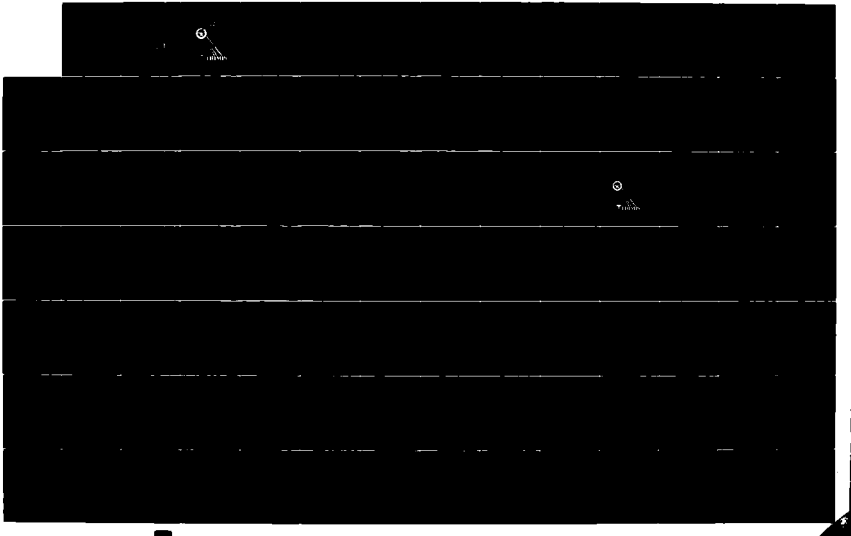
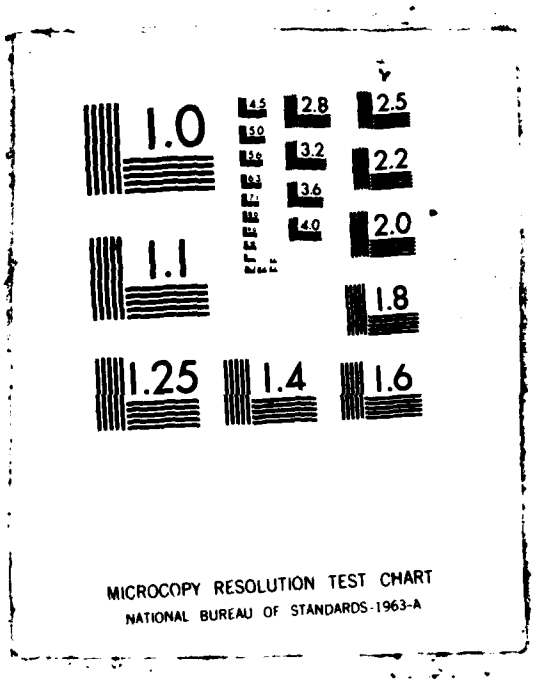
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The Automated Quality of Care Evaluation Support System (AQCESS) is a microcomputer based, integrated, terminal oriented, interactive, on-line computer system designed to support Patient Administration, Clinical Records and Quality of Care Evaluation functions within a Military Medical Treatment Facility. The AQCESS Training Aids were developed to aid the user in the implementation of the system.

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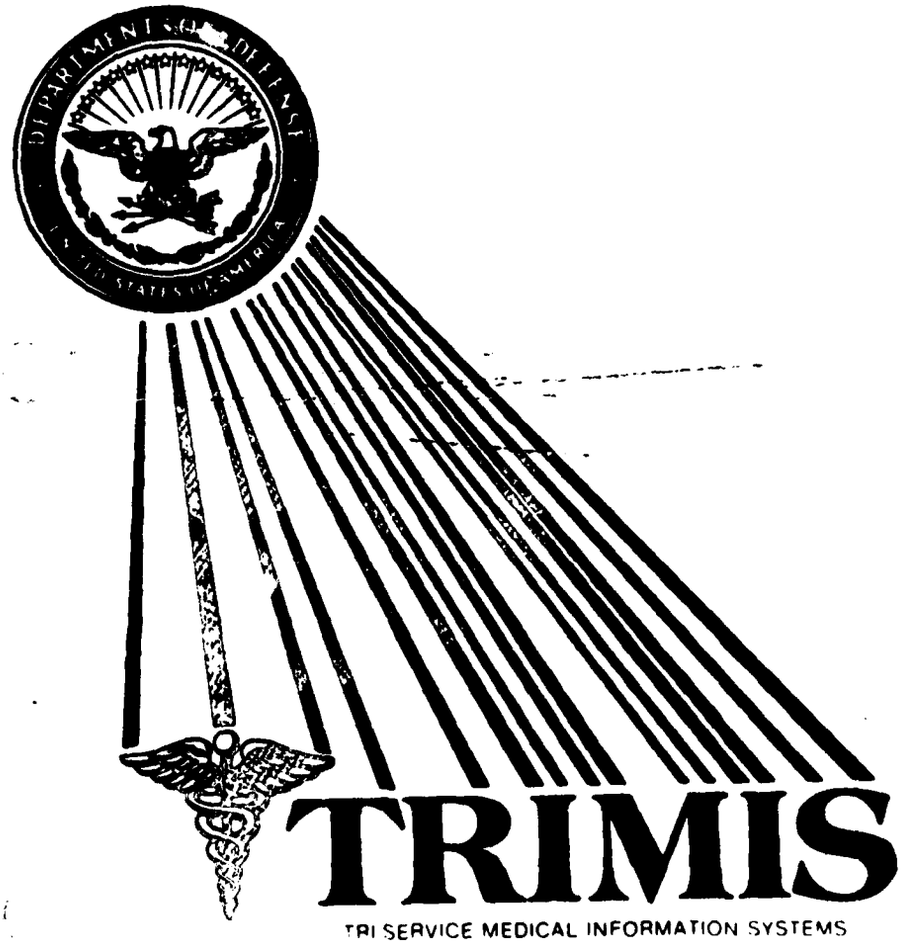
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AQCESS

QUALITY ASSURANCE TRAINING AID



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AQCESS ADMISSION AND DISPOSITION TRAINING AID

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PREFACE

Designed for use at 168 DoD hospitals, the Automated Quality of Care Evaluation Support System (AQCESS) is an interactive, menu-driven patient administration and quality assurance computer system. The system is composed of four subsystems, three of which are functional (Admission and Disposition, Clinical Records, and Quality Assurance). These subsystems allow the entry, updating, and display of data, as well as the production of reports for MTF's and higher command. The fourth, System Management, is separate from the functional areas of AQCESS and allows regulation of AQCESS operations and security.

Accompanying installation of AQCESS at your hospital is a fully-developed AQCESS Training Program, which includes several components. These are designed to support you through the formal AQCESS training period and as you continue to learn how to use AQCESS to perform specific processing tasks.

Training Directory	The AQCESS training directory works exactly the same as the live system. You can sign on to the system using a training user ID and password and perform all of the data entry and processing tasks that you will be performing in the live system. The training system is completely separate from the live hospital database.

AQCESS Training Database	A training database can be loaded into the training directory by the system manager. This database contains sample patient data which can be used to practice the system's information processing capabilities.
TUTOR ME	An online tutorial that consists of lessons that describe the functions and features of AQCESS.
AQCESS User Manual	Appendixes provide detailed information about individual fields, screens, and reports for each subsystem.
AQCESS Training Aids	Provide a self-instructional tool for learning AQCESS. A separate Training Aid is available for each subsystem; each one includes detailed step-by-step procedures for use of the subsystem, "Points to Remember," that highlight key information, and "Checkpoints" that enable you to monitor your learning progress. The Training Aids' introductions are designed for use with TUTOR ME.
AQCESS Packets	Contains practice cases for you to learn the processing functions of the system. These are provided by your system manager.

AQCESS A&D Report Packet	Contains a paper or "hard" copy of reports that are generated by AQCESS.
Quick Guide	Provides a means to quickly reference AQCESS processing and data entry features.
AQCESS Trainer Guide	Provides instructions to the trainer for delivering user training. Incorporates the the packets and training database.

As an integral component of the AQCESS Training Program, this Training Aid is designed to provide you with general information about AQCESS and detailed procedures that address use of its Quality Assurance subsystem.

Section 1 introduces AQCESS, its use, and its features while Section 2 provides an overview of Quality Assurance processing.

Sections 3 through 12 present the Quality Assurance functions. Each is addressed in a separate, tabbed section. The first page of each tabbed section outlines the function's procedures; this outline is followed by an illustration of the appropriate screen. Facing the screen is an overview of the function which provides access instructions, an outline of its purpose, and a brief description of the function. Then each procedure related to the function is explained in detail. Actions you take are signified by a bullet; those performed by AQCESS are enclosed in boxes.

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QUALITY ASSURANCE TRAINING AID

1.0

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QUALITY ASSURANCE TRAINING AID

1.0 INTRODUCTION

This section of the Admission and Disposition Training Aid provides an overview of AQCESS, its use, and its features. Sign-on procedures for the AQCESS tutorial, TUTOR ME, are included.

1.1 INTRODUCTION TO AQCESS

AQCESS, the Automated Quality of Care Evaluation Support System, is a computerized system intended to support quality of care and patient administration processing. This system has three basic objectives:

- To improve the quality and timeliness of the evaluation of health care;
- To support Patient Administration functions;
- To support Clinical Records processing.

AQCESS will make it easier for MTF personnel to keep and process accurate data, and make that data available to system users who need it. Specifically, AQCESS can help MTF personnel:

- Register, admit, and disposition patients;
- Keep track of patients' ward, clinical service, and physician assignments;
- Track patients who are absent from the MTF;

- o Complete the medical record and prepare monthly reports for submission to higher command;
- o Maintains ward status records to manage bed resources;
- o Produce forms and reports for individual patients and for the MTF as a whole;
- o Monitor quality of care indicators, and identify occurrences that could adversely affect the quality of health care;
- o Identify, document, and track quality of care problems;
- o Maintain provider profile and clinical indicator data.
- o Support Accounting Office administrative and reporting functions;
- o Calculate patient charges based on A&D data;
- o Support automated accounting with online payment posting and one-time charge posting;
- o Support recording of Dining Hall monies and reporting of Group Meal sales;
- o Automatically distribute payments to accounting funds and create cash collection vouchers;

- o Provide automated reporting necessary to manage the accounting function;

- o Provide outpatient clinics with a method of appointing an individual patient to a specific health care provider as opposed to a block-scheduled clinic;

- o Maintain a complete history of a patient's inpatient and outpatient care at the facility; and,

- o Create and maintain unique AQCESS reports.

