

**Clinical Information Support System
Occupational Health Record-Keeping System
User Guide**



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Getting Started

Getting Started in OHRS

The Occupational Health Record-keeping System (*OHRS*), is a web-based application that enables occupational health staff to create, maintain, and monitor medical records for VA employees and generate national, Veterans Integrated Service Network (*VISM*), and site-specific reports.

The OHRS help topics provide detailed information to assist Clinical Information Support System (*CISS*) site staff members and other users to successfully use CISS and OHRS.

The OHRS documentation is located on the VA [Software Document Library](#) (VDL) Web site.

Logging into CISS OHRS

To log into OHRS, you must be authorized to use the CISS Web application and OHRS. Use your VA Network user ID and password to access CISS. Then click the OHRS button, which is actually a link that navigates you to OHRS.

Note: You must have the appropriate security privileges to access OHRS, or the option does not display on the CISS page.

1. From the appropriate link, enter your VA Network User ID and password on the CISS window. If you need access to this application or need to reset your password, please log a ticket with the National Service Desk: 1-888-596-4357.

Department of Veterans Affairs
CISS | Clinical Information Support System

*This is a TEST environment.
 Do NOT use or enter real Patient Data.*

Welcome to CISS

Please enter your VA network User Name and Password to login.

Login

User Name :

Password : **Login**

Clinical Information Support System User Agreement

Users are prohibited from allowing ANYONE to use their User Name/Password codes.

WARNING - This system may contain Government information which is restricted to authorized users ONLY. Unauthorized access, use, misuse, or modification of this computer system or of the data contained herein or in transit to/from this system constitutes a violation of Title 18, United States Code, Section 1030, and may subject the individual to Criminal and Civil penalties pursuant to Title 26, United States Code, Sections 7213 (a), 7213A (The Taxpayer Browsing Protection Act), and 7431. This system and equipment are subject to monitoring to ensure proper performance of applicable security features or procedures. Such monitoring may result in the acquisition, recording and analysis of all data being communicated, transmitted, processed or stored in this system by a user. If monitoring reveals possible evidence of criminal activity, such evidence may be provided to Law Enforcement Personnel.

ANYONE USING THIS SYSTEM EXPRESSLY CONSENTS TO SUCH MONITORING.

- If you are experiencing problems/issues with the OHRs software application portlet, please contact the VA Service Desk (VASD) at 1-888-596-4357 to open up a Remedy Ticket. Software issues will not be monitored via the Contact Us link.
- If you have a question about the Occupational Health Record-keeping System (OHRs) Program, please send an email to [Pam Hirsch](#).

CISS Version: 1.4.0.83001 | © 2011 Clinical Information Support System | [Contact Us](#)

OHRs Log On

2. Click the OHRs link in the upper right corner (it looks like a button but behaves like a link).

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*This is a TEST environment.
 Do NOT use or enter real Patient Data.*

Station: Not Selected User Name: Moody, Susan G Log Out

CISS Home OHRs

Welcome to The Clinical Information Support System (CISS) portal!

Site Highlights:

- [VA Home Page](#)
- [VHA Home Page](#)

The CISS portal is development in the delivery of information and applications to the clinical user community. It provides a single point of access for the clinical user's application and information needs, facilitating faster and more efficient patient care.

[Read More ->](#)

Occupational Health Record-keeping System.

The CISS Program announces that its first partner system, Occupational Health Record-keeping System (OHRs), is now available for use.

[Read More->](#)

OHRs
 Occupational Health Record-keeping System

- If you are experiencing problems/issues with the OHRs software application portlet, please contact the VA Service Desk (VASD) at 1-888-596-4357 to open up a Remedy Ticket. Software issues will not be monitored via the Contact Us link.

OHRs Main Page

Logging Out

The Logout basic flow begins when you choose to log out of the system and ends when you exit the system.

1. Click the **Log Out** link on the top right.
2. A confirmation message is displayed. Click **OK** to confirm or **Cancel** to remain in the system.

Note: The system will log you out if you engage in no system activity for 15 minutes.

Login Lockout

If you attempt to log in with an incorrect password or user ID, the system gives you a warning message.

You will be locked out of the system if you do not enter the correct user ID or password on the third consecutive attempt – and you must consecutively enter the wrong password or the wrong user ID. If this happens, you need to contact your system administrator to have your ID unlocked.

The system gives you a message that reads, “You are currently locked out of the system. Please contact your OH System Administrator.”

Automatic Timeout

The system automatically logs you out after 15 minutes of inactivity. A warning message displays, counting down from 60 seconds until you are logged off the application. You may click the OK button to stop the count-down and continue working. Be aware that if the system automatically logs you off, your work is not saved.

CISS Home Page

This page describes the Clinical Information Support System (CISS) and describes the Occupational Health Record-keeping System (OHRS) as the first CISS partner system.

To access the OHRS application, click the OHRS button located at the top right side of the page.

NOTE: If you are experiencing problems with OHRS, there is contact information at the bottom of the application page to get support.

Selecting a Functional Station

When signing in, users may be prompted to choose the functional station in OHRS that they wish to access. Health care providers will see stations on a drop-down list where they have been assigned to work. The stations listed are determined by their profiles that have been set up in OHRS. Once selected, the station appears in the context bar at the top right side of the page.

1. Select the appropriate station from the drop-down list.
2. Click **Select** to display the OHRS home page.

Note: There are two types of stations in OHRS:

- A duty station is a location where a person is based (typically, it is where a person receives a paycheck). It may be a place where health care is not provided, such as a national cemetery or an office building.
- A functional station is a location where health care is provided (a treating facility), such as a VA medical center or clinic.

National Administrators who wish to generate reports do not see the page where they would select a functional station since their reports can span several stations and they have access to all of them.

OHRS General Window Layout

Here is an example of a basic OHRS window:

Department of Veterans Affairs
OHRS
Occupational Health Record-keeping System

CISS Clinical Information Support System

This is a TEST environment.
Do NOT use or enter real Patient Data.

Station: Not Selected User Name: Moody, Susan G Log Out

CISS Home OHRS

New OHRS 1.4 Feature Highlights!

- Print Cumulative Vaccination Record from patient Cover Sheet
- New vaccine encounters - Tdap, Td, TT and Pneumococcal Polysaccharide
- Pre-fill manufacturer and dose data for all vaccination encounters
- Encounters/Addendums can be added to patients with an inactive work status
- Respirator Fit Test encounters - if PAPR then Fit Test Information is not collected
- Context Sensitive Help

Welcome To SQA OHRS You Have Alerts

The Occupational Health Record-keeping System (OHRS) is designed to address clinical service needs of VA Employee Occupational Health Programs.

OHRS provides employee occupational health staff with the means to electronically record health information on employees, volunteers, academic affiliates and others who work in VA facilities. OHRS also provides occupational health staff the ability to generate reports and graphs thus providing the ability to analyze data needed to create a healthier and safe working environment.

Through role-based access, OHRS limits access to employee health records to those with a need to know. The OHRS System Administrators grant access to the OHRS application. Your role in

OHRS Window

The Banner

This is a graphical area that displays the Department of Veterans Affairs logo, the parent system, which is the Clinical Information Support System (CISS), and the name of the partner application (OHRs, Occupational Health Record-keeping System). It also includes photos of typical VA employees or clients.

The Context Bar

The right side of the Banner shows the user's duty station, user name, and log out link. There are also buttons of the applications that the user has permissions to use. If the user is an administrator, they can sign on with no duty station specified until they begin to perform the functions they have authorization to do.

The Menu

This is a list of items on the left side of the window. The Menu displays the actions that are available to you, based on your role.

Note: At the top of the menu is the Quick Search Bar. See [Searching for or Selecting a Patient](#).

The Content Area

This is a section of the window where you see explanatory text, and where all input, viewing, and OHRs tasks are performed. If there are error messages to your input, they display here.

There are also links, which look like buttons, to CISS Home and to the OHRs application in the Content Area.

The Footer

The Footer is displayed at the bottom of every window. It displays the version of the application, the copyright date, and a link to contact the application owners.

- If you are experiencing problems/issues with the OHRs software application portlet, **please contact the VA Service Desk (VAsD) at 1-888-596-4357 to open up a Remedy Ticket.** Software issues will not be monitored via the Contact Us link.
- If you have a question about the Occupational Health Record-keeping System (OHRs) Program, please send an email to [Pam Hirsch](#).

OHRs Version: 1.4.0.83001 | Flash Player: WIN 10,3,183,7 | © 2011 Clinical Information Support System | [Contact Us](#)

Help Button

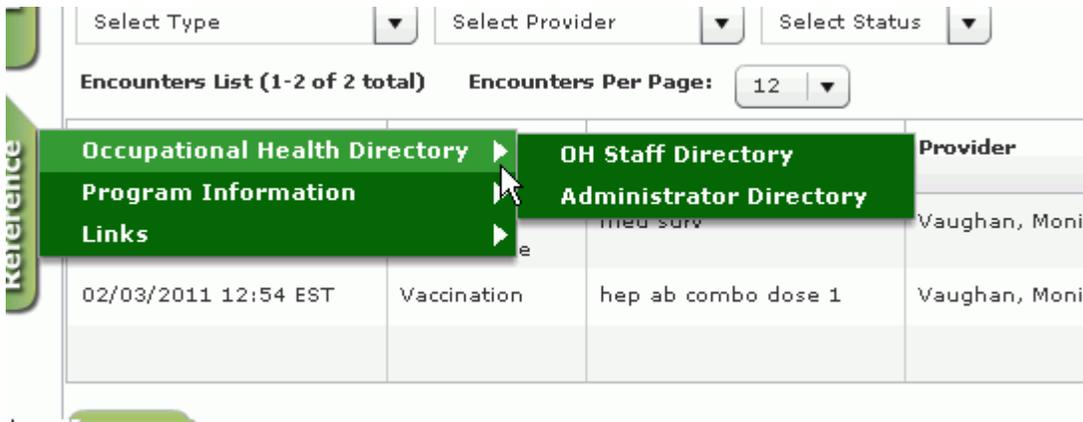
Clicking the help button on each page will display a context-sensitive help window that contains information specific to the tasks that can be performed on that application page. The window has a "Show Help TOC" link that, when clicked, displays the TOC for the entire help file. There is also a breadcrumb trail at the top of the window that shows the location of the help topic in the larger help file.

Accessing the Occupational Health (OH) Staff and Administrator Directories

As an OHRS user, you can search, view, and sort the Occupational Health (OH) Staff and Administrator Directories.

To access the Occupational Health (OH) Staff and Administrator Directories:

1. From the left side of the OHRS Home Page, click the **Reference** tab to display a fly-out menu for **Occupational Health Directory** and submenus for **OH Staff Directory** and **Administrator Directory** (see graphic below).



2. Select either directory's name to display it.

The Occupational Health (OH) Staff and Administrator Directories allow you to search by the following criteria:

- Last Name
- First Name
- Role
- Station
- VISN

You can send an email to individual or multiple staff member(s) from the OH Staff Directory page. Once you select the staff member(s) and click **Send Email**, the system should create an Outlook email message window and pull the staff email addresses into the **To:** line.

Displaying an Encounter's Notification Tab

Notifications are a text-based electronic messages linked to a patient encounter. They are messages that providers communicate regarding a patient's workability status (i.e., the patient is or is not available to work), reminders to a patient to return for follow-up care, etc.

Notifications can be generated manually or automatically. The system can automatically send notifications to a recipient when a patient encounter trigger is met, or a provider can manually select a notification and send it to a designated recipient. The recipient's work email address must be included.

The Notifications tab on a Patient record displays *all* of the notifications that exist for the patient.

Every notification is tied to an encounter. Depending on which encounters you are responsible for, i.e., if you created the encounter or are its expected co-signer, you can see various buttons and do various things with the notification. The one activity you cannot do from this window is to create a notification; that must be done in conjunction with the encounter itself.

Depending on your association with the notification's encounter, you can print, send, re-send, and view the notification, or any combination thereof.

Printing a Notification

Select a notification from the list and click Print to display the Notification as a PDF that you can print.

Emailing a Notification

You can email a pending notification if you have the rights. Check the Status column.

If you do, here is the window that displays. Note what you can do on this window:

Patient Information					
Name:	CISSPATIENT, ONETHOHFRYTYSIX	SSN:	XXX-XX-2194	Date of Birth:	01/07/1994
Gender:	Male	Patient Status:	Non-Paid Employee	Work Status:	Active
City:	Eau Claire	State:	Agascalientes		

Cover Sheet	Encounters	Notifications	Patient Information	WorkAbility
-------------	------------	---------------	---------------------	-------------

Notification Type:

Add New Recipient:

← Email Address must contain "va.gov"

Recipients:

Notification Text:

Date: 09/13/2009

To: _____

From: Occupational Health Services (OHS)

Subject: Follow Up Visit for Vaccination

You were evaluated on 09/13/2009 for Vaccination. We request that you:

Return To Occupational Health Clinic on 09/14/2009.

Please contact the Occupational Health Services (OHS) office at _____ if you have any questions or need to reschedule your follow up visit.

According to VA Policy, you must advise your supervisor when you leave your duty station.

Email Notification

To send the notification, enter the appropriate email address (an example is shown above), click Add, and click Email. Note that if you want to remove an email address before you send it, you can click Remove. Of course you can also cancel the action. Also note that you cannot edit the notification.

Re-emailing a Notification

If you have the rights, you can re-email a notification if it is complete, but note that it will be re-emailed to the original recipient only.

If you re-email the Notification, the system gives you a message.

Displaying the SOAPE Tabs

There are specific tabs within the Encounter tab itself that require data entry when you are creating a new encounter, regardless of the Encounter Type. The tabs are named:

- **Subjective**
- **Objective**
- **Assessment**
- **Plan***, which has two additional tabs:
 - Plan*
 - Plan Comments

- **Encounter Codes***, which also has two additional tabs:
 - Diagnosis Codes*
 - Procedure Codes*

You can see examples of the SOAPE tabs for a various encounters - Creating a Medical Surveillance Encounter, Creating a Vaccination Encounter (General Health), and Creating a Pandemic Influenza Encounter. Note that the first tab changes (and is not defined as SOAPE), depending on which encounter type you're entering. It gives you relevant information such as vaccination history for vaccination encounters, Respirator information for Medical Surveillance encounters, evaluation method for Pandemic Influenza encounters, etc.

For information on how to enter data in these various tabs, see [Creating a Vaccination Encounter \(General Health\)](#).

Logging a Remedy Ticket

If the application gives you an error at the time you log on or if you receive error messages that are NOT part of data entry (e.g., if you have not filled out an encounter correctly), you can:

- Contact the VA Service Desk to log a Remedy ticket – email VASD@va.gov or call 1-888-596-4357.
- If you have the knowledge and access, you may log a Remedy ticket yourself.

System Requirements

Understanding System Requirements

To use the CISS application, you must have:

1. Access to the Veterans Health Administration (*VHA*) Intranet via Microsoft Internet Explorer version 6.0 or higher, with Service Pack (*SP*) 2.
2. Standard 128-bit encrypted security (SSL) implemented on your computer - your system administrator can help if you do not know how to install it.
3. The latest version of Flash Player installed on your computer; if you do not have it installed, a message displays, instructing you to contact your Information Resource Management (*IRM*) point of contact to get the correct version of Flash Player installed.
4. An authorized user account that includes a defined user role within the application.

Application Conventions

Application Conventions

This OHRS help includes documentation conventions, also known as notations, which are used consistently throughout the topics.

Convention	Example
<Enter> indicates that the Enter key (or Return key on some keyboards) must be pressed.	Type Y for Yes or N for No and press <Enter>.
<Tab> indicates that the Tab key must be pressed.	Press <Tab> to move the cursor to the next field.
Bold typeface in a numbered list means a selection from a menu, link, or button.	Select Patient from the menu. Click the Log Out link. Click OK.

Note for Section 508 compliance: in this manual, instructions are written “to click” the mouse button. Alternatively, you can instead press <Enter> on the keyboard instead of using the mouse to click.

Hot Keys

Information about Microsoft keyboard shortcuts can be found at:

<http://www.microsoft.com/enable/products/keyboard.aspx>

Required Fields

All required fields in OHRS are marked with an asterisk (*). If required fields are left blank and you attempt to create or change a record, the system responds with an error message.

Deleting Non-Required Radio Buttons

Some entry screens have non-required choices displayed as radio buttons. If you mark one of these radio buttons unintentionally or want to leave it blank after you've selected one of them, press the **Delete** key.

Note: you cannot delete a selection of a required radio button choice. Also, you can only delete one non-required radio button at a time. If several radio buttons have been selected and you press the Delete key, only the last radio button will get "blanked out."

Screen Resolution

To work with OHRS, your screen resolution optimally should be greater than 1024 x 763; however, the application will work with the VA's lowest common denominator resolution of 800 x 600 – you will have to scroll horizontally in some cases at that low screen resolution.

Right (Alternate) Mouse Button Menu

On some lists, which display in table format, OHRS displays a right (or alternate) mouse-button command list. For example, on the list of completed reports, you can use the alternate mouse button to see a list of the commands that you can perform on a report.

Section 508 Requirements

Section 508 Compliance

The CISS-OHRS project team has worked closely with the VA's Section 508 office to assure that the application can be used with assistive technology software. Users with disabilities can use a variety of assistive technology software programs to access and navigate CISS-OHRS.

See [Right \(Alternate\) Mouse Button Menu](#).

On lists, which display in table format, OHRS displays a right (or alternate) mouse-button command list. For example, on the list of reports, you can use the alternate mouse button to see a list of the commands that you can perform on a report.

See [Section 508 Compliance for Combo Boxes](#) for a description of an alternate method the CISS-OHRS application uses to comply with accessibility for combo boxes.

For more information regarding Section 508 Compliance and Assistive Technology, go to the following links:

1. Information on Section 508 for the VA: <http://www.section508.va.gov/index.asp>
2. JAWS -- <http://www.freedomscientific.com/downloads/jaws/JAWS-previous-downloads.asp#EarlyThumbDrive>
3. JAWS Keystrokes: <http://www.freedomscientific.com/training/training-JAWS-keystrokes.htm>
4. Window Eyes -- <http://www.gwmicro.com/>

JAWS Note: If a user is using JAWS with the flex application, the vendor recommends that the tool is not configured with auto forms mode turned off.

There is a Section 508 compliant menu in OHRS. See [Section 508 for the OHRS Menu](#) for a description of the menu and how it adheres to Section 508 compliance.

Section 508 Compliance for Combo Boxes

For the purpose of this topic, a combo box is defined as a drop-down box where the user must choose a specific value from a list or select a date from a calendar interactive graphic.

For Section 508 Compliance, Microsoft standards use the Alt key plus the Up or Down arrow key for keyboard selection (as opposed to a mouse click) on combo boxes. CISS-OHRS was developed with a tool that does not employ the Microsoft standard, so here is how CISS-OHRS handles it:

Use the Control (**Ctrl**) key plus the Up or Down directional arrows (**Ctrl + Up Arrow, Ctrl + Down Arrow**) to select from a combo box.

Section 508 for the OHRS Menu

The OHRS menu is now 508 compliant.

To use the menu without the mouse:

1. Use the tab key to tab to the menu. It displays a light line surrounding it when it's selected, as shown.
2. Press **Enter** or the **Space Bar** to expand the menu.
3. Use the arrow keys to expand each expandable menu.
4. Press **Enter** for the menu item you want.

