td>
</tr>
<tr>
<td>Restraints and Position Aids</td>
<td>Applied By</td>
</tr>
<tr>
<td>Restraints and Position Aids</td>
<td>Comment</td>
</tr>
<tr>
<td>Principal CPT Modifier</td>
<td>CPT Modifier</td>
</tr>
<tr>
<td>Other Procedures Performed</td>
<td>Other Procedure</td>
</tr>
<tr>
<td>Other Procedures Performed</td>
<td>CPT Code</td>
</tr>
<tr>
<td>Other Procedures Performed</td>
<td>CPT Modifier</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Time Applied</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Time Released</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Site Applied</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Pressure Applied (in TORR)</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>Applied By</td>
</tr>
<tr>
<td>Thermal Unit</td>
<td>Thermal Unit</td>
</tr>
<tr>
<td>Thermal Unit</td>
<td>Temperature</td>
</tr>
<tr>
<td>Thermal Unit</td>
<td>Time On</td>
</tr>
<tr>
<td>Thermal Unit</td>
<td>Time Off</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Item</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Sterility Checked</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Sterility Expiration Date</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>RN Verifier</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Vendor</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Model</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Lot/Serial Number</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Sterility Resp</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Size</td>
</tr>
<tr>
<td>Prosthesis Installed</td>
<td>Quantity</td>
</tr>
<tr>
<td>Medications</td>
<td>Medication</td>
</tr>
<tr>
<td>Medications</td>
<td>Time Administered</td>
</tr>
<tr>
<td>Medications</td>
<td>Route</td>
</tr>
<tr>
<td>Medications</td>
<td>Dose</td>
</tr>
<tr>
<td>Medications</td>
<td>Ordered By</td>
</tr>
<tr>
<td>Medications</td>
<td>Administered By</td>
</tr>
<tr>
<td>Medications</td>
<td>Comments</td>
</tr>
<tr>
<td>Irrigation Solution(s)</td>
<td>Irrigation Solution</td>
</tr>
<tr>
<td>Irrigation Solution(s)</td>
<td>Time Utilized</td>
</tr>
<tr>
<td>Irrigation Solution(s)</td>
<td>Amount</td>
</tr>
<tr>
<td>Irrigation Solution(s)</td>
<td>Provider</td>
</tr>
<tr>
<td>Blood Replacement Fluids</td>
<td>Replacement Fluid Type</td>
</tr>
<tr>
<td>Blood Replacement Fluids</td>
<td>Quantity (ml)-</td>
</tr>
<tr>
<td>Blood Replacement Fluids</td>
<td>Source Identification</td>
</tr>
<tr>
<td>Blood Replacement Fluids</td>
<td>VA Identification</td>
</tr>
<tr>
<td>Blood Replacement Fluids</td>
<td>Comments</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Laser Unit/ID</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Duration</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Wattage</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Operator</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Plume Evacuator</td>
</tr>
<tr>
<td>Laser Unit(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Cell Saver ID</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Operator</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Amount Salvaged (ml)-</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Amount Reinfused (ml)-</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Comments</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Disposables Name</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Lot Number</td>
</tr>
<tr>
<td>Cell Saver(s)</td>
<td>Quantity</td>
</tr>
<tr>
<td>Anesthesia Technique(s)</td>
<td>Anesthesia Technique</td>
</tr>
<tr>
<td>Anesthesia Technique(s)</td>
<td>Principal Technique</td>
</tr>
<tr>
<td>Anesthesia Technique(s)</td>
<td>Anesthesia Agent</td>
</tr>
<tr>
<td>Anesthesia Technique(s)</td>
<td>Dose (mg)-</td>
</tr>
</tbody>
</table>
Transcription Billing Verification Report

This report can be run by division and provides information on all transcriptionists or one or more selected transcriptionists. It reports based on an entered date range. Since the VBC Line Count is only calculated for transcribed reports, it does not report on any document transcribed before the patch was installed.

The accuracy of this report depends on the accuracy of the data. Specifically, it depends on whether transcriptionists are reliably recorded in the header of each document. If you choose to use this report, you should follow the directions in the Text Integration Utilities (TIU) Line Count (TIU*1*250) Release Notes available from the VA Document Library (http://www4.va.gov/vdl/) to insure that each uploaded document has the needed data.

This example is a complete report for all facilities on the local VistA system for the month of August:

--- MIS Managers Menu ---
1 Individual Patient Document
2 Multiple Patient Documents
3 Print Document Menu ...
4 Search for Selected Documents
5 Statistical Reports ...
6 Unsigned/Uncosigned Report
7 Missing Text Report
8 Missing Text Cleanup
9 Signed/unsigned PN report and update
10 UNKNOWN Addenda Cleanup
11 Missing Expected Cosigner Report
12 Mark Document as 'Signed by Surrogate'
13 Mismatched ID Notes
14 TIU 215 ANALYSIS ...
15 Transcription Billing Verification Report
16 CWAD/Postings Auto-Demotion Setup

<CPM> Select Text Integration Utilities (MIS Manager) Option: 15 Transcription Billing Verification Report

--- Transcription Billing Verification Report ---
Select division: ALL// <Enter>
Specific Transcriptionist(s)? NO// YES
Select Transcriptionist(s):
1) ??
Choose from:
  INCORPORATED, ASCOTT TRANSCRIPTION ATI TRANSSCRIPTION SERVICE
  MEDTRAN, INC MTI TRANSSCRIPTION SERVICE

Please choose a KNOWN Transcriptionist (Duplicates not allowed).

1) ASCOTT INCORPORATED, ASCOTT TRANSCRIPTION ATI TRANSSCRIPTION SERVICE
2) MEDTRAN, INC MTI TRANSSCRIPTION SERVICE
3) <Enter>

Start Transcription Date [Time]: Jan 01, 2010// 1/1/09 (JAN 01, 2009)
Ending Transcription Date [Time]: Jan 31, 2010@23:59// <Enter> (JAN 31, 2010@23:59)

In this example, these company names have been entered into the New Person file and marked as belonging to the transcriptionist user class.
### TRANSCRIPTION BILLING REPORT

**CAMP MASTER**

for Documents Transcribed: 01/01/2009 to 01/31/2010    Printed: 05/05/2010 11:18

<table>
<thead>
<tr>
<th>Tran Date</th>
<th>Title</th>
<th>Patient</th>
<th>Aut</th>
<th>VBC Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/31/09</td>
<td>Discharge Summary</td>
<td>BCMA,ELEVEN-PATIENT (0011) JER</td>
<td>56.25</td>
<td></td>
</tr>
<tr>
<td>07/31/09</td>
<td>Discharge Summary</td>
<td>BCMA,ONE-PATIENT (0001) JER</td>
<td>56.31</td>
<td></td>
</tr>
</tbody>
</table>

Total for Transcriber ati = 112.56

<table>
<thead>
<tr>
<th>Tran Date</th>
<th>Title</th>
<th>Patient</th>
<th>Aut</th>
<th>VBC Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/23/09</td>
<td>Discharge Summary</td>
<td>EIGHTY,INPATIENT (0880) JER</td>
<td>55.91</td>
<td></td>
</tr>
<tr>
<td>07/23/09</td>
<td>Discharge Summary</td>
<td>BCMA,FIFTEEN-PATIENT (0015) JER</td>
<td>57.31</td>
<td></td>
</tr>
</tbody>
</table>

Total for Transcriber mti = 113.22

<table>
<thead>
<tr>
<th>Tran Date</th>
<th>Title</th>
<th>Patient</th>
<th>Aut</th>
<th>VBC Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>08/13/09</td>
<td>Discharge Summary</td>
<td>BCMA,EIGHTYTHREE-PA (0083) JER</td>
<td>55.91</td>
<td></td>
</tr>
<tr>
<td>08/27/09</td>
<td>Discharge Summary</td>
<td>NINETEYEIGHT,OUTPATIENT (0698) JER</td>
<td>55.91</td>
<td></td>
</tr>
<tr>
<td>08/27/09</td>
<td>Discharge Summary</td>
<td>CPRS,COMBATVET T (0000) JER</td>
<td>55.91</td>
<td></td>
</tr>
<tr>
<td>08/27/09</td>
<td>Discharge Summary</td>
<td>FIVEHUNDRED,LEVEN (0511) JER</td>
<td>55.91</td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit:

---

**TRANSCRIPTION BILLING REPORT**

**CINCINNATI**

for Documents Transcribed: 01/01/2009 to 01/31/2010    Printed: 05/05/2010 11:18

<table>
<thead>
<tr>
<th>Tran Date</th>
<th>Title</th>
<th>Patient</th>
<th>Aut</th>
<th>VBC Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/03/09</td>
<td>OPERATION REPORT</td>
<td>BCMA,EIGHT (0008) JER</td>
<td>1.40</td>
<td></td>
</tr>
</tbody>
</table>

Total for Transcriber tlc = 225.04

Total for Division = 450.82

Press RETURN to continue or '^' to exit:
TRANSCRIPTION BILLING REPORT
SUMMARY for ZZ ALBANY-PRRTP
for Documents Transcribed: 01/01/2009 to 01/31/2010  Printed: 05/05/2010 11:18

<table>
<thead>
<tr>
<th>Category</th>
<th>Documents</th>
<th>VBC Lines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division Totals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMP MASTER</td>
<td>9</td>
<td>450.82</td>
</tr>
<tr>
<td>CINCINNATI</td>
<td>1</td>
<td>56.54</td>
</tr>
<tr>
<td>Transcriber Totals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ati</td>
<td>2</td>
<td>112.56</td>
</tr>
<tr>
<td>mti</td>
<td>2</td>
<td>113.22</td>
</tr>
<tr>
<td>tlc</td>
<td>6</td>
<td>281.58</td>
</tr>
<tr>
<td>Station Totals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ZZ ALBANY-PRRTP</td>
<td>10</td>
<td>507.36</td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <Enter>
Chapter 6: TIU for Transcriptionists

Transcriptionists typically enter Providers’ discharge summaries, progress notes, or other documents:

1. directly from dictation, or
2. from uploaded transcribed ASCII documents in batch mode
   a. from remote microcomputers, using ASCII or KERMIT protocol upload, or
   b. from Host Files (i.e., DOS or VMS ASCII files) on the host system.

Options on this menu can be assigned accordingly.

Transcriptionist Menu

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter/Edit Discharge Summary</td>
<td>This option allows you to enter or edit discharge summaries and progress notes directly online. If the transcriptionist holds the AUTOVERIFY security key, each discharge summary will be verified automatically when the transcriptionist releases it.</td>
</tr>
<tr>
<td>Enter/Edit Document</td>
<td>This option allows you to enter/edit clinical documents directly online.</td>
</tr>
<tr>
<td>Upload Menu ...</td>
<td>This menu includes options to upload batches of documents, and to get help on the header formats for the various documents which have been defined for upload by your site.</td>
</tr>
<tr>
<td>List Documents for Transcription</td>
<td>Gets all UNDICTATED and UNTRANSCRIBED Documents for review, edit, and signature.</td>
</tr>
<tr>
<td>Review/Edit Document</td>
<td>Allows the user to interactively review, edit, and/or print documents.</td>
</tr>
<tr>
<td>Transcription Billing Verification Report</td>
<td>This option produces a report for the verification of transcription bills, using the Visible Black Character counting method described in VHA Directive 2008-042.</td>
</tr>
</tbody>
</table>
Enter/Edit Discharge Summary

Use this option to enter and edit discharge summaries directly online.

Steps to use option:

1. Select Enter/Edit Discharge Summary from the Transcriptionist Menu.

--- Transcriptionist Menu ---
1 Enter/Edit Discharge Summary
2 Enter/Edit Document
3 Upload Menu ...
4 List Documents for Transcription
5 Review/Edit Documents
6 Transcription Billing Verification Report

Select Text Integration Utilities (Transcriptionist) Option: 1 Enter/Edit Discharge Summary

2. Enter a patient’s name and choose an Admission from the choices offered.

Select Patient: TIUPATIENT,ONE TIUPATIENT,ONE 09-12-44 666233456 YES SC VETERAN
For Patient TIUPATIENT,ONE
The following ADMISSION is available:
  1> JUL 22, 1995@11:06 DIRECT TO: 1A
CHOOSE 1-1: 1 JUL 22 1991@11:06

  Patient: TIUPATIENT,ONE SSN: 666-23-3456 Sex: MALE
  Race: MEXICAN AMERICAN Age: 52 Claim #: UNKNOWN
  Adm Date: 12/22/96 Ward: 1A
  Dis Date: 02/12/97 Adm Dx: Stage IV non-Hodgkin’s Lymphoma

Correct VISIT? YES// <Enter>

URGENCY: routine// <Enter> routine
AUTHOR/DICTATOR: TIUPROVIDER,ONE
DICTATION DATE: <Enter> (FEB 12, 1997)
ATTENDING PHYSICIAN: TIUPROVIDER,ONE ot

Calling text editor, please wait...
1>DIAGNOSIS:

The attending must not be a provider that requires a cosignature, and must be in User Class PROVIDER (or a subclass).
Enter/Edit Discharge Summary cont’d

The text editor brought up a boilerplate template used for Discharge Summaries; entries...

3>
4>
5>
6>OPERATIONS/PROCEDURES:
EDIT Option: 1
1>DIAGNOSIS:
Replace : With : Lymphoma Replace
DIAGNOSIS: Lymphoma
Edit line: 6
6>OPERATIONS/PROCEDURES:
Replace : With : Chemotherapy Replace
OPERATIONS/PROCEDURES: Chemotherapy
Edit line: <Enter>
EDIT Option: <Enter>
Save changes? YES// <Enter>

Saving Discharge Summary with changes...
Is this Discharge Summary ready to release from DRAFT? YES// n  NO
NOT RELEASED.

You may enter another Discharge Summary. Press RETURN to exit.

Select PATIENT NAME: <Enter>
Enter/Edit Document

This option allows the transcriptionist to enter a new document (using a document title from the TIU document definition hierarchy) or to review, verify, send back to transcription, reassign, or print an existing document. The option produces a list of document definition types using search criteria such as status, search category, and reference date range, from which you select a document.

Steps to use option:

1. Select Enter/Edit Document from the Transcriptionist Menu.

2. Enter a patient’s name and choose the admission from the choices offered.
3. Enter the urgency (if routine, press Enter), author/dictator, dictation date, and attending physician.

<table>
<thead>
<tr>
<th>URGENCY: routine/ &lt;Enter&gt; routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHOR/DICTATOR: TIUPROVIDER,THREE TIUPROVIDER,THREE TT</td>
</tr>
<tr>
<td>DICTATION DATE: 9/30 (SEP 30, 1996)</td>
</tr>
<tr>
<td>ATTENDING PHYSICIAN: TIUPROVIDER,ONE TIUPROVIDER,ONE TO PGY2 RESIDENT</td>
</tr>
</tbody>
</table>

4. Your preferred editor appears (with boilerplate if any has been set up for this title) and you can now enter the text for this discharge summary.

Calling text editor, please wait...
1>DIAGNOSIS:
2>
3>
4>
5>
6>OPERATIONS/PROCEDURES:
EDIT Option: 2
2>
Replace <space> With diabetes retinopathy Replace diabetes retinopathy
Edit line: <Enter>
EDIT Option: <Enter>
Save changes? YES// <Enter>

Saving Discharge Summary with changes...
Is this Discharge Summary ready to release from DRAFT? YES// <Enter>
Discharge Summary Released.
Chart copy queued.

You may enter another Discharge Summary. Press RETURN to exit.

Select PATIENT NAME: <Enter>
Upload Menu

The Upload Menu contains options that allow the transcriptionist to upload a batch of clinical documents.

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upload Documents</td>
<td>This option allows transcriptionists to upload transcribed ASCII documents in batch mode, either from remote microcomputers, using ASCII or KERMIT protocol upload, or from Host Files (i.e., DOS or VMS ASCII files) on the host system. Your site may define the preferred file transfer protocol and the destination within VistA to which each report type (e.g., discharge summary, progress notes, Operative Report, etc.) should be routed.</td>
</tr>
<tr>
<td>Help for Upload Utility</td>
<td>This option displays information on the formats of headers for dictated documents that are transcribed off-line and uploaded into VistA. It also displays “blank” character, major delimiter, and end of message signal as defined by your site.</td>
</tr>
</tbody>
</table>

The upload utility permits mixed report types within a single batch. This allows the transcriptionist to enter each report in arrival sequence into a single ASCII file on the remote computer (e.g., using a proprietary word-processing program), and to transmit the text to the VistA host system as a one-step process. As this ASCII data arrives at the VistA host, it is read into a “buffer” file, and stored for subsequent “filing” by a special background process, called the “Router/filer.”

The Router/filer is queued upon completion of transmission of a given batch of reports, and will proceed to “read” each line of the buffer file, looking for a header. When a header is encountered, the filer will determine whether the record corresponds to a known report type, as defined by your site, and if so, it will attempt to direct the record to the appropriate file and fields in VistA.

**On occasion, the Router/filer will not be able to identify the appropriate record in the target file, and will, therefore, be unable to file the record. When this happens, the process will leave the record in the buffer file and send an alert to the user who invoked the upload utility, and to a group of users identified by the site as being able to respond to such filing errors.**
**Upload Menu cont’d**

When *any* of the alert recipients chooses to act on one of these alerts (by entering “VA” at any menu prompt, and choosing the alert on which they wish to act), they will be shown the header of the failed record, and allowed to inquire to the patient record, before being presented with their preferred VistA editor, and will then be allowed to edit the buffer (e.g., correct a bad social security number, admission date, etc.) and retry the filer. With each attempt to correct the buffered data and retry the filer, all alerts associated with that batch will be deleted (and if the condition remains uncorrected, re-sent), until all records in the batch are successfully filed.