AQCESS accomplishes its objectives through the following subsystems:

- o Admission and Disposition (A&D)
- o Clinical Records (CR)
- o Quality Assurance (QA)
- o System Management (SM)
- o Medical Services Accounting/Business Office (MSA/Business Office)
- o Appointing and Scheduling Module of the Outpatient Encounter subsystem (A&S)
- o Ad Hoc Report Generator (Ad Hoc).

Figure 1-1 shows the functions related to each AQCESS subsystem.

ADMISSION & DISPOSITION SUBSYSTEM
- Patient Identification (PTID)
- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

CLINICAL RECORDS SUBSYSTEM
- Clinical Records
- Clinical Records Reports

QUALITY ASSURANCE SUBSYSTEM
- Quality Assurance
- Profiling

SYSTEM MANAGEMENT SUBSYSTEM
- System Management

MEDICAL SERVICES ACCOUNTING SUBSYSTEM
- Cashier Processing
- Medical Services Accounting
- MSA/Business Office Reports

APPOINTING & SCHEDULING
- Appointing and Scheduling Module

AD HOC REPORT GENERATOR SUBSYSTEM

FIGURE 1-1 AQCESS SUBSYSTEMS AND FUNCTIONS

1.2 GUIDE TO AQCESS USE

AQCESS allows online entry, updating, or display of data using a computer terminal. It also provides for paper, or "hard," copy production of data in report format using a printer.

1.2.1 USE OF THE DEC TERMINAL AND PRINTER

A terminal is a tool you use consisting of a keyboard, which looks like a sophisticated typewriter keyboard, and a Cathode Ray Tube (CRT), which resembles a television screen. The particular terminal used for AQCESS is manufactured by Digital Equipment Corporation, so it is referred to as a DEC terminal. The DEC printer, a stand-alone unit, looks like a typewriter without keys. Together these pieces of equipment allow you to use AQCESS.

The **keyboard** is used to type, edit, and store data. In addition to the letter and number keys, this keyboard has other keys that you use to communicate with the computer about the data you type. Figure 1-2 summarizes the use of these keys. For more information, see TUTOR ME, Lesson 2.

The **CRT screen** allows you view data displayed by the system and to see data as you enter it in AQCESS.

The **printer** is used to produce hard copies of the data you see on the CRT screen or data generated by the system.

AQCESS can select and format data and print it in the form of reports for use in your MTF and for submission to higher command. This will eliminate the hours of work involved in manually preparing reports. And since production is faster, reports can be more timely and more useful to MTF staff.

Each terminal is set to default to a printer specified by the system manager. The default printer will print "hard" copies of the screens when you press the control key with P.

For each terminal, reports will be sent to print at a printer specified by the system manager.

Products such as admission forms and cards will also be set to print at a specific printer.

Your system manager is responsible for managing the system and setting up the printers.

Ask your supervisor or system manager to demonstrate how the printer is loaded with paper or forms and to indicate what other procedures are required for using this equipment.

Name & Symbol	Used With	When You Press this Key:
Return		Cursor moves from field to field. Used at the end of a screen, Return transmits the data entered to the system for storage.
Shift	Many Keys	The top character of a two-character key is entered, as on a standard typewriter.
Help		The screen displays information about the data field you are in, such as length, type, and format of the data you can enter. Also displays codes that can be entered in that field.
Explain Error		The screen displays a detailed explanation of the error message that is being displayed.
Back-up		Cursor moves back one field at a time. Cursor must be at the first character of the field when you press Back-up. This key doesn't work at the first field on the screen.
Entry Done		Cursor skips the remaining fields on the screen and moves to ENTER SELECTION at the bottom of the screen.

FIGURE 1-2 SPECIAL FUNCTION KEYS
(PAGE 1 of 2)

Name & Symbol	Used With	When You Press this Key:
ALL	Shift	Cursor moves from bottom of screen to the first accessible field on the screen; you can access any updateable field on the screen and enter data.
Delete DEL		Cursor backs up one space and deletes whichever letter occupied that space. Used to delete typographical errors that were just entered.
Clear Data	Shift	All the data entered in a field is erased. Cursor must be at the first character in a field when this key is pressed.
Cancel	Shift	The system abandons what you have been doing. No data entered immediately before cancelling is stored. You return to the previous processing function or screen.
CTRL	P	The screen being displayed is printed at the printer associated with your terminal.

FIGURE 1-2 SPECIAL FUNCTION KEYS
(PAGE 2 OF 2)

1.2.2 SYSTEM FEATURES

AQCESS enhances the information processing capabilities of your facility with clear, easy-to-use, automated procedures; editing mechanisms that help ensure the accuracy of entered data; and security features that protect the information contained in the system.

1.2.2.1 AQCESS SCREENS

Your CRT displays data in a predetermined format, called a screen. Areas of the screen where data can be typed or displayed are called fields. The cursor is a blinking rectangle that shows you where the first character of data will be entered.

AQCESS screens are designed consistently to facilitate entry of data. The name of the screen is displayed in the upper left corner; the current date and time is displayed in the upper right corner. Screen selections and options are separated from the screen's fields by a dotted line. Messages are displayed at the bottom of the screen.

There are two types of screens: menu screens and data entry screens. Menu screens list functions you can perform and allow you to choose a function by entering the letter or number representing it in a selection field.

Data entry screens are arrangements of fields in which you can enter data or where entered data is displayed. The lower portion of most data entry screens contains a sub-menu listing functions you can perform at this screen.

A screen segment is a group of related data fields that can replace part of a data entry screen. The area in which alternate screen segments can be displayed is called a screen window.

Some fields on screens are required, meaning that you must enter data in them. If data is not entered in a required field, an error message will be displayed. On the other hand, some fields cannot be used because they do not apply to your military department; you will not be able to access these fields.

Examples of AQCESS screens appear throughout this Training Aid, illustrating the Clinical Records functions.

1.2.2.2 ENTERING AND UPDATING AQCESS DATA

Usually, the first time you access a screen, the cursor will be positioned at the first field where you can enter data. You must begin your entry at the first character in the field.

You can update, or change data on a screen by typing over it. To move the cursor to a field you wish to update, you can (1) type the name of that field or part of the name at ENTER SELECTION and press Return. When you have entered the update, the cursor will return to ENTER SELECTION. Or (2) you can type ALL to go to each field on the screen. The cursor will return to ENTER SELECTION after the last field on the screen.

When you have finished an initial data entry or an update, the cursor is at ENTER SELECTION. To store the data you have just entered, press Return. No data is actually stored on the system until you do this.

1.2.2.3 SYSTEM EDITS

As you enter data, AQCESS edits, or checks, it protect the integrity of AQCESS data. There are three types of edits: validity, consistency, and final edits.

Validity edits are performed as you enter data in each field. These edits determine whether the data you enter fits the parameters set up for the individual field. For example, if you enter a date such as March 35th (where the date is greater than 31) or a Social Security Number such as 123-AB-4566 (where letters are included in a field that only allows numbers), validity edits will detect this as an error.

For some fields there is a list of codes that can be entered (this list is called a system table). Validity edits determine whether the code you entered exists in the table.

When you enter invalid data, a beep sounds and an error message, such as INVALID ENTRY, appears at the bottom of the screen along with a description of the kind of data or a list of codes that can be entered. The cursor goes to the beginning of the incorrect field, and you must enter valid data before you can go on. (You can press Return and that field will be redisplayed with the data it contained previously or it will be blank.)

Consistency edits are performed after you have completed data entry on an entire screen. Consistency edits check whether relationships between data entered in different fields are correct, since data entered in one field may be inconsistent with data entered in another field. For example, when you indicate in one field that a patient's status is active duty and in another field that the patient is 12 years old, a consistency edit detect this as an error.

When a consistency error is found, an error message is displayed and the cursor moves to the first field in the inconsistent relationship. If you press Return, the cursor will go to the next field involved in the error. You can change any of the fields involved. When the error is corrected, the cursor returns to ENTER SELECTION.

Usually you must correct a consistency error before you can go on. Occasionally you are given a warning of a condition that may or may not be inconsistent. Warning error messages are followed by the question, OVERRIDE? To override the message and indicate that this data is actually correct, enter Y.

The Clinical Records subsystem also performs edits on completed clinical records. These **final edits** check the CR data against the A&D data to verify that the information is correct. Errors are indicated on an error list. You must correct any errors either in A&D or CR before the record can be approved.

1.2.2.4 AQCESS SECURITY

Because AQCESS processes highly sensitive data on patient care, a number of provisions have been designed to protect the security of the data in the system. Among these features are user ID and password, time out, predesignated terminal capabilities, and secure reports.

Each user is assigned a private user ID and password, which are used to gain access to the system. Associated with each user ID and password are the system capabilities this user is authorized to perform.

Screens "time out," or are erased from the CRT, if no data is entered or no function key is pressed within a specified length of time. This prevents unattended terminals from being accessed by unauthorized personnel.

The capabilities that can be performed at each terminal are also designated.

Some reports are defined as "secure" reports and may only be printed on the primary printer for the report.

1.3 AQCESS TUTORIAL SIGN-ON PROCEDURE

The preceding sections of this Training Aid provide a general introduction and overview to AQCESS. This section serves to introduce you to the AQCESS tutorial, so you can use TUTOR ME and this Training Aid together to learn AQCESS.

Since you will be using the AQCESS on-line tutorial, TUTOR ME, as a first step in learning the system, you should know how to sign on to the tutorial. Look at the AQCESS terminal screen. You should see the words USER ID and below it, the word PASSWORD. You should also see a retangular blinking block by USER ID. This block is called the cursor and it shows you when you are on the screen. To sign on:

- Type the word TUTOR.
- Find the Return key on the keyboard and press it.
- Type the word ME.
- The screen should look like this:

```
USER ID TUTOR
PASSWORD ME
```

- Press Return.
- You are now signed on to the system in the AQCESS tutorial.

- Press Return again.
- You should see a list of the lessons provided in the AQCESS tutorial. These lessons are as follows:

  1. INTRODUCTION
  2. LEARNING YOUR KEYBOARD
  3. SCREEN PROCESSING
  4. DATA ENTRY AND EDITING
  5. DATA ENTRY SHORTCUTS
  6. SYSTEM FUNCTIONS

You will complete many of these lessons as part of your training program. To see the first tutorial, INTRODUCTION, find the number 1 on your keyboard and press it. Follow the instructions on the screen for completing the tutorial.