Additional Keyboard Navigation for Section 508 Compliance

Primarily, you use the Tab key to navigate the screen. When an item has focus, you see an outline or some type of highlighting on the screen to indicate that the functionality has focus and you can act on the item with keystrokes from the keyboard. The following keys perform the actions listed:

Space Bar

When an item is in focus, you can use the space bar to:

- Select buttons
- Select links; note that the OHRS link is an exception – you need to use the Enter key to navigate the OHRS link from the CISS home page.
- Select items from a list

Up/Down Arrows

When an item is in focus, you can use the up/down arrows to:

- Select items on the main menu
- Select and/or scroll through items in drop-down lists
- Scroll through a list
- Select and/or scroll through items on a grid list or search result list such as lists displayed on the Alerts screen, the patient search result screens, the duty station list, report list, etc.

Left/Right Arrows

When an item is in focus, you can use the left/right arrows to expand and collapse the sub-menus on the Menu and Reference menus.

Enter Key

When an item is in focus, you can use the Enter key to:

- Select a button
- Select items on a list
- Select links

Escape Key

When an item is in focus, you can use the escape key to collapse and exit the Menu and Reference pop-up menus and sub-menus.

Ctrl + Down Arrow

When an item is in focus, you can use the Ctrl + Down Arrow to expand drop-down lists.

Ctrl+ Home from OHRS

This key combination returns you to the OHRS home page.

Role-Based Access

Understanding Role-Based Access

The level of access to data and functions in CISS-OHRS varies depending on job function. Your System Administrator will work with you to determine the most appropriate level of access for your job functions.

Electronic Signature

Working with the Electronic Signature

To ensure security and provide audit information, all CISS-OHRS users with authority to document care must have an electronic signature code, or e-signature. Your e-signature is a secondary level of authentication and carries the same legal responsibilities as your written signature. It works in addition to your password to identify you. You must enter your e-signature when you confirm the encounter data that you enter.

Once you create your e-signature, do not share it with anyone. For your protection, your e-signature will be encrypted and will be unknown to anyone else, including computer programmers maintaining CISS-OHRS. If you forget your e-signature, it must be reset by a VistA system administrator.

NOTE: VistA ESig user account setup is required for CISS-OHRS users to use their e-signature in the application. If you are experiencing an ESig-related error when signing an encounter, contact the Local Site IRM who will verify that your VistA ESig user account is set up with at least one of the following:

- The user must have the [XOBE ESIG USER] Broker option added to his or her secondary menu.
- The [XOBE ESIG USER] Broker option must be added to the Common Menu [XUCOMMAND] in Kernel. (For IRM: this is the recommended option which enables all users on the system to have access to the ESig options so that the Broker option need not be assigned specifically to individual users)

Entering an Electronic Signature

You must have the appropriate security privileges to access the Enter Electronic Signature or the option does not display.

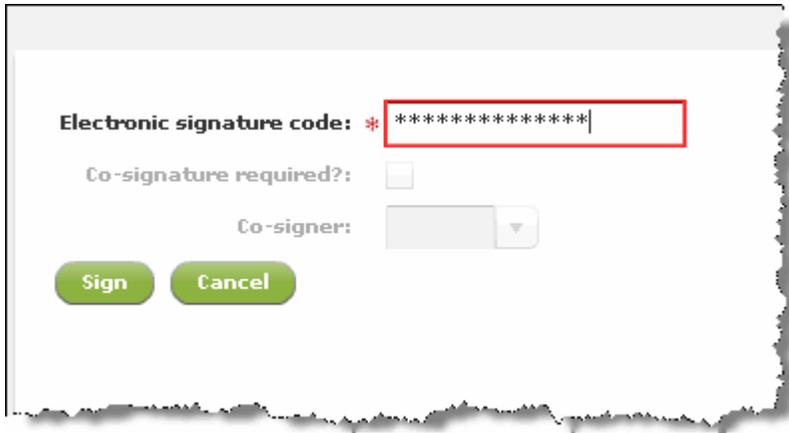
Note: The selected patient encounter, addendum, or OH form must have a status of **Open**.

1. Select the patient encounter or addendum you authored or an OH form linked to the patient encounter.
2. Click **Sign**.
3. Enter your VistA access code and verify code.



VistA Sign-in Window

4. Enter your electronic signature.



Electronic Signature Window

5. Click **Sign**.
6. Click **OK**.

Entering an Electronic Co-Signature

You must have the appropriate security privileges to access the Enter Electronic Co-Signature or the option does not display.

Note: Patient Encounter, addendum, or OH form is flagged that a co-signature is required and status is Cosign.

1. Choose to electronically co-sign a patient encounter, addendum, or OH form.
2. Enter electronic Co-Signature information
3. Select the VistA Login and follow the steps in [Entering an Electronic Signature](#).

Working with a User Profile

Managing My Profile

You may create, change, or view your user profile, depending on your security clearances. **My Profile** is used to view, create, or change your e-Signature code.

You must have the appropriate security privileges to access **My Profile** or the option does not display.

1. From the OHRS menu, select **My Profile**.
2. On the screen that displays, enter your VistA e-Signature Codes.
3. Select the **VistA Login** button. If appropriate, you see a window where you can make some changes.

- After you have created or changed your VistA e-Signature codes, click **Submit** to submit your user profile. It is validated and stored at the VistA site.

Note: The steps to create, view, or update a user profile are the same.

Working with Encounters

Understanding Patient Encounter Records

The Patient Record window, which is displayed after you've entered a new patient or if you select an existing patient, is divided into two basic sections.

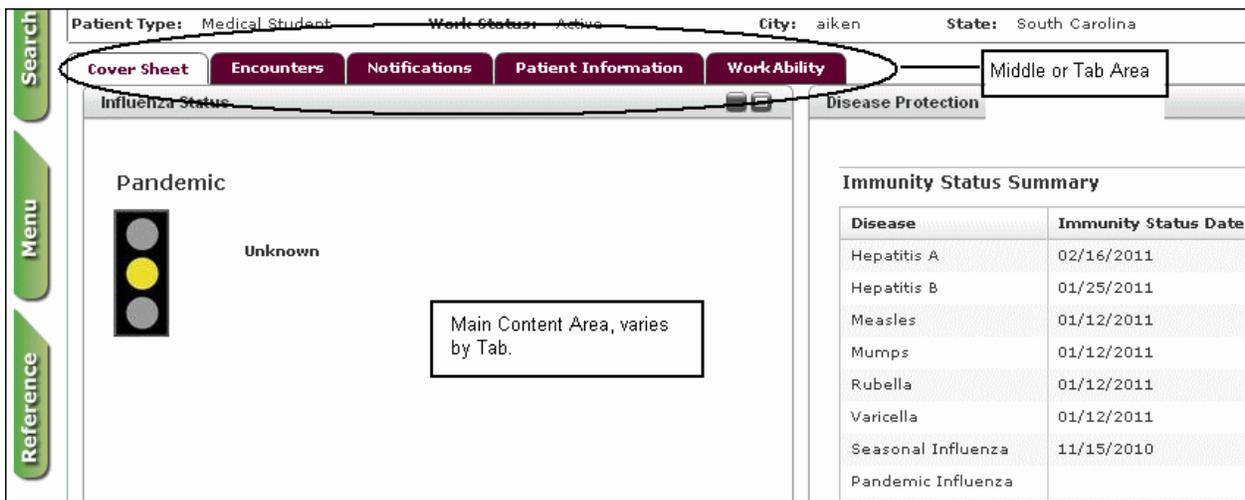
Displaying the Main Patient Record Window Sections

The top area is the very basic patient information: name, last four digits of social security number, date of birth, gender, patient type, work status, and city and state.



Patient Information on Main Window

The middle, or tab, area displays five tabs: Cover Sheet, Encounters, Notifications, Patient Information, and WorkAbility Information. The example below is specific to the selected test patient; not all patients will have the same information displayed. Also remember that the view you see is determined by your role, so that may be another reason what you see on this screen is different.



Tab and Main Content Areas

The largest area is the main content area, which varies according to the tab selected.

Displaying Patient Records on the Encounters Tab

The Encounters tab displays encounters that you have created for the selected patient or those that have been closed (signed or set as needing a co-signature). As an occupational health provider, you can view your own encounters with the status of open, closed, or co-sign. All encounters are displayed on the encounter list for the selected station. You cannot view the details of encounters created by other providers if the encounter status is open or co-signed, or if the encounter belongs to another station.

Encounter access is based on your user role. If your role allows you to access encounters, you will see them.

Displaying Patient Encounters (OH Provider View)

From this window you can:

1. Create a new encounter by clicking **Create**.
2. You can create General Health or Medical Surveillance Encounters. See [Creating a Patient Encounter](#) for more information.

It is also helpful to understand some specific layout properties of CISS-OHRS, and they are described in [Working with Specific Entry Items When Creating Encounters](#).

You can also search for another encounter. To do this:

1. Type free text words in the quick search box at the top of the content area and click Search. You will see a list of encounters that match the keywords entered. For example, you can type in keywords such as Medical Surveillance or Co-sign the list will be filtered.
2. Click **Reset** to clear the filter and view the entire list.

You can control what encounters are displayed by using the following drop-down lists, one at a time:

1. Select Type: to filter the encounter list by type, such as Immunization Authorization or Pandemic Influenza, click the Type drop-down and select a type.
2. Select Provider: to filter the list by provider name, click the Provider drop-down and select a provider.
3. Select Status: to filter the list by encounter status, click the Status drop-down and select Closed, Co-sign, or Open. Note that only the statuses that are available on the list are displayed in the drop-down.
4. Reset the search list and current view by clicking **Reset**.

View the existing encounters with the Encounters Chart view by clicking the **Chart** button. If you click the encounters plotted on the chart, you can view the encounters, but your ability to view follows the same rules defined in the list view. For information on how to work with the Encounter Chart view, see [Working with the Encounters Chart](#).

Displaying Selected Encounters (OH Provider View)

After you have selected an encounter from the list, the buttons that display, and the subsequent actions you can take, are dependent on the status of the encounter. You can view only your patient records that have a status of open, closed, or co-sign, and encounters that been assigned to you by another provider for co-signature.

Here is an encounter that has been left open for co-signature (see [Entering an Electronic Co-Signature](#) for more information on co-signatures).

Patient Information
Name: CISSPATIENTA, TWO THREE SSN: XXX-XX-1-11 Date of Birth: 01/03/1945
Gender: Female Patient Status: Employee Work Status: Active

Encounters Notifications Patient Information

Create View Co-Sign Addendums Notifications Print

Search: Search Reset Change View: Chart

Narrow Filters: To further narrow results below, select filter value from one of the dropdowns
Select Type: Select Provider: Select Status: Select Folder ID:

Encounters List (1-12 of 12 total) Encounters Per Page: 12

Date/Time	Type	Purpose	Provider	Status	Folder ID	Addendums	Notifications
02/26/2009 09:54 CST	Pandemic Influenza	test	CISSuserA, One	Open			
02/24/2009 17:29 EST	Medical Surveillance	test	CISSuserA, One	Closed			(1)
02/20/2009 10:45 CST	Immunization Administration	test	CISSuserA, One	Closed			
02/17/2009 06:54 CST	Pandemic Influenza	test	CISSuserA, One	Closed			(1)
02/13/2009 08:42 MST	Immunization Administration	test	CISSuserH, One	Closed			
02/13/2009 00:00 CST	Immunization Administration	test	CISSuserA, One	Closed			
02/11/2009 12:15 CST	Immunization Administration	test	CISSuserA, One	Closed			(2)
02/06/2009 13:09 CST	Immunization Administration	test	CISSuserA, One	Co-Sign		(4)	(2)
02/06/2009 13:05 CST	Immunization Administration	test	CISSuserA, One	Co-Sign			

Action buttons: Create, View, Co-Sign, Addendum, Notifications, and Print

the selected encounter

Create View Co-Sign Addendums Notifications Print

An Open Encounter

Create

The **Create** button allows you to create a new encounter. See [Creating a Patient Encounter](#).

View

The **View** button allows you to view read-only details of the highlighted encounter. See [Creating a Patient Encounter](#) for more information. Note that you can view details of closed encounters only. The restrictions as to which encounters you are allowed to see (for example, at your station) still apply.

Print

The Print button allows you to print a PDF version of an encounter. See [Creating a Patient Encounter](#) for details.

Co-sign

The **Co-sign** button is available only if you have requested a co-signature or are the person who needs to co-sign the encounter. The designated co-signer must co-sign the encounter before it can be closed. The co-signer has read-only access to the encounter.

Addendums

The Addendum button allows you to create an addendum for the patient encounter. If the co-signer adds an addendum before they co-sign the encounter, they need to co-sign the original encounter before they can sign the addendum. For information on creating addendums, see [Creating an Addendum for a Patient Encounter](#).

Notifications

The Notifications button displays all notifications associated with the selected encounter. Note that from here you can also create additional notifications.

Displaying the Risk Profile

The Risk Profile is located on the Patient Information Tab. It displays the risk profile for a patient, as every OHRS patient must have a risk profile created. The risk profile indicates how often a patient must be evaluated for the designated risk.

Viewing Disease Immunity

As an OHRS user, you can see a summary of a patient's immunity status on the patient cover sheet so that you can quickly get a "snapshot" of their immunization record.

You can see the Disease Immunity Summary Table from underneath the Encounter Distribution graphic on the patient's cover sheet.

The Disease Immunity Summary will always contain the following information:

- Disease
- Immunity Status Date
- Immunity Status

Note: The Disease Immunity Summary table will only contain a patient's latest immunity information. It will not contain a patient's immunity history.

Displaying the Work Profile

A patient's Work Profile is initially created when the patient's record is created or if the patient data comes from the PAID or VSS systems. The work profile shows information about where the patient works, their job code, job title, and provides supervisor information. The Work Profile may be updated; see [Creating and Updating the Work Profile](#) for more information.

Displaying the Demographic Information

A patient's Demographic information is initially created when the patient's record is created or if the patient data comes from the PAID VSS, or Other Federal Agency (OFA) systems. The demographic information shows name, address, phone, email, and emergency contact information for the patient. The Demographic Information may be updated (see [Updating the Demographic Information](#)).

Displaying the Patient Cover Sheet Pods

The Patient Cover Sheet pods are clickable pieces of content on the **Cover Sheet** tab which allow you to quickly view important high-level patient information. You can minimize and maximize any of the pods. When you minimize pods, the window automatically readjusts the remaining pods to fit into the cover sheet space. Minimized Pods are relocated to the bottom left of the window. You can drag and drop the Pods to change the order in which they display. Once you modify the view of the pods and log out, the system will retain your settings when you log back in.

Patient Information
 Names: C15SPATIENT, FOUR SSN: XXX-XX-9123 Date of Birth: 08/01/1970 Gender: Female
 Patient Type: Contractor Work Status: Active City: Sherry Point State: New Hampshire

Cover Sheet | Encounters | Notifications | Patient Information | Work Ability

Influenza Status

Pandemic



Susceptible

Seasonal



Immune By Vaccination

Disease Protection

Immunity Status Summary

Disease	Immunity Status Date	Immunity Status
Hepatitis A		
Hepatitis B		
Measles		
Mumps		
Rubella		
Varicella		
Seasonal Influenza	10/15/2009	Immune By Vaccination
Pandemic Influenza	09/29/2009	Susceptible
Diphtheria		
Pertussis		
Tetanus		

Vaccination Status Summary

Vaccine	Vaccination Status Date	Vaccination Status
Hepatitis A Vaccine		

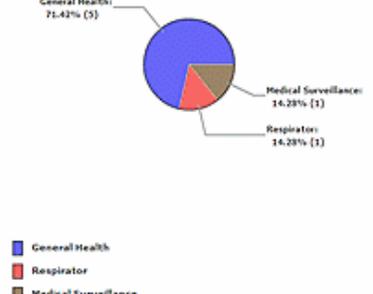
Full Shot Record



Visited Stations

Station Number	Station Name
442	CHEYENNE VAMC
532	DAYTON (#532)

Encounter Distribution



Respirator Fit Test Summary

Type of Respirator	Respirator Manufacturer	Manufacturer's Model Number	Face Piece Type	Respirator Size	Next Fit Test Date	Respirator Fit Test Status
Self Contained Breathing Apparatus (SCBA)	Survival	23454FE	Full Face Mask	Small (S)	08/25/2010	Pass

Patient Coversheet Pods

The Patient coversheet includes six Pods. The following table lists a description of each pod.

Pod	Description
Influenza Status	Displays a stop light warning view of the Influenza Status. For Pandemic and Seasonal either a green, yellow, or red light is displayed.
Disease Protection	Displays the Immunity Status Summary, the Disease, Immunity Status Date, and Immunity Status. This Pod allows you to sort in ascending or descending order by field. To do this, click on a particular field heading.
Full Shot Record	You can view this Pod as either a plot or line chart. Each gold colored diamond represents a particular vaccine and vaccination status date for a patient.
Visited	Displays the Station Number and Station Name. This Pod allows you to

Stations	sort in ascending or descending order by field. To do this, click on a particular field heading.
Encounter Distribution	Provides a pie chart view of the encounter categories (General Health, Medical Surveillance, and Respirator) for a given patient. Click on a particular section of the chart to select the pie piece and emphasize a category.
Respirator Fit Test Summary	Displays the Type of Respirator, Respirator Manufacturer, Manufacturer's Model Number, Face Piece Type, Respirator Size, Next Fit Test Date, and Respirator Fit Test Station. This Pod allows you to sort in ascending or descending order by field. To do this, click on a particular field heading.

Click on the tabs at the bottom of the coversheet to display a pod that has been minimized.



Minimized Coversheet Pods

If you maximize a pod, the entire window will expand to display the pod's content.

Printing Cumulative Vaccination Records

An OHRS user who has permission can print the vaccination record for a patient. The vaccination record will contain all vaccinations recorded on all closed encounters for the vaccination status' of Vaccination Complete and Vaccination In Progress for the patient in OHRS.

To print a cumulative vaccination record:

1. Search for a patient to display the patient's cover sheet.
2. Click the Print Cumulative Vaccination Record button at the top right of the page to display the record.
3. Click File > Print to print the record.

Viewing Respirator Fit Test Summary Information

You can view cumulative information about a patient's Respirator Fit Test (RFT) status in the "Respirator Fit Test Summary" table which is located in the Respirator Fit Test Summary pod on the cover sheet.

The RFT Summary table contains only the latest information about fit tests that passed on different types of respirators. It does not contain information about fit tests that failed. For example:

- If two RFT encounters have the same type of respirator and one failed the Fit Test, only the "passed" encounter information will be included. The "passed" encounter will be included even if it was done before the "failed" encounter.
- If two RFT encounters have different types of respirators and both passed the Fit Test, information from both encounters will be included in the RFT Summary table.

To view the Respirator Fit Test Summary information:

- With a patient selected, use the filter drop-down to narrow your results to Respirator **Fit Test** encounters.
- Click the patient's **Cover Sheet** tab, and then select the Respirator Fit Test summary pod.



Type of Respirator	Respirator Manufacturer	Manufacturer's Model Number	Face Piece Type	Respirator Size	Next Fit Test Date	Respirator Fit Test Status
Air filtering respirator	3M	123456	Half Face Mask - Filtering Face Piece	Extra-Small (XS)	10/01/2010	Pass

Respirator Fit Test Summary Information

Understanding Encounters

Encounters are the heart of OHRS, as they drive patient data gathering. Some data types gathered are encounter type, purpose, status, and provider. Encounters are used to incur reports, alerts, and other functionality within the system.

Creating a Patient Encounter

You must have the appropriate security privileges to access the Manage OH Encounter functions or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient.

1. With a patient record displayed, click the Encounters tab.
2. Select **Create**.
3. Enter the encounter information, which varies depending on the kind of encounter you are creating.
4. When you are finished entering all the information, sign the encounter. See [Working with the Electronic Signature](#).

Viewing and Printing a Patient Encounter

If you have the appropriate permission, you can view and print the encounters set up for a patient. You can search and sort the list of patient encounters.