**Batch Upload Reports**

**Kermit Protocol Upload**

If your site is using the upload option to transfer batches of discharge summaries from a remote computer using the Kermit transfer protocol, start the upload process by following the sequence below:

1. **Choose UP from your Upload Menu.**

   

   ![Menu Options]

   You are currently logged into DIVISION: SALT LAKE CITY HCS

   If a hospital location cannot be determined for an uploaded document, the document's division may be loaded with your log-in division.

   1  Upload Documents
   2  Help for Upload Utility

   Select Upload Menu Option: **UP**  Batch upload reports

   **KERMIT UPLOAD**

   Now start a KERMIT send from your system.

   Starting KERMIT receive.

   #N3

   ![Note]

   **Note:** When entering the Upload Menu you receive a warning which specifies which division you are logged into. If division information is not explicitly available in the header, then it uses division information from your most current login. To change this division without re-logging in, you can use the XUSER DIV CHG option from the TBOX menu.

2. **When you see the #N3 prompt, initiate the Kermit file transfer from your computer.** Try the default settings for the Kermit protocol as provided by your terminal emulation software. If you have problems, consult your terminal emulator user manual or contact your local IRM Service.
3. When the transfer is complete, you’ll see this message:

File transfer was successful. (1515 bytes)
Filer/Router Queued!
Press RETURN to continue...<Enter>
1  Upload Documents
2  Help for Upload Utility
Select Upload menu Option: <Enter>

ASCII Protocol Upload

If your site is using the upload option to transfer batches of discharge summaries from a remote computer using the ASCII transfer protocol, start the upload process by following the example shown below:

1. Choose UP from your Upload Menu.

   1  Upload Documents
   2  Help for Upload Utility

   Select Upload menu Option: UP  Batch upload reports

   ASCII UPLOAD

   Note: If you are at a site that uses multiple divisions, you will receive a warning at this time specifying which division you are logged into. If division information is not explicitly available in the header, then it uses division information from your most current login. To change this division without re-logging in, you can use the XUSER DIV CHG option from the TBOX menu.

2. When the “Initiate upload procedure:” prompt appears, initiate the ASCII file transfer from your computer.

   NOTE: If you have problems, consult your local IRM Service to see if the Terminal and Protocol Set-up parameters have been set up as shown in the Implementation and Maintenance Section of the TIU Technical Manual, or check the user manual for your terminal emulator.

   Initiate upload procedure:
   $HDR: DISCHARGE SUMMARY
   >PATIENT NAME: TIUPATIENT,ONE
   >SOC SEC NUMBER: 666-12-1212
   >ADMISSION DATE: 02/20/93
   >DISCHARGE DATE: 02/25/93
   >DICTATED BY: TIUPROVIDER,TWO
   >DICTATION DATE: 02/26/93
   >ATTENDING PHYSICIAN: TIUPROVIDER,TEN
   >TRANSCRIPTIONIST ID: T1212
   >URGENCY: PRIORITY
>DIAGNOSIS:
>1. Acute pericarditis.
>2. Status post transmetatarsal amputation, left foot.
>3. Diabetes mellitus requiring insulin.
>4. Diabetic neuropathy.
>
>Operations/Procedures performed during current admission:
>1. Status post transmetatarsal amputation of left foot on 3/17/93.
>2. Echocardiogram done 3/17/93.
>.
>.
>$END

Filer/Router Queued!

Press RETURN to continue...<Enter>

Handling upload errors

ASCII PROTOCOL UPLOAD / WITH ALERT:

1. Upload Documents
2. Help for Upload Utility

UPLOAD PROCESS (555972453) Failed: LOOKUP FAILED
Enter "VA VIEW ALERTS to review alerts
Select Upload menu Option: VA View Alerts

1. UPLOAD PROCESS (555972453) Failed: LOOKUP FAILED
   Select from 1 to 1
   or Enter ?, A, I, P, M, R, or ^ to exit: 1

The header of the failed record looks like this:

$HDR: DISCHARGE SUMMARY
PATIENT NAME: TIUPATIENT,ONE
SOCIAL SECURITY NUMBER: 666-09-1244P
DATE OF ADMISSION: 11/17/95
DATE OF DISCHARGE: 
DICTATED BY: TIUPROVIDER,TWENTY
DICTATION DATE: 4/16/96
ATTENDING PHYSICIAN: TIUPROVIDER,ONE
TRANSCRIPTIONIST: C7689
URGENCY: PRIORITY
$TXT

Inquire to patient record? YES// <Enter>

Select PATIENT: TIUPATIENT,ONE 09-12-44 666091244P TO VETERAN
The following admissions are available:

(dcs indicates a Discharge Summary exists)

<table>
<thead>
<tr>
<th>Date</th>
<th>Social Security Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>09-12-44</td>
<td>812091244P</td>
<td>Open</td>
</tr>
</tbody>
</table>

CHOOSE 1-3: 3
ASCII PROTOCOL UPLOAD / WITH ALERT (cont’d)

Patient: TIUPATIENT, ONE SSN: 666-09-1244P Sex: MALE
Ward: 1A Race: Age: 48
Att Phys: TIUPROVIDER, EIGHT Prim Phys: TIUPROVIDER, EIGHT
Adm Date: 11/16/95
Adm Dx: ILL

Select PATIENT: <Enter>

You may now edit the buffered upload data...
(Press PF1 then H for help)

$HDR: DISCHARGE SUMMARY
PATIENT NAME: TIUPATIENT, ONE
SOCIAL SECURITY NUMBER: 666-09-1244P
DATE OF ADMISSION: 11/16/95 = Cursor to this point and change the 7 to a 6, then
DATE OF DISCHARGE: Enter <PF1>E to exit and save
DICTATED BY: TIUPROVIDER, THREE
DICTATION DATE: 4/16/96
ATTENDING PHYSICIAN: TIUPROVIDER, TWO
TRANSCRIPTIONIST: C7689
URGENCY: PRIORITY

$TXT
DIAGNOSES:
2. Unstable angina prior to coronary artery bypass graft.
3. End stage renal disease.
4. Diabetes mellitus.
5. Hypertension.

Now would you like to retry the filer? YES// <Enter>
Filer/Router Queued!

1   Upload Documents
2   Help for Upload Utility

Select Upload menu Option: <Enter>

In the example above, notice that patient One TIUPatient had no admission on
11/17/96, so the filer could not create a record in the target file for this
discharge summary record. The user acts on the alert to correct the admission
date as 11/16/96, and retries the filer, which is now able to file the record
appropriately, and the alerts are removed for all recipients.
Avoiding Upload Errors

TIU uses header information to file uploaded notes in the TIU Document File (#8925). Naturally, if this information is inaccurate, then either a filing error is generated or the note is filed incorrectly.

Note: Certain errors in the upload header can cause the upload routine to file the note incorrectly. This is a patient safety issue, so the accuracy of captions should be verified where possible.

Each type of document has a different set of upload captions and, in some cases, a different upload routine. Each routine tries to avoid incorrect filing of notes by cross-checking the patient information and dates with other information such as the consult number or surgery case number. Some types of documents have unique fields to assist the upload program in accomplishing these cross checks and/or to file the document.

A missing field error is generated either when a required field is missing, or a field does not match the example data given in the Upload Help Display (see Display Upload Help below).

The following table gives information on required fields and the cross-checks performed on fields for several document classes:

<table>
<thead>
<tr>
<th>Type of Document</th>
<th>Caption</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRESS NOTES</td>
<td>SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>VISIT/EVENT DATE</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching visit or event.</td>
</tr>
<tr>
<td></td>
<td>TITLE</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>LOCATION</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>AUTHOR</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>DATE/TIME OF DICT</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td>DISCHARGE SUMMARY</td>
<td>PATIENT SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>DATE OF ADMISSION</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching admission date.</td>
</tr>
<tr>
<td></td>
<td>DICTATED BY</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>DICTATION DATE</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>ATTENDING PHYSICIAN</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>URGENCY</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td>Type of Document</td>
<td>Caption</td>
<td>Use</td>
</tr>
<tr>
<td>------------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>CLINICAL PROCEDURES</td>
<td>SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>TITLE</td>
<td>Required by filing routine. This is the name of the procedure. The patient record indicated by the SSN is checked for a matching procedure.</td>
</tr>
<tr>
<td></td>
<td>VISIT/EVENT DATE</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching visit or event.</td>
</tr>
<tr>
<td></td>
<td>CONSULT REQUEST NUMBER</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching consult, that the consult is a clinical procedure, and that results are available for interpretation.</td>
</tr>
<tr>
<td></td>
<td>TIU DOCUMENT NUMBER</td>
<td>Only required by filing routine when an incomplete CP document has been attached by the CPUser program. In this case, the consult request is checked for a matching TIU Document Number.</td>
</tr>
<tr>
<td></td>
<td>DATE/TIME OF DICTATION</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>LOCATION</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>AUTHOR</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td>CONSULTS</td>
<td>SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>TITLE</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>CONSULT REQUEST NUMBER</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching consult.</td>
</tr>
<tr>
<td></td>
<td>VISIT/EVENT DATE</td>
<td>Required by filing routine. The patient record indicated by the SSN is checked for a matching visit.</td>
</tr>
<tr>
<td></td>
<td>AUTHOR</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>LOCATION</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>DATE/TIME OF DICTATION</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td>Type of Document</td>
<td>Caption</td>
<td>Use</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>PROCEDURE REPORT</td>
<td>PATIENT SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>DOCUMENT NUMBER</td>
<td>Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date (an optional field).</td>
</tr>
<tr>
<td></td>
<td>SURGICAL CASE</td>
<td>Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date. Then, if there is more than one matching surgical case, it generates a missing field error.</td>
</tr>
<tr>
<td></td>
<td>DICTATION DATE</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>ATTENDING SURGEON</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>DICTATED BY</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td>OPERATION REPORT</td>
<td>PATIENT SSN</td>
<td>Required by filing routine</td>
</tr>
<tr>
<td></td>
<td>DOCUMENT NUMBER</td>
<td>Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date (an optional field).</td>
</tr>
<tr>
<td></td>
<td>SURGICAL CASE</td>
<td>Required by filing routine. If missing, the upload routine infers it from the SSN and Operation Date. Then, if there is more than one matching surgical case, it generates a missing field error.</td>
</tr>
<tr>
<td></td>
<td>DICTATION DATE</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>DICTATING SURGEON</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>ATTENDING SURGEON</td>
<td>Generates missing field error</td>
</tr>
<tr>
<td></td>
<td>STAT or ROUTINE</td>
<td>Generates missing field error</td>
</tr>
</tbody>
</table>
Display Upload Help

Transcriptionists may select this option in the Upload Menu to display the formats expected by the upload process for the report types defined at your site.

The captioned headers may be captured as ASCII data and used to build macros using a commercial word-processors (e.g., WordPerfect or Microsoft Word), thereby avoiding having to retype the captioned headers, while minimizing the risk of spelling errors or inconsistencies with the formats expected by the host system.

```
UP  Batch upload reports
HLP  Display upload help

Select Upload menu Option:  HLP  Display upload help
Select REPORT TYPE:  DISCHARGE SUMMARY//  <Enter>  Discharge Summary

$HDR:
DISCHARGE SUMMARY
SOC SEC NUMBER:  666-12-1212
ADMISSION DATE:  02/21/96
DISCHARGE DATE:  02/25/96
DICTATED BY:  TIUPROVIDER,TWO
DICTATION DATE:  02/26/96
ATTENDING:  TIUPROVIDER,SEVEN
TRANSCRIPTIONIST ID:  T1212
URGENCY:  PRIORITY
$TXT
  DISCHARGE SUMMARY Text
$END

*** 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>
Chapter 7: TIU for Remote Users

The options on this menu allow remote users (e.g., VBA RO personnel) to access documents which have been completed (i.e., legally authenticated by signature or cosignature, if necessary), to facilitate processing of claims.

Remote User Menu

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Patient</td>
<td>This option allows remote users (e.g., VBA RO personnel) to access individual documents which have been completed.</td>
</tr>
<tr>
<td>Document</td>
<td></td>
</tr>
<tr>
<td>Multiple Patient</td>
<td>This option allows remote users (e.g., VBA RO personnel) to review and print multiple documents which have been completed.</td>
</tr>
<tr>
<td>Documents</td>
<td></td>
</tr>
</tbody>
</table>
**Individual Patient Document**

**Steps to use option:**

1. **Select Individual Patient Document** from your TIU menu.

<table>
<thead>
<tr>
<th>Select Integrated Document Management Option: Individual Patient Document</th>
</tr>
</thead>
</table>

2. **Select a patient.**

| Select PATIENT NAME: TIUPATIENT,ONE 09-12-44 666233456 YES SC VETERAN | (2 notes) C: 05/28/96 12:37 (addendum 08/12/96 16:04) |
| | (2 notes) W: 05/28/96 12:33 |
| | A: Known allergies |
| | (3 notes) D: 07/08/96 14:14 |

Available documents: 02/17/92 thru 10/28/96 (54)

3. **Enter a date range to display documents for.**

<table>
<thead>
<tr>
<th>Please specify a date range from which to select documents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>List documents Beginning: 02/17/96// &lt;Enter&gt; (FEB 17, 1992)</td>
</tr>
<tr>
<td>Thru: 10/28/96// &lt;Enter&gt; (OCT 28, 1996)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1</th>
<th>01/09/96 17:51 Diabetes Education</th>
<th>FOUR TIUPROVIDER, MS3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adm: 07/22/91</td>
<td>SUBJECT: Diet etc.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>09/29/95 16:54 Lipid Clinic</td>
<td>FIVE TIUPROVIDER</td>
</tr>
<tr>
<td>Adm: 08/14/95</td>
<td>SUBJECT: Dyslipidosis</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>04/24/96 08:28 Lipid Clinic</td>
<td>ONE TIUPROVIDER, MD</td>
</tr>
<tr>
<td>Visit: 04/24/92</td>
<td>SUBJECT: Lipid test</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>02/17/96 08:00 Arterial Evaluation -</td>
<td>THREE TIUPROVIDER,</td>
</tr>
<tr>
<td>Visit: 02/17/92</td>
<td>SUBJECT: Rule out embolus, lower extremity &quot;^&quot; TO STOP: 2</td>
<td></td>
</tr>
</tbody>
</table>
Individual Patient Document, cont’d

4. Choose a document from the list.

Choose documents: (1-4): 1

Opening Diabetes Education record for review...

Browse Document

TIUPATIENT,ONE  666-23-3456  Visit Date: 01/09/96@17:06

DATE OF NOTE:JAN 09,1996@17:51:04  ENTRY DATE:JAN 09, 1996@17:51:04

Provided Mr. TIUPatient with Diabetes diet pamphlet and explained areas he especially needed to be concerned about.

/es/ Three TIUProvider, MD
for Five TIUProvider, MS3
Medical Student III

Select Action: Quit// Print

5. The document is printed at the device you specified.

TIUPATIENT,ONE  666-23-3456  Progress Notes

NOTE DATED: 01/09/96 17:51  DIABETES EDUCATION
ADMITTED: 07/22/91 11:06 1A
SUBJECT: Lipid TEST

Provided Mr. TIUPatient with Diabetes diet pamphlet and explained areas he especially needed to be concerned about.

Signed by: /es/ TIUPROVIDER,FIVE, MD
Medical Student III 01/23/96 08:34
Analog Pager: 1-900-555-8398
Digital Pager: 1-900-555-7883

Cosigned by: /es/ TIUPROVIDER,THREE
01/23/96 08:34
Analog Pager: 1-900-555-8398
Digital Pager:1-900-555-7883
Multiple Patient Documents

Use this option to see a list of clinical documents for more than one patient in TIU. You can specify types, categories, and time range.

⚠️ Caution: Avoid making your requests too broad (in statuses, search categories, and date ranges) because these searches can use a lot of system resources, slowing the computer system down for everyone. The example below would probably be too broad in a large hospital.

Steps to use option:

1. Select **Multiple Patient Documents** from your TIU menu.

   --- Remote User Menu ---

   1   Individual Patient Document
   2   Multiple Patient Documents

   Select Text Integration Utilities (Remote User) Option: 2 Multiple Patient Documents

2. Enter a status.

   Select Status: COMPLETED// **all** undictated untranscribed unreleased
   unverified unsigned uncosigned
   completed amended purged deleted

3. Select a document type (such as Discharge Summary, Progress Notes, Addendum).

   Select Clinical Documents Type(s): **All** Discharge Summary, Progress Notes, Addendum

4. Select one of the following search categories

<table>
<thead>
<tr>
<th></th>
<th>All Categories</th>
<th></th>
<th>Patient</th>
<th></th>
<th>Transcriptionist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All Categories</td>
<td>6</td>
<td>Patient</td>
<td>11</td>
<td>Transcriptionist</td>
</tr>
<tr>
<td>2</td>
<td>Author</td>
<td>7</td>
<td>Problem</td>
<td>12</td>
<td>Treating Specialty</td>
</tr>
<tr>
<td>3</td>
<td>Division</td>
<td>8</td>
<td>Service</td>
<td>13</td>
<td>Visit</td>
</tr>
<tr>
<td>4</td>
<td>Expected Cosigner</td>
<td>9</td>
<td>Subject</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Hospital Location</td>
<td>10</td>
<td>Title</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

   Select SEARCH CATEGORIES: AUTHOR// **all** All Categories
**Multiple Patient Documents, cont’d**

5. Enter a date range.