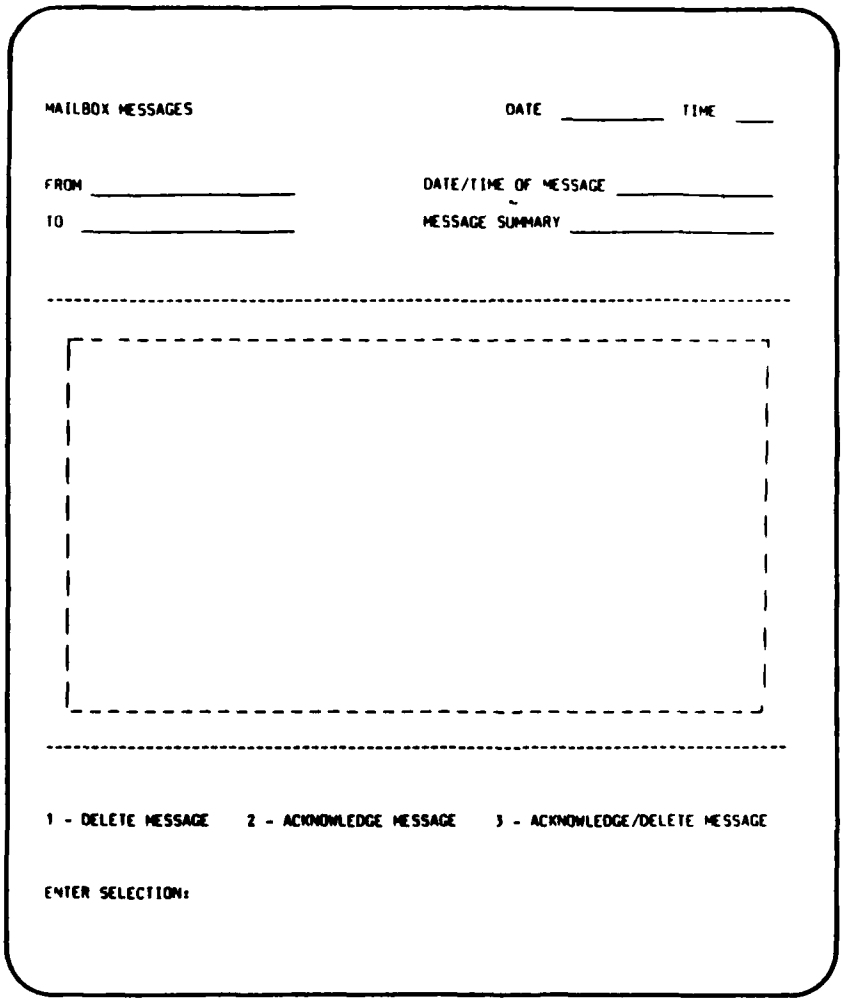


FIGURE 1.3 MAILBOX MESSAGE SCREEN

1.4 THE MAILBOX FUNCTION

ACCESS The Mailbox function is accessed by entering MX on the User Entry Menu.

PURPOSE The Mailbox function enables you to send 'mail' to other users. Messages can be viewed on the screen or printed on paper, acknowledged (returned to sender with or without notation), and deleted.

DESCRIPTION The Mailbox function is comprised of two screens: the Mailbox Message Screen and the Mailbox Candidate Message Screen. The Mailbox Message Screen is used to send, acknowledge, or delete a message. The Mailbox Candidate Message Screen is used to select a particular message from a group of messages for viewing.

OPTIONS On the Mailbox Message Screen:

1 - DELETE MESSAGE enables you to delete a message from your mailbox.

2 - ACKNOWLEDGE MESSAGE enables you to communicate to a sender that you have receive his or her message.

3 - ACKNOWLEDGE/DELETE MESSAGE enables you to acknowledge a message and to delete it from your mailbox.

On the Mailbox Candidate Message Screen:

S - SEND A MESSAGE enables you to send a new message. This option is used to access a blank Mailbox Message Screen.

1.4.1 TO SEND A MESSAGE

- Enter MX on the User Entry Menu Screen. Press Return.

The Mailbox Menu Screen is displayed. The FROM field defaults to your User ID. The DATE/TIME OF MESSAGE field defaults to the current date and time. The cursor is at the TO field.

- Enter the User ID of the individual who should receive your message. Press Return.

The cursor moves to MESSAGE SUMMARY.

- Enter a short description of the message. Press Return.

The cursor moves to the first character position of the message box.

- Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- o Press Return to send the message to the receiver.

The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.4.2 TO VIEW A MESSAGE

If you have a message in your mailbox, the system will display the following at the bottom of the User Entry Menu Screen: MAILBOX MESSAGES WAITING - ENTER MX FOR MAILBOX FUNCTION.

- Enter MX at ENTER SELECTION. Press Return.

The Mailbox Candidate Messages Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the number identifying the message you wish to view. Press Return.

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

Note: Only 10 messages can be listed on the Mailbox Candidate Messages Screen at one time. If you have accumulated 10 messages, the system will notallow you to

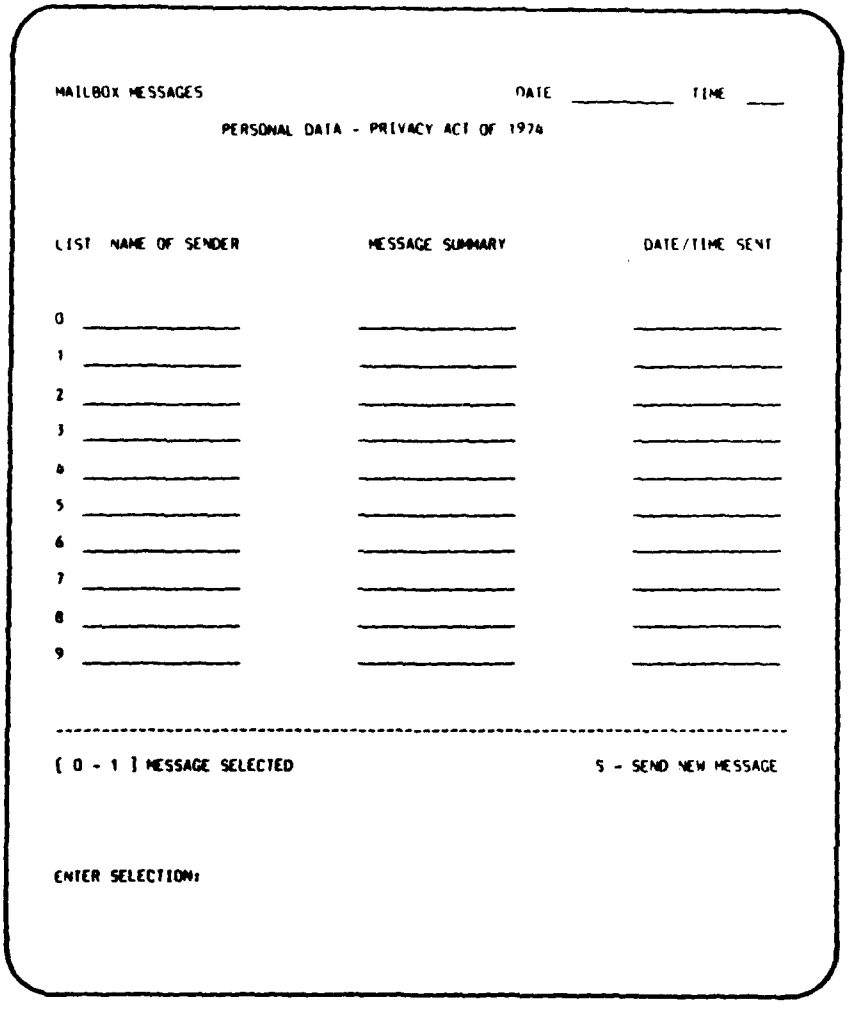
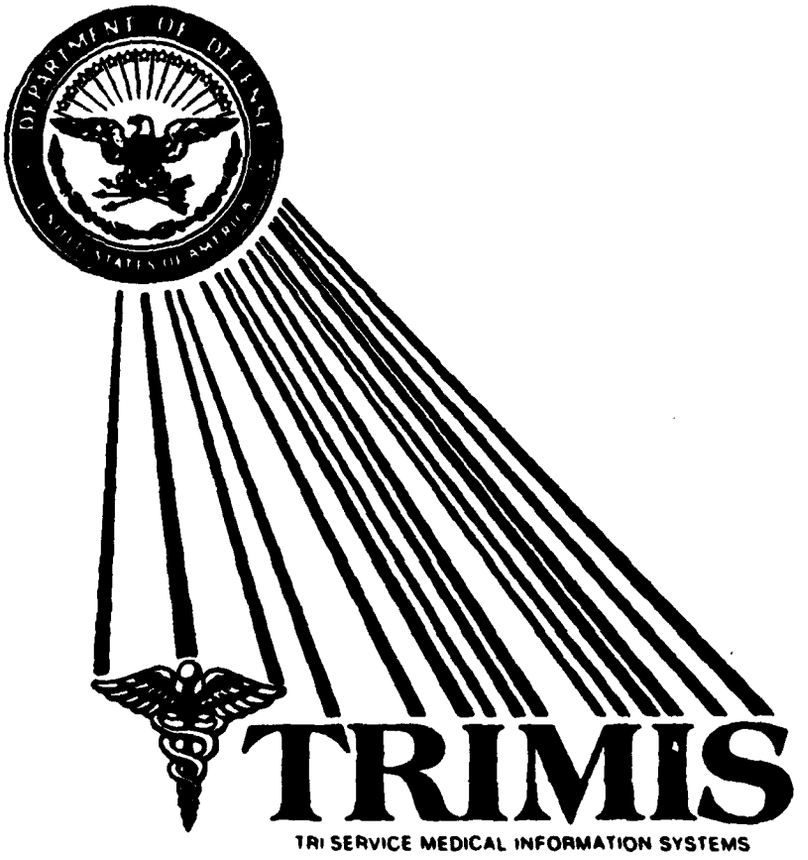


FIGURE 1.4 MAILBOX CANDIDATE MESSAGE SCREEN

AQCESS

ADMISSION & DISPOSITION TRAINING AID



AQCESS
QUALITY ASSURANCE TRAINING AID

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DOCUMENTATION CHANGE NOTICE

ORIGINATOR: NDC/FSI DATE: January 1987

DOCUMENT TITLE: AQCESS Admission & Disposition Training Aid

ISSUE NO.: 1

REVISION NO.: 2

THIS NOTICE INFORMS THE RECIPIENTS THAT THE DOCUMENT IDENTIFIED ABOVE HAS BEEN CHANGED. THE PAGES CHANGED BY THIS DCN ARE ATTACHED AND CARRY THE SAME DATE AS THIS DCN. THESE PAGES NEED TO BE INSERTED AND THE INDICATED PAGES REMOVED FROM YOUR DOCUMENT.