1. With a patient record selected from **Search Select Patient**, click the **Encounters** tab. If encounters have been entered for the patient, you will see a list of one or more encounters.
2. Highlight the encounter you want to read.
3. Select **View**. A detailed version of the encounter is displayed in read-only format.

4. If you want to print the encounter, select **Print**. A version of the encounter is displayed as a PDF and you may print it.

Working with the Encounters Chart

You can work with encounters via the chart view.

1. Highlight a chart item (as shown in the example above) and you see the same buttons at the bottom that you would see on the list view.
2. Click and hold the mouse on the large chart (the chart displaying gray and white bars) and pan (move mouse left or right) to change the timeline.

or

3. Click on one of the small charts in the lower section (outside the active region) and a slider displays.
4. Pull the slider with the mouse and the timeline changes. The larger chart adjusts based on the changes from the smaller charts in the lower section.

Note: The chart items in the active region defaults to the most recent five encounters, and you must have at least two encounters for the chart icon to display.

Deleting an Encounter or Addendum

An encounter or addendum can be deleted, but certain rules apply:

- An encounter or addendum in an Open status can be deleted by its creator.
- An encounter or addendum in a Closed or Co-sign status can be deleted by a Local, Regional, or National Administrator. However, if the administrator is the creator of the Closed or Co-sign encounter or addendum, they cannot delete it themselves and must have another administrator perform the delete action.

To delete an Open encounter or Addendum:

1. Select the desired encounter or addendum from the appropriate list in the Encounters tab.
2. Click **Delete**.
3. Click **Yes** in the confirmation pop-up window. The system deletes the encounter or addendum from the list.

To delete a Closed or Co-sign encounter or addendum:

1. Select the desired encounter or addendum from the appropriate list in the Encounters tab.
2. Click **Delete**.
3. Click **Yes** in the confirmation pop-up window. The system inserts "Erroneous Note" in the Type and Purpose columns for the encounter or addendum on the list; the Encounter or Addendum status changes to Deleted.

Changing a Designated Co-Signer for Encounters

If you are an OHRS Local, Regional, National Administrator, or the author of an encounter, you can change the designated co-signer for an encounter.

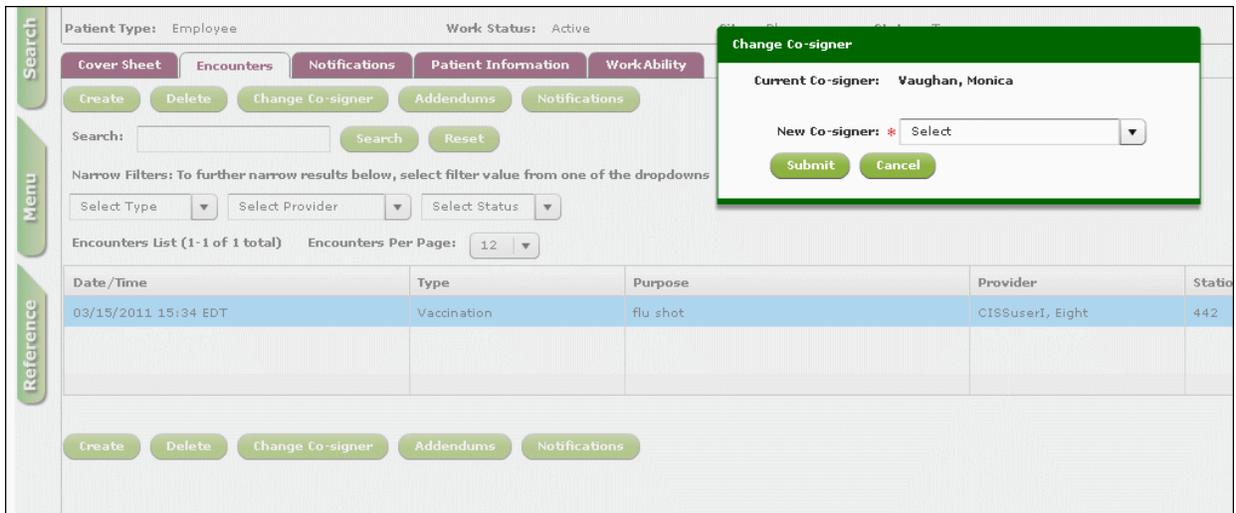
To change a co-signer:

1. Select a patient and navigate to the encounter list.
2. Select the encounter you want to change.

Note: Make sure that the status is "Co-Sign". If you have the correct permissions, the "Change Co-Signer" button displays.

The screenshot shows a web application interface for managing patient encounters. On the left, there is a vertical navigation bar with 'Search', 'Menu', and 'Reference' sections. The main content area is titled 'Patient Type: Employee', 'Work Status: Active', and 'City: Plano'. Below this, there are tabs for 'Cover Sheet', 'Encounters', 'Notifications', 'Patient Information', and 'WorkAbility'. The 'Encounters' tab is active, showing a row of buttons: 'Create', 'Delete', 'Change Co-signer', 'Addendums', and 'Notifications'. A search bar with 'Search' and 'Reset' buttons is present. Below the search bar, there are 'Narrow Filters' with three dropdown menus: 'Select Type', 'Select Provider', and 'Select Status'. The 'Encounters List (1-1 of 1 total)' is displayed with 'Encounters Per Page' set to 12. The table below has three columns: 'Date/Time', 'Type', and 'Purpose'. The first row is highlighted in blue and contains the text: '03/15/2011 15:34 EDT', 'Vaccination', and 'flu shot'. At the bottom of the interface, there is another row of buttons: 'Create', 'Delete', 'Change Co-signer', 'Addendums', and 'Notifications'.

3. Click Change Co-signer to display the pop-up window:



4. Select a new co-signer from the drop-down list and click **Submit**.

The changes are confirmed and the system executes the alert notification process. The new designated co-signer should now be able to sign the encounter.

Changing a Designated Co-Signer for Addendums

If you are an OHRS Local, Regional, or National Administrator or the author of an addendum, you can change the designated co-signer on an addendum.

To change a co-signer:

1. Select a patient and navigate to the encounter list.
2. Select the encounter you would like to change.
3. Click **Addendums** to view the addendum list.

Note: Make sure that the status is "Co-Sign." If you have the correct permissions, the "Addendums" button displays.

4. Select the addendum you would like to change.

Patient Type: Employee **Work Status:** Active **City:**

Cover Sheet **Encounters** **Notifications** **Patient Information** **Work Ability**

Delete Cancel Change Co-signer

Encounter Summary

Type	Purpose	Date/Time	Status	Provider
Medical Surveillance	Medical Surveillance	03/02/2011 10:49 EST	Closed	CISSuserA, One

Addendums List

Date/Time	Description
03/02/2011 11:04 EST	adding an addendum

5. Click **Change Co-signer** to display the pop-up window:

Patient Type: Employee **Work Status:** Active **City:** **State:**

Cover Sheet **Encounters** **Notifications** **Patient Information** **Work Ability**

Delete Cancel Change Co-signer

Change Co-signer

Current Co-signer: Vaughan, Monica

New Co-signer: *

Submit Cancel

Encounter Summary

Type	Purpose	Date
Medical Surveillance	Medical Surveillance	03/02/2011 10:49 EST

Addendums List

Date/Time	Description
03/02/2011 11:04 EST	adding an addendum

6. Select a new co-signer from the drop-down list and click **Submit**.

Note: The encounter must be signed before the addendum is signed.

The changes are confirmed. The system will then execute the alert notification process. The new designated co-signer should now be able to sign the encounter.

Working with Specific Entry Items When Creating Encounters

There are specific tabs within the Encounter tab itself that require data entry when you are creating a new encounter. Note that tabs named below with parentheses indicate that they are present with particular types of encounters only, currently Pandemic Influenza. The tabs are named:

1. Subjective
2. Objective
3. Assessment
4. Plan*, which has two additional tabs:
 - a. (Treatment) Plan
 - b. (WorkAbility)
5. (Follow-up Plan)
6. Plan Comment
7. Encounter Codes*, which also has two additional tabs:
 - a. Diagnostic Codes*
 - b. Procedure Codes*

An acronym for this set of tabs is SOAPE. Those which have an asterisk after them contain required fields.

You can see examples of the SOAPE tabs for a various encounters - [Creating a Medical Surveillance Encounter](#), [Creating a Vaccination Encounter \(General Health\)](#), and [Creating a Pandemic Influenza Encounter](#). Note that the first tab changes (and is not defined as SOAPE), depending on which encounter type you're entering. The first tab gives you relevant information such as vaccination history for vaccination encounters, Respirator information for Medical Surveillance encounters, evaluation method for Pandemic Influenza encounters, etc.

Encounter Codes Tab

The Encounter Codes tab is broken down into two additional sub-tabs, one for Diagnosis Codes and one for Procedure Codes. An example of the Diagnosis Codes tab is shown here. The Procedure Codes tab is similar, and they both work the same way, with the search button below the list of codes. You can search within the box to find the correct codes by entering a partial or whole name or number and clicking the Search button; after the appropriate code is displayed in the search box, select it and click **Select**.

For information on how to enter data in these windows, see [Creating a Vaccination Encounter \(General Health\)](#).

Creating a Medical Surveillance Encounter

One of the encounter types you can create is the Medical Surveillance encounter. You must have the appropriate security privileges to access the Medical Surveillance Encounter functions or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient. Second, you must have created a patient encounter using Manage OH Encounter.

1. With a patient selected, click **Create Encounter**.

The screenshot shows a web-based form titled "Create Encounter". At the top, there are five tabs: "Cover Sheet", "Encounters", "Notifications", "Patient Information", and "Work Ability". The "Encounters" tab is selected. Below the tabs, the form contains the following fields and controls:

- Date (MM/DD/YYYY): *** 02/09/2011 (with a calendar icon)
- Time (military): *** 14:59 EST
- Category: *** Medical Surveillance (dropdown menu)
- Type: *** Medical Surveillance (disabled dropdown menu)
- Purpose:** (empty text box)
- Submit** and **Cancel** buttons (green)

2. Select **Medical Surveillance** in the Category drop-down list.
3. The Type drop-down list defaults to Medical Surveillance and is disabled because there is no other type of Medical Surveillance encounter at this time.
4. Enter a purpose.
5. Click **Submit**.
6. In the Medical Surveillance Encounter window, click **Submit**. (At the current time, the system defaults the selection to Respirator on the right side box on this screen.)
7. Navigate to all of the SOAPE tabs and fill in all required information.
8. Under **Encounter Codes**, select the **Diagnosis Code** and **Procedure Codes** tabs and fill in required, appropriate information.
9. Click **Submit**.

Note: from here, you continue with the encounter, signing and/or getting it co-signed, thus closing the encounter. See [Entering an Electronic Signature](#) and [Entering Electronic Co-Signature](#).

Working with Assessments

Within the Medical Surveillance encounter, there is an Assessment tab where you can collect the following patient information regarding Medical Opinion:

- Further evaluation needed
- Medically cleared
- Medically cleared with restrictions
- Medically not cleared

If the Medical Opinion is specified as **Medically Cleared with Restrictions**, then you are required to capture the following information:

- Reason for Restriction
- If you select **Other**, you must enter comments explaining why you chose the Other option.

Respirator Fit Test Encounter Editing Considerations

The Safety Officer/Industrial Hygienist and/or a Respirator Fit Tester are the only OHRs users who can edit these encounters. Only the owner of the data captured in the Respirator Fit Test encounter can edit their own data. For instance, if the Trainer is a different person than the actual Fit Tester, the Trainer can update only the “Training Date Completed” and the “Name of the Person Conducting the Respirator Training” fields. Conversely, the author of the Respirator Fit Test Encounter will not be able to edit/change either of those fields.

Also, only the author (i.e., the Safety Officer/Industrial Hygienist or Respirator Fit Tester), can sign and close the encounter.

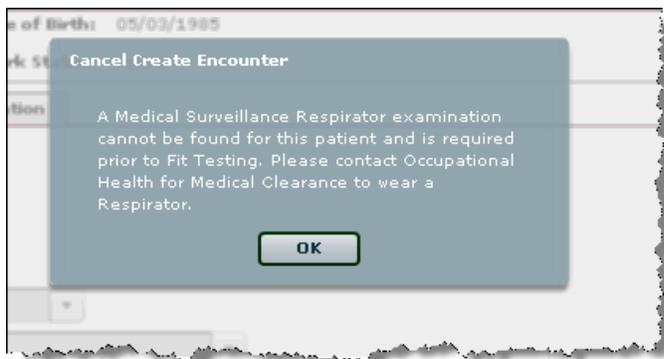
The patient must first be cleared to wear a respirator. This is done at the time a member of the OHRs medical staff creates and signs a Medical Surveillance encounter to clear the patient (see [Creating a Medical Surveillance Encounter](#)). If the patient is not cleared to wear a respirator, you receive an error message when you begin to create the encounter and you cannot continue. Only OHRs OH Providers and others with the appropriate permission can enter a Medical Surveillance encounter.

Note: the Medical Surveillance encounter must be closed before the patient is considered cleared and before a Respirator Fit Test encounter can be created.

Entering a Respirator Fit Test and Training Encounter

To enter a Respirator Fit Test encounter:

1. With a patient selected, click the **Encounter** tab. The Category of Respirator Fit and Type of Respirator Fit Test are already filled in for you.
2. Click **Submit**. If the patient is not cleared or if the patient needs further evaluation, you receive a message that states the patient has not been medically cleared to wear a respirator. If the patient has never had a Medical Surveillance Respirator examination encounter done you receive the following message:



Cancel Create Encounter Message

3. If the patient is medically cleared to wear a respirator, the SOAPE window displays and there is an additional tab called the Respirator Fit Test History tab. It displays information about a patient that may be medically cleared with restrictions, as well as a history of all other types of respirator fit test encounters.
4. Click the **Plan** tab and enter the required fields: the name of the person conducting the fit test, the next fit test date, and the name of the Facility Respiratory Protection Coordinator. There are search boxes you can use to search for names.
5. Click the **Encounter Codes** tab.
6. Click the **Procedure Codes** tab, select the **Diagnosis Code**.
7. Select a code or enter keywords in the Search box.
8. When you have the correct code highlighted, click **Select**.
9. Click the **Procedure Codes** tab.
10. Select a code or enter keywords in the Search box.
11. When you have the correct code highlighted, click **Select**.
12. Click **Submit**. At the end of each respirator fit test data entry, you can complete another fit test if you wish. Just answer YES to the question that is displayed. This enables you to either loop back to the beginning of the Plan section or to finalize the Fit Test encounter.
13. To complete another fit test, answer the questions for that particular respirator.
14. When you are ready to close the encounter, click **No** to the question that is displayed at the end of the fit test data entry, then click **Sign**. Follow the instructions in [Entering an Electronic Signature](#).

Note that you will be able to see the results of other respirators if the patient has been cleared to wear them. This displays in the **Plan** tab. As a Respirator Fit Test is completed for each respirator type, a grid displays at the top of the Plan tab that reflects the results of each Respirator Fit and mirrors the same column headings displayed on the Respirator Fit Test History tab.

Creating a Vaccination Encounter (General Health)

You must have the appropriate security privileges to access the Create Vaccination Encounter functions or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient. Second, you must have created a patient encounter using Manage OH Encounter.

1. With a patient selected, click **Create Encounter**.
2. From the Category drop-down, select **General Health**.
3. From the Type drop-down, select **Vaccination**.
4. Enter a purpose for the Vaccination encounter in the Purpose field.
5. Click **Submit**.

Available Vaccines

6. The list of vaccines displays. Select one or more of the vaccinations you intend to give the patient. You can use the Control key to select up to five vaccines, as long as they are compatible with each other (use your knowledge of the vaccines).
7. Click **Add**.
8. Click **Submit**. The Subjective, Objective, Assessment, Plan, and Encounter Codes (SOAPE) window displays.

Note: The History tab displays the Vaccination record and the Disease Immunity record. Note that the display here may differ from what you see in Reports (see [Understanding Reports](#)).

9. Click the Plan tab and enter the required information (marked with an asterisk). Also enter any Plan comments if necessary under the Plan Comments sub-tab, though this is not required.

Note: as shown in the sample below, often additional fields display, depending on what you select. For example, the Hepatitis A and B Combination screen will contain fields for Dose Received.

[Cover Sheet](#) | [Encounters](#) | [Notifications](#) | [Patient Information](#) | [Work Ability](#)



Encounter Detail: General Health / Vaccination

Encounter Date: * 03/23/2011 
Time (military): * 10:17 **EDT**

Purpose:

[History](#) | [Subjective](#) | [Objective](#) | [Assessment](#) | [Plan*](#) | [Encounter Codes*](#)

Plan | [Plan Comments](#)

Hepatitis A and B Combination Vaccine

Received Previously: * Yes No

Follow-Up Plan (select one or more): *

Return To Occupational Health Clinic on 

Return To Occupational Health Clinic on  **Time (military)**

Contact Occupational Health Clinic by  to schedule an appointment

Contact Occupational Health Clinic by 

Follow-Up with PCP

Consult To Clinic by  **Time (military)**

Contact Clinic by 

to schedule an appointment

No Further Follow-Up Indicated

10. Click the **Encounter Codes** tab at the bottom of the screen.
11. Under Encounter Codes, select the **Diagnosis Code**.
12. Select a code or enter keywords in the **Search** box. Choose a code for each vaccine you've entered. Note the code below is an example.
13. When you have the correct code highlighted, click **Select**. If you have more than one vaccine, you must select one diagnostic code at a time.
14. Click the **Procedure Codes** tab.
15. Select a code or enter keywords in the **Search** box. Choose a code for each vaccine you've entered. Note the codes below are examples.
16. When you have the correct code highlighted, click **Select**. If you have more than one vaccine, you must select one code at a time.
17. Click **Submit** and sign the encounter.

Note: On any vaccination encounter, you see a question as to whether or not the patient has received the vaccine previously.

If the patient has received the vaccination previously, here is what you should do:

1. Click the **Yes** radio button on the **Received Previously** question.
2. For a one-dose vaccine, fill in the **Date Received Previously** field. For a two- or more-dose vaccine (indicated by the appropriate number of “Dose” check boxes), fill in the **Date Received Previously** for each dose received.
3. Continue to fill out the remaining questions and complete the encounter.

Creating a Hepatitis A Vaccination Encounter

You can document patient Hepatitis A Vaccination details by accessing the Hepatitis A vaccine option from the available list of vaccines from the Encounters tab once you create an encounter.

Once you are In the **Plan** section, be sure to enter all required fields for the vaccine and check one or more follow-up Plan options. Additionally, be sure to enter all required fields for both the **Diagnosis** and **Procedure** codes (each under the **Encounter Codes** tab). You may also enter any comments you may have on the **Subjective**, **Objective**, and **Assessment** tabs.

If you click **Yes** to indicate that the Hepatitis A vaccine has been received previously, you will need to indicate the date the vaccine was received. You also need to indicate the date each dose was received.

History | Subjective | Objective | Assessment | **Plan*** | Encounter Codes*

Plan | Plan Comments

Hepatitis A Vaccine

Received Previously: * Yes No

Dose 1 Received:

Date Received Previously: * 09/25/2006

Dose 2 Received:

Hepatitis A - Date Dose Received

Next, proceed to the Medically Contraindicated question. If the Hepatitis A vaccine is Medically Contraindicated, you are taken directly to the follow-up plan information as detailed in [Creating a Vaccination Encounter](#).

Medically Contraindicated: * Yes No
Patient given Vaccination Information Sheet: * Yes No
Date VIS Given: * 11/30/2009
VIS Publication Date: * 03/06/2009
Declination Statement Signed: * Yes No Not Applicable
Date Statement Signed: * 11/30/2009

Follow-Up Plan (select one or more): *
 Return To Occupational Health Clinic on 05/21/2010
 Return To Occupational Health Clinic on **Time (military)**
 Contact Occupational Health Clinic by **to schedule an appointment**
 Contact Occupational Health Clinic by
 Follow-Up with PCP
 Consult To **Clinic by** **Time (military)**
 Contact **Clinic by**
to schedule an appointment
 No Further Follow-Up Indicated

Hepatitis A Vaccine – Not Medically Contraindicated

If the Hepatitis A vaccine is not Medically Contraindicated, complete all remaining questions and then proceed to the follow-up plan.