```
Start Reference Date [Time]: T-7/<Enter>  (JUN 02, 1997)
Ending Reference Date [Time]: NOW/<Enter>  (JUN 09, 1997@11:19)
Searching for the documents..
```

6. All the documents for the criteria selected are displayed. Choose an action to perform, then the document to perform it on.

```
<table>
<thead>
<tr>
<th>Patient</th>
<th>Document</th>
<th>Ref Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIE</td>
<td>ADVANCE DIRECTIVE</td>
<td>06/06/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to CLINICAL WARNING</td>
<td>06/05/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Adverse React/Allergy</td>
<td>06/05/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>CRISIS NOTE</td>
<td>06/05/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>FANCY RAT NOTES</td>
<td>06/04/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to Adverse React/Aller</td>
<td>06/04/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to Adverse React/Aller</td>
<td>06/04/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>FANCY RAT NOTES</td>
<td>06/03/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to FANCY RAT NOTES</td>
<td>06/03/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to Discharge Summary</td>
<td>06/02/97</td>
<td>completed</td>
</tr>
<tr>
<td>TIUPATIE</td>
<td>Addendum to Discharge Summary</td>
<td>06/02/97</td>
<td>unsigned</td>
</tr>
</tbody>
</table>
```

Select Action: Quit// P=13
DEVICE: HOME// PRINTER
Multiple Patient Documents, cont'd

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>AGE</th>
<th>SEX</th>
<th>RACE</th>
<th>SSN</th>
<th>CLAIM NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT, SEVEN</td>
<td>66</td>
<td>M</td>
<td>AMER</td>
<td>666-04-2591P</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADM DATE</th>
<th>DISC DATE</th>
<th>TYPE OF RELEASE</th>
<th>INP</th>
<th>ABS</th>
<th>WARD NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAY 30, 1997</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DICTATION DATE: JUN 02, 1997
TRANSCRIPTION DATE: JUN 02, 1997
TRANSCRIPTIONIST: jg

DIAGNOSIS:
toe injury

OPERATIONS/PROCEDURES:
evaluated for prosthesis

SIGNATURE APPROVING PHYSICIAN/DENTIST

COPY

JUN 02, 1997@16:55:56 ADDENDUM:
In remission.

SIGNATURE APPROVING PHYSICIAN/DENTIST

Three TIUProvider, MS
Chapter 8: Progress Notes Print Options

Clinicians can print progress notes but most printing is geared towards MAS and managing this function on a medical center level.

TIU offers two methods of printing documents:

1. **Print actions on option screens**: Clinicians may print all types of documents using a variety of methods from the List Manager interface for TIU, including Progress Notes, Discharge Summaries, Consults, etc. Work and chart copies are possible. Chart copies are the recommended type of printed copy, but many sites still want to print work copies. For example, you may want to print work copies of unsigned notes.

Other than the above List Manager printing, all other print options are on print menus. Only signed notes are available from these options.

2. **Progress Notes Print Menus**

Progress Notes Print Menu
   For many types of users: clinical, administrative, management.

MAS Options to Print Progress Notes
   For printing at the Wards and Clinics, both by individual patient and batch printing.
## Progress Notes Print Menu

All of the options on this menu support the printing of chart or work copies.

**NOTE:** The location print option prints for any location that has signed notes entered for it, but it doesn’t track anything.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author– Print Progress Notes</td>
<td>This option produces chart or work copies of progress notes for an author, for a selected date range.</td>
</tr>
<tr>
<td>Location– Print Progress Notes</td>
<td>This option prints chart or work copies of progress notes for all patients who were at a specific location when the notes were written. The patients whose progress notes are printed on this report may not still be at that location. If Chart Copy is selected, each note will start on a new page.</td>
</tr>
<tr>
<td>Patient– Print Progress Notes</td>
<td>This option prints or displays progress notes for a selected patient by a selected date range.</td>
</tr>
<tr>
<td>Ward– Print Progress Notes</td>
<td>This option allows you to print progress notes for all patients who are now on a ward for a selected date range. This option is only for ward locations. NOTE: Copies can only be printed to a printer, not to a computer screen.</td>
</tr>
</tbody>
</table>

### MAS Options to Print Progress Notes

The MAS options are intended for printing at the Wards and Clinics, both by individual patient and batch printing.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission- Prints all PNs for Current Admission</td>
<td>This option prints all progress notes for a selected patient for the current admission if patient is an inpatient or LAST admission if the patient has been discharged.</td>
</tr>
<tr>
<td>Batch Print Outpt PNs by Division</td>
<td>This option batch prints outpatient progress notes in terminal digit order by division. Locations that the site would like excluded from this job may edit field #3 in file #8925.93. If the location is not entered in file #8925.93, it WILL be included.</td>
</tr>
<tr>
<td>Outpatient Location- Print Progress Notes</td>
<td>This option is designed to be used primarily by MAS. It produces CHARTABLE notes and tracks the last note printed for the selected outpatient location. Output is sorted in alphabetical order by patient.</td>
</tr>
<tr>
<td>Ward- Print Progress Notes</td>
<td>This option allows the printing of Progress Notes for ALL patients on the ward at the time the job is queued to print. All of the notes for a selected date range (regardless of the location of the note) will print. This option is only for WARD locations. NOTE: Copies can only be printed to a printer, not to a computer screen.</td>
</tr>
</tbody>
</table>
---Print Progress Notes---

PNPA   Author- Print Progress Notes
PNPL   Location- Print Progress Notes
PNPT   Patient- Print Progress Notes
PNPW   Ward- Print Progress Notes

Select Progress Notes Print Options Option: author- Print Progress Notes

Print Progress Notes for a Selected AUTHOR

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

AUTHOR: TIU_PROVIDER, THREE     TT     MD

Print Notes Beginning: t-100 (MAY 01, 1996)
Thru: t-60 (JUL 10, 1996)

Searching for the notes........
>> 8 notes found for TIU_PROVIDER, Three
Do you want WORK copies or CHART copies? CHART// <Enter>
DEVICE: HOME// PRINTER

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

ANDERSON, H C  666-12-3456                                  Progress Notes
-------------------------------------------------------------------------
NOTE DATED: 05/08/96 11:01    DIABETES EDUCATION
ADMITTED: 04/21/96 10:00 2B
-------------------------------------------------------------------------
SUBJECTIVE: 45 year old AMERICAN INDIAN here for
initial evaluation of his DYSLIPIDEMIA.
COPIED FROM TIU_CLIENT TO TIU_PATIENT...

PMH:

Significant negative medical history pertinent to the
evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION HISTORY: CURRENT MEDICATIONS

DIET:     Counseled on AHA Step I diet today by NINE TIU_PROVIDER.
See her evaluation.

ACTIVITY:

OBJECTIVE:     HT: 70 (08/23/95 11:45)     WT: 207 (08/23/95 11:45)
               TSH/T4: 1.7/1.1
               FBG: 200       HEMOGLOBIN A1C: 15.2
               SGOT: 44       URIC ACID: 4.7

Enter RETURN to continue or '^' to exit: <Enter>
ASSESSMENT: 1. MALE with / without documented CAD
2. CV Risk factors:
3. Lipid pattern:

PLAN: 1. Implement recommendations to lower fat intake.
2. Repeat FBG and HBG A1C on:
3. Return to review lab on:

Signed by: /es/ Three TIUProvider, MS
Physician Assistant 06/21/96 07:47
Analog Pager: 555-1213
Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit:<Enter>

NOTE DATED: 06/21/96 11:38 SOCIAL WORK SERVICE
ADMITTED: 06/01/96 10:00 2B
Follow-up to 6/1/96 visit.

Signed by: /es/ Three TIUProvider, MS
Physician Assistant 06/21/96 07:47
Analog Pager: 555-1213
Digital Pager: 555-1215

Enter RETURN to continue or '^' to exit:<Enter>

NOTE DATED: 07/03/96 14:18 LIPID CLINIC
ADMITTED: 05/28/96 15:58 1A
SUBJECTIVE: 65 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for
initial evaluation of his DYSLIPIDEMIA.
MORE STUFF...

PMH:

Significant negative medical history pertinent to the
evaluation and treatment of DYSLIPIDEMIA:

FH:

SH:

MEDICATION HISTORY: CURRENT MEDICATIONS

DIET: Counseled on AHA Step I diet today by NINE TIUPROVIDER.

ACTIVITY:
OBJECTIVE:     HT:  70 (08/23/95 11:45)   WT:  178 (07/01/96 17:15)
   TSH/T4: 1.7/1.1
   FBG: 223     HEMOGLOBIN A1C: 15.2
   SGOT: 44     URIC ACID: 4.7

ASSESSMENT:    1.      MALE with / without documented CAD
                2.      CV Risk factors:
                3.      Lipid pattern:

PLAN:          1.      Implement recommendations to lower fat intake.
                2.      Repeat FBG and HBG A1C on:
                3.      Return to review lab on:

Signed by: /es/  Three TIUProvider, MS
            Physician Assistant 07/03/96 14:19
            Analog Pager: 1-900-555-8398
            Digital Pager: 1-900-555-7883

Enter RETURN to continue or '^^' to exit: ^
Location – Print Progress Notes Example

Select Progress Notes Print Options Option: Location- Print Progress Notes

-------------------------------------------
Print Progress Notes for a Selected LOCATION
-------------------------------------------

Select HOSPITAL LOCATION NAME: GENERAL MEDICINE TIUPROVIDER,TWENTY

Available notes: Sep 06, 1995 thru Oct 02, 1996
Print Notes Beginning: t-30 (SEP 08, 1996)
Thru: t (OCT 08, 1996)

Searching for the notes...
>> 2 notes found for GENERAL MEDICINE
Do you want WORK copies or CHART copies? CHART// <Enter>

DEVICE: HOME// <Enter> VAX

-------------------------------------------
TIUPATIENT,ONE 666-23-3456 Progress Notes
-------------------------------------------
NOTE DATED: 10/01/96 11:59 BP TEST
VISIT: 04/18/96 10:00 GENERAL MEDICINE
   NAME: TIUPATIENT,ONE
   SEX: MALE
   DOB: SEP 12,1944
ALLERGIES: Amoxicillin, Aspirin, MILK
LABS: No data available
LIPIDS: No data available
   HT: 72 (08/23/95 11:45)
   WT: 190 (08/23/95 11:45)

Signed by: /es/ Three TIUProvider, MS
10/01/96 15:38
Analog Pager: 1-900-555-8398
Digital Pager: 1-900-555-7883

Enter RETURN to continue or '^' to exit: <Enter>

-------------------------------------------
TIUPATIENT,SEVEN 666-04-2591P Progress Notes
-------------------------------------------
NOTE DATED: 09/17/96 13:37 LIPID CLINIC
VISIT: 08/18/96 08:00 GENERAL MEDICINE
SUBJECTIVE: 55 year old AMERICAN INDIAN OR ALASKA NATIVE MALE here for
   initial evaluation of his DYSLIPIDEMIA.
PMH:
   Significant negative medical history pertinent to the
   evaluation and treatment of DYSLIPIDEMIA:
FH:
SH:
MEDICATION
HISTORY: CURRENT MEDICATIONS
DIET: Counseled on AHA Step I diet today by NINE TIUPROVIDER.

Enter RETURN to continue or '^' to exit: <Enter>
Location – Print Progress Notes Example cont’d

TIUPATIENT,SEVEN 666-04-591P Progress Notes

09/17/96 13:37 ** CONTINUED FROM PREVIOUS SCREEN **

ACTIVITY:


TSH/T4: 1.7/1.1

FBG: 200 HEMOGLOBIN A1C: 15.2

SGOT: 44 URIC ACID: 4.7

ASSESSMENT: 1. MALE with / without documented CAD
2. CV Risk factors:
3. Lipid pattern:

PLAN: 1. Implement recommendations to lower fat intake.
2. Repeat FBG and HBG A1C on:
3. Return to review lab on:

Signed by: /es/ Three TIU Provider, MD
10/02/96 10:34
Analog Pager: 1-900-555-8398
Digital Pager: 1-900-555-7883

Enter RETURN to continue or '^

Select HOSPITAL LOCATION NAME: ^Patient– Print Progress Notes Example
Select Progress Notes Print Options Option: p Patient-Print Progress Notes
Print Progress Notes for a Selected PATIENT
------------------------------------------------------------------
Select PATIENT NAME: TIUPATIENT, THIRTEEN 04-01-44 666776641
YES SC VETERAN
(1 note ) W: 09/02/95 09:00
Available notes: Sep 06, 1995 thru Mar 21, 1996
Print Notes Beginning: t-360 (APR 08, 1995)
Thru: t (APR 02, 1996)
Searching for the notes.......
>> 5 notes found for TIUPATIENT, THIRTEEN
Do you want WORK copies or CHART copies? CHART/> <Enter>
Do you want to start each note on a new page? NO/> <Enter>
DEVICE: HOME/> <Enter> LAT TERMINALS

------------------------------------------------------------------
TIUPATIENT, EIGHT 666-77-6641 Progress Notes
------------------------------------------------------------------
NOTE DATED: 09/01/95 12:00 General Note
VISIT: CARDIOLOGY
This is a very sad situation. It is also a general progress note. We hope the patient does better in the future.
She is quite nice, clean and nice.

Signed by: /es/ NINE TIUPROVIDER
VERIFIER 09/06/95 21:51

NOTE DATED: 09/02/95 09:00 Clinical Warning
VISIT: CARDIOLOGY
Beware: this patient bites.

Signed by: /es/ NINE TIUPROVIDER
VERIFIER 09/06/95 21:53

NOTE DATED: 11/08/95 15:20 History & Physical Ex
VISIT: 09/05/95 11:00 DIABETES CLINIC
SUBJECT: TESTING THE GLUCOSE LEVEL

1. Chief Complaint: Numbness in legs
   Reason for Admission (if different from #1)

2. History of Present Illness: Type 2 onset 1993
   Medication Allergies: Penicillin causes rash
   Current Medications: Oral insulin

Enter RETURN to continue or '^' to exit: <Enter>
Patient – Print Progress Notes Example cont’d

TIUPATIENT,EIGHT  666-77-6641  Progress Notes
11/08/95 15:20  ** CONTINUED FROM PREVIOUS SCREEN **

PAST HISTORY
1. Hospitalizations: 6/10/93
   Surgeries:                               Injuries:
   Illness:                                 Disabilities:
   Transfusion(s): ( )Yes (X)No
      If Yes, give date(s):

2. Unusual Childhood Illnesses:
   Immunizations:
      (X)DT last booster: 1/90    ( )Pneumonia    ( )Flu
      ( )Hep B                   ( )Other:

3. Habits:  (x)Smoking    (x)Alcohol    ( )Drugs
   Caffeine Use:  (x)Coffee    ( )Tea         ( )Cola
      ( )Suicide Attempts     ( )OTHER:

4. SOCIAL/MILITARY HISTORY (Occupations):
   ( )WWI   ( )WWII   ( )KOREAN   (x)VIETNAM   ( )GULF WAR
   Travel:
   Source of Income: ( )Job   ( )Retired   (x)Pension   ( )Other

5. REVIEW OF SYSTEMS:

6. PHYSICAL:
   BP:  Lying:           Sitting:            Standing:

2. General:  (x)Well    ( )Obese    ( )Thin    ( )Malnourished    ( )Neat
   ( )Chronically Ill    ( )Toxic    ( )Acute Distress

Head:
Eyes:
ENT:

Enter RETURN to continue or '^' to exit: <Enter>
**Patient – Print Progress Notes Example cont’d**

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Progress Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIUPATIENT,EIGHT 666-77-6641</td>
<td><strong>CONTINUED FROM PREVIOUS SCREEN</strong></td>
</tr>
</tbody>
</table>

11/08/95 15:20

6. Neck:

7. Chest and Breasts:

8. Lungs:

9. Lymphatics (Cervical, Epitrocholear, Axillary, Inguinal, Popliteal):

10. Heart:

11. Abdomen:

12. Pelvic/Genitalia (Penis, Scrotum, Testicles):

13. Rectal:

14. Neurological:
   - Cranial Nerves:
   - Peripheral Neurological exam:
     - Reflexes: 0 - No reflex \( \_ \)
     - 1 - Hyporeflexia \( \_ \)
     - 2 - Average \( \_/ \)
     - 3 - Brisk \( \_/ \)
     - 4 - Hypereflexia \( \_/ \)

15. Musculoskeletal:
   - Upper Extremities:
   - Lower Extremities:
   - Spine:

16. Psychiatric:
   - Are any cognitive impairments noted? \( \_ \)Yes \( \_ \)No
   - Are any communication impairments noted? \( \_ \)Yes \( \_ \)No

17. Skin:

7. WOMEN’S GYNECOLOGICAL HISTORY AND PHYSICAL EXAM

   HISTORY:
   - Menarche: \( \_ \)Yes \( \_ \)None Interval/Duration:
   - Characteristics:

Enter RETURN to continue or ‘^’ to exit: <Enter>
Patient – Print Progress Notes Example cont’d

---

**CONTINUED FROM PREVIOUS SCREEN**

Last Pap: Results: Previous Gyn Surgery:  
Birth Control Method: Number of Pregnancies:
Miscarriages: 
Stillbirths: Live Births: Menopause Onset: What effect:  
Hormones: Prior STD History: 
Last Mammogram: Results: 

Number of sexual partners in the past six months?  
Y N 
SYMPTOMS DESCRIPTION 
( ) ( ) Stress Incontinence  
( ) ( ) Vaginal Discharge/Itching  
( ) ( ) Rash/Sores  
( ) ( ) Lower Abdominal Pain  
( ) ( ) Dyspareunia  
( ) ( ) Breast Lumps/Pain  
( ) ( ) Breast Rash/Nipple Discharge  
( ) ( ) Abnormal Bleeding  
( ) ( ) Other:  

PHYSICAL EXAMINATION:
NOTE: Ohio State Law requires that every female inpatient receive a breast and pelvic exam unless one was performed within the preceding 12 months or the patient refuses the examination in writing. (Patient must sign below).  

BREASTS:  

<table>
<thead>
<tr>
<th>Quadrant</th>
<th>Quadrant</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>/ /</td>
<td>/ /</td>
<td></td>
</tr>
<tr>
<td>1 1 1</td>
<td>1 1 1</td>
<td></td>
</tr>
<tr>
<td>1 1 --o--</td>
<td>1 1 --o--</td>
<td></td>
</tr>
<tr>
<td>1 1 1</td>
<td>1 1 1</td>
<td></td>
</tr>
</tbody>
</table>

GENITALIA (Vulva, Urethra, Vagina, Cervix, Fundus, Adnexa)  

PATIENT REFUSAL OF EXAMINATION  
[ ] I do not wish to receive a breast or pelvic exam at this time.  
[ ] I would like to be scheduled for an outpatient breast and pelvic exam at the Women's Health Clinic.

Patient's Signature:______________________________________

8. INITIAL IMPRESSION/ASSESSMENT:  
9. WORKING DIAGNOSIS:  
10. PLAN:  
Enter RETURN to continue or '^' to exit: <Enter>
Patient– Print Progress Notes Example, cont’d

TIUPATIENT, TWENTY 666-77-6641 Progress Notes

11/08/95 15:20 ** CONTINUED FROM PREVIOUS SCREEN **

NOTE DATED: 03/20/96 08:30 Diabetes Education - Glucose Monitoring
VISIT: 03/19/96 08:00 DIABETES EDUCATION
SUBJECT: TESTING MULTIPLE COPY

Date of Class:
Class: Advantage Blood Glucose Monitor
Process: Lecture, Demonstration, and Return Demonstration
Issued: Advantage monitor, Level I and II glucose control solutions, and 3 boxes (50 each) Advantage test strips.

Subjective: Patient states:
- Tests his BG ___ times/day
- Has not received previous directions.

Objective:
Patient attended class. With Significant Other? No  Yes
Any observed barriers to learning? No Yes

Concepts:
1. Location of batteries.
2. Using memory.
3. Coding machine.
4. Using glucose control. These expire 3 mo after opening.
5. Performing a blood glucose test.
   A. Clean fingertip (only) with warm soap and water.
   B. Use side of any or all fingertips unless there is sore or other damage present.
6. Proper care and storage of machine and strips.
   A: Knowledge deficit r/t Advantage SBGM
 P: If no previous directions received, recommend 1-2 X day test and prn any signs low blood sugar.
RX:
1. Advantage glucose monitor kit (To pharmacy)
2. Advantage glucose control solutions. Disp 1 box Q 3 mo. Refill X3. (To pharmacy).
3. No Advantage Test Strips. Disp: 0 Boxes Q 3 mo. Refill X3.
   No Monojector. Only one. No Refill.
   No Lancets. #100 Q 3 mo. Refill X3.

Evidence of Learning: Patient coded, used glucose controls, and checked his own blood sugar during class. When mistakes were made, they were acknowledged by patient and corrective action stated.

Signed by: /es/ TIUPROVIDER, THREE
PGY3 MEDICAL RESIDENT 03/20/96 08:31
Ward – Print Progress Notes Example

This option is usually used by the night ward clerk. The output is in RM/BED order to facilitate filing. It prints all notes after the last time they were printed, and for ALL current inpatients on the ward, regardless of whether the location of the note is that ward, a nice feature for transferred patients or patients with outpatient clinic appointment notes. This print option requires that you specify a printer; you can’t print to the screen.

Print by Ward is designed to support batch printing. It has the unique ability to determine when the last note was printed so that sites can now capture the infamous “orphan” note which was a problem under Progress Notes 2.5. A new page is started for each patient.