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v through viii	v and viii	X		
5-1 and 5-2	5-1 and 5-2	X		
5-17 through 5-24	5-17 through 5-24	X		
5-31 through 5-34	5-31 through 5-34	X		
6-5 and 6-6	6-5 and 6-6	X		
8-5 through 8-10	8-5 through 8-10	X		
11-1 and 11-2	11-1 and 11-2	X		
11-7 through 11-10	11-7 through 11-10	X		
12-15 and 12-16	12-15 and 12-16	X		

* R = REPLACES EARLIER PAGES A = ADDED D = DELETED

PREFACE

Designed for use at 168 DoD hospitals, the Automated Quality of Care Evaluation Support System (AQCESS) is an interactive, menu-driven patient administration and quality assurance computer system. The system is composed of four subsystems, three of which are functional (Admission and Disposition, Clinical Records, and Quality Assurance). These subsystems allow the entry, updating, and display of data, as well as the production of reports for MTF's and higher command. The fourth, System Management, is separate from the functional areas of AQCESS and allows regulation of AQCESS operations and security.

Accompanying installation of AQCESS at your hospital is a fully-developed AQCESS Training Program, which includes several components. These are designed to support you through the formal AQCESS training period and as you continue to learn how to use AQCESS to perform specific processing tasks.

Training Directory	The AQCESS training directory works exactly the same as the live system. You can sign on to the system using a Training User ID and password and perform all of the data entry and processing tasks that you will be performing in the live system. The training system is completely separate from the live hospital database.

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AQCESS Training Database	A training database can be loaded into the training directory by the system manager. This database contains sample patient data which can be used to practice the system's information processing capabilities.
TUTOR ME	An online tutorial that consists of lessons that describe the functions and features of AQCESS.
AQCESS User Manual	Appendixes provide detailed information about individual fields, screens, and reports for each subsystem.
AQCESS Training Aids	Provide a self-instructional tool for learning AQCESS. A separate Training Aid is available for each subsystem; each one includes detailed step-by-step procedures for use of the subsystem, "Points to Remember," that highlight key information, and "Checkpoints" that enable you to monitor your learning progress. The Training Aids' introductions are designed for use with TUTOR ME.
AQCESS Packets	Contains practice cases for you to learn the processing functions of the system. These are provided by your system manager.

AQCESS A&D Report Packet	Contains a paper or "hard" copy of reports that are generated by AQCESS.
Quick Guide	Provides a means to quickly reference AQCESS processing and data entry features.
AQCESS Trainer Guide	Provides instructions to the trainer for delivering user training. Incorporates the the packets and training database.

As an integral component of the AQCESS Training Program, this Training Aid is designed to provide you with general information about AQCESS and detailed procedures that address use of its Admission and Disposition subsystem.

Section 1 introduces AQCESS, its use, and its features while Section 2 provides an overview of Admission and Disposition processing.

Sections 3 through 12 present the Admission and Disposition functions. Each is addressed in a separate, tabbed section. The first page of each tabbed section outlines the function's procedures; this outline is followed by an illustration of the appropriate screen. Facing the screen is an overview of the function which provides access instructions, an outline of its purpose, and a brief description of the function. Then each procedure related to the function is explained in detail. Actions you take are signified by a bullet; those performed by AQCESS are enclosed in boxes.

"Points to Remember" (which list items of importance) and "Checkpoints" (which help you monitor your progress as you learn AQCESS) are included throughout the Training Aid.

To train yourself to use AQCESS, consult the Admission and Disposition, Clinical Records, and Quality Assurance Training Aids and the online tutorial, TUTOR ME. Use the procedure outlined in Section 1.4 to sign on to the tutorial. Perform the practice exercises provided in the associated AQCESS Packets (which are available from your system manager) and use the "Checkpoints" provided in each section of the Training Aids to monitor your learning progress. Repeat exercises and review procedures whenever you cannot answer a "Checkpoint" question readily.

ADMISSION AND DISPOSITION TRAINING AID

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ADMISSION AND DISPOSITION TRAINING AID

1.0 INTRODUCTION

This section of the Admission and Disposition Training Aid provides an overview of AQCESS, its use, and its features. Sign-on procedures for the AQCESS tutorial, TUTOR ME, are included.

1.1 INTRODUCTION TO AQCESS

AQCESS, the Automated Quality of Care Evaluation Support System, is a computerized system intended to support quality of care and patient administration processing. This system has three basic objectives:

- To improve the quality and timeliness of the evaluation of health care;
- To support Patient Administration functions;
- To support Clinical Records processing.

AQCESS will make it easier for MTF personnel to keep and process accurate data, and make that data available to system users who need it. Specifically, AQCESS can help MTF personnel:

- Register, admit, and disposition patients;
- Keep track of patients' ward, clinical service, and physician assignments;
- Track patients who are absent from the MTF;

- o Complete the medical record and prepare monthly reports for submission to higher command;
- o Maintains ward status records to manage bed resources;
- o Produce forms and reports for individual patients and for the MTF as a whole;
- o Monitor quality of care indicators, and identify occurrences that could adversely affect the quality of health care;
- o Identify, document, and track quality of care problems;
- o Maintain provider profile and clinical indicator data;
- o Support Accounting Office administrative and reporting functions;
- o Calculate patient charges based on A&D data;
- o Support automated accounting with online payment posting and one-time charge posting;
- o Support recording of Dining Hall monies and reporting of Group Meal sales;
- o Automatically distribute payments to accounting funds and create cash collection vouchers;

- o Provide automated reporting necessary to manage the accounting function;
- o Provide outpatient clinics with a method of appointing an individual patient to a specific health care provider as opposed to a block-scheduled clinic;
- o Maintain a complete history of a patient's inpatient and outpatient care at the facility; and,
- o Create and maintain unique AQCESS reports.

AQCESS accomplishes its objectives through seven subsystems:

- o Admission and Disposition (A&D)
- o Clinical Records (CR)
- o Quality Assurance (QA)
- o System Management (SM)
- o Medical Services Accounting (MSA/Business Office)
- o Appointing and Scheduling Module of the Outpatient Encounter Subsystem (A&S)
- o Ad Hoc Report Generator (Ad Hoc)

Figure 1-1 shows the functions related to each AQCESS subsystem.

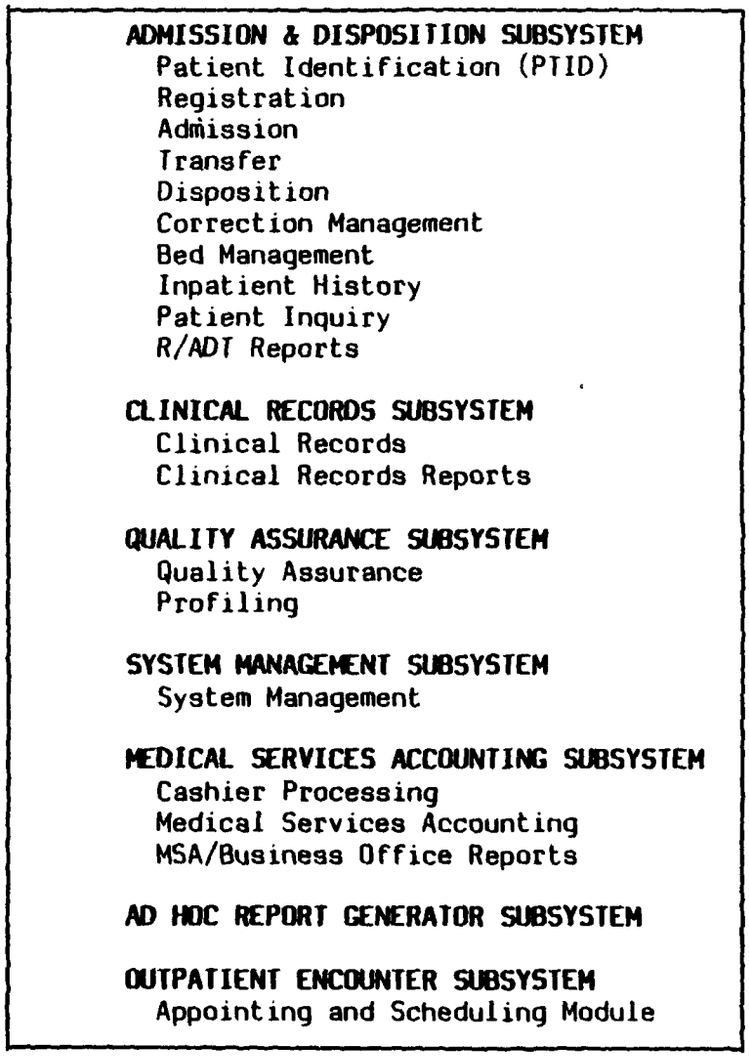


FIGURE 1-1 AQCESS SUBSYSTEMS AND FUNCTIONS

1.2 GUIDE TO AQCESS USE

AQCESS allows online entry, updating, or display of data using a computer terminal. It also provides for paper, or "hard," copy production of data in report format using a printer.

1.2.1 USE OF THE DEC TERMINAL AND PRINTER

A terminal is a tool you use consisting of a keyboard, which looks like a sophisticated typewriter keyboard, and a Cathode Ray Tube (CRT), which resembles a television screen. The particular terminal used for AQCESS is manufactured by Digital Equipment Corporation, so it is referred to as a DEC terminal. The DEC printer, a stand-alone unit, looks like a typewriter without keys. Together these pieces of equipment allow you to use AQCESS.

The **keyboard** is used to type, edit, and store data. In addition to the letter and number keys, this keyboard has other keys that you use to communicate with the computer about the data you type. Figure 1-2 summarizes the use of these keys. For more information, see TUTOR ME, Lesson 2.

The **CRT screen** allows you view data displayed by the system and to see data as you enter it in AQCESS.

The **printer** is used to produce hard copies of the data you see on the CRT screen or data generated by the system.