After you complete all required fields, sign the Encounter. You can then select the completed Encounter and view the Immunity and Vaccination status in the History section of the Encounter.

You can also select the Encounter and click **View** to see the patient information. You can click **Print** to view the patient information in a printable PDF format.

Understanding Dynamic Doses in Vaccination Encounters

Dynamic Doses occur when the number of doses a patient needs to receive in a vaccination encounter has changed. For example, in the pandemic influenza vaccination encounter, the required number of doses was formerly two, but now the dose is one. When you go to the Plan section of an encounter, the Dose # drop-down displays the correct number of doses in a vaccine. In one-dose vaccination encounters, you will not see the Dose # drop-down.

Dynamic Doses can also occur when different users require a different number of doses to be considered vaccinated. One patient may need a one-dose vaccine while another patient may need a two-dose vaccine. In this situation, the number of doses in a vaccine is

variable. If a vaccination encounter has a variable number of doses, there is a “Required Number of Vaccine Doses” drop-down in the Plan section.

The drop-down shows the maximum number of doses in the vaccine and asks you to tell how many doses a patient needs. For example, if the “Required Number of Vaccine Doses” lists up to three doses but your patient just needs one dose, you would answer “1.”

Creating a Pandemic Influenza Encounter

The Pandemic Influenza (Pan Flu) encounter is used to document screening and treatment for pandemic influenza. It is to be used in the event of an outbreak to track exposures, determine who is at risk, and in what capacity they may work.

The Vaccination Encounter is used to document vaccination against pandemic influenza. OHRS has the ability to report the vaccination and immunity status of employees and others as well as their ability to work. You must have the appropriate permission to access the Generate Pandemic Influenza Template functions or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient. Second, you must access the Encounter tab to create this encounter. Third, you must select the General Health category and then the Pandemic Influenza encounter type.

1. After you have submitted the general encounter information described in the note above, you see the Evaluation tab of the Pandemic Influenza encounter.
2. Select the Evaluation Method. The remainder of the questions that are asked are contingent upon the evaluation method you select.
3. Click the Subjective tab and enter all required information. Note that the defaults for the symptoms are No. You may change these as needed.
4. Click the Objective tab and enter all required information.
5. Click the Assessment tab.
6. Enter the Pandemic Influenza health status.
7. Click the Plan tab.
8. Enter all required information under the Treatment Plan, WorkAbility, and Follow-up sub-tabs. Note that the number of questions to answer will change on many of these tabs, depending on the answers selected.
9. Click the Encounter Codes tab.
10. Under Encounter Codes, select the Diagnosis Codes tab
11. Highlight the appropriate diagnosis code for the Pandemic Influenza from the search box and click Select.
12. Select the Procedure Codes tab and fill in the required code.
13. Click Submit.
14. If there are errors, you need to correct them before you can submit and save the encounter. They will be listed.
15. If there are no errors, you see a window that tells you the Pandemic Influenza Encounter was saved successfully, and you can do one of two or three things:
 - a. Press a button link to go directly to the Vaccination Encounter window to create a Pandemic Influenza Vaccination encounter
 - b. Sign the Pandemic Influenza Encounter
 - c. Click OK to leave the Pandemic Influenza Encounter open

The appearance of the link to go to the Vaccination window (option A, above) is dependent upon the answer to the Vaccination Administered question under the Treatment Plan sub-tab in step #8; it must be set **Yes**.

The screenshot shows a web-based patient encounter form. At the top, a dark purple header contains the text "Patient Information". Below this, a white box displays patient details: Name: CISSPATIENT, ONETHOHTWFIVE; SSN: XXX-XX-1175; Date of Birth: 01/26/1992; Gender: Female; Patient Status: Employee; Work Status: Active; City: ; State: . Below the patient information is a navigation bar with five tabs: "Cover Sheet", "Encounters" (which is highlighted in red), "Notifications", "Patient Information", and "WorkAbility". The main content area is titled "Pandemic Influenza Encounter" and contains a form with the following fields: "Encounter Date: * 10/06/2009" with a calendar icon, "Time (military): * 14:38" with a time selection icon, and "MDT". Below these fields is a "Purpose:" label followed by an empty text input box. A large white box with a dark border contains a success message: "The Pandemic Influenza Encounter was saved successfully." Below the message, there is instructional text: "Select the Vaccination Encounter button to go directly to the Create Pandemic Influenza Vaccination Encounter Screen. The Vaccination Encounter button will also be available after signing the encounter." At the bottom of this box are three green buttons: "OK", "Sign", and "Vaccination Encounter".

Creating an Adverse Reaction Encounter

The Adverse Reaction Encounter is used to document any adverse reactions a patient may have due to receiving a medication.

You must have the appropriate permission to access the Create Adverse Reaction Encounter functions or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient.

1. With a patient selected, click the **Encounter** tab.
2. From the **Category** drop-down, select **General Health**.
3. From the **Type** drop-down, select **Adverse Reaction**.
4. Enter a purpose for the Adverse Reaction encounter in the Purpose field (optional).
5. Click **Submit**.
6. The SOAPE window displays. The first tab is **Evaluation Method**, not History; it is like the Pandemic Influenza Encounter in this way.
7. Select the appropriate Evaluation Method from the drop-down (clinic visit or telephone consultation (abbreviated "consult") under the Evaluation Method tab.
8. Click the **Subjective** tab and check the appropriate radio buttons to describe the patient's symptoms. Note that if the patient is female, there is a mandatory question regarding pregnancy at the top of the screen above the "Patient Complains of" section. Remember that every field that displays an asterisk is required. The default setting for the symptom descriptions is "No." If you answer "Yes," additional comment text fields display, but comment text is not mandatory.
9. If you have selected the **Clinic Visit** evaluation method, click the **Objective** tab. The Objective tab contains three sub-tabs, **Vital Signs**, **Examination of Systems**, and **Adverse Reaction**. On the Examination of Systems sub-tab, you can collect physical attributes from your patient. If any value listed is set to Abnormal, you are required describe the findings.
10. Regardless of the type of Evaluation Method, enter the appropriate data in at least the mandatory fields under all displayed tabs.
11. Under the **Adverse Reaction** tab, the required fields are adverse onset date, illness at the time, any pre-existing conditions. Also note that you must add a medication that the person is having an adverse reaction to (or presumably you would not be entering an adverse reaction encounter at all). To add the medication, click the appropriate Add button, and you see another window from which to choose your options. When searching for a medication, you must enter **three characters** of a generic medication name to open the search list.
12. You must answer **Yes** or **No** to the question that asks whether or not the patient has taken any other medications within four weeks of taking the first medication. If Yes, you must use the Add button to choose the medications (as many that have been taken). See sample below:
13. Note that the medication list contains vaccines as well as medications, as a vaccine is a medication.
14. Click the **Assessment** tab and select **Yes** under the applicable major reaction type you observed in the patient. At least one value must be set to Yes. If you choose **Other**, you must enter a comment.
15. Click the **Plan** tab. This tab has three sub-tabs, **Treatment Plan**, **WorkAbility**, and **Follow-up Plan**. Enter the required information in each.

16. Click the **Encounter Codes** tab. This tab has two sub-tabs, Diagnosis Codes and Procedure Codes. Enter the required information in each.
17. After you have entered all the required fields, click **Submit**. If there are any problems with the encounter, you receive a message and an opportunity to reenter the data.
18. To close the encounter, you must sign it and (if required) set it for co-signature.

Using the Quick Load Vaccination Function

The Quick Load Vaccination option allows you to enter multiple encounters quickly during the time you are vaccinating several people at a time. This way records are kept for all of the patients whom you vaccinate.

To use Quick Load:

1. Select **Patient** from the menu tab on the left.
2. Select **Quick Load Vaccination**.
3. Note that the Administration Date field defaults to the current Date and the Purpose defaults to Quick Load Vaccination. You can accept the defaults or change them.
4. Select either the Pandemic or Seasonal Influenza vaccine from the **Vaccine** drop-down.
5. Click **Submit**. The SOAPE window is displayed, with the Plan tab open.
6. Enter the required fields. Note that you are not allowed to enter information in some fields because the information is not relevant to a group vaccination setting. You are also required to enter the Follow-up Plan section.
7. Select the **Encounter Codes** tab and enter the required fields. The Diagnosis and Procedure Codes are defaulted for your selection. Make sure you select both the **Diagnosis Codes** and **Procedure Codes** tabs.
8. Click **Submit**.
9. Enter your Access and Verify Codes for VistA. You have to do this only once per OHRS session:
10. Enter your e-Signature code for VistA and click **Sign**.
11. Click **OK** to the confirmation message.

Next to display is the verification of your electronic signature, followed by a three-part window where you can select patients, or where you can edit the quick load vaccine administration information. (Only two parts of the window display at first.)

12. Enter the patient's last name and last four digits of the SSN, the entire SSN (no dashes), or their last name and click **Search**.
13. Select the patient from the list. The window expands and displays part 3, the quick load encounter window:

Quick Load Vaccination: Seasonal Influenza Vaccine

Step 1 - Verify Quick Load Information:

Dose #: Dose: .5 ml

Route: Intradermal Injection Site: Arm, Left Upper

Drug Company: Merck Lot Number: 10049444

Step 2 - Search/Select Patient: Please enter at least one of the following search criteria then select a patient.

First Initial of Last Name + Last 4-digit SSN:

SSN (no dashes):

Last Name:

82 patient(s) match entered criteria.

Last Name	First Name	Middle Name	SSN	Date of Birth	Gender	Patient Status	Work Status
CISSPATIENT	FOUR		246789123	08/01/1970	Female	Contractor	Active
CISSPATIENT	NINE		000000031	02/01/1970	Male	Contractor	Active
CISSPATIENT	ONETHOHEITY		000002228	01/11/1995	Female	Employee	Active
CISSPATIENT	ONETHOHEITYET		000002236	01/19/1995	Female	Employee	Active
CISSPATIENT	ONETHOHEITYFIVE		000002233	01/16/1995	Female	Employee	Active
CISSPATIENT	ONETHOHEITYFOUR		000002232	01/15/1995	Female	Employee	Active

Quick Load Patient Select

You can click **Edit Quick Load** at the top of the window if you need to change anything, such as Route of the vaccine being administered to all the patients or you can edit the administration information at the patient level on the bottom of the screen.

When you are ready, click **Submit**. You see an informational message that the encounter was successfully created for the particular patient.

You can continue to select patients and submit encounters as you administer the vaccines with this window.

Note: When you submit vaccine information for the selected patient, the system will perform validity checks as well as a check on the vaccine being administered. If the patient has an existing vaccination record that requires no further action, or an additional action, you will receive a warning message with the next steps.

After you have completed this quick load session, click **Complete Quick Load**. This action allows you to exit from the Quick Load function.

82 patient(s) match entered criteria.

Last Name	First Name	Middle Name	SSN	Date of Birth	Gender	Patient Status	Work Status
CISSPATIENT	ONETHOHETYET		000002236	01/19/1995	Female	Employee	Active
CISSPATIENT	ONETHOHETYFIVE		000002233	01/16/1995	Female	Employee	Active
CISSPATIENT	ONETHOHETYFOUR		000002232	01/15/1995	Female	Employee	Active
CISSPATIENT	ONETHOHETYNINE			01/20/1995	Female	Employee	Active
CISSPATIENT	ONETHOHETYONE			01/12/1995	Female	Employee	Active
CISSPATIENT	ONETHOHETYSEV			01/18/1995	Female	Employee	Active

Step 3 - Selected Patient Information for: CISSPATIENT, ONETHOHETYET

To change information for this patient only, use the following field(s). To change information for the entire Quick Load, click on Edit Quick Load button above.

Dose: * .5 ml

Route: * Intradermal

Injection Site: * Arm, Left Upper

Administration Date (MM/DD/YYYY): * 09/04/2009

Administration Time (military): * 14:33

Follow-Up Plan (select one or more): *

Return To Occupational Health Clinic on []

Return To Occupational Health Clinic on [] Time (military) []

Contact Occupational Health Clinic by [] to schedule an appointment

Contact Occupational Health Clinic by []

Follow-up with PCP

Consult To [] Clinic by [] Time (military) []

Contact [] Clinic by [] to schedule an appointment

No Further Follow-Up Indicated

Submit Reset

Complete Quick Load

Selected patient - change that patient's vaccine information only if necessary, then click Submit

After you have completed vaccinating all the patients, click Complete Quick Load.

Quick Load Encounter Patient Data Entry

Note: The **Selected Patient** information in the third part of the screen (Step 3) now also includes the patient's name, social security number, address, and phone number.

After the quick load vaccination encounter is signed/closed, it cannot be edited or updated. If you need to make any changes to the quick load vaccination information after the encounter is closed, you must add an addendum to the individual Vaccination encounter for each quick load patient.

Collecting WorkAbility Information for a Patient Encounter

WorkAbility information is that which allows supervisors or other OHRS personnel to see whether or not a particular OH patient (employee, volunteer, provider, etc.) is able to work and if they have any restrictions.

OHRS users are required to collect WorkAbility information when they create an encounter under the General Health category (and eventually, all encounter types under the Occupational Encounter category). The General Health encounter types that require WorkAbility to be collected are:

- Adverse Medication/Vaccination Reaction
- Personal health concerns
- Impaired employee
- Infectious disease
- Pandemic influenza
- Smallpox

Note: As of May 2009, WorkAbility information will be collected in the Pandemic Influenza encounter only.

To collect WorkAbility information:

1. Create an encounter, such as a Pan Flu encounter
2. In the SOAPE area, click the **Plan** tab.
3. Under the **Plan** tab, select the **WorkAbility** tab and answer the preliminary questions. Depending on the answers to the preliminary questions, additional questions may need to be answered.

Note: The encounter cannot be signed until all the required WorkAbility questions have been answered. These questions include the preliminary WorkAbility questions and if there are any restrictions to the patient's ability to work, at least one restriction must be selected.

4. Depending on the restrictions you select, you may have to enter additional weight, frequency, or detail on each restriction selected. For example, if "use of arm" is the restriction selected, you must specify which arm(s) and if it can be used continuously or only intermittently. Many permutations exist for each restriction, most based on the CA-17 form.

If notifications are generated as a result of the answers to the WorkAbility questions, the notifications will be sent as per notification rules. And, after the encounter has been signed, the patient's supervisor receives an informational alert as per alert rules.

5. OHRS users who have the proper permission can print WorkAbility at the patient and encounter levels.

WorkAbility at the Patient Level

Displaying and Printing Workability at the Patient Level

If you have permission, you can view all WorkAbility information previously collected at the individual patient level. This provides a summary view of all WorkAbility dates, duty status and restrictions for the patient.

Displaying Patient-Level WorkAbility Information

To display the WorkAbility information:

1. Make sure you are signed in to OHRS and have your duty station selected.
2. Select the patient whose WorkAbility information you want to see.
3. Click the WorkAbility tab.
4. If WorkAbility information was collected during an encounter, it will display in a list. You can then select the specific encounter whose WorkAbility information you would like to view.

Printing Patient-Level WorkAbility Information

If you have permission to access and print a patient encounter, you can also print any previously collected WorkAbility information from the summarized view at the patient level. The encounter where the WorkAbility information was collected must be in a Closed or Co-Sign status. You can print one or more sets of WorkAbility information at one time. Each individual evaluation will print so that the user has a separate copy of each evaluation printed.

To print the WorkAbility information:

1. Display the WorkAbility information as described in [Displaying Patient-Level WorkAbility Information](#) or select the desired WorkAbility encounter in the WorkAbility list.
2. Click **Print**. The PDF is displayed. See Printing WorkAbility Information Only for details on what is printed.

Printing Workability

Printing WorkAbility at the Encounter Level

If you have the authority, you can print a patient's WorkAbility information at the encounter level. You can do this in two ways.

Printing WorkAbility Information Only

If you have the authority, you can print a patient's WorkAbility information alone, without the encounter or addendum information and its sub-sections for information on Addendums). If you have the permission to access and print a patient encounter, you have permission to print the WorkAbility information.

To print the WorkAbility information only:

1. Select the appropriate encounter from the list. The encounter has to be in either the Closed or the Co-sign status.
2. Click **View**.
3. Click the Print WorkAbility button.

Printing WorkAbility with an Encounter

You may want to print the WorkAbility information along with the encounter for a patient so that all appropriate, authorized OHRS users can have a hard copy. Any OHRS user who has permission to print an encounter will see the patient's WorkAbility information, which prints on a separate page after the encounter and any addendum information that exists.

The WorkAbility information is helpful for planning staffing needs. You can see whether or not the patient can return to work with or without restrictions, and if there are restrictions, from what dates those restrictions are in effect.

Search Select Patient

Working with OH (Occupational Health) Patients

OHRS supports various roles in the system. A user may be a supervisor, OH or non-OH RN, OH or non-OH RN student, OH or non-OH provider, OH or non-OH clerk, the VistA lab, or a local, regional, or system Administrator, to name a few. The role the person has in OHRS determines what functionality they can perform within OHRS.

An OH patient in the OHRS system may be assigned any of the following statuses within OHRS: applicant, contractor, employee, medical student, non-paid employee, nursing student, other Federal Agency employee, or volunteer, to name a few.

OHRS stores data on patient encounters, and encounters are defined as any interaction between a person who is a provider and a person who is a patient. The encounter records

the encounter type, purpose, status, and provider, and other specific clinical data obtained during the patient's visit with the provider.

It also allows you, with appropriate permission, to add an addendum to the encounter if needed. OHRS provides scheduled and unscheduled reports on items such as vaccination rates and immunity status. These reports can help management identify who is due for vaccination, who has received a vaccination and who has declined a vaccination.

OHRS allows you, with appropriate permission, to electronically sign or co-sign a patient encounter. It shares Electronic Signature Code information with the VistA application that resides within the same duty station. However, this interface does not share patient-specific data. Instead, it allows OHRS users who have signature permission to maintain one signature code that they will use in both OHRS and CPRS. OHRS allows you to update your signature code and then, it shares this with the VistA system at your duty station.

Searching for or Selecting a Patient

You must have the appropriate security privileges to access the Search/Select Patient function or the option does not display.

When searching for a patient, you can see information only for patients that you have a need to know about, based on your role. Typically you are restricted to seeing patient information only for those patients assigned to the duty station(s) that has been assigned to your User ID.

The Search/Select Patient basic flow begins when you choose to search for an existing OH patient and ends when you confirm the selection of the OH patient.

1. Select **Patient** from the menu.
2. Select **Search Select Patient**.
3. Enter any of the three search criteria options.
4. Click **Search**.

Tip:

You can also do a quick search on a patient from the Search option on the main menu.

1. Type the patient's last name and click **Search**.
2. With either method, the search results display a list of patients at that duty station.
3. Highlight the user you want and click **Select**.

Note that this list may consist of patient matches to patient entries in the Personal and Accounting Integrated Data (PAID) and/or Voluntary Service System (VSS). Assuming you are working with the patient at the time you are looking up their record, you need to verify that you have the correct patient's record selected. A window displays asking you to confirm if the patient is the correct one. You can also associate the patient with another duty station on this window.

Creating a New Patient

You must have the appropriate permission to access the **Create New Patient** function or the option does not display.

1. Select **Create New Patient**.
2. Enter the new patient information.
3. Click **Add**. On the confirmation window that displays, click **OK** to confirm and add the patient or **Cancel** to ignore the new patient addition.