```
Print Progress Notes for ALL patients on WARD
---------------------------------------------------------------------
Select WARD Location: 6  1A

Print Notes Starting With (DATE/TIME): t-20  (MAY 23, 1997)..........       
>> 32 notes found for WARD 1A

DEVICE: PRINTER

======================================================================
MEDICAL RECORD                                            Progress Notes
======================================================================
NOTE DATED: 05/27/97  12:13  CLINICAL WARNING
ADMITTED: 04/20/97  15:58  1A

Mr. TIUPatient is becoming violent and self-destructive again. Will try a new Prescription.

Signed by:/ es/ Ten TIUProvider, MD
05/27/97  12:14

05/28/98  09:45    Addendum
Mr. TIUPatient is more calm, and responding to counseling and medication

Signed by:/ es/ Ten TIUProvider, MD
05/28/97  10:14

NOTE DATED: 04/20/97  12:13  CLINICAL WARNING
ADMITTED: 04/20/97  15:58  1A

Mr. TIUPatient is violent and self-destructive again. Prescribed tranquilizer.

Signed by:/ es/ Ten TIUProvider, MD
04/20/97  01:20

TIUPATIENT,SEVEN            REGION 5                Printed: 06/09/97  11:50
```
Chapter 9: Managing TIU: Introduction

TIU is managed through use of the following tools:

- Menu assignments
- Parameter set-ups
- Document Definitions
- User Class set-up

See the *TIU Implementation Guide* for more detailed instructions on performing these various set-ups.

**TIU Maintenance Menu**

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Menu Text</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIU PARAMETERS MENU</td>
<td>TIU Parameters Menu</td>
<td>This option allows the Clinical Coordinator or IRMS Application Specialist to set up either the Basic or Upload Parameters for TIU.</td>
</tr>
<tr>
<td>USR CLASS MANAGEMENT MENU</td>
<td>User Class Management</td>
<td>Menu of options for managing User Class Definition and Membership.</td>
</tr>
<tr>
<td>TIU IRM TEMPLATE MGMT</td>
<td>TIU Template Mgmt Functions</td>
<td>Menu options for managing pre-defined templates created by your medical center.</td>
</tr>
<tr>
<td>TIUHL7 Message Manager</td>
<td>TIUHL7 MSG MGR</td>
<td>Utility for viewing message going in and out of the TIU Generic HL7 Interface.</td>
</tr>
<tr>
<td>TIU TEXT EVENT EDIT</td>
<td>Text Event Edit</td>
<td>Menu option to set up a text event in the TIU TEXT EVENTS file (#8925.71) so that an alert will be sent to the team(s) specified in the TIU TEXT EVENTS file immediately after a TIU document (progress note, consult, etc.) is created and signed.</td>
</tr>
<tr>
<td><strong>TIU ABBV ENTER EDIT</strong></td>
<td><strong>TIU Unauthorized Abbreviation (Enter/Edit)</strong></td>
<td>Allows local sites to enter/edit their LOCAL unauthorized abbreviation(s) in the &quot;TIU UNAUTHORIZED ABBREVIATION&quot; File (#8927.9). “CLASS” (# .02) field defaults to LOCAL, &quot;ABBREVIATION EXACT MATCH&quot; (#.03) field defaults to YES, and “STATUS” (#.04) field defaults to ACTIVE when staff enter a new abbreviation. Local sites can only edit the ABBREVIATION EXACT MATCH and the STATUS fields when the CLASS field is set to LOCAL. Sites cannot edit an entry when the CLASS field is set to NATIONAL.</td>
</tr>
<tr>
<td><strong>TIU ABBV LIST</strong></td>
<td><strong>List Unauthorized Abbreviations</strong></td>
<td>Produces a printed copy of all unauthorized abbreviations, active only or active with inactive.</td>
</tr>
<tr>
<td><strong>TIU DOWNTIME BOOKMARK PN</strong></td>
<td>Contingency Downtime Bookmark Progress Notes</td>
<td>Menu option to set up notes to alert clinicians of computer downtime during defined time periods so that clinicians can check patients’ paper records, if necessary.</td>
</tr>
</tbody>
</table>
Legal Requirements

Patient Confidentiality
TIU works with patient records and documents. All users are reminded to be aware of the confidentiality of these records.

Electronic Signature
TIU uses a combination of menu access, User Classes, and Electronic Signature codes to maintain security and responsibility. Individuals in the system who have authority to approve actions, at whatever level, have an **electronic signature code**. Like the access and verify codes used when gaining access to the system, the electronic signature code is not visible on the screen. These codes are also encrypted so that they are unreadable to other users, even when viewed in the user file by those with the highest levels of access. Electronic signature codes are required by TIU for every action that currently requires a signature on paper.

How to Change Your Electronic Signature Code

1. Select User’s Toolbox from the Mailman Menu.
2. Select Edit Electronic Signature Code from the User’s Toolbox menu.

3. Enter your initials.
4. At the “Signature Block Printed Name:” prompt, enter your name as you want it printed on forms that require your signature.

    **NOTE:** If the SIGNATURE BLOCK PRINTED NAME and SIGNATURE BLOCK TITLE fields are disabled at your site, contact your supervisor to request entry of your name and title.

5. At the “Signature Block Title:” prompt, enter your job title as you want it printed on forms that require your signature.
6. Enter your office phone number.

   **Enter your signature code.**
Cosignature

Cosignature requirements are determined at local levels. Sites or departments can set Cosignature requirements for certain kinds of documents through the Document Parameter Edit option on the TIU Parameters Menu. Individual clinicians can designate a default cosigner on their Personal Preferences option.

Links and Relationships with Other Packages

TIU is closely linked to other applications and utilities — Authorization/Subscription Utility (ASU) List Manager utility, the Computerized Patient Record System (CPRS), Visit Tracking, etc. This linkage should remain transparent to users, but the IRM Service and Clinical Coordinators will need to coordinate the components.

Instructions will be provided (with a TIU patch) for setting up the interface with CPRS.

See the User and Technical Manuals of the above-listed packages for further instructions about interfaces.
Chapter 10: Menus and Option Assignment

TIU menus and options are not exported on a single menu, but as individual menus intended for categories of users. These are described in earlier sections of this manual and also here. Sites may rearrange these as needed. Recommended assignments are also listed on the following pages. We’ve also included an example of a potential Clinical Coordinator Menu.

<table>
<thead>
<tr>
<th>Progress Notes(s)/Discharge Summary [TIU] ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Progress Notes User Menu ...</td>
</tr>
<tr>
<td>1    Entry of Progress Note</td>
</tr>
<tr>
<td>2    Review Progress Notes by Patient</td>
</tr>
<tr>
<td>2b   Review Progress Notes</td>
</tr>
<tr>
<td>3    All MY UNSIGNED Progress Notes</td>
</tr>
<tr>
<td>4    Show Progress Notes Across Patients</td>
</tr>
<tr>
<td>5    Progress Notes Print Options...</td>
</tr>
<tr>
<td>6    List Notes By Title</td>
</tr>
<tr>
<td>7    Search by Patient AND Title</td>
</tr>
<tr>
<td>8    Personal Preferences...</td>
</tr>
<tr>
<td>9    ALL Documents requiring my Additional Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharge Summary User Menu ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Individual Patient Discharge Summary</td>
</tr>
<tr>
<td>2    All MY UNSIGNED Discharge Summaries</td>
</tr>
<tr>
<td>3    Multiple Patient Discharge Summaries</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrated Document Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Individual Patient Document</td>
</tr>
<tr>
<td>2    All MY UNSIGNED Documents</td>
</tr>
<tr>
<td>3    All MY UNDICTATED Documents</td>
</tr>
<tr>
<td>4    Multiple Patient Documents</td>
</tr>
<tr>
<td>5    Enter/edit Document</td>
</tr>
<tr>
<td>6    ALL Documents requiring my Additional Signature</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Preferences ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Personal Preferences</td>
</tr>
<tr>
<td>2    Document List Management</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Text Integration Utilities (MRT) ...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1    Individual Patient Document</td>
</tr>
<tr>
<td>2    Multiple Patient Documents</td>
</tr>
<tr>
<td>3    Review Upload Filing Events</td>
</tr>
<tr>
<td>4    Print Document Menu ...</td>
</tr>
<tr>
<td>1    Discharge Summary Print</td>
</tr>
<tr>
<td>2    Progress Note Print</td>
</tr>
<tr>
<td>3    Clinical Document Print</td>
</tr>
<tr>
<td>5    Released/Unverified Report</td>
</tr>
<tr>
<td>6    Search for Selected Documents</td>
</tr>
<tr>
<td>7    Unsigned/Uncosigned Report</td>
</tr>
<tr>
<td>8    Reassignment Document Report</td>
</tr>
<tr>
<td>9    Review unsigned additional signatures</td>
</tr>
</tbody>
</table>
## TIU Menus and Options cont'd

### Text Integration Utilities (MIS Manager) ...
1. Individual Patient Document
2. Multiple Patient Documents
3. Print Document Menu ...
   1. Discharge Summary Print
   2. Progress Note Print
   3. Clinical Document Print
4. Search for Selected Documents
5. Statistical Reports...
6. Unsigned/Uncosigned Report
7. Missing Text Report
8. Missing Text Cleanup
9. Signed/unsigned PN report and update
10. UNKNOWN Addenda Cleanup
11. Missing Expected Cosigner Report
12. Mark Document as 'Signed by Surrogate'
13. Mismatched ID Notes
14. TIU 215 ANALYSIS ...
15. Transcription Billing Verification Report
16. CWAD/Postings Auto-Demotion Setup

### Text Integration Utilities (Transcriptionist) ...
1. Enter/Edit Discharge Summary
2. Enter/Edit Document
3. Upload Menu...
   1. Upload Documents
   2. Help for Upload Utility
4. List Documents for Transcription
5. Review/Edit Documents
6. Transcription Billing Verification Report

### CWAD/Postings Auto-Demotion Setup ...
1. Select a CWAD/Postings TITLE for auto-demotion
2. Select a Non-Posting TITLE as the demotion target
3. Enter RETURN to continue or `^^` to exit
4. Done. Post-Signature code has been set (or reset) as follows:
5. TITLE: and POST-SIGNATURE ACTION:

### Text Integration Utilities (Remote User) ...
1. Individual Patient Document
2. Multiple Patient Documents

### Progress Notes Print Options ...
- PNPA: Author- Print Progress Notes
- PNPL: Location- Print Progress Notes
- PNPT: Patient- Print Progress Notes
- PNPW: Ward- Print Progress Notes

### Document Definitions (Clinician) ...
1. Edit Document Definitions
2. Sort Document Definitions
3. View Objects

### MAS Options to Print Progress Notes...
- Admission: Prints all PNs for Current Admission
- Batch Print Outpt PNs by Division
- Outpatient Location: Print Progress Notes
- Ward: Print Progress Notes
**TIU Menus and Options cont'd**

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<td>4 Create Objects</td>
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<td>10 Unauthorized Abbreviations (Enter/Edit)</td>
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<tr>
<td>11 List Unauthorized Abbreviations</td>
</tr>
<tr>
<td>13 Contingency Downtime Bookmark Progress Notes</td>
</tr>
</tbody>
</table>

---

**TIU Conversion Clean-up Menu [GMRP TIU]**

This menu comes with Patch GMRP*2.5*44 which is distributed prior to TIU to help clean up the Generic Progress Notes File (#121) and the Generic Progress Notes Title File (121.2). It also contains options to assist in populating the TIU Document Definition File (8925.1), which is roughly equivalent to file #121.2.

This menu is NOT exported on any existing menu. It should be assigned to the person responsible for getting the Progress Notes package ready for conversion to TIU. We suggest that this be limited to one person per site or several people working closely together on these clean-up exercises.

| 1 Calculate Number of PNs per TITLE |
| 2 Number of Notes per TITLE - Report |
| 3 DELETE a Progress Notes TITLE |
| 4 MOVE Notes to Another TITLE |
| 5 Edit TITLE - Enter/Edit Doc Class |
| 6 TITLEs Sorted by Document Class - Report |
| 7 CONVERT TITLEs (#121.2) to TIU (#8925.1) |
| PRT Title of Progress Note |
| UN List Unsigned Progress Notes by AUTHOR |
| DEL Delete a Signed Progress Note |
Suggested Clinical Coordinator Menu

TIU doesn’t export a Clinical Coordinator Menu. However, sites may wish to create one which includes most of the other menus and options, except possibly IRM options requiring programmer access.

<table>
<thead>
<tr>
<th>Menu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Text Integration Utilities (Transcriptionist) ...</td>
</tr>
<tr>
<td>Text Integration Utilities (MRT) ...</td>
</tr>
<tr>
<td>Progress Notes(s)/Discharge Summary [TIU] ...</td>
</tr>
<tr>
<td>Text Integration Utilities (MIS Manager) ...</td>
</tr>
<tr>
<td>Text Integration Utilities (Remote User) ...</td>
</tr>
<tr>
<td>Progress Notes Print Options ...</td>
</tr>
<tr>
<td>MAS Options to Print Progress Notes...</td>
</tr>
<tr>
<td>Document Definitions ...</td>
</tr>
<tr>
<td>TIU Parameters Menu...</td>
</tr>
<tr>
<td>User Class Management ...</td>
</tr>
<tr>
<td>Upload Menu</td>
</tr>
</tbody>
</table>
# Menu Assignment

We recommend assigning menus as follows:

<table>
<thead>
<tr>
<th>Option Name</th>
<th>Menu Text</th>
<th>Description</th>
<th>Assign to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIU MAIN MENU TRANSCRIPTION</td>
<td>Text Integration Utilities (Transcriptionist)</td>
<td>Main Text Integration Utilities menu for transcriptionists.</td>
<td>Transcriptionists</td>
</tr>
<tr>
<td>TIU MAIN MENU MRT</td>
<td>Text Integration Utilities (MRT)</td>
<td>Main Text Integration Utilities menu for Medical Records Technicians.</td>
<td>Medical Records Technicians</td>
</tr>
<tr>
<td>TIU MAIN MENU MGR</td>
<td>Text Integration Utilities (MIS Manager)</td>
<td>Main Text Integration Utilities menu for MIS Managers.</td>
<td>MIS Managers.</td>
</tr>
<tr>
<td>TIU MAIN MENU CLINICIAN</td>
<td>Progress Notes(s)/Discharge Summary [TIU]</td>
<td>Main Text Integration Utilities menu for Clinicians.</td>
<td>Clinicians</td>
</tr>
<tr>
<td>TIU MAIN MENU REMOTE USER</td>
<td>Text Integration Utilities (Remote User)</td>
<td>This option allows remote users (e.g., VBA RO personnel) to access only those documents that have been completed, to facilitate processing of claims on a need-to-know basis.</td>
<td>VBA RO personnel, etc.</td>
</tr>
<tr>
<td>TIU PRINT PN USER MENU</td>
<td>Progress Notes Print Options</td>
<td>Menu for printing Progress Notes.</td>
<td>ADPACs, managers</td>
</tr>
<tr>
<td>TIU MAS PRINT PN MENU</td>
<td>MAS Options to Print Progress Notes</td>
<td>Menu of options for printing Progress Notes for specific locations, individually or by batch</td>
<td>MAS ADPACs &amp; supervisors</td>
</tr>
<tr>
<td>TIUF DOCUMENT DEFINITION</td>
<td>Document Definitions</td>
<td>Document Definition (Clinician) Document Definition (Manager)</td>
<td>Clinicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clinical Coordinator, IRM staff</td>
</tr>
<tr>
<td>TIU IRM MAINTENANCE MENU</td>
<td>IRM Maintenance Menu</td>
<td>This option allows IRM staff to set/modify the various parameters controlling the behavior of TIU, as well as the definition of TIU documents.</td>
<td>IRM, maybe Clinical Coordinators (or some of the options on the menu)</td>
</tr>
<tr>
<td>GMRP TIU</td>
<td>TIU Conversion Clean-up Menu</td>
<td>A menu of options for getting the Progress Notes package ready for conversion to TIU</td>
<td>ADPACs, IRM, or Clinical Coordinators. Limit to few.</td>
</tr>
</tbody>
</table>
Chapter 11: Setting up TIU Parameters

TIU Parameters Menu

This menu contains options for Clinical Coordinators or IRM Application Specialists to set up the basic parameters (including Upload parameters) for TIU.

<table>
<thead>
<tr>
<th>Menu Text</th>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic TIU Parameters</td>
<td>TIU BASIC PARAMETER EDIT</td>
<td>This option allows you to enter the basic or general parameters which govern the behavior of the Text Integration Utilities</td>
</tr>
<tr>
<td>Modify Upload Parameters</td>
<td>TIU DOCUMENT PARAMETER EDIT</td>
<td>This option allows the definition and modification of parameters for the batch upload of documents into VistA.</td>
</tr>
<tr>
<td>Document Parameter Edit</td>
<td>TIU UPLOAD PARAMETER EDIT</td>
<td>This option allows you to enter the parameters that apply to specific documents (i.e., Titles), or groups of documents (i.e., Classes, or Document Classes).</td>
</tr>
<tr>
<td>Division - Progress Notes Print Params</td>
<td>TIU PRINT PN DIV PARAM</td>
<td>These parameters are used by the [TIU PRINT PN BATCH INTERACTIVE] and [TIU PRINT PN BATCH SCHEDULED] options. If the site desires a header 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.”</td>
</tr>
<tr>
<td>Progress Notes Batch Print Locations</td>
<td>TIU PRINT PN LOC PARAMS</td>
<td>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.</td>
</tr>
</tbody>
</table>

**NOTE:** The TIU Implementation Guide and TIU Technical Manual contain instructions and examples for using these options.
Chapter 12: Document Definitions

TIU uses a document storage database called the Document Definition hierarchy. This hierarchy provides the building blocks for Text Integration Utilities (TIU). It allows documents (Titles) to inherit characteristics of the higher levels, Class and Document Class, such as signature requirements and print characteristics. This structure, while complex to set up, creates the capability for better integration, shared use of boilerplate text, components, and objects, and a more manageable organization of documents. End users (clinical, administrative, and MIS staff) need not be aware of the hierarchy. They work at the Title level with the actual documents.