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AQCESS can select and format data and print it in the form of reports for use in your MTF and for submission to higher command. This will eliminate the hours of work involved in manually preparing reports. And since production is faster, reports can be more timely and more useful to MTF staff.

Each terminal is set to default to a printer specified by the system manager. The default printer will print "hard" copies of the screens when you press the control key with P.

For each terminal, reports will be sent to print at a printer specified by the system manager.

Products such as admission forms and cards will also be set to print at a specific printer.

Your system manager is responsible for managing the system and setting up the printers.

Ask your supervisor or system manager to demonstrate how the printer is loaded with paper or forms and to indicate what other procedures are required for using this equipment.

Name & Symbol	Used With	When You Press this Key:
Return		Cursor moves from field to field. Used at the end of a screen, Return transmits the data entered to the system for storage.
Shift	Many Keys	The top character of a two-character key is entered, as on a standard typewriter.
Help		The screen displays information about the data field you are in, such as length, type, and format of the data you can enter. Also displays codes that can be entered in that field.
Explain Error		The screen displays a detailed explanation of the error message that is being displayed.
Back-up		Cursor moves back one field at a time. Cursor must be at the first character of the field when you press Back-up. This key doesn't work at the first field on the screen.
Entry Done		Cursor skips the remaining fields on the screen and moves to ENTER SELECTION at the bottom of the screen.

FIGURE 1-2 SPECIAL FUNCTION KEYS (PAGE 1 of 2)

Name & Symbol	Used With	When You Press this Key:
ALL	Shift	Cursor moves from bottom of screen to the first accessible field on the screen; you can access any updateable field on the screen and enter data.
Delete DEL		Cursor backs up one space and deletes whichever letter occupied that space. Used to delete typographical errors that were just entered.
Clear Data	Shift	All the data entered in a field is erased. Cursor must be at the first character in a field when this key is pressed.
Cancel	Shift	The system abandons what you have been doing. No data entered immediately before cancelling is stored. You return to the previous processing function or screen.
CTRL	P	The screen being displayed is printed at the printer associated with your terminal.

FIGURE 1-2 SPECIAL FUNCTION KEYS
(PAGE 2 OF 2)

1.2.2 SYSTEM FEATURES

AQCESS enhances the information processing capabilities of your facility with clear, easy-to-use, automated procedures; editing mechanisms that help ensure the accuracy of entered data; and security features that protect the information contained in the system.

1.2.2.1 AQCESS SCREENS

Your CRT displays data in a predetermined format, called a screen. Areas of the screen where data can be typed or displayed are called fields. The cursor is a blinking rectangle that shows you where the first character of data will be entered.

AQCESS screens are designed consistently to facilitate entry of data. The name of the screen is displayed in the upper left corner; the current date and time is displayed in the upper right corner. Screen selections and options are separated from the screen's fields by a dotted line. Messages are displayed at the bottom of the screen.

There are two types of screens: menu screens and data entry screens. Menu screens list functions you can perform and allow you to choose a function by entering the letter or number representing it in a selection field.

Data entry screens are arrangements of fields in which you can enter data or where entered data is displayed. The lower portion of most data entry screens contains a sub-menu listing functions you can perform at this screen.

A screen segment is a group of related data fields that can replace part of a data entry screen. The area in which alternate screen segments can be displayed is called a screen window.

Some fields on screens are required, meaning that you must enter data in them. If data is not entered in a required field, an error message will be displayed. On the other hand, some fields cannot be used because they do not apply to your military department; you will not be able to access these fields.

Examples of AQCESS screens appear throughout this Training Aid, illustrating the Clinical Records functions.

1.2.2.2 ENTERING AND UPDATING AQCESS DATA

Usually, the first time you access a screen, the cursor will be positioned at the first field where you can enter data. You must begin your entry at the first character in the field.

You can update, or change data on a screen by typing over it. To move the cursor to a field you wish to update, you can (1) type the name of that field or part of the name at ENTER SELECTION and press Return. When you have entered the update, the cursor will return to ENTER SELECTION. Or (2) you can type ALL to go to each field on the screen. The cursor will return to ENTER SELECTION after the last field on the screen.

When you have finished an initial data entry or an update, the cursor is at ENTER SELECTION. To store the data you have just entered, press Return. No data is actually stored on the system until you do this.

1.2.2.3 SYSTEM EDITS

As you enter data, AQCESS edits, or checks, it protect the integrity of AQCESS data. There are three types of edits: validity, consistency, and final edits.

Validity edits are performed as you enter data in each field. These edits determine whether the data you enter fits the parameters set up for the individual field. For example, if you enter a date such as March 35th (where the date is greater than 31) or a Social Security Number such as 123-AB-4566 (where letters are included in a field that only allows numbers), validity edits will detect this as an error.

For some fields there is a list of codes that can be entered (this list is called a system table). Validity edits determine whether the code you entered exists in the table.

When you enter invalid data, a beep sounds and an error message, such as INVALID ENTRY, appears at the bottom of the screen along with a description of the kind of data or a list of codes that can be entered. The cursor goes to the beginning of the incorrect field, and you must enter valid data before you can go on. (You can press Return and that field will be redisplayed with the data it contained previously or it will be blank.)

Consistency edits are performed after you have completed data entry on an entire screen. Consistency edits check whether relationships between data entered in different fields are correct, since data entered in one field may be inconsistent with data entered in another field. For example, when you indicate in one field that a patient's status is active duty and in another field that the patient is 12 years old, a consistency edit detect this as an error.

When a consistency error is found, an error message is displayed and the cursor moves to the first field in the inconsistent relationship. If you press Return, the cursor will go to the next field involved in the error. You can change any of the fields involved. When the error is corrected, the cursor returns to ENTER SELECTION.

Usually you must correct a consistency error before you can go on. Occasionally you are given a warning of a condition that may or may not be inconsistent. Warning error messages are followed by the question, OVERRIDE? To override the message and indicate that this data is actually correct, enter Y.

The Clinical Records subsystem also performs edits on completed clinical records. These **final edits** check the CR data against the A&D data to verify that the information is correct. Errors are indicated on an error list. You must correct any errors either in A&D or CR before the record can be approved.

1.2.2.4 AQCESS SECURITY

Because AQCESS processes highly sensitive data on patient care, a number of provisions have been designed to protect the security of the data in the system. Among these features are user ID and password, time out, predesignated terminal capabilities, and secure reports.

Each user is assigned a private user ID and password, which are used to gain access to the system. Associated with each user ID and password are the system capabilities this user is authorized to perform.

Screens "time out," or are erased from the CRT, if no data is entered or no function key is pressed within a specified length of time. This prevents unattended terminals from being accessed by unauthorized personnel.

The capabilities that can be performed at each terminal are also designated.

Some reports are defined as "secure" reports and may only be printed on the primary printer for the report.

1.3 AQCESS TUTORIAL SIGN-ON PROCEDURE

The preceding sections of this Training Aid provide a general introduction and overview to AQCESS. This section serves to introduce you to the AQCESS tutorial, so you can use TUTOR ME and this Training Aid together to learn AQCESS.

Since you will be using the AQCESS on-line tutorial, TUTOR ME, as a first step in learning the system, you should know how to sign on to the tutorial. Look at the AQCESS terminal screen. You should see the words USER ID and below it, the word PASSWORD. You should also see a retangular blinking block by USER ID. This block is called the cursor and it shows you when you are on the screen. To sign on:

- Type the word TUTOR.
- Find the Return key on the keyboard and press it.
- Type the word ME.
- The screen should look like this:

```
USER ID TUTOR
PASSWORD ME
```

- Press Return.
- You are now signed on to the system in the AQCESS tutorial.

- Press Return again.

- You should see a list of the lessons provided in the AQCESS tutorial. These lessons are as follows:

  1. INTRODUCTION

  2. LEARNING YOUR KEYBOARD

  3. SCREEN PROCESSING

  4. DATA ENTRY AND EDITING

  5. DATA ENTRY SHORTCUTS

  6. SYSTEM FUNCTIONS

You will complete many of these lessons as part of your training program. To see the first tutorial, INTRODUCTION, find the number 1 on your keyboard and press it. Follow the instructions on the screen for completing the tutorial.

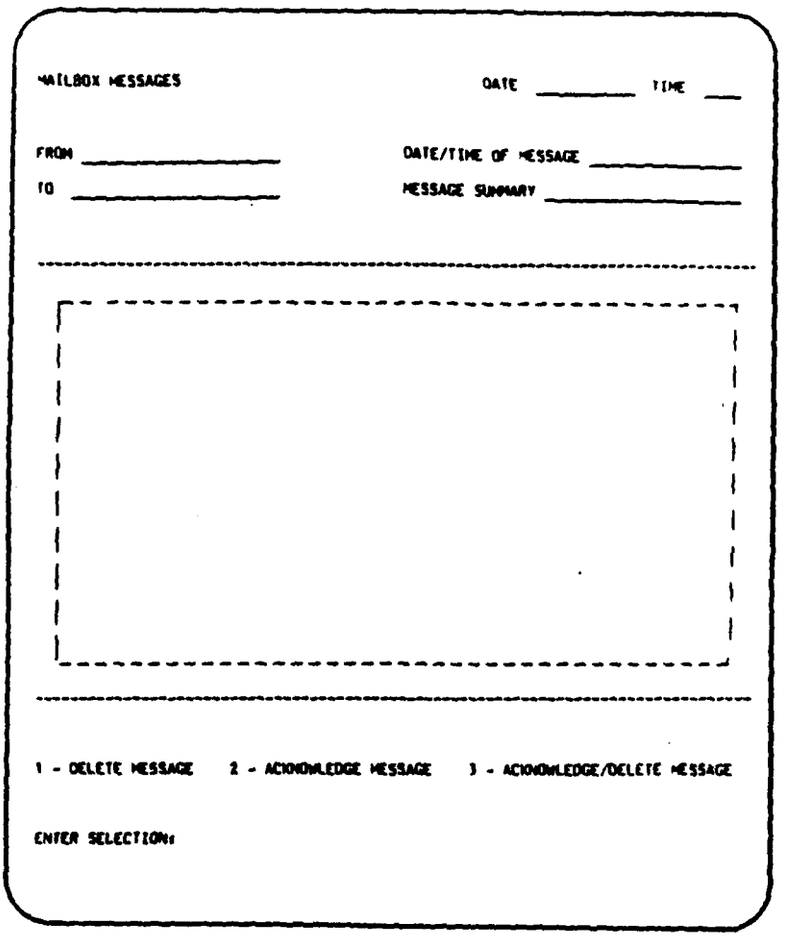


FIGURE 1.3 MAILBOX MESSAGE SCREEN

1.4 THE MAILBOX FUNCTION

ACCESS The Mailbox function is accessed by entering MX on the User Entry Menu.