When you are adding a new patient, if either the

- Social Security
or
- Last Name, First Name, Date of Birth AND Gender

match a record that already exists within OHRS from PAID or VSS, you are given the option to select the existing record within OHRS or cancel out of the new creation. No duplicate records are allowed to be created. If there are data integrity issues, the OHRS end user must work through the VA Human Resources specialist or application Administrator to correct them.

Special Considerations When Creating a New Patient

Here is helpful information to know when creating a new patient:

Complete Address and Social Security Number

If you enter the patient's full address, you do not need to enter their social security number; however, if you leave the address fields blank, you are required to enter the social security number. Neither of these fields is marked as required, but there are instructions on the page and you receive an appropriate error message if you attempt to add the patient without either a full address or a social security number.

Veterans Affairs Administration Field

This drop-down field's purpose is to capture the patient's Veterans Affairs Administration affiliation. It is a required field, dependent upon selected patient type – i.e., it is either selectable or not, depending on the patient type you select. For example, if your patient is an employee, you must select one of the choices in the drop-down. If your patient is an Other Federal Agency employee or a volunteer, you cannot edit the field and its default is "No Affiliation." For all other patient types, you can select one of the choices in the field.

Working with Notifications

Selecting the Notification Library

You can select the Notification Library from the menu item.



Notification Template Library

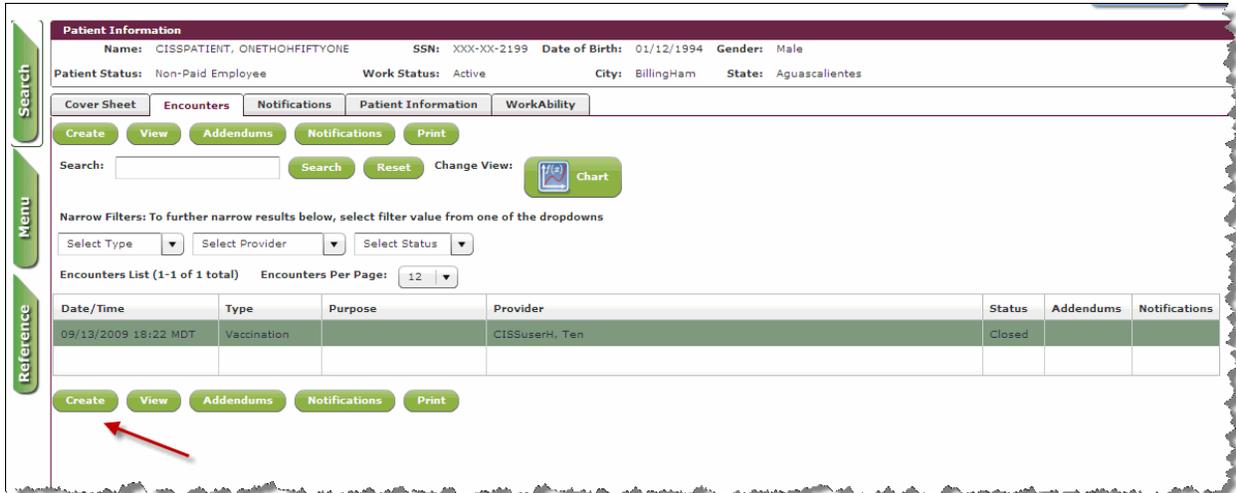
1. Select the Notification Library menu item.
 2. Highlight the template you wish to use.
 3. Click **Add**.
- or
4. If you wish to add all templates, click **Add All**.
 5. You may also remove templates from the list or print a selected template by clicking the appropriate buttons (Remove, Remove All, or Print).

Working with Notifications from the Encounters List

You can do certain activities with notifications, which are text-based emails based on the encounter, only when you select the Notification from the Encounters list.

Creating and Sending Notifications

To create notifications, you must have the encounter selected from your Encounters list and click the **Notifications** tab. You see the following:

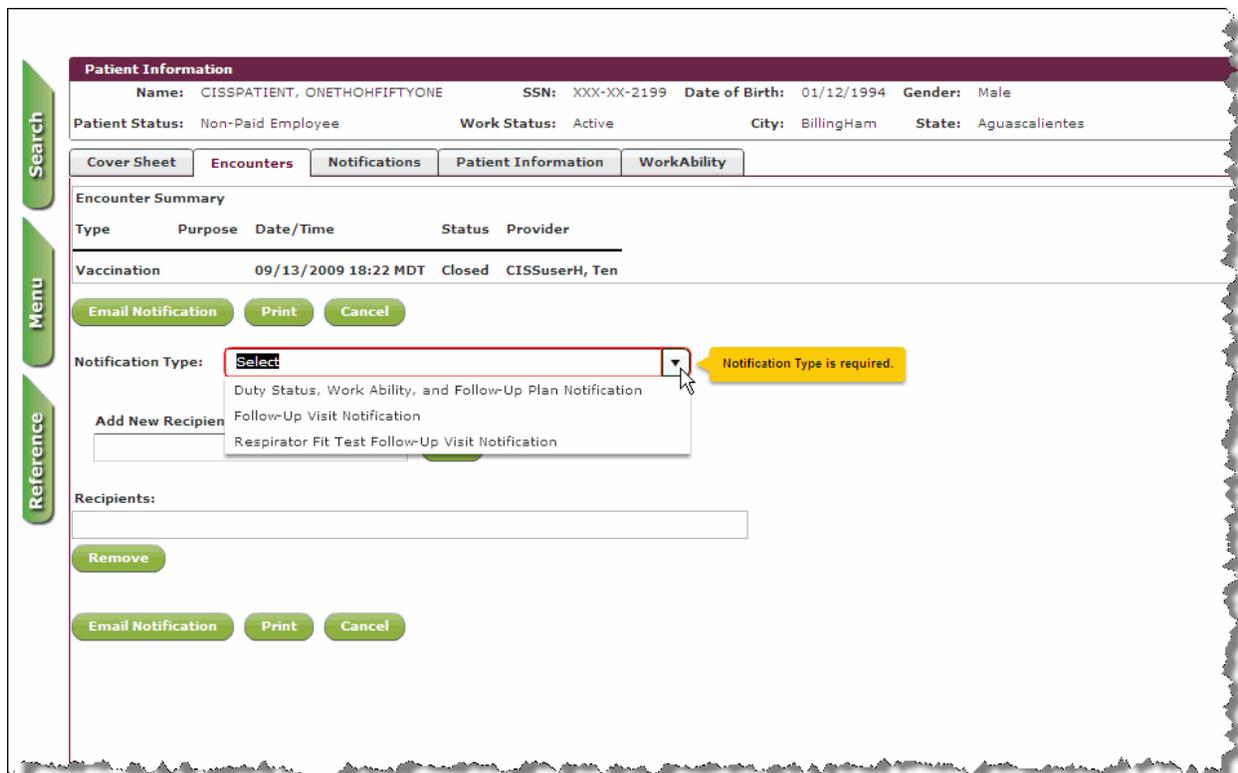


The screenshot displays a patient information system interface. At the top, there is a 'Patient Information' header with fields for Name (CISSPATIENT, ONETHOHFIFTYONE), SSN (XXX-XX-2199), Date of Birth (01/12/1994), and Gender (Male). Below this, there are tabs for 'Cover Sheet', 'Encounters', 'Notifications', 'Patient Information', and 'WorkAbility'. The 'Encounters' tab is active, showing a search bar, a 'Search' button, and a 'Reset' button. There are also 'Addendums', 'Notifications', and 'Print' buttons. A 'Narrow Filters' section includes dropdown menus for 'Select Type', 'Select Provider', and 'Select Status'. Below this is an 'Encounters List (1-1 of 1 total)' with a table containing one row of encounter data. At the bottom of the table, there are 'Create', 'View', 'Addendums', 'Notifications', and 'Print' buttons. A red arrow points to the 'Create' button.

Date/Time	Type	Purpose	Provider	Status	Addendums	Notifications
09/13/2009 18:22 MDT	Vaccination		CISSuserH, Ten	Closed		

Creating a Notification

1. Click **Create**.
2. Select a Notification type from the drop-down.



Entering Info and Emailing Notification

3. Enter the recipient's email address in the "Add New Recipient" box and click **Add**.
4. Click **Email Notification**.

Printing Notifications

You can also print a notification that you've selected by clicking the **Print** button. The Notification is displayed as a PDF that you can print.

Re-emailing Notifications

If you have created the notification, you can re-email it by clicking the Email button.

Displaying and Working with Addendums

Displaying and Working with Addendums for a Patient Encounter

Addendums are additional pieces of information that are associated with an encounter. Addendums can be created and managed by those same providers that have the ability to create encounters; however, the rules of who can view, create, or change an addendum are the same as for encounters.

If you have the appropriate permission, you can view and print the addendums set up for a patient.

The Addendums window tab displays addendums that you have created for the selected patient, or those that have been closed (signed or set as needing a co-signature). As an occupational health provider, you can view your own addendums with the status of open, closed, or co-sign. All addendums are displayed on the addendum list for the selected encounter. You cannot view the details of an addendum created by other providers if the addendum status is open or co-signed, or if the addendum belongs to another encounter.

You can create an addendum, delete, edit, cancel, or sign a selected addendum. You can also see if an encounter has existing addendums from the encounter list (if you have permission to see the encounter).

Creating an Addendum for a Patient Encounter

You must have the appropriate security privileges to access the Encounter Addendums function or the option does not display.

Note: First, you must have a patient selected from either Search Select Patient or Create New Patient. Second, you must have created a patient encounter using Manage OH Encounter. Third, you must have an encounter selected and the encounter must have a status of Closed or Co-sign.

To create an addendum:

1. With the encounter selected, click Addendums.
2. Click **Create**.
3. Enter the Addendum title and note.
4. Click **Submit**. The addendum is added and you receive a confirmation message.

Working with Patient Information

Creating and Updating Patient Information

Patient Information consists of the patient's Risk Profile, Work Profile, and Demographics.

Patient Information

Name: CISSPATIENT, ONETHOHFIFTYONE SSN: XXX-XX-2199 Date of Birth: 01/12/1994 Gender: Male

Patient Status: Non-Paid Employee Work Status: Active City: BillingHam State: Aguascalientes

Cover Sheet Encounters Notifications Patient Information WorkAbility

Risk Profile

Risk Location: * Location B

Assessment Type Job Risk Category * Frequency * Start Date *

TB Risk * Once 09/03/2009

Hepatitis B Risk * Exempt 09/03/2009

Job Risk 1 Asbestos Every 3 years 09/03/2009

Add Job Risk

Submit Reset Cancel

Viewing Patient Information

You create patient information when you create the patient encounter. You can update the patient information when necessary; however, the rules of who can view, create, or change patient information are the same as for encounters.

Creating and Updating the Risk Profile

The Risk Profile displays the risk profile for a patient, and every OHRS patient must have a risk profile created. The risk profile indicates how often a patient must be evaluated for the designated risk.

To create the Risk Profile, you must have a patient and encounter selected.

1. Under the Patient Information tab, select the **Risk Profile** tab.
2. Enter the risk location (this is tied to the Duty Station).

Note: There are two risks required for patient information: TB and Hepatitis B. For both of these risks, the frequency of a test for the patient is either exempt (as shown above) or required.

3. For the TB risk, select the appropriate frequency (or exempt)
4. For the Hepatitis B risk, select **Required** or **Exempt**.
5. Add a job risk if needed. See hints for frequency of tests if appropriate; otherwise, select from the choices offered. Be sure to enter the start date of the test. The start date cannot be in the future. You may add more than one job risk:

Patient Information

Name: CISSPATIENT, ONETHOHFIFTYONE SSN: XXX-XX-2199 Date of Birth: 01/12/1994 Gender: Male

Patient Status: Non-Paid Employee Work Status: Active City: BillingHam State: Aguascalientes

Cover Sheet Encounters Notifications **Patient Information** WorkAbility

Risk Profile

Risk Location: * Location B

Assessment Type	Job Risk Category *	Frequency *	Start Date *
TB Risk *		Once	09/03/2009
Hepatitis B Risk *		Exempt	09/03/2009
Job Risk 1	Select	Every 3 years	09/03/2009
Job Risk 2	Lead	Every 2 months	09/14/2009

Frequency should be Every 2 months for the first six months then every six months.

Add Job Risk

Submit Reset Cancel

Adding More Information to Risk Profile

6. Click **Submit**.

You can update the patient risk profile if you have the appropriate security settings. Follow the same instructions as **Create**, except you won't need to enter a risk location (unless you are updating it).

A risk profile generates an Alert for this patient, for instance, if the patient is due for a vaccine for Hepatitis B or for a TB screening.

Creating and Updating the Work Profile

A patient's Work Profile is initially created when the patient's record is created or if the patient data comes from the PAID or VSS systems.

To create the Work Profile, you must first have a patient selected.

1. In the Patient Information window, select the Work Profile tab.
2. The work status is entered from the PAID or VSS systems.
3. Enter any of the optional information.
4. Enter the supervisor name.

or

5. If you do not know, click **Search**.

6. Enter as much information as you know. If there are many supervisors with the same first characters in the last name, you receive a warning message.
7. Highlight the correct supervisor name and click **Select**.
8. Click **Submit**. A confirmation message displays.

To update the work profile, the steps are nearly identical to adding a work profile. However, you must have the proper permission to update a work profile, and the access rules are the same as the access rules for working with an encounter.

Updating Demographic Information

Each patient has one demographic profile. The Demographic Information is created initially when the patient data comes from the PAID or VSS systems, or part of the Other Federal Agency (OFA) file loads. If the patient is not an employee, volunteer, or OFA employee, and therefore not part of the PAID, VSS, or OFA file loads, then you can enter certain demographic information manually.

To update the Demographic Information, you must first have a patient selected. See *Creating a New Patient*.

1. Select the Patient Information tab under the encounter, and then select the Demographics tab. Note that you cannot change any data that comes from the PAID system. If data is loaded from the VSS or OFA files, the default affiliation is "No Affiliation" and cannot be modified. All other patient types can be edited on the Demographics window.
2. Enter the required information, indicated by asterisks.

Note: The **Home Phone** field is free-form text and can be from 1 to 30 alphanumeric characters – it can include text, such as "ext." for extension.

3. Click **Submit**.

Note: The National Administrator can set an "Erroneous Patient" flag for a patient. These patients are not included in any reports. Once a patient is made "Erroneous," only the National Administrator can do a *Search and Select Patient* task. No other role has access to these records.

Working with Alerts

Managing Alerts

Alerts are system-generated messages that provide information. Alerts are either Informational or Actionable, marked as "I" or "A" in the list of alerts' Type column. You must have the appropriate permission to view alerts. You can delete an Informational Alert; however, you cannot delete an Actionable Alert until you perform the required action (e.g., sign an encounter).

You must be logged into a duty station to see the alerts for that duty station. If you are assigned more than one duty station, you can change duty stations directly from the alerts window.

If you have the appropriate permission, you see an **Alert** message on the initial CISS-OHRS window as soon as you log in. You may click the **Alerts** link at the top, or select **Alerts** from the menu:

- You see a list of alerts for your duty station.
- From this window, if you have the appropriate permission, you can view, forward, or delete the alert (if it is an informational alert). You can also cancel out of this view, or refresh the view (additional or fewer alerts might display).

Here is a description of the columns on the Alerts list.

Type

This column indicates if an alert is I, information only, or A, action required. The column can be sorted by Action or Informational

Patient

Alerts are listed by patient name and can be sorted alphabetically or in reverse alphabetical order.

Alert Date/Time

This column is the date/time alert was triggered and can be sorted by newest to oldest or oldest to newest.

Message

The message text or partial text for the alert; the column can be sorted alphabetically or in reverse alphabetical order.

From

This column displays the sender of the Alert. The column can be sorted alphabetically or in reverse alphabetical order.

Viewing Alerts

If you have the appropriate permission, you can view alerts (and take appropriate action, if needed).

1. Navigate to the Alerts window from the menu or the Alerts link on the CISS-OHRS home page.
2. Select the alert you want and click **View**.

3. You are taken to the window from where the alert was generated, in this case, the Patient's Risk Assessment for a particular encounter.
4. In the case of an actionable alert, the system takes you to the window where you can perform the action. For example, for an encounter that requires a co-signature, the system takes you the co-sign window for that encounter.

Forwarding Alerts

You can forward informational alerts to different providers.

To forward the alert:

1. Select the alert from the list.
2. Click **Forward**. You see the following window:
3. Select the appropriate user whom you want to receive the alert.
4. Click **Forward**. The number of alerts on your window decreases by one.

Deleting Alerts

To delete an alert:

1. Select the alert you want to delete.
2. Click **Delete**.

Note: You can delete informational alerts any time. You can delete Actionable alerts only after you have completed the required action.

Working with Reports

Understanding Reports

You must have the appropriate security privileges to access the Reports function or the option does not display.

With the Reports function, you can:

1. See a list of reports
2. Run a selected report
3. Schedule a report
4. View completed reports in either PDF or excel spreadsheet format.

After you've displayed the list of completed reports, you can do the following with a selected report:

- View
- Delete
- Extend the expiration date

- View report parameters

To see a list of reports, select **Report List** from the menu. The list is displayed in a table format, and has the following headings: Report Type, Report ID, Report Name, Report Format (.xls or PDF), Submitted By, Date/Time Run, and Expiration Date.

After you've displayed the list, you can use an ascending or descending sort filter to sort it by its headings. The filter button displays after you select the heading.

Here is a sample list of the reports and their descriptions:

Duty Status Reports – WorkAbility

This report displays information on employees with the Recommended Duty Status of Return to Duty No Restrictions, Return to Duty With Restrictions, and Off-Duty. If there is an outbreak of flu, the facility needs to know who can work full time, who is off work, and who can work in a limited capacity. This ability to work equates to "Recommended Duty Status." This report can be detailed or summary, and can be localized to the local area, VISN (Region), or the nation.

Immunity Status Report

This report looks at the most current immunization status in the patient record for the selected vaccine and determines if a patient is immune by the vaccination parameters (by vaccination, by history, etc.), or is susceptible by other parameters (vaccination refused, etc.). It can be a detailed or summary report and can be localized to the local area, VISN, or the nation. Only closed vaccination encounters are included in this report.

Vaccination Rate Report

This report shows the percentage of patients who are vaccinated or not vaccinated for a specific vaccine. If a patient does not have an immunization history in the system, they are considered unvaccinated for purposes of this report. It is a summary report only, but can be localized to the local area, VISN, or the nation.

Vaccination Status Report

This report displays a patient's vaccination status, which can be either vaccinated, not vaccinated, or vaccination in progress. Rules are different for every vaccine. You can run the report against only one vaccine at a time. This report can be a summary report or a detailed report and can be localized to the local area, VISN, or the nation. Only closed vaccination encounters are included in this report.

Medical Surveillance Clearance Report

This report displays if a patient is medically cleared to work with a respirator or not. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Infectious Disease Exposure Report

This report displays information about patients who have been exposed to a specific infectious disease and lists if they have used protective equipment, such as a mask or respirator. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Infectious Disease Surveillance Report

This report displays information about patients with suspected, probable, or confirmed cases of a specific infectious disease. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Other Federal Agency Vaccination Status Report

This report displays the vaccination status of patients who belong to Federal Agencies other than the Veterans' Administration. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Respirator Fit Test and Training Report

This report displays information about patients' respirator fit test and training results. It can be only a detailed report.

Respirator Usage Report for Passed Status

This is a Summary Station report that aggregates counts of respirator type, model, manufacturer, size, and number who passed the Respirator Fit Test encounter.

OHRs User Access Tracking Report

This report displays information about end users of the OHRs system, including data about their login activity; it can be only a summary report and can be localized to the local area, VISN, or the nation. Only local, regional, and national administrators can run this report.