Plan the Document Definition Hierarchy your site or service will use before installation of TIU and conversion of progress notes. This step is critical to the organization of existing and future documents in each site’s implementation of TIU. A worksheet is provided in Appendix A of the TIU Implementation Guide to help build the three basic levels.

Example of Document Definition Hierarchy
### Document Definition Options

<table>
<thead>
<tr>
<th>Option Text</th>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Edit Document Definitions</strong></td>
<td>TIUFH EDIT DDEFS</td>
<td>This option allows you to 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/edited using the Edit Options.</td>
</tr>
<tr>
<td><strong>Create Document Definitions</strong></td>
<td>TIUFC CREATE DDEFS</td>
<td>This option allows you to 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 presents 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.</td>
</tr>
<tr>
<td><strong>Sort Document Definitions</strong></td>
<td>TIUFA SORT DDEFS</td>
<td>This option allows you to view parts of the hierarchy by selected sort criteria. It displays the selected entries in alphabetic order by Name, rather than in hierarchy order. Depending on sort criteria, entries can include Objects. The Sort option allows you to view and edit entries.</td>
</tr>
<tr>
<td><strong>Create Objects</strong></td>
<td>TIUFJ CREATE OBJECTS MGR</td>
<td>This option allows you to 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.</td>
</tr>
<tr>
<td><strong>View Objects</strong></td>
<td>TIUFJ VIEW OBJECTS MGR</td>
<td>This option allows you to look at 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.</td>
</tr>
</tbody>
</table>

**NOTE:** For further information about using the Document Definition system, see the TIU/ASU Implementation Guide or the TIU Technical Manual.
Chapter 13: Defining User Classes

The Authorization/Subscription Utility (ASU), which is distributed with TIU, provides a mechanism for sites to associate users with User Classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. It also allows privileges to be inherited, through its use of a hierarchical structure. A set of Business Rules (which can be modified or added to by sites) further strengthens the Utility’s ability to define roles and responsibilities for clinical documents.

See the ASU Clinical Coordinator Manual or the TIU/ASU Implementation Guide for more information about ASU, its relationship to TIU, and its implementation.

User Class Management Menu

<table>
<thead>
<tr>
<th>Option</th>
<th>Option Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>User Class Definition</td>
<td>USR CLASS DEFINITION</td>
<td>This option allows review, addition, editing, and removal of User Classes.</td>
</tr>
<tr>
<td>List Membership by User</td>
<td>USR LIST MEMBERSHIP BY USER</td>
<td>This option allows review, addition, editing, and removal of individual members to and from User Classes.</td>
</tr>
<tr>
<td>List Membership by Class</td>
<td>USR LIST MEMBERSHIP BY CLASS</td>
<td>This option allows review, addition, editing, and removal of individual members to and from User Classes.</td>
</tr>
<tr>
<td>Edit Business Rules</td>
<td>USR EDIT BUSINESS RULES</td>
<td>This option allows the user to enter Business Rules authorizing specific users or groups of users to perform specified actions on documents in particular statuses (e.g., an UNSIGNED PROGRESS NOTE may be EDITED by a PROVIDER who is also the EXPECTED SIGNER of the note, etc.).</td>
</tr>
<tr>
<td>Manage Business Rules</td>
<td>USR BUSINESS RULE MANAGEMENT</td>
<td>This option allows you to list the Business rules defined by ASU, and to add, edit, or delete them, as appropriate.</td>
</tr>
</tbody>
</table>
Chapter 14: National Document Titles

Certain entries in the Document Definition file have been exported either with TIU and/or with various TIU patches. The operation of certain functions in VistA and CPRS depends on these entries being there. These entries include certain classes, document classes, and titles. Most exported Document Definitions are marked “National.” Local editing of National Document Definitions is severely restricted.

Note: You must limit your editing of national Documents Definitions to actions permitted by the exported Document Definition options. Other editing will cause certain functions of VistA and CPRS to not work properly.

National Classes
Classes are the most fundamental unit of organization in the Document Definition file.

CLINICAL DOCUMENTS is the root class for all other classes and document classes. PROGRESS NOTES contains note titles that appear on the Notes tab of CPRS. DISCHARGE SUMMARY contains note titles that appear on the D/C Summ (Discharge Summary) tab of CPRS. LR LABORATORY REPORTS was released with patch TIU*1*137 in support of Anatomic Pathology. You should not add any local document classes to this class. CLINICAL PROCEDURES was released with patch TIU*1*109. SURGICAL REPORTS was released with patch TIU*1*112 and is not used until the surgery patch SR*3*100 is installed.
National Document Classes

Four of the national document classes are in support of CWAD (CRISIS NOTE, CLINICAL WARNING, ADVERSE REACTION/ALLERGY, ADVANCE DIRECTIVE). If these are changed, then CWAD will not function properly. The same is true for other document classes such as ADDENDUM, DISCHARGE SUMMARIES, and ASI-ADDICTION SEVERITY INDEX. The last of these contains notes pushed from the Psychiatry Package.

For the LR ANATOMIC PATHOLOGY document class, nine (9) business rules were exported by patch USR*1*23, the companion patch to TIU*1*137. These rules help to ensure that the Anatomic Pathology features of the Lab Package function properly. All access to the titles in this document class (creating, editing, signing, cosigning, and printing) except viewing takes place through the Lab Package. Local sites must not circumvent the rules by adding, modifying, or overriding the business rules. (A list of the exported business rules is in the TIU/ASU Implementation Guide, Exported Business Rules section.)

Note: The TIU class, document class, user class, note titles, and business rules installed by patch TIU*1*137 and USR*1*23 must not be modified in any way or the Anatomic Pathology enhancements to the Lab Package will not work properly. An exception exists in the case of USR*1*31, which 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. See the section USR*1*31 Impact on Business Rules in the TIU Implementation Guide for details.

For document class PATIENT RECORD FLAG CAT I, a business rule was exported by patch USR*1*24, the companion patch to TIU*1*165, that limits the writing of notes in this document class to a select group. This select group is made up of members of the user class DGPF PATIENT RECORD FLAGS MGR. Circumventing this rule violates the intent of keeping the flag documentation process in the hands of qualified domain experts.


HISTORICAL PROCEDURES contains medicine procedures that were converted to TIU notes by TIU*1*182 in support of the Medicine Package Conversion patch MD*1*5. This document class must be left with status INACTIVE.
The complete list of national document classes is:

ADDENDUM
ADDITION SEVERITY INDEX
ADVANCE DIRECTIVE
ADVERSE REACTION/ALLERGY
C & P EXAMINATION REPORTS
CLINICAL WARNING
CRISIS NOTE
DISCHARGE SUMMARIES
HISTORICAL PROCEDURES
LR ANATOMIC PATHOLOGY
PATIENT RECORD FLAG CAT I
PATIENT RECORD FLAG CAT II
OPERATION REPORTS
NURSE INTEROPERATIVE REPORTS
ANESTHESIA REPORTS
PROCEDURE REPORT (NON-O.R.)
SCI OUTCOMES

Note: Although CONSULTS was not exported as “National,” the same cautions apply. If you make explicit changes to CONSULTS, then the Consults tab of CPRS may not work properly.

TIU*1*169 supports patch DVBA*2.7*53 C & P WORKSHEET MODULE PHASE. These patches together allow users to create C & P Examination documents and store them in TIU. The advantage to this is that providers are allowed to view the C & P exams in CPRS along with the rest of a patient’s medical record. C & P documents are entered through the C & P Worksheet Module using a title in the C & P EXAMINATION REPORTS Document Class. Upon signing, the C & P Exams are retained in AMIE and stored in TIU.

Further information on this can be found in the AMIE Regional Office User Manual.

National Titles

ADDENDUM
ADVANCE DIRECTIVE
ADVERSE REACTION/ALLERGY
ANESTHESIA REPORT
ASI-ADDITION SEVERITY INDEX
CLINICAL WARNING
DISCLOSURE OF ADVERSE EVENT NOTE
COMPUTER DOWNTIME
CRISIS NOTE
DISCHARGE SUMMARY
HISTORICAL CARDIAC CATHETERIZATION PROCEDURE
HISTORICAL ECHOCARDIOGRAM PROCEDURE
HISTORICAL ELECTROCARDIOGRAM PROCEDURE
HISTORICAL ELECTROPHYSIOLOGY PROCEDURE
HISTORICAL ENDOSCOPIC PROCEDURE
HISTORICAL EXERCISE TOLERANCE TEST PROCEDURE
HISTORICAL HEMATOLOGY PROCEDURE
HISTORICAL HOLTER PROCEDURE
HISTORICAL PACEMAKER IMPLANTATION PROCEDURE
HISTORICAL PRE/POST SURGERY RISK NOTE
HISTORICAL PULMONARY FUNCTION TEST PROCEDURE
HISTORICAL RHEUMATOLOGY PROCEDURE
LR AUTOPSY REPORT
LR CYTOPATHOLOGY REPORT
LR ELECTRON MICROSCOPY REPORT
LR SURGICAL PATHOLOGY REPORT
NURSE INTERPRETATIVE REPORT
OPERATION REPORTS
PATIENT RECORD FLAG CATEGORY I
PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE
PATIENT RECORD FLAG CATEGORY I – URGENT ADDRESS AS FEMALE
PATIENT RECORD FLAG CATEGORY I – MISSING PATIENT
RISK OF CJD
SCI CRAIG HANDICAP ASSESSMENT & REPORTING TECHNIQUE - SHORT FORM
SCI DIENER SATISFACTION WITH LIFE SCALE
SCI GENERAL NOTE
SCI FUNCTIONAL INDEPENDENCE MEASURE
WRIISC ASSESSMENT NOTE
PROCEDURE REPORT

Note: The HISTORICAL titles in document class HISTORICAL PROCEDURES were created by patch TIU*1*182 with status INACTIVE. The status of these titles MUST REMAIN inactive in order to prevent users from entering notes on these titles. All notes on these titles are auto-generated by the Medicine Conversion patch MD*1*5.

Note: The TIU document classes, user class, category I note title, and category I business rule installed by patches TIU*1*165 and USR*1*24 must not be modified in any way or Patient Record Flags may not work properly.
Note: PATIENT RECORD FLAG CATEGORY I - HIGH RISK FOR SUICIDE was created for the High Risk Mental Health Patient – Reminder and Flag. This new title is used with the new High Risk for Suicide PRF.

Note: PATIENT RECORD FLAG CATEGORY I – URGENT ADDRESS AS FEMALE was created for the High Risk Mental Health Patient – Reminder and Flag Increment 6. This new title is used with the new URGENT ADDRESS AS FEMALE Suicide PRF, mandated by the Undersecretary of Health’s legal solution.

Note: PATIENT RECORD FLAG CATEGORY I – MISSING PATIENT was created for missing and wandering patients. This new title is used with the Missing Patient, PRF.

Patch TIU*1*159 implements the War-Related Illness and Injury Study Centers (WRIISC pronounced “risk”) note title and template. The associated note title is WRIISC ASSESSMENT NOTE. This note is described in the memo Description of WRIISC Programs and Associated Referral Process accompanying the patch. To get it to work properly a Clinical Coordinator authorized to edit shared templates must perform the following steps from the CPRS GUI:

9. Go to the Notes tab.
10. From the Options menu, select Edit Shared Templates.
11. In the Shared Templates pane highlight document Titles.
12. From the Tools menu select Import Template.
13. Select WRIISCASSESSMENT.TXML and press Open.
14. Highlight the WRIISC ASSESSMENT template.
15. In the Associated Title list box, select WRIISC ASSESSMENT NOTE.
16. Press OK.

Once these steps have been performed, the template and note title will work for all CPRS users. Further information about setting up shared templates is available in the Computerized Patient Record System (CPRS) User Guide in the section on Creating Personal Document Templates.

Patch TIU*1*261 permits an authorized user to rescind an Advance Directive document by changing the title to RESCINDED ADVANCE DIRECTIVE.

Patch TIU*1*261 supports Imaging patch MAG*3.0*121, which provides the ability to watermark images "RESCINDED".
Note: EXACT TITLE NAMES are REQUIRED

The title of the Advance Directive to be rescinded must be ADVANCE DIRECTIVE
The title it is changed to when it is being rescinded must be RESCINDED ADVANCE DIRECTIVE

Both LOCAL and National Standard titles must be as above. Variations on either title will cause the Change Title action to fail to watermark images as rescinded. These exact titles are required by policy. See the VHA HANDBOOK 1004.02 section on Advance Directives:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=2042
Chapter 15: TIU Alert Tools

Starting with patch TIU*1*158, there is a new option in the TIU Management Menu that allows refresh and manipulation of TIU alerts, especially with respect to signatures. These tools are designed to assist CACs, and other users with TIU management responsibilities, to help control the backlog of unsigned notes. It accomplishes this by providing flexible control over alert generation.

The following actions are available:

BROWSE DOCUMENT—If authorized, presents a read only view of a selected document.

CHANGE VIEW—Allows entry new search criteria.

COMBINATION ALERTS—Allows the sending of new alerts for single or multiple documents to the expected signers (AUTHOR/DICTATOR, EXPECTED COSIGNER/ATTENDING PHYSICIAN, and ADDITIONAL SIGNER(S)) and one or more third parties. RESEND rules outlined below apply for a document's expected signers.

DELETE ALERTS—Allows deletion of all the alerts for a single or multiple documents.

DETAILED DISPLAY—If authorized, allows the viewing of document details.

EDIT DOCUMENT—If authorized, allows the editing a selected TIU document.

IDENTIFY SIGNERS—If authorized, allows the editing of the expected signers of a TIU document and removal of additional signers.

RESEND ALERTS—Allows the regeneration of alerts for a single document or multiple documents; all alerts associated with each document are deleted before being resent. Previously sent 3rd Party Alerts would be deleted and need to be resent. Alerts are sent appropriate to the document's status and only to expected signers as follows:

The Author/Dictator & Expected Co-signer/Attending—only receive alerts if they have not signed.

Additional Signer(s)—will only receive alerts if the document has been signed.

THIRD PARTY ALERTS—Allows the sending of new alerts for a single document or multiple documents to one or more third parties regardless of the document's status.
Business rules are checked and adhered to, so while anyone who has access to this option can use it, you may be blocked from certain functions such as viewing unsigned notes.

In the following example, TUI Alert Tools are accessed through the TIU Maintenance Menu [TIU IRM MAINTENANCE MENU], a year of notes are checked for Dr. Snow, then alerts are resent for an unsigned note:

Select TIU Maintenance Menu Option: 5  TIU Alert Tools

Select DOCUMENT STATUS: UNSIGNED// ?

1  undictedated  5  unsigned  9  purged
2  untranscribed  6  uncosigned  10  deleted
3  unreleased  7  completed  11  retracted
4  unverified  8  amended

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

Select STATUS: UNSIGNED// ALL undictedated untranscribed unreleased unverified unsigned uncosigned completed amended purged deleted retracted

Select SEARCH CATEGORY: AUTHOR// ?

1  Author  3  Expected Cosigner  5  Additional Signer
2  Dictator  4  Attending Physician

Enter selection(s) by typing the name(s), number(s), or abbreviation(s).

Select SEARCH CATEGORY: AUTHOR// ALL Author Dictator Expected Cosigner Attending Physician Additional Signer

Select NEW PERSON: TIUPROVIDER,SEVEN  CRS  PHYSICIAN

Start Reference Date [Time]: T-7//t-365 (JUN 04, 2002)

Ending Reference Date [Time]: Jun 04, 2003// <Enter> (JUN 04, 2003)

Searching for the documents... TIU Alert Tools  Jun 04, 2003@14:01:48  Page: 1 of 1.
Alert Tools FAQ

Q. My search results by an ADDITIONAL SIGNER and UNSIGNED documents aren't showing any matches but I know they exist. What's wrong?

A. Additional signers are usually added AFTER a document has been signed or co-signed. Add UNCOSIGNED and COMPLETED documents to your search criteria.

Q. I want to regenerate alerts for an UNCOSIGNED document, but I don't want the AUTHOR to get alerted. Should I just send a 3rd Party Alert to the EXPECTED COSIGNER?

A. You could, but if you select RESEND ALERTS, the regenerated alerts are context sensitive and sent only to individuals that have NOT signed the document; in this case, only the EXPECTED COSIGNER and any ADDITIONAL SIGNERS that have not signed will be alerted.

Q. I selected RESEND ALERTS and my 3rd Party Alerts disappeared! What happened?
A. A document's alerts are deleted before being regenerated so that they remain accurate regarding the document's status; 3rd Party Alerts are deleted as well and must be resent since they are not officially part of the document's record and cannot be automatically regenerated.

Q. I changed the ADDITIONAL SIGNER for a document using IDENTIFY SIGNERS, but it didn't update in the display. Why not?
A. Because there can be more than one ADDITIONAL SIGNER, unless the ADDITIONAL SIGNER matches the search criteria, it won't be displayed.

Q. I added an ADDITIONAL SIGNER for a document using IDENTIFY SIGNERS, but it didn't update in the display. Why not?
A. Because there can be more than one ADDITIONAL SIGNER, unless the ADDITIONAL SIGNER matches the search criteria, it won't be displayed.

Q. The AUTHOR of several documents (requiring co-signature) is gone and I want to regenerate the alerts for the EXPECTED COSIGNER so they can SIGN and COSIGN these UNSIGNED documents. Should I use RESEND?
A. It depends. Default alert behavior would be to send the alert AFTER the author has signed and in this case, the EXPECTED COSIGNER would have never received the alerts initially or even after using RESEND.

However, with TIU*1*151, a new document parameter was added that could be set so that the EXPECTED COSIGNER could receive the alert IMMEDIATELY; even if the AUTHOR has not signed.

This parameter is shown below:

```
------
SEND COSIGNATURE ALERT: After Author has SIGNED// ?
Specify when the alert for cosignature should be sent
Choose from:
  0   After Author has SIGNED
  1   Immediately
------
```

If you have NOT specifically set this parameter or have it set to "After Author has SIGNED", you'll need to use a 3rd Party Alert to the EXPECTED COSIGNER or change the parameter's setting to "Immediately" before using RESEND.

If you HAVE set this parameter to "Immediately", you can use RESEND.
Q. I used RESEND ALERT and the EXPECTED COSIGNER didn't get alerted! Why?

A. Two possible reasons. The first, please see the question just before this one.

The second, the EXPECTED COSIGNER may be inactivated or DIUSER'd. Currently, kernel does not alert these individuals who are inactive or terminated.

TIU*1.0*158 will inform the user that an individual entered as a 3rd Party Alert recipient is inactive/DIUSER'd. However, it does not verify every individual attached to a document since this would be too system intensive and time consuming on a batch send of alerts.

Q. I used RESEND ALERT and no alerts were resent to anyone, even though it appeared that alerts were being re-generated. Why?

A. While TIU may create and attempt to regenerate the alerts (this will always happen if TIU Alerts attempts to fulfill a user's request), it has no way of actually confirming whether or not kernel will send an alert to an individual associated with a document (See #7).

The important rule to remember is that kernel will not actually send alerts to inactivated or terminated users.

Additionally, TIU sends alerts based on the current status of the document and whether or not the recipient still needs to sign the document. If an individual has already signed, they should not receive an alert. However, if a user associated with a document has already signed and they are sent a 3RD PARTY ALERT, they will receive another alert.

Q. I sent the AUTHOR (who has already signed) a 3RD PARTY ALERT and now they can't process it! What should I do?

Just RESEND ALERTs for that document. All alerts will be deleted and regenerated; 3RD PARTY ALERTS that had been manually generated will have to be re-entered (See #3).
Chapter 16: HL7 Generic Interface

The purpose of the HL7 Generic Interface is to create a Health Level Seven (HL7) line to Text Integration Utilities (TIU) that will support the upload of a wide-range of textual documents from Commercial-Off-the-Shelf (COTS) applications in use now and in the future at Veteran Administration (VA) Medical Centers. Projects that may work with the interface are the Remote Order Entry System (ROES) software used by the Denver Distribution Center (DDC), the Precision Data Solutions Transcription Service software, and the VA Home Telehealth software.

The project creates a single COTS/application interface specification to allow textual documents to be uploaded and displayed in CPRS. This allows clinicians to view information from the COTS package without leaving the patient’s electronic medical record.

Generic HL7 will not work with external software unless it is specifically set up to do so. The details of how to do this are contained in the Text Integration Utilities (TIU) Generic HL7 Handbook. This handbook describes the HL7 fields required for each document type and gives additional information on system features and vendor guidelines. To retrieve this document go to the VistA Document Library at (http://www.va.gov/vdl/), then click on CPRS: Text Integration Utility (TIU).

Message Manager
The only place where the Generic HL7 Interface is visible is in the TIU Maintenance Menu. The TIUHL7 Message Manager has been added to this menu to assist medical center in setting up the interface.

If an error message is returned, it will be contained in clear text explaining the error.

The following is an example of using the HL7 message Manager to check an error message:

Select TIU Maintenance Menu Option: ?
1  TIU Parameters Menu ...
2  Document Definitions (Manager) ...
3  User Class Management ...
4  TIU Template Mgmt Functions ...
5  TIU Alert Tools
6  Active Title Cleanup Report
7  TIUHL7 Message Manager
8  Title Mapping Utilities ...
9  Text Event Edit
10 Unauthorized Abbreviations (Enter/Edit)
11 List Unauthorized Abbreviations
12 Contingency Downtime Bookmark Progress Notes

Select TIU Maintenance Menu Option: 7  TIUHL7 Message Manager

Searching for messages.....

Refresh Message List
The messages displayed by the Message Manager are from the XTEMP Global, which is set to delete messages after seven (7) days. In other words, VistA discards HL7 messages that are more than seven (7) days old.
Chapter 17: Setting Up TIU Text Events

Patch TIU*1*296 modifies the TIU application to send a TIU alert to the appropriate service provider(s) immediately after a staff member screens a patient and signs the associated note. The service provider(s) will be alerted prior to the note being co-signed by the licensed clinician responsible for reviewing and approving the note. Prior to this modification, TIU alerts were not sent to all service providers. This resulted in missed opportunities to provide needed services for patients while the patients are on site, and forced staff to take time to contact patients and reschedule needed services.

A new Text Event Edit [TIU TEXT EVENT EDIT] option is available in the TIU Maintenance menu.

Select OPTION NAME: TIU MAINTENANCE MENU  TIU IRM MAINTENANCE MENU  TIU Maintenance Menu

Select the Text Event Edit menu option to set up a “text event” in the TIU TEXT EVENTS file (#8925.71). Complete all fields, including the trigger text to be searched for in a TIU document (progress note, consult note, etc.). If the trigger text is found in the TIU document, then an alert is sent to the team(s) specified in the file.

The following example shows “ab color blindness” as the trigger text [TEXT TO SEARCH]. The alert message [ALERT MESSAGE] patient has ab color blindness will be sent to the specified service provider [CPRS TEAM]. An alert [SIGNER ALERT MESSAGE] is also sent to the individual who signed the note.

Select TIU Maintenance Menu <TEST ACCOUNT> Option: txt  Text Event Edit

Select TIU TEXT EVENTS NAME: test 5
Are you adding 'test 5' as a new TIU TEXT EVENTS (the 8TH)? No// yes  (Yes)
NAME: test 5//
STATUS: ?
Enter a 0 for inactive or a 1 for active
Choose from:
0 INACTIVE
1 ACTIVE
STATUS: 1 ACTIVE
TEXT TO SEARCH: ?
Answer must be 3-200 characters in length.
TEXT TO SEARCH: ab color blindness
CASE SENSITIVE: ?
Enter a 0 for NO or a 1 for YES.
Choose from:
0 NO
Note: Any TIU document that is to be used to trigger these alerts must have the MUMPS code 'D TASK^TIUTIUS(DA)' entered in the POST-SIGNATURE CODE field (#4.9) in the TIU DOCUMENT DEFINITION file (#8925.1). This field can only be edited by IRM personnel.

Note: TIU*1*297 modified the [TIU TEXT EVENT EDIT] option to allow users who don’t have the at-sign (@)-Programmer access to add/update/delete entries to the TIU TEXT EVENTS (#8925.71) file.
Chapter 18: Unauthorized Abbreviations

A newly created “TIU UNAUTHORIZED ABBREVIATION” File (#8927.9) contains a standard set of fourteen unauthorized abbreviations from The Joint Commission. Staff may add additional abbreviation(s) to match any unapproved abbreviations they have identified in local policy.

The use of this functionality is optional. Work with your Health Information Management (HIM), the facility Chief, and Chief of Staff to determine whether this functionality should be turned on by setting STATUS to ACTIVE for each individual unauthorized abbreviation.

A newly created menu option, "Unauthorized Abbreviations (Enter/Edit)" [TIU ABBV ENTER EDIT], maintains unauthorized abbreviation data in the "TIU UNAUTHORIZED ABBREVIATION" File (#8927.9).

Another newly created menu option, "List Unauthorized Abbreviations" [TIU ABBV LIST], lists all the abbreviations in file (#8927.9). These two new options are located under the existing "TIU Maintenance Menu" [TIU IRM MAINTENANCE MENU].

The application is deployed with STATUS field set to "Inactive." It is turned on by updating at least one abbreviation to a status of "Active." If the STATUS of an unauthorized abbreviation is set to ACTIVE in the “TIU Unauthorized Abbreviation” File (#8927.9), any use of the abbreviation in a CPRS progress NOTE will be listed in the "CPRS - Insufficient Authorization" box. The note cannot be signed unless the CPRS Note Editor removes or spells out each unauthorized abbreviation that is listed in the “CPRS Insufficient Authorization” box.

Requirements for the "Unauthorized Abbreviations (Enter/Edit)" option are:

1) Fourteen unauthorized abbreviations from The Joint Commission are released with “CLASS” (#.02) field set to LOCAL and “STATUS” (#.04) field set to INACTIVE in the "TIU UNAUTHORIZED ABBREVIATION" File (#8927.9). These are: "IU, MgSO4, MS, MSO4, QD, Q.D., qd, q.d., QOD, Q.O.D., qod, q.o.d., U, u."

2) NATIONAL unauthorized abbreviation(s) cannot be added or modified locally. No entries with a CLASS (#02) field set to NATIONAL were released with patch TIU*1.0*297.

3) No unauthorized abbreviation entry can be deleted once it is created.

4) The name of the unauthorized abbreviation in field (.01) cannot be changed or deleted once it is created, but STATUS (.04) field can be changed to either ACTIVE or INACTIVE.

5) The name of unauthorized abbreviations in field (.01) cannot include the following punctuations: |^&~\:;,!?

6) The name of unauthorized abbreviations in field (.01) is not case sensitive.

7) The requirement for case sensitivity check for an unauthorized abbreviation name is determined by the "ABBREVIATION EXACT MATCH" (#.03) field.
8) When a new unauthorized abbreviation is created, the ABBREVIATION EXACT MATCH field (#.03) defaults to "YES." Local staff can change the value in this field.

9) The CLASS (#.02), ABBREVIATION EXACT MATCH (#.03), STATUS (#.04), and NOTE (#.05) fields are audited using FileMan.

10) Local staff cannot change any NATIONAL unauthorized abbreviation. However, they can add/modify/activate/inactivate any LOCAL unauthorized abbreviation in field (#.03) and field (#.05).

11) The NOTE (#.05) field in the LOCAL Unauthorized Abbreviation option can be edited locally regardless of STATUS (#.04) field.

12) The LOCAL Unauthorized Abbreviation option can be managed by local staff to serve any general medical and business practice need. Local staff can inactivate any local abbreviation in STATUS (#.04) field when an unauthorized abbreviation is no longer needed.

**CPRS – Progress Note / Sign Note Now**

Since this patch is released with STATUS Field in the TIU UNAUTHORIZED ABBREVIATION File (#8927.9) set to Inactive, any use of an unauthorized abbreviation in a CPRS progress NOTE will not be listed when the Progress Note editor clicks “Sign Note Now,” unless the STATUS of the abbreviation is set to ACTIVE.

**Example of no unauthorized abbreviation being noted at CPRS / Sign Note Now:**

![Example of no unauthorized abbreviation being noted at CPRS / Sign Note Now](image)

**Example of activating the STATUS field for abbreviation “QOD”:**

```
Select OPTION NAME: TIU MAINTENANCE MENU TIU IRM MAINTENANCE MENU TIU Maintenance Menu
10 Unauthorized Abbreviations (Enter/Edit)
11 List Unauthorized Abbreviations
Select TIU Maintenance Menu <TEST ACCOUNT> Option: 10 Unauthorized Abbreviations (Enter/Edit)

Enter/Edit Unauthorized Abbreviation(s)