PURPOSE The Mailbox function enables you to send 'mail' to other users. Messages can be viewed on the screen or printed on paper, acknowledged (returned to sender with or without notation), and deleted.

DESCRIPTION The Mailbox function is comprised of two screens: the Mailbox Message Screen and the Mailbox Candidate Message Screen. The Mailbox Message Screen is used to send, acknowledge, or delete a message. The Mailbox Candidate Message Screen is used to select a particular message from a group of messages for viewing.

OPTIONS On the Mailbox Message Screen:

1 - DELETE MESSAGE enables you to delete a message from your mailbox.

2 - ACKNOWLEDGE MESSAGE enables you to communicate to a sender that you have receive his or her message.

3 - ACKNOWLEDGE/DELETE MESSAGE enables you to acknowledge a message and to delete it from your mailbox.

On the Mailbox Candidate Message Screen:

S - SEND A MESSAGE enables you to send a new message. This option is used to access a blank Mailbox Message Screen.

1.4.1 TO SEND A MESSAGE

- Enter MX on the User Entry Menu Screen. Press Return.

The Maibox Menu Screen is displayed. The FROM field defaults to your User ID. The DATE/TIME OF MESSAGE field defaults to the current date and time. The cursor is at the TO field.

- Enter the User ID of the individual who should receive your message. Press Return.

The cursor moves to MESSAGE SUMMARY.

- Enter a short description of the message. Press Return.

The cursor moves to the first character position of the message box.

- Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- o Press Return to send the message to the receiver.

The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.4.2 TO VIEW A MESSAGE

If you have a message in your mailbox, the system will display the following at the bottom of the User Entry Menu Screen: MAILBOX MESSAGES WAITING - ENTER MX FOR MAILBOX FUNCTION.

- Enter MX at ENTER SELECTION. Press Return.

The Mailbox Candidate Messages Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the number identifying the message you wish to view. Press Return.

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

Note: Only 10 messages can be listed on the Mailbox Candidate Messages Screen at one time. If you have accumulated 10 messages, the system will notallow you to

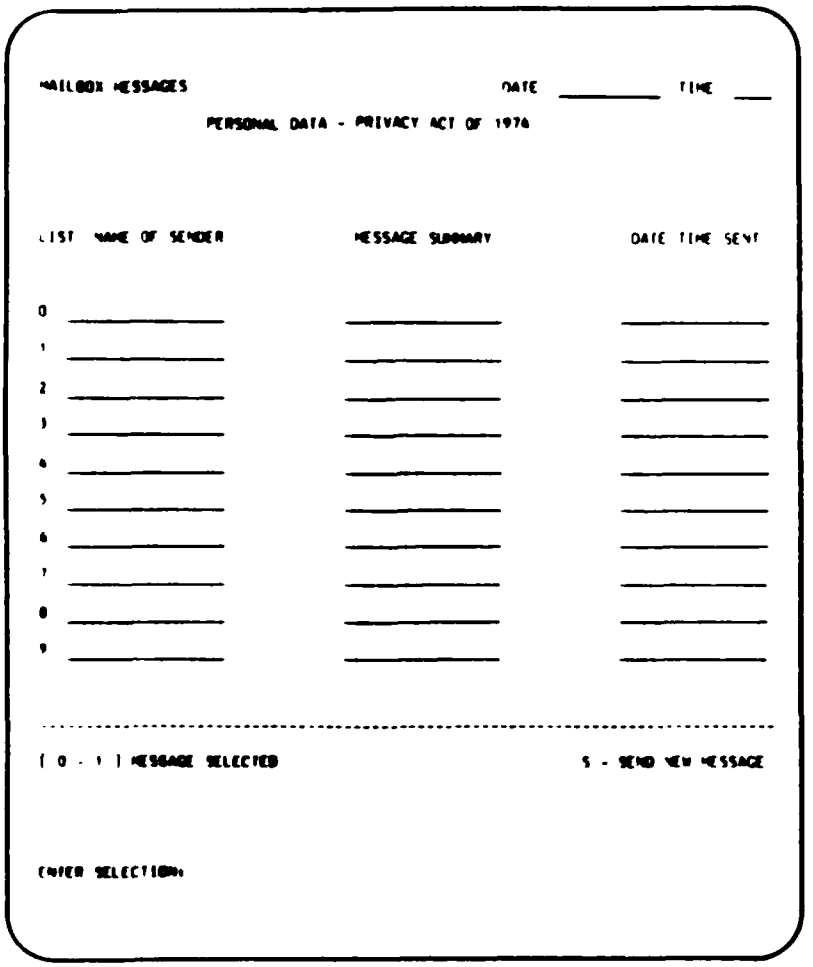


FIGURE 1.4 MAILBOX CANDIDATE MESSAGE SCREEN

send mail. You must delete stored messages to reinstate the capability. Messages which you wish to save can be printed using the CTRL P function at ENTER SELECTION.

To delete a message:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 1 at ENTER SELECTION. Press Return.

The message is deleted. The User Entry Menu is displayed.

To acknowledge a message:

1. If you wish to send an acknowledgment message back to the sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter ALL. Press Return.

The cursor moves to the TO field.

- o Press Return until you move the cursor into the message box. Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- o Enter 2 at ENTER SELECTION. Press Return.

Note: *If you wish to acknowledge* the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send the acknowledgement message to the sender. The User Entry Menu screen is displayed. The cursor is at ENTER SELECTION.

2. If you wish to acknowledge receipt of a message but you do not want to send a new message back to the original sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- Enter 2 at ENTER SELECTION. Press Return.

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send an acknowledgement to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.5 GLOSSARY OF TERMS

A&D	Admission and Disposition. The AQCESS subsystem that processes patient administration information.
Ad Hoc	Ad Hoc Report Generator. The AQCESS subsystem that allows users to create MTF-specific AQCESS reports.
A&S	Appointing and Scheduling. The module of the Outpatient Encounter subsystem of AQCESS that processes outpatient booking information.
AQCESS	Automated Quality of Care Evaluation Support System.
Character	Any letter, number, symbol, or space in a field.
CR	Clinical Records. The AQCESS subsystem that processes clinical records information.
Codes	Characters which are abbreviations for words. For example, "S" might designate marital status of single.
Computer	A device capable of accepting data (input), applying prescribed processes (program) to the data, and supplying the results of these processes as meaningful information (output).

Computer Hardware	A computer's mechanical, magnetic, electronics, and electrical equipment.
Computer Terminal	The device with which data is input or output. It consists of a keyboard and Cathode Ray Tube (CRT).
CRT	Cathode Ray Tube. The screen or display unit on a computer terminal which resembles a television.
Cursor	The blinking rectangle used on the CRT screen to mark the current position on the screen where data can be entered or a selection made.
Data	A collection of facts or figures.
Database	A collection of data.
Data entry screen	A screen on which data is input.
DEERS	Defense Enrollment Eligibility Reporting System. A system that Patient Administration systems can interface with to get information about an individual's eligibility for care.
Default	A selection made automatically by the system when no explicit choice is specified by the user.

DoD	Department of Defense.
Down	The condition in which the computer is not operational.
Edit	Computer activities that check input for validity and consistency.
Enter	The process by which information is transmitted to the computer through a terminal.
Field	The various areas of the screen that always contain the same type of information (e.g., the NAME field.)
Input	The transfer of data into the computer. The data to be processed.
Keyboard	The rows of keys attached to the CRT, used to communicate data to the computer.
Label	The pieces of information on a screen that identify the data to be entered in a field.
Menu Screen	A screen which allows you to select from a list of processing options.
MTF	Medical Treatment Facility; a military hospital.

MSA	Medical Service Accounting. The AQCESS subsystem that automates the accounting process.
Numeric	Pertaining to a character set that contains numbers only.
On-line	The state in which a terminal can be used to send information to or receive information from the computer.
Output	Information produced by a computer in a readable form such as a printed report or information on a display screen.
Password	A confidential code that allows access to the computer system. Passwords are part of a security system that allows only authorized personnel access to the system.
Printer	The equipment used to print messages, forms, labels, and reports.
QA	Quality Assurance. The AQCESS subsystem that processes quality assurance information.
Required field	A field on a screen where data must be entered.
Screen	The display surface of a terminal or the information on the terminal.

Sign-on	The identification process that a user performs to begin work with a computer system. In AQCESS, sign-on consists of a user ID and a password. These are assigned by the system manager.
Software	A set of computer programs, procedures, rules, and documentation recorded in the computer's memory that operates and directs the use of the computer hardware.
Submenu	A menu found on the bottom of a data entry screen that lists the other options for that screen.
Up	The condition in which the computer is operational.
Update	Changing data after it is stored in the system.
User	One who uses the computer system on a day-to-day basis.

1.6 CHECKPOINT

Your reading of Section 1, Introduction, provides a basic understanding of AQCESS. Use the questions listed below to check your progress. If you cannot readily answer a question, review the pertinent subsection. Verify your answers by checking those shown on the next page.

1. List the seven subsystems that process AQCESS information.

   _____

   _____

   _____

2. Generally describe the kind of information that is processed by these subsystems.

   _____

   _____

   _____

3. How does AQCESS use menu and data entry screens to help you organize information that is to be entered?

   _____

   _____

   _____

4. How do you get data in AQCESS?

_____

_____

_____

5. How does AQCESS ensure that entered data is accurate and sensible?

_____

_____

_____

6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

	Action	Keys
____	You want to know the valid entries for a field.	a. Clear Data b. Delete c. Entry Done d. Return e. Explain Error f. Help
____	You want to delete information from a field in which it has been stored.	
____	You made a typo and want to correct it.	
____	You have finished all required entries on a screen and want to store the information.	
____	You need additional information to correct an error condition.	

CHECKPOINT ANSWERS

1. List the seven subsystems that process AQCESS information.

   Admission & Disposition, Quality Assurance, Clinical Records, System Management, Medical Service Accounting, The Appointing and Scheduling Module of the Outpatient Encounter Subsystem, and the Ad Hoc Report Generator.

2. Generally describe the kind of information that is processed by these subsystems.

   patient registration, admission, disposition info; quality of care info; provider profile and performance; resource use.