Note: If OHRs doesn't have any patients that fall within the report parameters you selected, it will output a "No data found that meets the selected report criteria" message.

Running a Report

To run a selected report:

1. Highlight the report you want from the list of reports.
2. Click **Run Report**.
3. From the window that displays, enter the required information. It will differ based on the type of report you are running.

Note: if you choose the As of Date, it will collect data that was entered on or before the As Of Date.

The screenshot shows a web application window titled "Report List" with three tabs: "Report List", "Scheduled Reports", and "Completed Reports". The selected report is "Infectious Disease Surveillance Report (ID 4)". The form contains the following fields and options:

- From Date:** * [Date Picker] **To Date:** [Date Picker] **OR** **As of Date:** [Date Picker]
- Report Format:** * Select (dropdown menu)
- Infectious Disease:** * Select (dropdown menu)
- Case Status:** * ALL Confirmed Probable Suspected
- Patient Status:** * ALL
 - Applicant Contractor Employee
 - Medical Student Non-Paid Employee Nursing Student
 - Other Other Federal Agency Employee Other Student
 - Resident Physician Visitor Volunteer
- Veterans Affairs Administration:** ALL NCA VA VBA VHA
- File Type:** * PDF XLS

Report Data Selection

4. Select the Duty Station(s) from which you want to run the report.
5. Select the way the report is to be generated – in PDF or .xls format.
6. Click **Run Report**.

Scheduling a Report

To schedule a report:

1. With the report you wish to schedule highlighted from the list of reports, click **Schedule Report**. You can schedule a report to run during a specific day and time and can request that the system send an email notification to you after the report has been run.

Report List Scheduled Reports Completed Reports

Search Filter

Report Type:

Report Type	Report ID	Report Title
Adverse Reaction	AR 1	Adverse Reaction Report
Adverse Reaction	AR 3	Adverse Reaction Type by Medication Report
Adverse Reaction	AR 2	Other Federal Agency Adverse Reaction Report
Adverse Reaction	AR 4	Other Federal Agency Adverse Reaction Type by Medication Report
Infectious Disease	ID 1	Immunity Status Report
Infectious Disease	ID 5	Infectious Disease Exposure Report
Infectious Disease	ID 4	Infectious Disease Surveillance Report
Infectious Disease	ID 6	Other Federal Agency Vaccination Status Report
Infectious Disease	ID 7	Vaccination Administration Report
Infectious Disease	ID 2	Vaccination Rate Report
Infectious Disease	ID 3	Vaccination Status Report
Medical Surveillance	MS 1	Medical Surveillance Clearance Report
Respiratory Protection Program	RPP 1	Respirator Fit Test and Training Report
Respiratory Protection Program	RPP 2	Respirator Usage Report for Passed Status
System Usage	SU 2	OHRs User Access Tracking Report
WorkAbility	WA 1	Duty Status Report

Run Report Schedule Report

2. Select at least the required information.

Report Name: Adverse Reaction Report (AR 1)

Report Format: * Detailed

Medication: * Select

Manufacturer:

Lot Number:

Patient Type: *

ALL

Applicant Contractor Employee

Medical Student Non-Paid Employee Nursing Student

Other Other Federal Agency Employee Other Student

Resident Physician Visitor Volunteer

Veterans Affairs Administration: ALL NCA VA VBA VHA No Affiliation

Duty Station *

VISN/SITE SITE

▶ VISN 10

▶ VISN 19

Add

Add All

Remove

Remove All

Search

File Type: * PDF XLS

Next **Reset** **Cancel**

3. Click **Next**.

[Report List](#) | [Scheduled Reports](#) | [Completed Reports](#)

Report Name: Adverse Reaction Report (AR 1)

Frequency - "How often does the report run?"

Generate Report: * Daily/Weekly

Day to Generate Report: * Monday Tuesday Wednesday
 Thursday Friday Saturday
 Sunday

Time to Generate Report: * Select hour(s) Select minute(s)

Email Report Notification To: To enter multiple emails, separate each address with a comma (,).
 Brian.Lynch@va.gov

Date Range - "What data should be displayed?"

From Date | **To Date**

Current day
 Specific fixed date:
 Exactly 1 Week(s) prior to current day
 First day of Previous Month

Cleanup - "Completed reports should be retained for how many days?"

Keep report for: * 365 days

[Schedule Report](#) | [Back](#) | [Reset](#) | [Cancel](#)

4. Enter at least the required scheduling parameters that display. The parameters differ depending on the schedule frequency chosen. Note that the time is in military time – i.e., 0 hours = midnight, 23 hours = 11 p.m. You may also enter email addresses of people who need to be notified that the report has been completed.
5. Click **Schedule Report**.
6. After the system has scheduled the report, you may click the **Scheduled Reports** tab to see what has been scheduled. If you highlight a report, you can cancel it. Only the person who scheduled the report may cancel it.

Report List Scheduled Reports Completed Reports		
Report Type	Report ID	Report Title
Adverse Reaction	AR 1	Adverse Reaction Report

Viewing Scheduled Reports

To view a list of scheduled reports:

1. Select the Scheduled Reports tab.
2. You can see the reports that have been scheduled and the local date/time stamp when each is scheduled to run. The time is in military time format.
3. To cancel a scheduled report, highlight the report and click the Cancel button. Note that the **Cancel** button is displayed only if you are the requester who scheduled the report.

Viewing a Completed Report

Completed reports are displayed in a list, and the list contains all OHRS list attributes. You can sort lists by any heading, and you can use the right (alternate) mouse button to bring up a list of available commands.

To view a report after you have run or scheduled it (and it has run):

1. Select the **Completed Reports** tab. Remember that you can sort the list that displays by any of its headings.
2. Highlight the report you want to view.
3. Click the **View** button.
4. To view the highlighted report's parameters, click the View Parameters button. The parameters display.

When reports are run in .xls format, the Excel spreadsheet has two tabs: one for report parameters and one for report data.

Completed reports expire one year after they have been generated (run) and they are deleted from the system. You may extend the report's expiration date by clicking the Extend Expiration button. This action extends the report's expiration date to one year from the current date, or the date you execute the command.

Working with the Completed Reports Search Filter

From the Completed Reports tab, a Search Filter allows you to sort by:

- Report Type
- Report Title
- File Type
- Date Run
- Expiration Date
- Report ID
- Submitted By

Completed Reports Search Filter

Each filter drop-down allows you to customize your filter results. Once you select your filter details, click **Filter** to sort the Reports data. Click **Reset** to clear the filter drop-down contents. The Search Filter allows you to select from values that already exist in the completed reports list. For example, if you see **Respiratory Protection Program** in your completed reports list, you will also see it in the search filter options.

Report Type	Report ID	Report Title	Report Format	File Type	Submitted By	Date Run	Expiration Date
Respiratory Protection Program	RPP 2	Respirator Usage Report for Passed Status	Summary	PDF	CISSuserS, Four	10/16/2009 15:31 CDT	10/16/2010
Respiratory Protection Program	RPP 2	Respirator Usage Report for Passed Status	Summary	PDF	ciss1, ciss1	10/16/2009 15:27 EDT	10/16/2010
Respiratory Protection Program	RPP 2	Respirator Usage Report for Passed Status	Summary	PDF	CISSuserA, One	10/16/2009 15:16 EDT	10/16/2010

Search Filter Results

Sorting the List

You can sort the list of completed reports with or without using the search filter. You can click on any of the column headers to sort by that column in ascending or descending order. The **Date Run** column is automatically a secondary sort, and all sorts display in descending (newest to oldest) date order as default. You can change the default to ascending (oldest to newest) by clicking the Date Run column, but this action removes your first column sort.

Generating an OHSR User Access Tracking Report

As an OHRS User, you can run a User Access Tracking report to generate information about end users of the OHRS system and also to provide you a glimpse into specific time periods of login activity.

The following roles can run the user access tracking report: National Administrator, Regional Administrator, and OH Local Administrator. If you are a National Administrator, the report format privileges are different.

You must have the correct privileges to run a user access tracking report. If you do not, you will not be able to choose a station from which to run the detailed report.

Generating Medical Surveillance Reports

If you have the proper permission, you can run a report that displays a list of patients who are or are not medically cleared for a specific surveillance (such as a respirator – the only medical surveillance available currently). These reports can be detailed or summary.

Various users are allowed to run the medical surveillance report, including safety officers, but administrators are allowed to run summary reports only.

Generating Other Federal Agency Reports

You can run vaccination status reports that display information on the vaccination status of patients who are from Federal agencies other than the Veterans' Administration. The reports are generated per vaccination and can be generated as a summary and a detailed report. The summary report displays the specific vaccination status of vaccinated, vaccination in progress, and not vaccinated.

The detailed report displays the names of people who are active employees of the other Federal agencies who have a vaccination encounter in OHRS. It displays whether they have been vaccinated or not, based on the encounter. It groups the patients by Agency.

The detailed report is an exception to the OHRS rule that National Administrators can run summary reports only. In this instance, National Administrators can run detailed reports.

These reports will look at **all** Other Federal Agency (OFA) patients whose Visited Station (at the 3-digit station number) is the same as the Visited Station selected in the report parameters. If the report is run using the "From and To Dates" the system will include any OFA patient who has had a Work Status of active (no separation date) at least one day within the dates specified. If the report is run using the "As of Date," the system will exclude those patients who have a Work Status of "Inactive."

Working with Adverse Reaction Reports

Adverse Reaction Reports

There are four Adverse Reaction reports. The first is the Detailed Station Adverse Reaction report and it tracks detailed information on patients who have had an adverse reaction to some medication and therefore have an encounter created for them in OHRS. The second is the Detailed Other Federal Agency Adverse Reaction report and it tracks detailed information on Other Federal Agency employees who have had an Adverse Reaction to some medication and therefore have an encounter created for them in OHRS.

There are also two summary reports available: Adverse Reaction Type by Medication, and Other Federal Agency Adverse Reaction Type by Medication. These two reports display the type of adverse reactions, by medication. The Adverse Reaction Type by Medication report displays the medication-induced adverse reaction information captured for VA employees by duty station, and the Other Federal Agency Adverse Reaction Type by Medication captures the same information for patients of other Federal Agencies who have visited VA stations.

All of these reports can be run for only one medication at a time, and can be generated further for a specific date range for the encounters, lot number, or manufacturer.

Detailed Station Adverse Reaction Report

This report allows practitioners to track, by medication, any adverse reaction to a medication dispensed or taken. A "Detailed Station Adverse Reaction" report lists the names of VA (or OFA) patients in a duty station who have had adverse reactions documented in an Adverse Reaction encounter. The report output includes the Adverse Onset date, the manufacturer, the lot number, and the reaction type.

Detailed Other Federal Agency Adverse Reaction Report

This report allows practitioners to track, by medication, any adverse reaction to what was dispensed or taken. A Detailed Station Adverse Reaction report lists the names of Other Federal Agency patients in a visited station who have had adverse reactions documented in an Adverse Reaction encounter. The report output includes the Adverse Onset date, the manufacturer, the lot number, and the reaction type.

Here is an example of an Other Federal Agency Detailed Station Adverse Reaction report. The same type of information is available in a non-OFA format, too:



Detailed Other Federal Agency

Adverse Reaction to **HEPATITIS B Report**

Visited Station : CHEYENNE VAMC(#442)

Other Federal Agency	Name	Adverse Onset Date	Manufacturer	Lot Number	Reaction Type
Central Intelligence Agency	CISSTESTPAT, PATIENT	09/09/2009	pfizerq	123456	Other
Central Intelligence Agency	CISSTESTPAT, PATIENT	09/18/2009	pfizer	456	Convulsions, includes febrile seizure Dyspnea and respiratory abnormalities Encephalitis, myelitis and encephalomyelitis
Central Intelligence Agency	CISSTESTPAT, PATIENT	09/22/2009	pfizer	123	Convulsions, includes febrile seizure
Central Intelligence Agency	CISSTESTPAT, QC-A	09/02/2009	PFIZER	123456	Other
Central Intelligence Agency	CISSTESTPAT, QC-A	09/07/2009	PFIZER	456	Encephalitis, myelitis and encephalomyelitis
Central Intelligence Agency	CISSTESTPAT, QC-A	09/08/2009			Allergic Arthritis
Central Intelligence Agency	CISSTESTPAT, QC-A	09/11/2009	pfizer	456	Urticaria, include angioedema Allergic Arthritis
Central Intelligence Agency	CISSTESTPAT, QC-B	09/14/2009			Dyspnea and respiratory abnormalities Other
Central Intelligence	CISSTESTPAT, QC-B	09/15/2009			Convulsions, includes febrile seizure

Page 1 of 4

Other Federal Agency Detailed Station Adverse Reaction Report

Summary Adverse Reaction Type by Medication Reports

This report allows practitioners to track, by medication, the types of adverse reactions encountered by patients. The report can be grouped by each visited station, depending on the permissions of the person running the report. There are two types of these reports, one for Other Federal Agency (OFA) patient data, and one for non-OFA patient data.

If you choose to run the Other Federal Agency Adverse Reaction Type by Medication Report, it displays the same type of information but is grouped by each agency selected, then by visited duty station.

To run these reports, use the instructions found in [Running a Report](#).

Here is a sample of each of the summary Adverse Reaction Type by Medication reports, starting with OFA:



**Summary Other Federal Agency Adverse Reaction Type by Medication Report
for HEPATITIS B**

Visited Station : CHEYENNE VAMC(#442)

Other Federal Agency	Reaction Type	Manufacturer	Lot Number	Route of Administration	Total Number
Central Intelligence Agency	Allergic Arthritis	pfizer	456	Intramuscular	1
	Allergic Arthritis			Intramuscular	1
	Sub Total				2
	Convulsions, includes febrile seizure			Intramuscular	1
	Sub Total				1
	Dyspnea and respiratory abnormalities	pfizer	456	Intramuscular	1
	Sub Total				1
	Urticaria, include angioedema			Intramuscular	1
	Sub Total				1
TOTAL					5
Department of Defense	Other			Intramuscular	3
	Sub Total				3
TOTAL					3
TOTAL					8

Summary Other Federal Agency Adverse Reaction Type by Medication Report



Summary Adverse Reaction Type by Medication Report for HEPATITIS B

Duty Station : CHEYENNE VAMC(#442)

Reaction Type	Manufacturer	Lot Number	Route of Administration	Total Number
Acute transverse myelitis	johnson & johnson	8keu	Intramuscular	1
Acute transverse myelitis	Pfizer		Intramuscular	1
Acute transverse myelitis				1
Sub Total				3
Allergic Arthritis	PFIZER	123456	Intramuscular	1
Sub Total				1
Anaphylaxis	PFIZER	123456	Intramuscular	1
Sub Total				1
Autoimmune Hepatitis	Pfizer		Intramuscular	1
Autoimmune Hepatitis				1
Sub Total				2
Bell's Palsy	PFIZER	123456	Intramuscular	1
Bell's Palsy	Pfizer		Intramuscular	1
Bell's Palsy				1
Sub Total				3
Convulsions, includes febrile seizure	pfizer	123	Intramuscular	4
Convulsions, includes febrile seizure	pfizer	456	Intramuscular	1
Sub Total				5

Page 1 of Summary Adverse Reaction Type by Medication Report (non-OFA)

Summary Adverse Reaction Type by Medication Report for HEPATITIS B

Duty Station : CHEYENNE VAMC(#442)

Reaction Type	Manufacturer	Lot Number	Route of Administration	Total Number
Sub Total				2
Other	Pfizer	12345	Intramuscular	1
Other	PFIZER	123456	Intramuscular	3
Other	pfizer	456789	Intramuscular	1
Other	pfizerq	123456	Intramuscular	1
Other	PFZER	123456	Intramuscular	1
Other			Intramuscular	5
Other				4
Sub Total				16
Sudden Death	Pfizer		Intramuscular	1
Sudden Death				1
Sub Total				2
TOTAL				43
GRAND TOTAL				43

Page 2 of Summary Adverse Reaction Type by Medication Report (non-OFA)

Running an Adverse Reaction Type by Medication Report

This report will aggregate and present summary information about the types of Adverse Reactions to medications that occur and are documented within Adverse Reaction Encounters in OHRS. This report allows health practitioners to track if specific Manufacturers and Lot Numbers are generating large numbers of Adverse Reactions. This information will enable the health practitioners to avoid Medications that are causing health issues.

This is a Summary report. Follow the same steps in [Running a Report](#) to run the Adverse Reaction Type by Medication Report.

Report List Scheduled Reports Completed Reports

Search Filter

Report Type:

Report Type	Report ID	Report Title
Adverse Reaction	AR 3	Adverse Reaction Type by Medication Report

Report List – Adverse Reaction Type by Medication Report

The report output includes VISN, Duty Station, Reaction Type, Manufacturer, Lot Number, Route of Administration, and the Total Number. This is an example of what the report should look like:

OHRs Occupational Health Record-keeping System

From Date: 08/01/2009
To Date: 10/26/2009
Date/Time Run: 10/26/2009 10:02 EDT

National Summary Adverse Reaction Type by Medication Report for ACEBUTOLOL

VISN	Duty Station	Reaction Type	Manufacturer	Lot Number	Route of Administration	Total Number
VISN 23	SIOUX FALLS VAMROC(#438)	Allergic Arthritis	Pfizer	10A010	Intradermal	1
	SIOUX FALLS VAMROC(#438)	Allergic Arthritis	Pfizer	10A011	Intradermal	1
	SIOUX FALLS VAMROC(#438)	Allergic Arthritis	Pfizer	10A012	Intradermal	1
	SIOUX FALLS VAMROC(#438)	Allergic Arthritis	Pfizer	10A013	Intradermal	1
		Sub Total				4
	TOTAL					4
	TOTAL					4
	GRAND TOTAL					4

National Summary Adverse Reaction Type by Medication Report

Working with Infectious Disease Reports

Running Infectious Disease Reports

If you have the proper permission, you can run an exposure or surveillance report that displays information about patients who have been exposed to an infectious disease. You can run a detailed or summary report depending on your permissions. A summary report lists the numbers of patients with an infectious disease and a detailed report includes patient names and dates of exposure.

Running an Infectious Disease Exposure Report

You can generate a Detailed Exposure report that will give you the names of patients who have been exposed to an infectious disease with or without the use of personal protective

equipment, or you can generate a Summary Exposure report that will show you the number of patients who have been exposed to an infectious disease with or without the use of personal protective equipment.

Note: On both the summary and detailed reports, if a patient was exposed to a specified infectious disease more than once, both exposures will be counted.

Here is a sample of a Summary Infectious Disease Exposure Report:

OHRs Occupational Health Record-keeping System				From Date: 05/31/2009 To Date: 06/15/2009 Date/Time Run: 07/07/2009 17:47 CDT	
National Report Infectious Disease Exposure Report Pandemic Influenza					
VISN	Duty Station	No Protection	Mask	Respirator	Total
VISN 10	DAYTON(#552)	6	6	6	18
TOTAL		6	6	6	18
VISN	Duty Station	No Protection	Mask	Respirator	Total
VISN 19	CHEYENNE VAMC(#442)	8	7	6	21
	SALT LAKE CITY HCS(#660)	10	10	10	30
TOTAL		18	17	16	51

Summary Infectious Disease Exposure Report

Note: The exposure report displays the VISNs and Duty Stations that you selected.

Running an Infectious Disease Surveillance Report

You can generate a Detailed Infectious Disease Surveillance Report that lists the names of patients in a duty station with suspected, probable, and confirmed cases of an infectious disease by the Service Product Line, Occupational Series, and Location. The detailed report will also give the Date of Decision (the date when it was decided that the patient had a suspected, probable, or confirmed case of the infectious disease).