Enter Unauthorized Abbreviation: QOD

The abbreviation QOD already exists.
```

1) Q.O.D. : EXACT-MATCH=YES STATUS=INACTIVE CLASS=LOCAL
For EDIT Unauthorized Abbreviation, Select number: (1-4): 2
Unauthorized Abbreviation: QOD
ABBREVIATION EXACT MATCH: YES
STATUS: INACTIVE
NOTE:
STATUS for this Unauthorized Abbreviation 'QOD' is ACTIVE now.

Example of checking the Audit Log after activating STATUS for abbreviation “QOD”:

Example of STATUS change of “QOD” to active in the Unauthorized Abbreviations File (#8927.9):
Chapter 19: Setting up Contingency Downtime Bookmark Progress Notes

The Contingency Downtime Bookmark Progress Notes option in the TIU Maintenance Menu allows sites to add a progress note to the electronic record of all inpatients and outpatients who were seen during computer system downtime. The progress note states that a computer outage occurred, and alerts medical staff to search the patient's paper records for non-electronic documentation created during the outage.

To set up a contingency downtime bookmark progress note:

1. Select the Contingency Downtime Bookmark Progress Notes [TIU DOWNTIME BOOKMARK PN] option from the TIU Maintenance Menu [TIU IRM MAINTENANCE MENU]. The “Bookmark Progress Note after a Downtime” screen displays.

2. Enter a TIU DOCUMENT DEFINITION NAME. This must be a locally-approved title that is mapped to the enterprise-standard COMPUTER DOWNTIME title.

3. Enter "S" or "U" to define whether the downtime was Scheduled or Unscheduled.

   - Was the downtime (S)cheduled or (U)nscheduled? UNSCHEDULED
   - What was the starting time of the outage? T-2@2200 (NOV 07, 2017@22:00)
   - What was the ending time of the outage? T-2@23:47 (NOV 07, 2017@23:47)
   - Who will be the AUTHOR of the note? TIUUSER,ONE// OT DEVELOPER
   - What shall the Date/Time of the Note be? NOW// T-2@23:54 (NOV 07, 2017@23:54)

   - Select one of the following:
     - A All Outpatient Clinics
     - S Selected Outpatient Clinics
     - N No Outpatient Clinics

   - In addition to Inpatients, File Notes for Outpatient Clinics? [A/S/N]: All Clinics

   - In addition to yourself, who shall receive email notification of this event?
     - Select NEW PERSON NAME: EPIP,USER UE 118 ADMIN ASSISTANT
4. Enter the starting time of the outage. For example, enter "T@[24-hour time]" to set the date as today. Type "??" and then press Enter to see all valid time formats.

5. Enter the ending time of the outage.

6. Enter the Author of the note (using "lastname,firstname" format). The default entry is the logged-in user.

7. Enter the Date/Time of the note; the default is NOW. This entry determines where the note appears in a sorted list of all progress notes.

8. Specify whether All (A), Selected (S), or No (N) outpatient clinics were affected by the outage. Choosing "Selected" opens the HOSPITAL LOCATION file. Enter the desired clinics to include. Press Enter at the prompt to continue to the next step.

9. At the "Select NEW PERSON NAME:" prompt, enter the name (in "lastname,firstname" format) of any other user(s) that you wish to receive a notification of the downtime event. To enter multiple names, press Enter after each entry. The notification will list the patients who have had this downtime bookmark progress note appended to their record.

10. At multi-divisional sites, the "Select division: ALL//" prompt appears. Enter the division(s) affected by the outage. You can use MEDICAL CENTER DIVISION NUM, NAME, FACILITY NUMBER, or TREATING SPECIALTY to designate the division. Type "??" to display a numbered list of available divisions.

11. The system creates a progress note containing standard text and generates a preview of the note. Enter “Yes” at the "Do you wish to edit the text?" prompt if you wish to edit the progress note text. A text editor will open, from which you can edit the note text. Press CTRL+E to exit the text editor. The "Do you wish to edit the text?" prompt displays again; enter "No" to continue.

**NOTE:** The use of this functionality is optional; therefore, the boilerplate text will not initially be stored in the document definition until the first use of the option to implement the functionality. After the first use, the boilerplate text will be stored and can be edited via the usual TIU document definition edit options.
occurred for 1 hour and 47 minutes between:  
Tuesday, Nov 07, 2017 22:00 and Tuesday, Nov 07, 2017 23:47

Before, during and after this period of downtime, medical record documentation may have been collected on paper. Documents such as progress notes, orders, results, medication administration records (MAR) and procedure reports may have been collected, but may not be reflected in the electronic record or they may be scanned into the record at a later date.

Do you wish to edit the text? No/

12. The downtime note will be signed as an Administrative Closure, so the Administrative Closure signature block is displayed. At the "Enter your Current Signature Code" prompt, enter your code to sign and close the note. If you do not enter the signature within 60 seconds, you must restart entry of the note.

The note(s) will have the following administrative closure (not a signature):
Administrative Closure: 4/11/16
by: TIUSER, ONE, Developer

You will now be asked for an electronic signature to begin this process. This is a security measure to start the background task, but it is not used to sign the notes themselves. If you are not the AUTHOR, your name will show for the administrative closure, but not as the author of the note.

You have 60 seconds/try and a maximum of 3 attempts to enter a proper code.

Enter your Current Signature Code: SIGNATURE VERIFIED

13. At the "Queue the report to Taskman?" prompt, enter “No” to view the report on your screen now or enter “Yes” to send the report to Taskman to view later (the default is "Yes"). The report lists the patients impacted by the downtime, grouped by inpatients, discharged patients, and outpatient clinics, and indicates whether the downtime progress note was successfully appended to each patient's record. Regardless of your response, an email message containing the patient list and progress note status is sent to the recipients designated in step 9.

NOTE: You might want to queue the report since the generation of a large report can tie up your computer for a long period of time.

14. To view the Contingency Downtime Bookmark Progress Notes, look at the Progress Notes in a patient's record in VistA or the CPRS GUI.

NOTE: Only one progress note will be filed for any patient with multiple appointments (whether inpatient, outpatient, or both) at different clinics during the outage period.
Chapter 20: Helpful Hints/Troubleshooting

FAQs (Frequently Asked Questions)

+ NOTE: Most of these questions were received from TIU/ASU test sites. Thanks to everyone who contributed!

Q: We just entered all of our Providers into the Person Class file (when the Ambulatory Care Reporting Project came out). Do we have to do this all over again for the User Class file in ASU? Why can’t TIU and ASU just use the Person Class?

A: The Provider Class in ASU fulfills a different function, and therefore its database design is a different kind of hierarchy.

A patch to ASU in the near future will help assure that your efforts in populating the Person Class Membership at your site are not lost, or repeated. We are developing a mapping between a subset of the exported User Classes and the Person Class File (i.e., for each Person Class, there will be a corresponding User Class), which will help you “autopopulate” User Class Membership, assure that future changes to an individual’s Person Class Membership are reflected automatically in his User Class Membership, and allow resolution of privileges for inter-facility access to data. We recommend that you initially implement TIU and ASU by populating only the most essential User Classes (i.e., Provider; MRT; Chief, MIS; and Transcriptionist), and use the forthcoming patch to assist you in autopopulating more specific User Classes when you have become acquainted with the two products.

Q: We’ve heard that implementation of TIU is very complex and time-consuming. How long does it take?

A: TIU implementation is complex, but the amount of time it takes to implement has to do with the complexity of the site, how many users, the database and hierarchy size, the level of users, and how dependent the site is on the package (obviously a site that is totally electronic has very different issues than a site where participation is optional. It took a test site with a million+ notes about 2.5 weeks to run their Progress Notes conversion.
FAQs cont’d

Q: Will the Discharge Summary and Progress Notes packages be gone once files are converted to TIU?

A: Discharge Summary V. 1.0 and Progress Notes V. 2.5 should be made "Out of Order" once the conversions have been run, staff trained, and the cut-over started. The data in files 121 and 128 will remain until your site decides to purge these files. We suggest that they remain intact until you're sure the conversions have run correctly and the implementation is going smoothly.

Q: Can TIU be used without converting the Discharge Summaries until much later?

A: TIU can be used without converting Discharge Summary, but we strongly recommend that Progress Notes and Discharge Summary both be converted to TIU at the same time, to avoid complications.

+ NOTE: You cannot run dual implementations of Discharge Summary; that is, Discharge Summary 1.0 and Discharge Summary through TIU.

Q: Is it possible to load ASU in production and start populating the groups before we load TIU?

A: Yes you can. The Business Rules will not be functional because they are tied to the Document Definition File, but you will be able to populate the Class memberships.

Q: Do we have to delete or sign unsigned notes before we can convert them?

A: No, you don’t have to delete or sign the unsigned notes. The conversion will move them as is. However, you probably don’t want to be moving old, irrelevant notes from one package to the other. By the way, notes for test patients are NOT moved; they are ignored.
**FAQs cont’d**

**Q:** Can we require a Cosignature for a particular note?

**A.** Yes, you can set Cosignature requirements for document classes or titles. Use the option *Document Parameter Edit*, as described in the *TIU Implementation Guide*. Individual clinicians can designate an expected Cosigner through their *Personal Preferences* option (described on page 64 of this manual).

**Q** Why do we have to enter Visits and encounter data for Progress Notes? What are “Historical Visits”?

**A:** Visit data is now required for every outpatient encounter. The vast majority of Progress Notes are already linked to an admission and don’t require additional visit information to be added.

A historical visit or encounter is a visit that occurred at some time in the past or at some other location (possibly non-VA). Although these are not used for workload credit, they can be used for setting up the PCE reminder maintenance system, or for other non-workload-related reasons.

**NOTE:** If month or day aren’t known, historical encounters will appear on encounter screens or reports with zeroes for the missing dates; for example, 01/00/95 or 00/00/94.

**Q:** Are there any terminal settings that we need to be aware of for TIU? On the VT400 setting in Smart Term, the bottom half of the Create Document Definitions screen was not scrolling properly. It was writing over previous lines and got very confusing!

**A:** Various terminal emulators can affect applications using the List Manager interface. The VT220 and 320 work very well with List Manager.
FAQs cont’d

Q: I have gotten my 600 clinic and ward locations set up, but when I try to print by ward I am only allowed to print to a printer. This is not true under the Print by Hospital Location, where I can print to the screen. What is the difference?

A: Print by Ward is designed to support batch printing. It has the unique ability to determine when the last note was printed so that sites can now capture the infamous “orphan” note which was a problem under Progress Notes 2.5. You might consider adding a message on entry into the option to inform users that they can only print to a printer (not on screen).

Q: Can we share business rules with other sites.

A: It isn’t yet known how appropriate or desirable it is to share business rules amongst sites. The package is exported with all the business rules needed to run the standard package. The differences are usually on a medical center basis.

For example, one site wants all users to be able to see all UNSIGNED notes. ON the flip side, another site doesn’t want any users to be able to print or view UNCOSIGNED notes until the cosigner has signed. Two very different views. Just because you are in the same VISN doesn’t mean you would view these issues in the same light. Another example is the hospital that wants to restrict the entering/viewing/printing of every Progress Note by TITLE. You can do this, but it is not something we would recommend.

We strongly recommend that you work with the exported business rules for a while before making any changes.

Q: When I read my Discharge Summaries after they come back from the transcriptionist, there are dashes (or other funny characters) sprinkled throughout; what do these mean and what am I supposed to do?

A: These characters (your site determines whether they will be dashes, hyphens or some other character) indicate words or phrases that the transcriptionist was unable to understand. You need to replace these with the intended word or phrase before you’ll be able to sign the document.
FAQs cont’d

Q: What is the best editing/word-processing program and how can I learn how to use it?

A: This is partly a matter of personal preference and partly a matter of what’s available at your site. Commercial word-processors are available at some sites. The FileMan line editor and Screen Editor are available at all sites. Of these two, most Discharge Summary users prefer the Screen Editor. Your IRM office or ADPACs can help you get set up with the appropriate editor and provide training. The Clinician Quick Reference Card summarizes the FileMan Screen Editor functions.

Q: Why should a site require “release from transcription”?

A: Release from transcription is required to prevent a discharge summary from becoming visible to other users before the person entering the summary has completed the entry. For example, if a transcriptionist needed to leave the terminal, the summary would not be available for anyone else to look at until the summary is “released from transcription.”

Q: Why can’t we use extended ASCII characters (e.g., °, ≥, ∆, etc.) in our documents to be uploaded?

A: These alternate character sets are not standardized across operating systems and your MUMPS system may not be set up to store them.
FAQs cont’d

Questions about Reports and Upload

Q: At present we put all discharges in the Discharge Summary package. We do allow Spinal Cord Injury to put “interim” summaries in on their patients every 6 months or annually. These reports stack up under the admission date and are all under that one date upon discharge.

When patients are transferred to the Intensive Care Units, they may have a very long/complicated summary to describe the care while in the unit. This should be an interward transfer note, but some of our physicians feel that due to the complexity of care delivered in the unit, this should be included in their Discharge Summary, BUT should have its own date (episode of care). I realize that the interward transfer note is a progress note and very few of our physicians are using progress notes. Our physicians seem to want to have that interward transfer information in these complex cases attached to the Discharge Summary.

My question is will TIU offer us anything different that will satisfy our physicians? I still do not have a mental picture of what it will look like when I go to look up a DCS or PN from the TIU package. Will the documents be intermingled and arranged by date? I am a firm believer in calling things what they are and putting them where they belong when it comes to organizing our electronic record. I hate to see the DSC and interward transfers go together now in the DCS package as it does create a problem when the patient is actually discharged and Incomplete Record Tracking (IRT) thinks he was discharged when the interim was written. Does anyone have any thoughts and can someone show me how it looks when I get TIU and look up documents on a patient?

A: From: TIU Developer

Interim Summaries may be easily defined in TIU, and linked with the corresponding IRT deficiency. Parameters determining their processing requirements, as well as the format of a header for uploading them in mixed batches with Discharge Summaries, Operative Reports, C&P exams, and Progress Notes can all be defined without modifying any code. A patch will be necessary to link them to a specific transfer movement, and to introduce a chart copy of the appropriate Standard Form. This involves a modest programming effort, but will have to be prioritized along with a number of other requests.
**FAQs cont’d**

We need the help of the user community to try to sort out the relative priorities of each of these tasks, along with your patience, as we work to deliver as many of them as possible, as timely as possible...

**A:** From a user/coordinator:

A possible solution to the problem of rotating residents is to set up your summary package with the author not needing to sign the summary. This allows the attending physician to sign the report. While the residents may rotate in and out, the attending usually remains the same through the course of the patients stay.

**Q.** What are sites doing with C&Ps, & op notes?

It is my understanding that C&Ps are a type of discharge summary.  

I’ve tried creating “C&P EXAM” as a title underneath the “DISCHARGE SUMMARY” document class. I get TYPE errors when uploading test documents. The document parameters are defined for the upload fields.

**A:** From a user/coordinator: OP reports and C&P exams reside in their appropriate packages. You can use the TIU upload utility to put them there.  

As for OP notes, we have several titles (i.e. Surgeon’s Post-OP note).

Do you have TIU in the APPLICATION GROUP field of the Surgery and C&P file?

Our FILE File has this for our Surgery file:

```
NUMBER: 130    NAME: SURGERY
APPLICATION GROUP: GMRD
APPLICATION GROUP: TIU
```

**Q:** Can we do batch upload of Progress Notes by vendor through TIU?

**A:** Yes, you may now batch upload Progress Notes through TIU. See instructions earlier in this manual (under Setting Parameters) or in the TIU Technical Manual.
**FAQs cont’d**

**Q:** Currently our Radiology reports are uploaded by the vendor. Can this functionality be built into TIU?

**A:** You may upload Radiology Reports, but it will be necessary to write a LOOKUP METHOD to store several identifying fields in the Radiology Patient File. The remainder are stored in the Radiology Reports File, along with the Impression and Report Text. (The TIU and Radiology development teams will work together on a lookup method, as development priorities allow.)

**Q:** We have hundreds of entries in files 128.1 and 128.5 to be cleaned up, because many duplicate discharge summaries were mistakenly uploaded by the transcriptionists of our vendor. How can we clean up these files?

**A:** You can use the *Individual Patient Document* option on the GMRD MAIN MENU MGR menu, along with VA FileMan, to clean up the Discharge Summary files.

**Questions about Document Definition (Classes, Document Classes, Titles, Boilerplate text, Objects)**

**Q:** After the initial document definition hierarchy is built and used, can we modify the hierarchy structure if we feel it is incorrectly built? How flexible is this file?

**A:** Once entries in the hierarchy are in use, you can’t move them around. It would be wise to think your hierarchy through before installation. Don’t rush the process. If necessary, create new classes, document classes, and titles (the Copy function streamlines creating new titles), and deactivate the old ones. The users won’t be aware of the change if the Print Name is the same, but the .01 Name is new.
FAQs cont’d

Q: Who creates titles and boilerplates at a site?

A: Many test sites restrict the creation of titles and boilerplates as much as possible. At one site, users submit a request for a title or boilerplate. IRMS or the clinical coordinator create the boilerplate and/or title and forward it to the Chairman of the Medical Records Committee for approval. Once approved it is made available for use. Titles are name-spaced by service and the use of titles is restricted by user class. With the ability to search by title, keeping the number of titles small and their use specific can be very useful. For example, when patient medication education is documented on an electronic progress note it can be reviewed easily.

Some of the other sites allow the ADPACs to create boilerplates without going through such a formal review process. Another site restricts this function to the Clinical Coordinator. It was designed so that sites can do whatever they are most comfortable with.

Q: The root Class supplied with the package is CLINICAL DOCUMENTS. Can a peer class level be made using our configuration options? Ex: ADMINISTRATIVE DOCUMENTS

A: You cannot enter a class on the same level as Clinical Documents. In TIU Version 1.0, entries can only be created under Clinical Documents.

Q: I’ve changed the technical and print names for a Document Class, but it doesn’t seem to have changed when I select documents across patients. What am I doing wrong?

A: When you select documents across patients, you are presented with a three-column menu. The entries in this menu are from the Menu Text subfield of the Item Multiple. To make a consistent change, you must update Menu Text as well as Print Name when you change a Document Definition name.
FAQs cont’d

Q: How can I print when I’m in Document Definitions options?

A: All Document Definitions printing is done using 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 the action PS or PL. To locate the appropriate data use the Edit, Sort, or Create option to list appropriate entries.

To print a list, select the PS or PL action at this point. To print information on a single given entry, first locate the entry in one of the above lists, then select either the Detailed Display action or the Edit Items action. Edit View shows all available information for a given entry. Edit Items shows the items of a given entry. Then select PS or PL. Enter PS for Print Screen to print the current display 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.

Enter PL for Print List to print more than one visible screen of information. Print List prints the entire vertical list of entries and information, including entries and 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.

Q: Is it possible for sites to share objects they create locally?

A: 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 CIO Field Offices (formerly known as ISCs or IRMFOs). Use at your own risk!

⚠️ NOTE: TIU-Health Summary objects that are exchanged between sites will always import in with “NO OWNER” (field #.05-PERSONAL OWNER in file #8925.1 TIU DOCUMENT DEFINITION). The system software cannot be made to automatically use the importing user’s name during the installation process. The TIU-HS objects will work fine in reminder dialogs, but you may find a problem with not being able to VIEW the object in the CPRS GUI Template Editor due to “no owner” being designated after installing. When you try to select an object in the CPRS Template editor, you may get an error message. See the TIU Technical Manual for instructions on how to assign yourself as an owner.
Helpful Hints/Troubleshooting, cont’d

Q: Is there any way to change the Title of a Progress Note? For example, if I want to change one of my CWAD notes to a Nursing Psychology note, is that possible?
A: Yes. Use the “hidden” action Change Title.

Q: Is there a way to access progress notes that have been linked to a problem? I can’t seem to find how this is done.
A: Assuming that notes are being linked to problems, you can use the Show Progress Notes Across Patients option to search for notes by Problem. When prompted to
Select SEARCH CATEGORIES:, enter Problem.

Select Progress Notes User Menu Option: Show Progress Notes Across Patients
Select Status: COMPLETED//ALL undicted untranscribed unreleased unverified unsigned completed, amended purged deleted
Select Progress Notes Type(s): ALL Advance Directive, Adv React/Allergy Crisis Note Clinical Warning Historical Titles
Select SEARCH CATEGORIES: AUTHOR//PROB Problem
Select PROBLEM: ANGINA PECTORIS, UNS
2 matches found
  1 Angina pectoris, unstable
  2 Other and unspecified angina pectoris
Type “^” to STOP or Select 1-2: 1
Start Reference Date [Time]: T-2//T-9999 (JAN 20, 1970)
Ending Reference Date [Time]: NOW//<Enter> (JUN 06,1997@09:00)
Searching for the documents.

Of course, this query has several limitations:

- Only one problem may be selected at a time (i.e., you can’t select ANGINA PECTORIS OR AIHD as a search criterion)
- Problems can’t be “grouped” or expressed ambiguously (e.g., a search for ANGINA PECTORIS, rather than ANGINA PECTORIS, UNSTABLE, would not have found this record), and
- The only way for this benefit to be exercised at all is for the clinicians at your facility to be actively using Problem List.

Still, if you’re interested in a focused search for all notes about a specific problem, and if your facility has committed to the use of the Problem List package, this can be a powerful asset for retrospective research, utilization review, and epidemiological studies. With the Preventive Measures for certain chronic diseases being made part of the Director’s performance appraisal, being able to easily pull notes that document what was done for those problems is of HIGH importance.
Facts & Helpful information

Action abbreviations on List Manager screens

The TIU and ASU packages don’t use mnemonics (abbreviations or numbers) for actions (protocols) on List Manager screens, partly because it’s difficult to make them consistent with other packages and what users expect. Sites, however, can feel free to add whatever their users would like to have (e.g., $ for Sign).

Shortcuts

At any “Select Action” prompt, you can type the action abbreviation, then the = sign and the entry number (e.g., E=4).
Jump to Document Def in the Edit Document Definition option takes you directly to a document definition (Class, Document Class, or Title) if you know the name.
When reviewing several notes, the up-arrow (^) entry takes you to the next note. To exit from the review, enter two up-arrows (^^).

Visit Information

When you enter a Progress Note for an outpatient, this Progress Note now needs to be associated with a “visit.” For the majority of Progress Notes, this visit association is done in the background, based on Scheduling or Encounter Form data. If a visit has already been recorded for the date your Progress Note refers to, but the Progress Notes wasn’t linked (e.g., for standalone visits such as telephone or walk-in visits), you can select a visit from the choices presented to you during the PN dialogue. If no visit has been recorded, you must create a new visit. See the example below.

NOTE: As of patch TIU*1*269 – Updates for ICD-10, selection from appropriate ICD diagnoses or procedures (ICD-9 or ICD-10) can be made, depending on the Date of Visit. The dialogue confirming the selections will include the ICD coding system as well as the ICD code.

Example: Entry of Progress Note that needs Visit Information

Select PATIENT NAME: TIUPATIENT,FIVE  TIUPATIENT,FIVE  4-9-46  666668829
YES  SC VETERAN
(7 notes)  D: 07/11/00 08:41
A: Known allergies

Enter RETURN to continue or '^^' to exit: <Enter>

Enrollment Priority: GROUP 3  Category: IN PROCESS  End Date:

Do you wish to see any of these notes? NO// <Enter>
TITLE: ADVERSE  11/12 ADVERSE REACTION/ALLERGY TITLE
**Example: Entry of Progress Note, cont’d**

This patient is not currently admitted to the facility...

Is this note for INPATIENT or OUTPATIENT care? OUTPATIENT/\ <Enter>  

The following SCHEDULED VISITS are available:

<table>
<thead>
<tr>
<th>No.</th>
<th>Date/Time</th>
<th>Visit Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>JUN 29, 1999@08:00</td>
<td>ONCOLOGY</td>
</tr>
<tr>
<td>2</td>
<td>JUN 24, 1999@11:00</td>
<td>NO ACTION TAKEN ONCOLOGY</td>
</tr>
<tr>
<td>3</td>
<td>JUN 24, 1999@10:00</td>
<td>NO ACTION TAKEN ONCOLOGY</td>
</tr>
<tr>
<td>4</td>
<td>JUN 24, 1999@09:00</td>
<td>NO ACTION TAKEN CARDIOLOGY</td>
</tr>
<tr>
<td>5</td>
<td>JUN 24, 1999@08:00</td>
<td>GENERAL MEDICINE</td>
</tr>
</tbody>
</table>

CHOOSE 1-5, or  
<UP>SCHEDULED VISITS, <F>UTURE VISITS, or <N>EW VISIT  
<RETURN> TO CONTINUE  
OR ‘^’ TO QUIT: N

**PATIENT LOCATION:**  GENERAL MEDICINE// <Enter>  
Enter Visit Date/Time: NOW// <Enter>  
(JUL 13, 200009:21:24)

**TYPE OF VISIT:** AMBULATORY// <Enter> (WALK-IN)  
AMBULATORY (WALK-IN)

Enter/Edit PROGRESS NOTE...

**Patient Location:**  GENERAL MEDICINE  
**Date/time of Visit:** 07/13/00 09:21  
**Date/time of Note:** NOW  
**Author of Note:** TIUPROVIDER,SEVEN

...OK? YES//<Enter>  

Calling text editor, please wait...  
1>Treatment for allergic reaction to injury.  
2><Enter>  

EDIT Option: <Enter>  

Saving Adverse React/Allergy with changes...  
Is this Adverse React/Allergy ready to release from DRAFT? YES// <Enter>  
Adverse React/Allergy Released.

Enter your Current Signature Code: <Enter Signature> SIGNATURE VERIFIED..

Select PRIMARY PROVIDER: TIUPROVIDER,SEVEN // <Enter>  
TIUPROVIDER,SEVEN  
CRS  
PHYSICIAN

Please Indicate the Diagnoses for which TIUPATIENT,FOUR was Seen:  
A list of diagnoses relating to the clinic, as defined using the AICS package, is presented for you to choose from.
Example: Entry of Progress Note, cont’d

Select Diagnoses (<RETURN> to see next page of choices):  (1-52): 9

Please Indicate the Procedure(s) Performed on TIUPATIENT,EIGHT

NEW PATIENT
1 Brief Visit  16 Cardioversion  29 Small Joint (Phalanx
2 Limited Exam  17 EKG  DISLOCATION REG. MAN
3 Intermediate Exam  18 Pericardiocentesis  30 Elbow
4 Extended Exam  19 Thoracotomy  31 Nasal
5 Comprehensive Exam  20 Removal Impacted Cer  32 Phalanx
ESTABLISHED PATIENT
6 Brief Exam  21 Anterior, Simple  35 Temporomandibular
7 Limited Exam  22 Anterior, complex  36 Finger Splint
8 Intermediate Exam  23 Posterior  37 Forearm Splint
9 Extended Exam  24 Foreign Body Removal  38 Injection Tendon She
10 Comprehensive Exam  26 PROFESSIONAL C  39 Admin Oxygen
11 Brief Visit  27 MISCELLANEOUS
12 Limited Visit  28 Major Joint (shoulde I&D
13 Intermediate Visit  29 ARTHROCENTESIS  40 Inhalation Therapy
14 Comprehensive Visit  30 NASAL CAUTERING AND  41 Peak Flow Spirometry
15 Cardiovascular  31 Orthopedic  42 Foley Catherter
16 Brief Exam  32 MANDATED SERVICES  43 Abcess
17 Intermediate Exam  33 Radial Head  44 Less than 2.5 cm
18 Extended Exam  34 Shoulder
19 Removal Impacted Cer  45 2.6 - 7.5 cm
20 Thoracotomy  46 Greater than 7.5 cm
21 Anterior, Simple  47 Burns 1 * Local Trea
22 Anterior, complex  48 Dressings Medium
23 Posterior  49 Dressings Small
24 Foreign Body Removal  50 Transfusion
25 Air ambulance servic  51 Venipuncture
26 PET follow SPECT  52 OTHER Procedure
27 Intermediate  53 OTHER Procedure
28 Major Joint (shoulde I&D

Select Procedures (<RETURN> to see next page of choices):  (1-42): 24

43 Abcess
FOREIGN BODY REMOVAL W/ MOD W/ MOD X 2:

How many times was the procedure performed? 1// <Enter>

Current CPT Modifiers:
- 26 PROFESSIONAL COMPONENT
- 32 MANDATED SERVICES

Select another CPT MODIFIER: ??

Choose from:
22 UNUSUAL PROCEDURAL SERVICES
23 UNUSUAL ANESTHESIA
26 PROFESSIONAL COMPONENT
32 MANDATED SERVICES
47 ANESTHESIA BY SURGEON
50 BILATERAL PROCEDURE
51 MULTIPLE PROCEDURES
52 REDUCED SERVICES
53 DISCONTINUED PROCEDURE
54 SURGICAL CARE ONLY
55 POSTOPERATIVE MANAGEMENT ONLY
56 PREOPERATIVE MANAGEMENT ONLY
57 DECISION FOR SURGERY

A list of CPT Modifiers can be printed out by entering two question marks (??) at the prompt.
Example: Entry of Progress Note, cont'd

58        STAGED OR RELATED PROC BY SAME PHYS DURING POSTOP PERIOD
59        DISTINCT PROCEDURAL SERVICE
62        TWO SURGEONS
66        SURGICAL TEAM
73        DISC O/P HOSP/AMB SURG CENTER (ASC) PROC PRIOR ADMIN-ANESTH
74        DISC O/P HOSP/AMB SURG CENTER (ASC) PROC AFTER ADMIN-ANESTH
76        REPEAT PROCEDURE BY SAME PHYSICIAN
77        RETURN TO OP ROOM FOR RELATED PROC DURING POSTOP PERIOD
79        UNRELATED PROC OR SERVICE BY SAME PHYS DURING POSTOP PERIOD
80        ASSISTANT SURGEON
81        MINIMUM ASSISTANT SURGEON
82        ASSISTANT SURGEON (WHEN QUAL RES SURGEON NOT AVAIL)
90        REFERENCE (OUTSIDE) LABORATORY
99        MULTIPLE MODIFIERS
AA        ANESTHESIA PERF BY ANESGST
AS        PA,NP,CN ASSIST-SURG
QX        CRNA SVC W/ MD MED DIRECTION
QZ        CRNA SVC W/O MED DIR BY MD
SG        ASC FACILITY SERVICE
TC        TECHNICAL COMPONENT

Select another CPT MODIFIER: 47  ANESTHESIA BY SURGEON
Select another CPT MODIFIER: <Enter>

DRESSINGS MEDIUM:

How many times was the procedure performed? 1// <Enter>
Select CPT MODIFIER: <Enter>

Was this encounter related to any of the following:

Service Connected Condition? Y  YES

You have indicated the following data apply to this visit:

DIAGNOSES:
   (ICD-9-CM 995.3) Allergic Reaction  <<< PRIMARY

PROCEDURES:
   65205    Foreign Body Removal W/ Mod w/ mod x 2
   CPT Modifier(s):
            -26  PROFESSIONAL COMPONENT
            -32  MANDATED SERVICES
            -47  ANESTHESIA BY SURGEON
   16015    Dressings Medium

SERVICE CONNECTION:
Service Connected? YES

...OK? YES// <Enter>

Posting Workload Credit...Done.
Print this note? No// <Enter>  NO

You may enter another Progress Note. Press RETURN to exit.

Select PATIENT NAME:
Visit Orientation

Why associate Progress Notes with Visits?

**Database design:** An event (clinical or otherwise) may be fully described by five key attributes or parameters: Who, what, when, where, and why. Three of these (i.e., who, when, and where), are all encoded in the Visit File entry itself. The remaining two parameters (what, and why), are generally included in the content of the document.

**The VHA Operations Manual, M-1, Chapter 5** requires that every ambulatory visit have at least one Progress Note. Deficiencies with respect to this requirement can only be identified if Progress Notes are associated with their corresponding Visits.

**Inter-facility data transfer** requires identification of the Facility from which the data originated. Because the Facility is an attribute of the Visit file entry, it is not necessary to maintain a reference to the facility with every clinical document.

**Workload Capture,** particularly for telephone and standalone encounters, where the only record of the encounter is frequently a Progress Note, can be easily accommodated, provided that notes are associated with visits.

“**Roll-up**” of documentation by Care Episode. To allow access to all information pertaining to a given episode of care (e.g., for close-out of a hospitalization), a visit orientation is essential.

**Integration with PCE, Ambulatory Care Data Capture, and CIRN.** The visit orientation provides a useful associative entity for interfaces with other clinical data repositories that allow query and report generation based on the existence of a variety of coded data elements. For example, a search of PCE to identify all patients with AIHD who were discharged without a prescription for aspirin prophylaxis might identify a cohort of patients for further evaluation. The ability to call for all the cardiology notes entered during the corresponding care episodes could revolutionize retrospective chart review).
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
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<tr>
<td><strong>ASU</strong></td>
<td>Authorization/Subscription Utility, an application that allows sites to associate users with user classes, allowing them to specify the level of authorization needed to sign or order specific document types and orderables. ASU is distributed with TIU in this version; eventually it will probably become independent, to be used by many VistA packages.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>A functional process that a clinician or clerk uses in the TIU computer program. For example, “Edit” and “Search” are actions. Protocol is another name for Action.</td>
</tr>
<tr>
<td><strong>Boilerplate Text</strong></td>
<td>A pre-defined TIU template that can be filled in for Titles, speeding up the entry process. TIU exports several Titles with boilerplate text which can be modified to meet specific needs; sites can also create their own.</td>
</tr>
<tr>
<td><strong>Business Rule</strong></td>
<td>Part of ASU, Business Rules authorize specific users or groups of users to perform specified actions on documents in particular statuses (e.g., an unsigned progress note may be edited by a provider who is also the expected signer of the note).</td>
</tr>
<tr>
<td><strong>Class</strong></td>
<td>Part of Document Definitions, Classes group documents. For example, “Progress Notes” is a class with many kinds of progress notes under it. Classes may be subdivided into other Classes or Document Classes. Besides grouping documents, Classes also store behavior which is then inherited by lower level entries.</td>
</tr>
<tr>
<td><strong>Clinician</strong></td>
<td>A doctor or other provider in the medical center who is authorized to provide patient care.</td>
</tr>
<tr>
<td><strong>Component</strong></td>
<td>Components are “sections” or “pieces” of documents, such as Subjective, Objective, Assessment, and Plan in a SOAP Progress Note. Components may have (sub)Components as items. They may have Boilerplate Text. Components may be designated as “Shared.”</td>
</tr>
</tbody>
</table>
CPRS

Computerized Patient Record System. A comprehensive VistA program, which allows clinicians and others to enter and view orders, Progress Notes and Discharge Summaries (through a link with TIU), Problem List, view results, reports (including health summaries), etc.

CWAD

Cautions, Warnings, Adverse Reactions, Directives; a type of Progress Note.

Discharge Summary

Discharge summaries are summaries of a patient’s medical care during a single hospitalization, including the pertinent diagnostic and therapeutic tests and procedures as well as the conclusions generated by those tests. They are required for all discharges and transfers from a VA medical center, domiciliary, or 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 are categories that group documents (Titles) with similar characteristics together. For example, Nursing Progress Notes might be a Document Class, with Nursing Dialysis Progress Notes, Nursing psychology Progress Notes, etc. as Titles under it. Or maybe the Document Class would be Psychology Notes, with Psychology Nursing Notes, Psychology Social Worker Notes, Psychology Patient Education Notes, etc. under that Document Class.

Document Definition

Document Definition is a subset of TIU that provides the building blocks for TIU, by organizing the elements 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. It also allows the creation and use of boilerplate text and embedded objects.
### Glossary, cont’d

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<td><strong>HIMS</strong></td>
<td>Hospital Information Management System, common abbreviation/synonym used at VA site facilities; also known as MIS (see below).</td>
</tr>
<tr>
<td><strong>IRT</strong></td>
<td>Incomplete Record Tracking, a package TIU can interface with to transmit incomplete progress notes and discharge summaries.</td>
</tr>
<tr>
<td><strong>Interdisciplinary Note</strong></td>
<td>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 signed by other providers, then attached to the original note.</td>
</tr>
<tr>
<td><strong>MIS</strong></td>
<td>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).</td>
</tr>
<tr>
<td><strong>MIS Manager</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>MRT</strong></td>
<td>Medical Record Technician in the Medical Information Section of Medical Administration Service at the site facility 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.</td>
</tr>
</tbody>
</table>
Object

Objects are a device to extract data from other VistA packages to insert into boilerplate text of progress notes or discharge summaries. This is done by having a placeholder name embedded in the predefined boilerplate text of Titles, such as: “PATIENT AGE.” The creator of the Object types the placeholder name into the boilerplate text of a Title, enclosed by ”|”s. If a Title has the following 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 ...” where the age for this specific patient is pulled from the patient database.

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

Title

Titles are definitions for documents. They store the behavior of the documents which use them.

User Class

User Classes are the basic components of the User Class hierarchy of ASU (Authorization/Subscription Utility) which allows sites to designate who is authorized to do what to documents or other clinical entities.
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