3. How does AQCESS help you organize information that is to be input?

   Menu screens enable you to choose a particular processing function. Data entry screens and related screen segments collect information for that function in a sequence that is logical and that facilitates information storage and reporting.

4. How does AQCESS acquire its information?

   Information is input into a computer terminal.

5. How does AQCESS ensure that its information is accurate and sensible?

Validity edits check data as it is input. You are notified of an invalid entry by a beep and a message that describe the error condition. Consistency edits check to see that the relationships between data entered in different fields is valid. If an entry in one field is incompatible with an entry in another field, an error message is displayed.

6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

	Action	Keys
f	You want to know the valid entries for a field.	a. Clear Data b. Delete c. Entry Done d. Return e. Explain Error f. Help
a	You want to delete infomation from a field in which it has been stored.	
b	You made a typo and want to correct it.	
d	You have finished all required entries on a screen and want to store the information.	
e	You need additional information to correct an error condition.	

ADMISSION AND DISPOSITION TRAINING AID

2. ADMISSION AND DISPOSITION OVERVIEW

This section provides you with a summary of Admission and Disposition Processing and instructions for accessing this function.

2.1 ADMISSION AND DISPOSITION PROCESSING

The Admission and Disposition processes include a number of functions related to patient record-keeping. You will be able to:

- Enter (or update) demographic information on a patient, so the patient can be registered.
- Enter (or update) information on a patient's admission to the MTF.
- Enter (or update) information on why and how a patient leaves the MTF, so the patient can be dispositioned.
- Enter (or update) information documenting a patient's transfer among wards, beds, providers, clinical services, and changes in status during a hospital episode in the MTF.
- Enter (or update) the status of a patient's medical problems.

- o View information on a patient's current or previous inpatient episodes at your MTF.

- o Generate reports related to Admission and Disposition processes.

- o Correct data entry errors.

- o Define new wards, and view and update information on bed availability in each ward.

2.2 ACCESSING ADMISSION AND DISPOSITION

The User Entry Menu provides access to all the Admission and Disposition processes.

R - Registration Processing
A - Admission Processing
D - Disposition Processing
T - Transfer Processing
1 - R/ADT Reports
H - Inpatient History
I - Patient Inquiry
B - Bed Management Processing
E - Correction Management

The cursor will always be at ENTER FUNCTION on the User Entry Menu Screen. Enter the letter of the process you wish to access, then press Return.

SECTION 3. PATIENT IDENTIFICATION (PTID)

PROCEDURE		PAGE
3.1	To Create a New Record	3-5
3.2	To Locate an Existing Record	3-8
3.2.1	To Locate a Record by Register Number	3-9
3.2.2	To Locate a Record by SSN/FMP	3-10
3.2.3	To Locate a Patient Record by SSN	3-11
3.2.4	To Perform a Name Search for an Existing Record	3-12
3.3	Points to Remember	3-14
3.4	Checkpoint	3-16

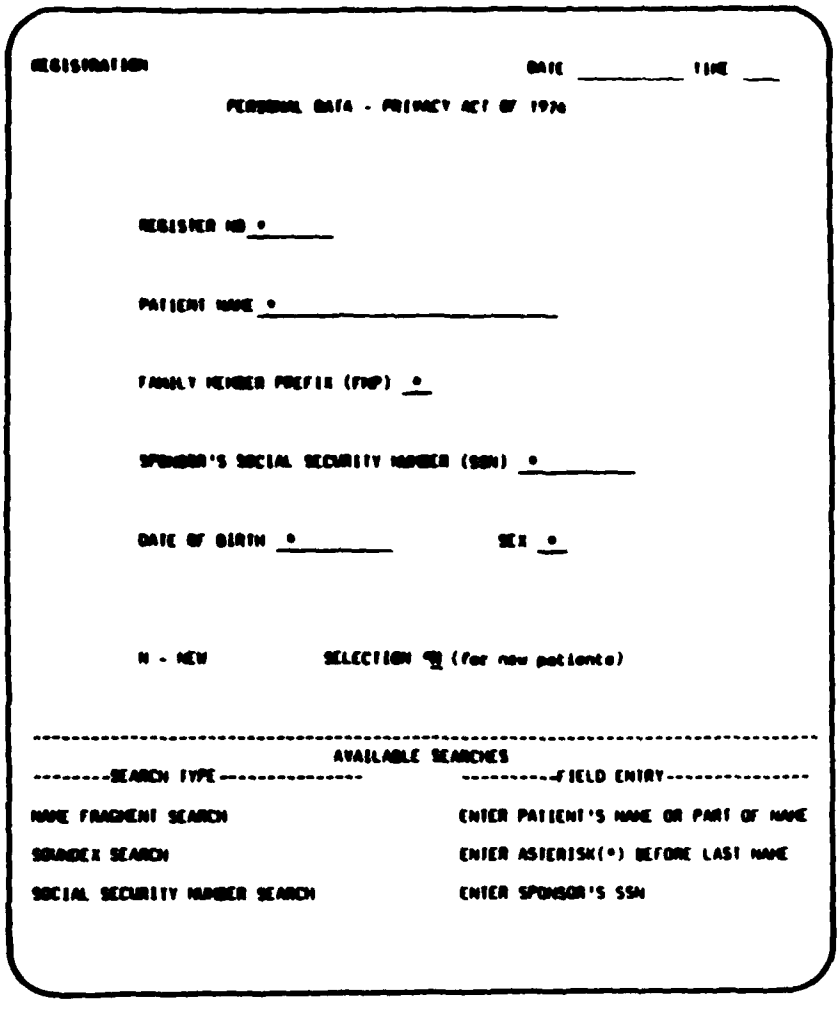


FIGURE 3.1 THE PATIENT IDENTIFICATION (PTID) SCREEN

3. THE PATIENT IDENTIFICATION (PTID) SCREEN

ACCESS The PTID Screen is displayed when you select any of the following functions from the User Entry Menu:

R - Registration Processing
A - Admission Processing
D - Disposition Processing
T - Transfer Processing
H - Inpatient History

PURPOSE The PTID Screen enables you to begin creation of a new patient record in Registration and Admission, or to locate an existing record by REG NO, SSN/FMP, or NAME search.

DESCRIPTION PTID collects data items that identify a patient: register number, patient name, family member prefix (FMP), sponsor's social security number (SSN), patient's date of birth (DOB), and patient's sex.

To create a record for a new patient, enter all of this information with the exception of the REG NO, which is generated by the system or manually assigned when the patient is admitted.

To locate an existing record for a patient, enter the register number or the SSN and FMP together.

If you do not have the information to locate a patient by register number or SSN/FMP, it is possible to search the data base by patient name. The system will locate all of the patients with the same name or beginning with the letters entered. These names are displayed on a candidate list from which the patient is selected.

OPTIONS

There are two options on the PTID Screen. Enter N at SELECTION to indicate that the patient is new. This will set up a new patient record. Or simply press Return which causes the system to locate an existing record.

3.1 TO CREATE A NEW RECORD

- Enter A on the User Entry Menu Screen, then press Return.

The PTID Screen is displayed. The cursor is in the REGISTER NO field.

Note: If this is a new patient you do not enter a REG NO.

- Press Return to move to the next field: NAME.

- Enter the patient's last name, comma, first name followed by a space, and middle initial. Press Return.

The cursor moves to the next field: FAMILY MEMBER PREFIX (FMP).

- Enter the FMP code for the new patient.

The cursor moves automatically to the next field: SPONSOR'S SOCIAL SECURITY NUMBER (SSN).

- Enter the sponsor's SSN. (Spaces or hyphens are not required but may be entered.) Press Return.

The SSN is redisplayed with hyphens. The cursor moves to the next field: DATE OF BIRTH.

- Enter the patient's date of birth and Return.

The date of birth is redisplayed (as in 05 JAN 1953). The cursor moves to the next field: SEX.

- Enter the sex code for the patient.

The cursor moves to SELECTION.

- Enter N for "new" to begin the new patient record, and press Return.

At this point, AQCESS checks whether any similar records already exist. Three situations are possible:

A record may already exist for this patient.

If a record already exists on a patient with the same FMP and SSN, a Candidate List Screen appears listing this person.

- You must either select this record from the Candidate List or go back and change the PTID data you just entered.

A similar record may already exist.

If a record already exists on a person with the same last name, same first four letters of the first name, same SSN, and a different FMP, a Candidate List Screen will appear listing this person.

- You can check the Candidate List data to see if this is really the same patient you just entered PTID data for.

- If they appear to be the same, you can access the existing record through the Candidate List Screen.

- If you can tell that the patient on the Candidate List is not the same as the one you just entered, you can type R at ENTER SELECTION to continue registering your new patient. The Registration Screen will be displayed.

No identical or similar records already exist.

The Primary Registration Screen is displayed. If the patient is a dependent of a registered sponsor, the sponsor's information is displayed by the system. The cursor is at PATIENT: ADDRESS.

- Complete the Registration screen as outlined in the Registration section of this manual.

3.2 TO LOCATE AN EXISTING RECORD

Note: To locate an existing patient record using the PIID Screen, you must enter the data that identifies a single record to the system, i.e., REG NO or SSN with the correct FMP.

- o Enter a letter on the User Entry Menu to identify the AQCESS process you wish to use.

The PTID Screen is displayed so that the patient's record can be identified.

- o Enter identifying data: REG NO, SSN, FMP, and Name or partial name. (See following procedures.)

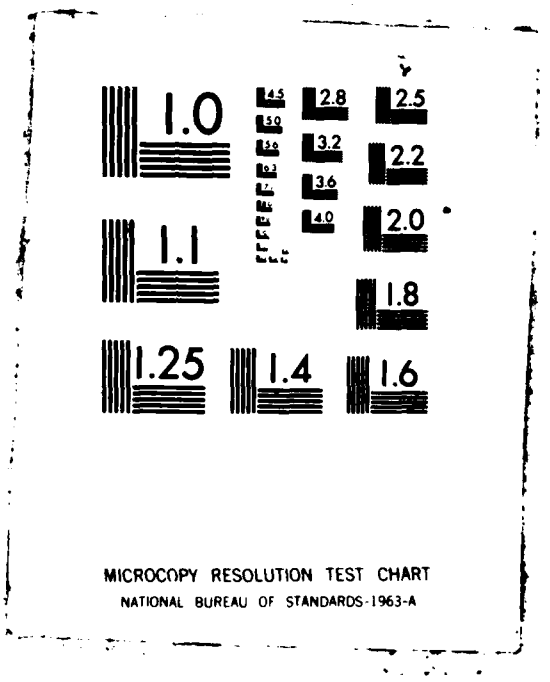
3.2.1 TO LOCATE A RECORD BY REG NO

- o If you know the patient's register number, enter it at REG NO on the PTID Screen and Return once.