You can also generate a Summary Infectious Disease Surveillance Report that displays the number of employees in a duty station, VISN, or throughout the nation with suspected, probable, confirmed cases of an infectious disease by Service Product Line, Occupational Series, and Location.

Here is an example of a Summary Infectious Disease Surveillance Report:

VISN	Duty Station	Suspected	Probable	Confirmed	Total Cases
VISN 10	DAYTON(#552)	10	8	31	49
TOTAL		10	8	31	49

VISN	Duty Station	Suspected	Probable	Confirmed	Total Cases
VISN 19	CHEYENNE VAMC(#442)	11	11	24	46
	SALT LAKE CITY HCS(#660)	11	10	20	41
TOTAL		22	21	44	87

Summary Infectious Disease Surveillance Report

Note: For the assessment categories, the order of severity is Confirmed, Probable, and Suspected, with Confirmed being the highest and Suspected the lowest. If a patient has more than one encounter with different assessments, the system will count only the encounter with highest severity level in the summary report.

For example, if a patient has three encounters with three different assessments, only the Confirmed assessment will be counted in the summary report. If a patient has one encounter with a Suspected assessment and another with a Probable assessment, only the Probable assessment will be counted in the summary report.

However, in the detailed report, all assessments are included. For example, if CISS patient Two had one "Probable" assessment and a "Confirmed" one, both assessments are noted in the detailed report but only the "Confirmed" assessment is counted in the summary report.

Working with Vaccination Reports

Generating Vaccination Reports

If you have permission in OHRS, you can generate Vaccination reports for any vaccination. You can run summary or detailed vaccination status reports, depending on your permission settings. If you have a single role and if you are allowed to generate reports, you are allowed to generate them based on that role and its functional areas only.

If you have a dual role, such as that of an administrator, the reports you can generate are based on the functional area you are responsible for or any exceptions driven by the business rules for the individual report.

Generating a Vaccination Administration Report

This report displays the Number of Vaccination Doses Administered by the Visited Station. You can run the report against only one vaccine at a time. This report is a summary report and can be localized to the division or VISN level, or run at the national level. All encounters where the "Yes" radio button was selected next to **Vaccination Administered** will be included in this report. Only closed vaccination encounters are included in this report.

Below is a sample of Summary Vaccination Administration Report:



National Report Summary Vaccination Administration Report Hepatitis B Vaccine

VISN 10

Visited Station	Number of Vaccination Doses Administered
DAYTON (NHCU)(#5529AA)	2
LIMA(#552GB)	2
SPRINGFIELD CBOC(#552GD)	1
<u>552 TOTAL</u>	<u>5</u>
VISN 10 TOTAL	5

VISN 19

Visited Station	Number of Vaccination Doses Administered
CHEYENNE NHCU(#4429AA)	1
CHEYENNE VAMC(#442)	23
<u>442 TOTAL</u>	<u>24</u>
NEPHI(#660GI)	2
SALT LAKE CITY HCS(#660)	2
<u>660 TOTAL</u>	<u>4</u>
VISN 19 TOTAL	28
GRAND TOTAL	33

Vaccination Administration Report

Generating a Vaccination Status Report

This report displays a patient's vaccination status. You may want to know if patients:

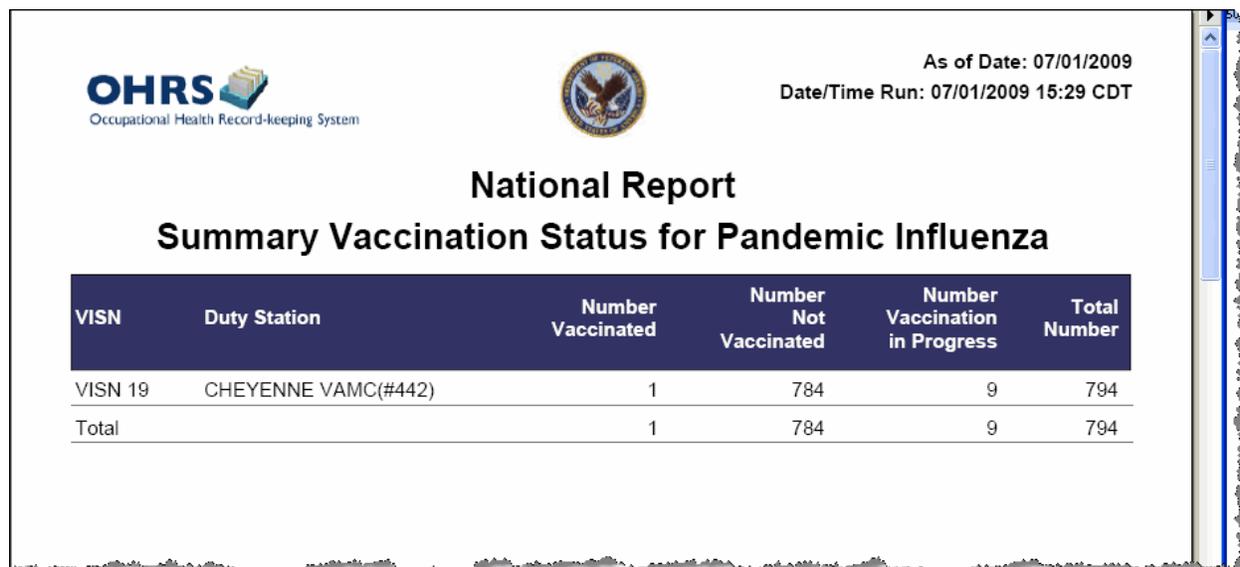
- Are vaccinated
- Are not vaccinated
- Have the vaccine in progress

Rules are different for each vaccine. You can run the report against only one vaccine at a time. Only closed vaccination encounters are included in this report.

There are two types of vaccination status reports, summary and detailed. If you have the appropriate permission, you can run one or both. Summary reports display the number of patients, while detailed reports display the names of patients. Reports are divided by duty station and/or VISN (if local or regional), or by National.

This report will look at all patients whose duty station (at the 3-digit level) is the same as the Duty Station selected in the report parameters. If the report is run using the "From and To Dates" the system will include any patient who has had a Work Status of "active" (no separation date) at least one day within the dates specified. If the report is run using the "As of Date," the system will exclude those patients who have a Work Status of "Inactive."

Here is a sample of a summary report from a National Administrator:



As of Date: 07/01/2009
Date/Time Run: 07/01/2009 15:29 CDT

National Report Summary Vaccination Status for Pandemic Influenza

VISN	Duty Station	Number Vaccinated	Number Not Vaccinated	Number Vaccination in Progress	Total Number
VISN 19	CHEYENNE VAMC(#442)	1	784	9	794
Total		1	784	9	794

Summary Vaccination Status Report

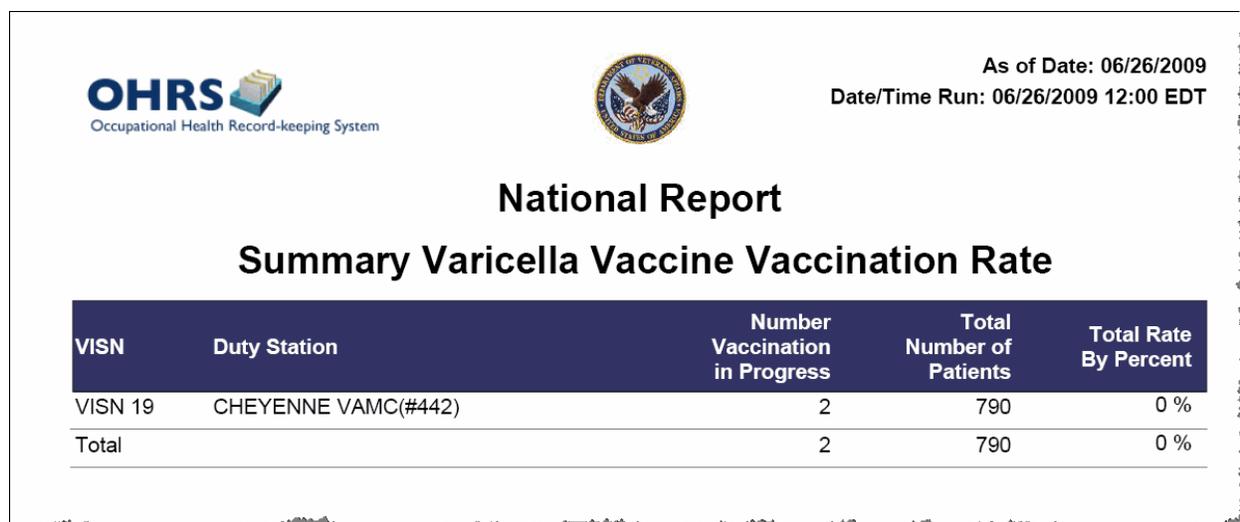
Note: National Administrators cannot run detailed reports.

Generating a Vaccination Rate Report

This report displays the percentage of patients who are or who are not vaccinated for a specific vaccine. If patients do not have a vaccination history in the system, they are considered unvaccinated for purposes of this report. It is a summary report only, but can be localized to the division or VISN level, or run at the national level.

This report will look at all patients whose duty station (at the 3-digit level) is the same as the Duty Station selected in the report parameters. If the report is run using the "From and To Dates" the system will include any patient who has had a Work Status of "active" (no separation date) at least one day within the dates specified. If the report is run using the "As of Date," the system will exclude those patients who have a Work Status of "Inactive."

Here is a sample of a Vaccination Rate Summary Report at the National level:



As of Date: 06/26/2009
Date/Time Run: 06/26/2009 12:00 EDT

National Report
Summary Varicella Vaccine Vaccination Rate

VISN	Duty Station	Number Vaccination in Progress	Total Number of Patients	Total Rate By Percent
VISN 19	CHEYENNE VAMC(#442)	2	790	0 %
Total		2	790	0 %

Vaccination Rate (National) Report

Generating an Immunity Status Report

This report looks at the most current immunization status in the patient record for the selected vaccine and determines if a patient is immune by the vaccination parameters (by vaccination, by history, etc.), or is susceptible by other parameters (vaccination refused, etc.). It can be a summary or detailed report, depending on your permission settings. The summary report lists the number of patients who are immune, susceptible, or both while the duty report gives the names of patients who are immune, susceptible, or both. It can be localized to the division or VISN level, or run at the national level. Only closed vaccination encounters are included in this report.

This report will look at all patients whose duty station (at the 3-digit level) is the same as the Duty Station selected in the report parameters. If the report is run using the "From and To Dates" the system will include any patient who has had a Work Status of "active" (no separation date) at least one day within the dates specified. If the report is run using the "As of Date," the system will exclude those patients who have a Work Status of "Inactive."

Note: the detailed report lists the “Date of Decision” if it exists in the patient record (the date it was decided that a patient is immune or susceptible to a specific disease).

Below is a sample of a Summary Immunity Status report (National):

Summary Immunity Status for Pandemic Influenza					
Duty Station : CHEYENNE VAMC(#442)					
Service/Product Line	Occupational Series	Location	Number Immune	Number Susceptible	Total Number
Biomedical Engineering	Biomedical Equipment Support Specialist	Location B	0	34	34
	Sub Total		0	34	34
Sub Total			0	34	34
Medical	Physician Assistant	risk location field text	0	1	1
	Sub Total		0	1	1
Sub Total			0	1	1
Nursing	Nursing Assistant	Location C	0	24	24
	Sub Total		0	24	24
	Registered Nurse		0	1	1
	Sub Total		0	1	1
Sub Total			0	25	25
Office of Information and Technology	Administrative Support	Location B	0	23	23
	Sub Total		0	23	23
Sub Total			0	23	23
Physical Medicine and Rehabilitation	Biomedical Equipment Support Specialist	Location A	0	24	24
	Sub Total		0	24	24
Sub Total			0	24	24
Research	Anthropologist		0	1	1
	Sub Total		0	1	1
Sub Total			0	1	1
TOTAL			0	794	794

Immunity Status Summary (National) Report

Generating Duty Status Reports

Generating Duty Status Reports (WorkAbility)

As an OHRS user, you can run a report that provides information on employees with the Recommended Duty statuses of Return to Duty No Restrictions, Return to Duty With Restrictions, and/or Off Duty. In the OHRS world, this information is also known as WorkAbility. There are two types of WorkAbility reports, summary and detailed. To run the report, start by selecting WorkAbility from the reports list.

The summary report lists the number of patients at the station, VISN, or national level with a specific Recommended Duty Status while the detailed report gives the name of each patient with a specific Recommended Duty Status.

Note: At the time that OHRS is to go live into production, there will be no existing encounters with WorkAbility. This means that under certain report scenarios, patient records that have no WorkAbility will be included in the report output.

You must have the correct permission to run a duty status report. If you do not, you will not be able to run it. You will know if you cannot choose a duty station from which to run the report.

The instructions for running the Summary Status Report are the same as those found in [Running a Report](#).

A Summary Duty Status Report for a station is sorted by Station, then by Service/Product Line, and then by Occupational Series.

The steps for running a Detailed Duty Status Report are the same as those for running a Summary report, except you will need to select Detailed from the Report Format drop-down, and only certain roles such as OH Provider, have permission to run a Detailed report.

On a Detailed report, if you select a Recommended Duty Status of Return to Duty With Restrictions or Off Duty, the system gives you the option of filling in the "Duty Status Expires Within X Days" field. You can then enter the number of days from the report run date to the Duty Status expiration date and you will find out which users are due for re-evaluation.

For example, if you run a report on May 2 and select "Duty Status Expires Within 10 Days," the system lists the users whose duty status expires on May 12.

Working with Respirator Fit Test Reports

Generating a Respirator Fit Test and Training Report

As an authorized OHRS user, you can generate a Respirator Fit Test and Training Report that provides Fit Test Detail by person so that you can assess the overall status of those who have been Fit Tested and Trained by Service/ Product Line, Occupational Series and

Location. You can generate a Detailed Respirator Fit Test and Training Report. You can select all patient types to display in the VISN or National report.

The steps for Generating a Respirator Fit Test Report are the same as those for [Running a Report](#).

The following report data appears on the Respirator Fit Test and Training Report:

- From/To or As of Date
- Date/Time Report Run
- Duty Station (Name and Station Number)
- Service/Product Line
- Occupational Series
- Location
- Name
- Respirator Status
- Respirator Type
- Respirator Manufacturer
- Manufacturer Model Number
- Respirator Size

Note: If the Respirator Size is listed as “Other”, you can access the Encounter on OHRS to view the comments.

- Training Completed Date
- Encounter Status (Open or Closed)

Note: This Report pulls patients with an Active Work Status.

Information for Respirator Fit Testers, Safety Officers, and RFT Trainers

When generating Respirator Fit Test reports, note that there are two Patient Status types for whom you would never perform a fit test – Contractor and Visitor. Do not select these patient status types when creating your RFT report.

Generating a VISN/National Respirator Usage Report for Passed Status

If you have the appropriate permissions, you can generate a VISN/National Respirator Usage Report for Passed Status that aggregates counts of Respirator Type, Status, Manufacturer, and the number of people who passed Fit Test by Service/Product Line and Occupational Series. This is a Summary report.

You can select all patient types to display in the VISN/National report.

The screen shot below shows how this report appears in the report list.

Report Type	Report ID	Report Title
Adverse Reaction	AR 3	Adverse Reaction Type by Medication Report
Adverse Reaction	AR 2	Other Federal Agency Adverse Reaction Report
Adverse Reaction	AR 4	Other Federal Agency Adverse Reaction Type by Medication Report
Infectious Disease	ID 1	Immunity Status Report
Infectious Disease	ID 5	Infectious Disease Exposure Report
Infectious Disease	ID 4	Infectious Disease Surveillance Report
Infectious Disease	ID 6	Other Federal Agency Vaccination Status Report
Infectious Disease	ID 2	Vaccination Rate Report
Infectious Disease	ID 3	Vaccination Status Report
Medical Surveillance	MS 1	Medical Surveillance Clearance Report
Respiratory Protection Program	RPP 2	Respirator Usage Report for Passed Status

Respirator Usage Report for Passed Status - Report List

The steps for generating a VISN/National Respirator Usage Report are the same as those for [Running a Report](#).

Depending on your permissions, the title of the report and data generated in the columns of the report will vary. For example, if the regional administrator generates the report, the title is, "VISN Report," if the national administrator generates the report, the title is "National Report," and if the VISN-National Safety IH generates the report, the title is "VISN/National Report."

Note: Only the respirator type(s) you select will be listed in the Respirator VISN/National Respirator Usage Report.

Generating a Respirator Usage Report for Passed Status

This is a Summary Station report that aggregates counts of respirator type, model, manufacturer, size, and number which passed the Respirator Fit Test encounter.

To run or schedule the report:

1. Select **Menu > Reports > Report List** to display a list of available reports.
2. Select the **Respirator Usage Report for Passed Status**.
3. Click **Run Report** to display the next page (see graphic below).

Note: to schedule a report, see [Scheduling a Report](#).

From Date: * To Date: OR As of Date:

Report Format: * Summary

Respirator Type: * ALL
 Air filtering respirator Powered air purifying respirator (PAPR) Self Contained Breathing Apparatus (SCBA)
 Supplied Air Respirators(SAR) Other

Patient Type: * ALL
 1st Assistant Test Applicant Contractor
 Employee JAS1 Medical Student
 Non-Paid Employee Nursing Student Other
 Other Federal Agency Employee Other Student Resident Physician
 Visitor Volunteer

Veterans Affairs Administration: ALL NCA VA VBA VHA No Affiliation

Duty Station *
 VISN/SITE SITE

ALASKA VA HLTOR SYSTEM (AVAHS) (#463)
ALEXANDRIA VAMC (#502)
ALTOONA (#503)
AMARILLO HCS (#504)
ANN ARBOR VAMC (#506)
ASHEVILLE VAMC (#637)
ATLANTA VAMC (#500)

Add
Add All
Remove
Remove All

Search

File Type: * PDF XLS

Run Report Reset Cancel

4. Select a date range for the report.
5. Select a respirator type.
6. Select a patient type.
7. Select one or more duty stations using the Add or Add All buttons.
8. Select a file type.
9. Click **Run Report**.
10. Click the Completed Reports tab.
11. Select the completed report.
12. Click the **View** button to display the report (see graphic below).



National/VISN Report Respirator Usage Report for Passed Status

VISN	Duty Station	Service/ Product Line	Occupational Series	Respirator Type	Respirator Manufacturer	Respirator Model	Size	Total Passed Fit Test
VISN 19	CHEYENNE VAMC(#442)		Welder	Air filtering respirator	3M	test delete	XS	1
	<i>Sub Total</i>							1
TOTAL								1
VISN	Duty Station	Service/ Product Line	Occupational Series	Respirator Type	Respirator Manufacturer	Respirator Model	Size	Total Passed Fit Test
GRAND TOTAL								1

Working with Administrative Tasks

Performing Administrative Tasks

Administrators have the ability to manage various tasks. They can manage the permission settings that drive the activities a particular provider can perform, assign administrative and functional stations to a system user within their own station, and manage the users under their own area or those of areas under their responsibility. There are also various levels of system administrators: Local, Regional, and National.

Local Administrators can assign stations to a system user within their own station.

Regional Administrators and National Administrators have a larger pool of stations they can assign a system user. This is helpful when a system user is an OH provider at multiple facilities.

Managing System Users

If you have the appropriate permission you can perform the Manage System User functions, or the option does not display.

To manage a system user:

1. Select **Administration**.
2. Select Manage System User.
3. Enter the user ID of the person whom you want to manage

or

4. Enter the last name and click **Search**.
5. Highlight the user you want and click **Select**. The following window displays.
6. Select the appropriate role for this user and click **Add**.
7. The functional stations available to the administrator display on the left. To narrow the choices available, type a station number in the **Filter** box and click **Filter**. Then select the appropriate stations and click **Add**.
8. When you have all the choices you want for this user, click **Submit**.

Managing System Roles

The Manage System Role screens allow an administrator to assign or remove permissions that are linked to roles, or to create a role.

To assign or remove permissions for a role:

Follow this path to display the Manage System Role screen: **Menu > Administration > Manage System Role**.

1. Select a role in the drop-down menu and click the **Select** button to display the Role Name screen.
2. Select an Available Permission from the left-hand list and then click the **Add** button to add the permission to the role, or select an Assigned Permission from the right-hand list and click the **Remove** button to delete the permission from the role.
3. Click Submit to save changes to the role.

To create a role:

1. In the Manage System Role screen, enter a role name in the text box and click **Add** to display the Role Name screen.
2. Select an Available Permission from the left-hand list and then click the **Add** button to add the permission to the role. After adding the permission, it can be removed by selecting it and clicking **Remove**.

Inactivating a System User

The Administrator can inactivate a system user. This function is used when a user is no longer employed, for instance, or for other reasons that would require a user's ID to be inactivated. This requires that you enter a precise date and a reason.

To inactivate a system user:

1. Select **Administration**.
2. Select **Manage System User**.
3. Enter the user ID of the person whom you want to manage

or

4. Enter the last name and click **Search**.
5. Highlight the user you want and click **Select**.
6. Select the **Inactivate** check box.
7. Select an Inactivate date.
8. Select an Inactivate reason.
9. Click **Submit** when finished to save changes.

Unlocking and Locking a System User

The Administrator can unlock a system user whose ID has been locked out as well as lock a system user out of the system if there is an appropriate reason.

To lock or unlock a system user:

1. Select **Administration**.
2. Select **Manage System User**.
3. Enter the user ID of the person whom you want to manage

or

4. Enter the last name and click **Search**.
5. Highlight the user you want and click **Select**.
6. Select the **Locked** check box to lock a user ID, or deselect the box to unlock the user ID.
7. Click **Submit** when finished to save changes.

Unlocking a System Administrator

If a local administrator is locked out of the system, only a regional with the assigned responsibility for that local administrator and national administrator can unlock them. The locked out administrator sees a message to contact their regional and/or national administrator for assistance.

If the regional administrator is locked out of the system, only a national administrator can unlock them. The locked out regional administrator sees a message to contact the national administrator for assistance.

If the national administrator is locked out of the system, only another national administrator can unlock them. The system will display a message to contact another national administrator for assistance.

Creating a System User

To create a user in the OHRS system, they first have to be in the PAID or VSS systems. They will be in the list as defined in [Managing System Users](#), and the steps for adding the user to the system are exactly the same as found in this topic.

To create a system user:

1. Select **Administration**.
2. Select **Manage System User**.
3. Enter the user ID of the person whom you want to create

or

4. Enter the last name and click **Search**.
5. Highlight the user you want and click **Select**.
6. Select the appropriate role for this user and click **Add**.

The functional stations available to the administrator display on the left. To narrow the choices available, type a station number in the Filter box and click **Filter**. Then select the appropriate stations and click **Add**.

7. When you have all the choices you want for this user, click **Submit**.

Reconciling Patients

Reconciling patients is a function of the National, Regional, and Local Administrator.

While attempting to load new patients into OHRS or update existing patients within OHRS with new or updated data received from the PAID, VSS, or Patient Import load process, OHRS may encounter a potential duplicate patient that needs to be reconciled. OHRS identifies potential duplicate patients when it attempts to load a patient record when:

- OHRS finds more than one patient record in the OHRS system that matches the SSN, Last Name, First Name, DOB, and Gender of the PAID record on file.
- OHRS finds more than one patient record in the OHRS system that matches the SSN of the PAID record on file.
- OHRS finds a patient record in the OHRS system that matches the Last Name, First Name, DOB, and Gender of the patient record in the load.
- OHRS finds more than one patient record in the OHRS system that matches the Last Name and DOB of the patient record in the load.

The OHRS Patient Reconcile process allows you to (1) update existing patient demographics information in the OHRS system with the new information from the load process (PAID/VSS/Patient Import) that appeared on the first column in the Patient Reconcile screen or (2) determine that the existing patients on the OHRS system are not the same person, and create a new patient record in OHRS for the patient from the Load process.

If you have the appropriate security privileges, you can perform the Reconcile Patients function. If not, the option does not appear.

To see the patients that need to be reconciled:

1. Select **Administration** from the Menu.
2. Select **Reconcile Patients** from the Administration menu.

The potential patient records to be loaded into OHRS from the PAID/VSS/Patient Import databases are displayed at the top. The records in the bottom view represent the patients already established in OHRS that are potential matches.

3. On the top table pane, select a patient to see the details. The potential matches that already exist within OHRS are displayed at the bottom.

CISS Portal Desktop - Windows Internet Explorer

http://vawww-sqa.relx.ciiss.med.va.gov/ciiss/ciiss.portal?_nfpb=true&_pageLabel=CISS_PORTLET_OHRS

Station: Not Selected User Name: CISSuserS, Four Log Out

CISS Home OHRS

Patient List from PAID/VSS/Patient Import

SSN	Name	Date of Birth	Gender	Source
666660085	OHRSPATIENTA, PAIDTEST15 PAID_OFA	01/31/1960	Female	PAID
666660081	VSSPATIENT3823, VSSFNAME3823 MIDDLE 1	03/11/1955	Female	PAID
666660082	LASTNAME1A, PAID_PATIENT01 MIDDLE 2	01/01/1960	Female	PAID
455000902	VSSPATIENT902, VSSFNAME902	10/07/1924	Female	PAID
000991005	S1_PROD_REG, SQA TEST PATIENT 5 E	06/04/1974	Female	PAID
	VSSPATIENT60, VSSFNAME60 VSSMNAME60	03/12/1956	Female	VSS

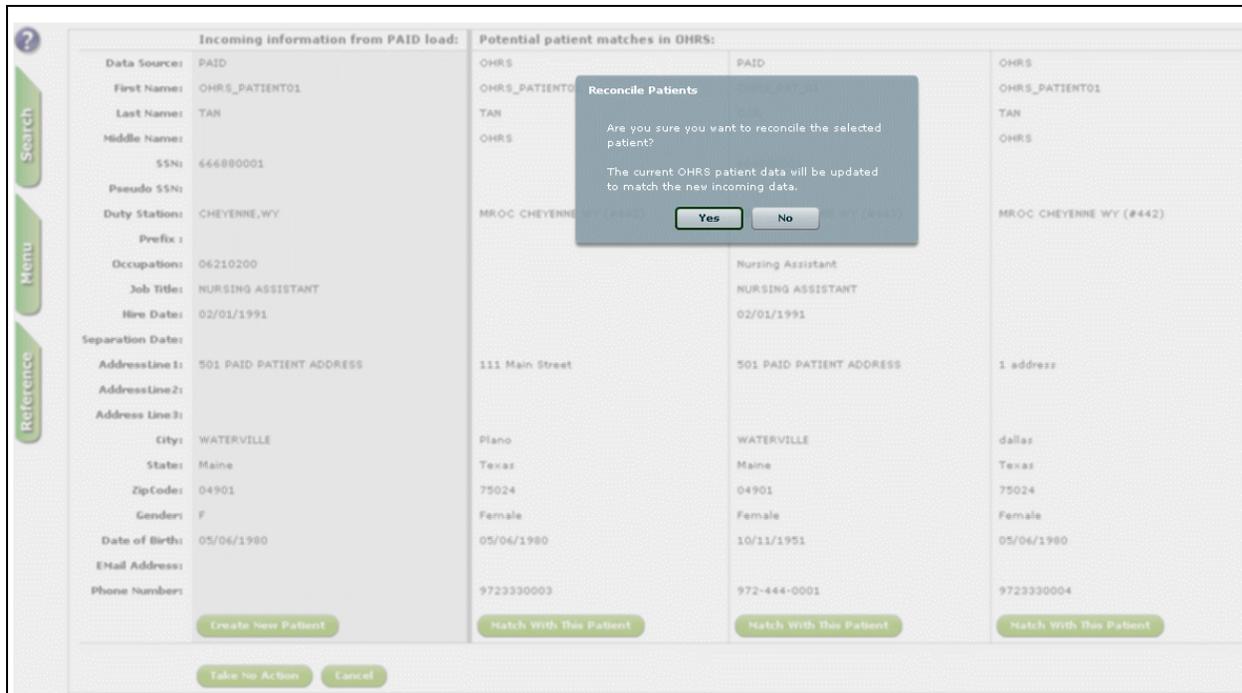
Patient Matches from OHRS

SSN	Name	Date of Birth	Gender	Source
	OHRSPATIENTA, ONE	01/31/1960	Female	OHRS
666660084	OHRSPATIENTA, PAIDTEST12 PAID_OFA	01/31/1960	Male	PAID

Reconcile Cancel

Local intranet 100%

- Click **Reconcile** to display patient detail information. Review these patient information details and determine if they are the same person in the Patient Reconcile screen.



Once you click **Yes** on the **Reconcile Patients** confirmation window, OHRIS will reconcile and replace the existing OHRIS patient information with the patient record from the load.

OHRIS will display the following message on the screen once the reconcile process completed:

"Patient reconciled successfully."

If you wish to ignore the incoming record and to NOT perform any updates of the patient data in OHRIS, you can click the Take No Action button. This will remove the incoming record from the reconcile list and NOT perform any updates to the patient data in OHRIS.

To create a new patient demographics record from the patient information on the load without reconcile with an existing matched OHRIS patient record if they are not the same person:

1. Click the **Create New Patient** button for the patient from the load in the first column.
2. OHRIS will pop-up a confirmation window to ask you "Are you sure you want to create a new patient?" Click **Yes** if you want to proceed with creating new patient or click **No** if you do not want to proceed with the create action.
3. Once you click **Yes** on the Create Patient confirmation window, OHRIS will create a new patient demographics record with the data from the load process (PAID/VSS/Patient Import).
4. OHRIS will display the following message on the screen once create patient process completed: "Patient created successfully."
5. If the patient information matches an existing patient identity traits (SSN, Last Name, First Name, Date of Birth, Gender) in the OHRIS system during the Create

Patient process, OHRS will display an error message indicating that "Patient not created as patient with matching identity traits already exists in the system."

You can also get to the **Reconcile** page while viewing the alerts for your station. See [Alerts](#) for more details on how to view the alerts.

1. In the **Alerts** page, select an alert that indicates that "the PAID and/or the VSS data processing has identified potential duplicate patients."
2. Click **View** to display the **Reconcile Patients** page.

Working with Reference Data

This feature allows you to create, view, and update reference data used within the OHRS application. Reference data is the standard data that is stored and used within the OHRS application, often via a drop-down or selection list. An example of reference data is the list of Other Federal Agencies (OFA) available on Patient Demographics and OFA reports.

You can add and update data within the OFA reference table. Delete/inactivate and other tables will be available in future functionality. You can use the current **Administration** menu and the new **Manage Reference Data** menu option, to create new entries and update entries in any pre-defined reference data table.

You must have the appropriate security privileges to access the Manage Reference Data menu option. If you have the **Update Reference Data** permission, you can perform all Manage Reference Data functions.

As an authorized user, you need to be well trained on how the reference data is set up and aware of all the areas of the OFA reference table that are utilized within the OHRS application prior to modifying the data.

To access Reference Data, complete the following steps:

1. Select the Manage Reference Data menu option. A new window containing the available reference data tables opens.
2. If you are an authorized user, from the **Reference Data Selection** list, select the table that contains the reference data you wish to modify.
3. After making a selection, a grid containing the actual data table rows displays. If no data exists in the database, the message "No data present in the selected table" displays.
4. You will now be able to add new data or update existing data in the table. Select **Submit** to save your changes and propagate them throughout OHRS. Select **Cancel** to exit.

Frequently Asked Questions

Q: How do I enter the date in the date field?

A: You must enter the date in mm/dd/yyyy form or you can use the calendar method.

Q: Why is my signature code not working?

A: Are you using the correct duty station?

Did you use the correct signature code?

If you continue to have problems, contact your Administrator.

Q: Why can't I get to Manage System User?

A: Only the Administrator has the Manage System User function.

Q: Why am I receiving an error when I enter my signature code?

A: If you have entered an invalid signature code you receive the following error:

Electronic Signature Code is incorrect. Please re-enter.

Entering the correct signature code will resolve this error.

If you have forgotten your signature code, contact your Administrator.

Reference Material

Technical Service Project Repository

Additional CISS documentation is available on the Technical Project Service Repository ([TSPR](#)).

Security within OHRS

Security

CISS-OHRS leverages security that has been implemented throughout the VA enterprise, such as ActiveDirectory, and is aligned with the HealthVet Common Services direction for security. VA enterprise security is detailed in The VA Handbook 6500, which can be found at: <http://www1.va.gov/vapubs/>.

CISS-OHRS was developed to be in compliance with the Privacy Act of 1974, HIPAA, and Section 508.

Glossary

A

Addendums: Extra information added to an encounter.

Adverse Reaction Reports: Reports that track detailed information on patients who have had an adverse reaction to some medication and therefore have an encounter created for them in OHRS.

Alerts: Alerts are system-generated messages that provide information. Alerts are either Informational or Actionable. You must have the appropriate security access to view alerts.

Assessment: Within the Medical Surveillance encounter, there is an Assessment tab where you can collect the following patient information regarding Medical Opinion: Further evaluation needed, Medically cleared, Medically cleared with restrictions, Medically not cleared.

B

Banner: The graphical area that displays the Department of Veterans Affairs logo, the parent system, which is the Clinical Information Support System (CISS), and the name of the partner application (OHRS, Occupational Health Record-keeping System). It also includes photos of typical VA employees or clients.

C

CISS: The Clinical Information Support System (CISS) is a web-based portal application that provides a central interface for users to access information and applications necessary for their role.

Content Area: The section of the window where you see explanatory text, and where all input, viewing, and OHRS tasks are performed. If there are error messages to your input, they display here. There are also links, which look like buttons, to CISS Home and to the OHRS application in the Content Area.

Context Bar: The dark blue banner at the bottom of the Banner that shows the user's duty station, user name, and log out link. There are also buttons of the applications that the user has permissions to use. If the user is an administrator, they can sign on with no duty station specified (as in the example above) until they begin to perform the functions they have authorization to do.

D

Demographic Information: Demographic information includes name, address, phone, email, and emergency contact information for a patient.

Duty Station: A location where a person is based (typically, it is where a person receives a paycheck). It may be a place where health care is not provided, such as a national cemetery or an office building.

Duty Status Reports – WorkAbility: This report displays information on employees with the Recommended Duty Status of Return to Duty No Restrictions, Return to Duty With Restrictions, and Off-Duty. If there is an outbreak of flu, the facility needs to know who can work full time, who is off work, and who can work in a limited capacity. This ability to work equates to “Recommended Duty Status.” This report can be detailed or summary, and can be localized to the local area, VISN (Region), or the nation.

E

Electronic Signature/E-signature: Your e-signature is a secondary level of authentication and carries the same legal responsibilities as your written signature. It works in addition to your password to identify you. You must enter your e-signature when you confirm the encounter data that you enter.

Encounter: Encounters are times when a patient is treated or evaluated by medical staff.

Footer: The Footer is displayed at the bottom of every window. It displays the version of the application, the copyright date, and a link to contact the application owners.

Functional Station: A location where health care is provided (a treating facility), such as a VA Hospital/Medical Center or clinic.

I

Immunity Status Report: This report looks at the most current immunization status in the patient record for the selected vaccine and determines if patient is immune by the vaccination parameters (by vaccination, by history, etc.), or is susceptible by other parameters (vaccination refused, etc.). It can be a detailed or summary report. Only closed vaccination encounters are included in this report.

Infectious Disease Exposure Report: This report displays information about patients who have been exposed to a specific infectious disease and lists if they have used protective equipment, such as a mask or respirator. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Infectious Disease Surveillance Report: This report displays information about patients with suspected, probable, or confirmed cases of a specific infectious disease. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

IRM: Information Resource Management

M

Medical Surveillance Clearance Report: This report displays if a patient is medically cleared to work with a respirator or not. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

Menu: The list of items on the left side of the window. The Menu displays the actions that are available to you, based on your role.

N

Notifications: Notifications are a text-based electronic messages linked to a patient encounter. They are messages that providers communicate regarding a patient's workability status (i.e., the patient is or is not available to work), reminders to a patient to return for follow-up care, etc.

O

OHRS: OHRS (the Occupational Health Record-keeping System), is the initial CISS partner system. It is a web-based application that enables occupational health staff to create, maintain, and monitor medical records for VA employees and generate national, VISN, and site-specific reports.

OHRS User Access Tracking Report: This report displays information about end users of the OHRS system, including data about their login activity. It can be only a summary report and can be localized to the local area, VISN, or the nation. Only local, regional, and national administrators can run this report.

Other Federal Agency Vaccination Status Report: This report displays the vaccination status of patients who belong to Federal Agencies other than the Veterans Administration. It can be a summary or detailed report and can be localized to the local area, VISN, or the nation.

P

PAID: Personal and Accounting Integrated Data

Pandemic Influenza Encounter: The pandemic influenza encounter is used to document screening and treatment for pandemic influenza. It is to be used in the event of an outbreak to track exposures, determine who is at risk, and in what capacity they may work.

Patient Cover Sheet Pods: The Patient Cover Sheet pods are clickable pieces of content on the Cover Sheet tab which allow you to quickly view important high-level patient information.

Q

Quick-Load Vaccination Function: The Quick-Load Vaccination option allows you to enter multiple encounters quickly during the time you are vaccinating several people at a time.

R

Remedy Ticket: A support request that is sent to the VA Service Desk.

Respirator Fit Test and Training Report: This report displays information about patients' respirator fit test and training results. It can be only a detailed report.

Respirator Fit Test Report: This report displays information about patients who passed the respirator fit test. It can be only a summary report and can be localized to the local area, VISN, or the nation.

Risk Profile: Displays the risk profile for a patient, and every OHRS patient must have a risk profile created. The risk profile indicates how often a patient must be evaluated for the designated risk.

Role-based Access: The level of access to data and functions in CISS-OHRS varies depending on job function.

S

Section 508 Compliance: Applications that are Section 508 compliant can be used with assistive technology software.

SOAPE Tabs: There are tabs within the Encounter tab itself that require data entry when you are creating a new encounter, regardless of the Encounter Type. The tabs are named: **S**ubjective, **O**bjective, **A**ssessment, **P**lan, and **E**ncounter Codes.

SP: Service Pack

U

User Profile: A user profile is called My Profile and is accessed from the left menu bar. It contains user information such as the user's role.

V

Vaccination Encounter: The Vaccination Encounter is used to document vaccination against pandemic influenza. OHRS has the ability to report the vaccination and immunity status of employees and others as well as their ability to work.

Vaccination Rate Report: This report shows the percentage of patients who are vaccinated or not vaccinated for a specific vaccine. If a patient does not have an immunization history in the system, they are considered unvaccinated for purposes of this report. It is a summary report only, but can be localized to the local area, VISN, or the nation.

Vaccination Status Report: This report displays a patient's vaccination status, which can be either vaccinated, not vaccinated, or vaccination in progress. Rules are different for every vaccine. You can run the report against only one vaccine at a time. This report can be a summary report or a detailed report and can be localized to the local area, VISN, or the nation. Only closed vaccination encounters are included in this report.

VHA: Veteran's Health Administration

VISN: Veterans Integrated Service Network

VSS: Voluntary Service System

W

Work Profile: The work profile shows information about where the patient works, their job code, job title, and provides supervisor information.

WorkAbility: WorkAbility information is that which allows supervisors or other OHRS personnel to see whether or not a particular OH patient (employee, volunteer, provider, etc.) is able to work and if they have any restrictions.

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