- o Press the ENTRY DONE key to move the cursor to SELECTION.

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3.2
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4.0
4.5
5.0
5.6
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

The cursor moves to SELECTION.

- Press Return (without typing N) to search for the patient's record.

The screen displayed contains data on this patient. Which screen is displayed depends on the function you selected from the User Entry Menu. A DEERS eligibility check will be initiated if Registration or Admission Processing was selected.

- Press the Cancel key to get back to the PTID Screen.

3.2.2 TO LOCATE A RECORD BY SSN/FMP

- If you do not know the patient's REG NO, press Return twice.

The cursor moves to FMP.

- Enter the patient's FMP. The cursor automatically moves to SSN. Type in the sponsor's SSN and press Return.

- Press the Entry Done key to move the cursor to SELECTION. (Do not type N.)

- Press Return to search.

The system locates the patient's record by the sponsor's SSN and then the FMP. The next screen displayed will contain data on that patient. The specific screen displayed depends on the function you selected from the User Entry Menu. A DEERS eligibility check has been initiated.

- Press the Cancel key to return to the PTID Screen.

3.2.3 TO LOCATE A PATIENT RECORD BY SSN

- On the PTID Screen, enter the sponsor's SSN and press Return once.

- Press the Entry Done key to move the cursor to SELECTION.

- Press Return at SELECTION to search.

The Candidate List Screen is displayed. The system locates all records with the specified SSN, i.e., all family members. The cursor is at ENTER SELECTION.

- o Select the number corresponding to the family member whose record you wish to process and press Return. The cursor is at ENTER SELECTION. A DEERS eligibility check will be initiated when the patient is selected.

- o To exit the screen without selecting a record, press Return.

3.2.4 TO PERFORM A SEARCH FOR AN EXISTING RECORD

- o On the PTID Screen, press Return at REG NO to move the cursor to the PATIENT NAME field and enter the patient's name or partial name. Press Return.

Note: Entering the patient's last name or partial last name and the first letter of the first name will cause the system to locate all of the patients with matching characters in the last name and the same first letter of the first name.

- Press the Entry Done key to move the cursor to SELECTION.

The cursor moves to SELECTION.

- Press Return to search.

The Candidate List Screen is displayed. All patients having names that match the criteria you entered will be displayed. The cursor is at ENTER SELECTION.

Note: You can enter an FMP, partial DOB, and sex as search criteria to limit the number of candidates listed on the Candidate List.

Note: If you enter the sponsor's SSN in addition to the last name, the Candidate List Screen will display only the sponsor with that SSN and all the sponsor's family members.

- Enter N to view each page of the Candidate List.

- o Enter the number to the left of the name of the patient whose record you wish to process and press Return.

The next screen will contain data on this patient. The screen depends on the function selected from the User Entry Menu. The cursor is at ENTER SELECTION.

3.3 POINTS TO REMEMBER

1. You can locate a patient's record directly by REG NO, or by sponsor SSN and the patient's FMP.

2. You can search for a record by entering the patient's partial name or SSN. Type * before the name if you don't have the correct spelling. You can restrict all searches by entering additional search criteria.

3. The patient is assigned a REG NO only after admission is complete and the patient's registration and admission information has been entered and stored.

4. When creating a record for a new patient, complete the PTID Screen to identify the patient. If a patient is already registered with the same name, SSN, and FMP, you must either select that patient or change the PTID data you just entered. If a very similar record already exists (see Section 3.1), it will appear on the Candidate List. Check the list to be certain the new patient is not listed. If the patient whose information you entered is on the Candidate List, select that patient by number.

   If the patient is not duplicated on the list, enter R to continue the new registration.

5. You cannot update information using the PTID Screen. To correct PTID information, use the Registration Screen described in the next section.

6. Patient identification information entered on the PTID Screen is not stored until registration is complete. Therefore, if you cancel out of the Registration Screen before completing the information and storing it, no patient record will exist.

7. The PTID Screen is used to create patient records or locate existing records. For new records, the Registration Screen follows the PTID Screen. If you're accessing an existing record, the screen you see next will depend on which function you've selected from the User Entry Menu. For example, the Primary Admission Screen follows the PTID Screen in Admission processing.

8. A DEERS eligibility check is initiated when a specific patient is selected. The search criteria DEERS uses to check eligibility include the sponsor's SSN, the patient's DOB, and the FMP. For more information on the DEERS eligibility check, see Section 4.1.1.

3.4 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

SECTION 4. REGISTRATION

PROCEDURE		PAGE
4.1	To Register a New Patient.....	4-5
4.1.1	DEERS Eligibility Check.....	4-9
4.2	Options.....	4-14
4.2.1	To Request Registration Products Option 1.....	4-15
4.2.2	To Verify Essential Data Option 2.....	4-16
4.2.3	To View Reg History Data Option 3.....	4-18
4.2.4	To Redisplay Sponsor Data Option 4.....	4-18
4.3	To View or Update the Registration Screen.....	4-18
4.4	Points to Remember.....	4-20
4.5	Checkpoint.....	4-22

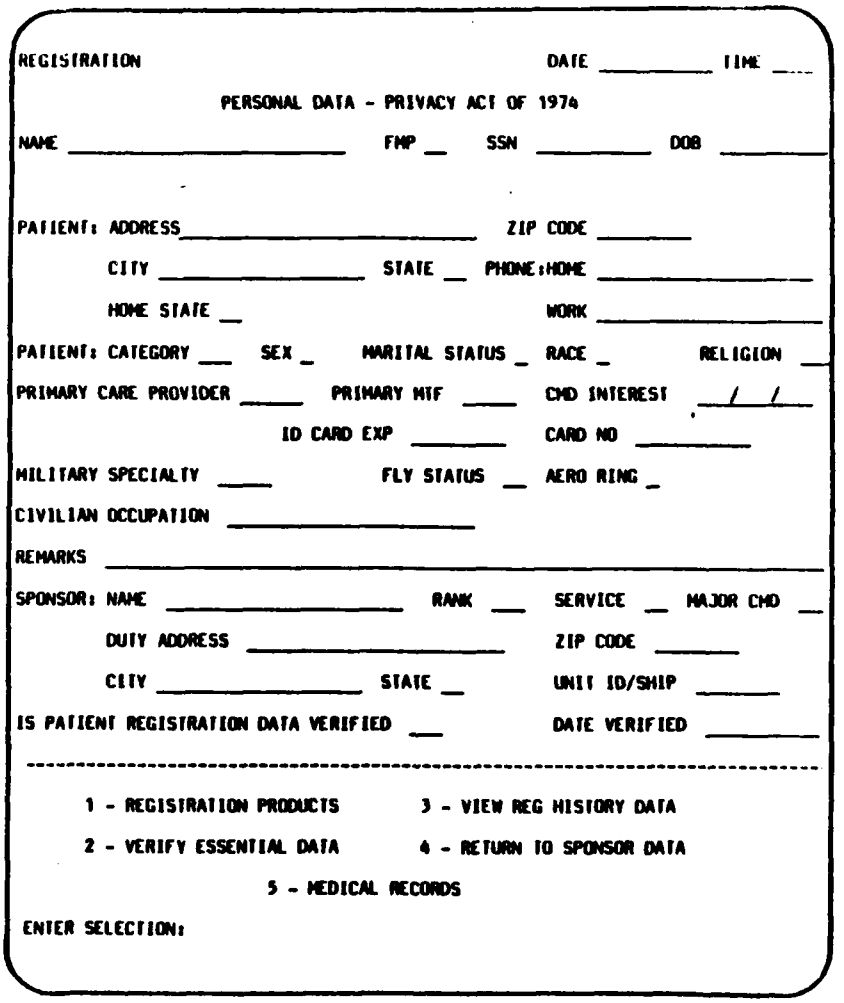


FIGURE 4.1 PRIMARY REGISTRATION SCREEN

4. REGISTRATION PROCESSING

ACCESS Registration processing is accessed by selecting R (Registration Processing) or A (Admission Processing) from the User Entry Menu. The PTID Screen is displayed first. The PTID Screen is used to create a new patient record or access an existing record using any valid search data. Once the patient is identified on the PTID Screen, the Primary Registration Screen will be displayed.

PURPOSE Registration processing allows you to:

1. Collect demographic information on persons eligible for care at the MTF.
2. View and update existing patient registration records.
3. Specify the location(s) of the patient's medical record(s).

DESCRIPTION Registration processing uses one primary registration screen, made up of two screen segments: Patient Data and Sponsor Data. This screen collects demographic information on a patient prior to admission.

The patient's name, FMP, SSN, DOB, and sex are carried over from the PTID screen.

OPTIONS

1 - REGISTRATION PRODUCTS enables you to request Registration Forms.

2 - VERIFY ESSENTIAL DATA enables you to verify that registration information or updates have been reviewed by the patient and are correct and complete.

3 - VIEW REG HISTORY DATA enables you to view information on previous episodes.

4 - RETURN TO SPONSOR DATA enables you to redisplay the Sponsor Data segment of the Primary Registration Screen.

4.1 TO REGISTER A NEW PATIENT

- o Enter R on the User Entry Menu and press Return

The PTID screen is displayed. The cursor is at REG NO.

- o Complete the required information on the PTID Screen. Refer to Section 3 for information on how to do this.

Note: If the patient is a sponsor with a dependent who has been previously registered, a partial record for the sponsor exists.

The Registration Screen is displayed. If any other family member has been registered, data will default from that record. The cursor is at PATIENT ADDRESS.

- o Enter or update the patient's street address and press Return.

The cursor moves to the next field: ZIP CODE. When you enter a zip code that is in the system zip code table, the name of the city and state are filled in automatically.

- o Enter the patient's zip code and press Return.

The cursor moves to the next field: CITY. You can change the city and state if they were filled in automatically.

- o Continue to enter the patient information required in each field using the Help key for code tables and field requirements.

Note: Sponsor Data. If you entered an FMP of 20 on the PTID Screen, indicating that his patient is a sponsor, the patient's name is carried over to SPONSOR: NAME on the Registration Screen. If you enter a patient category indicating that this patent is required or a depending of a retired or deceased sponsor, the sponsor data will default to the patient name and address.

- o Continue entering or updating sponsor information.

- o When the last field of sponsor data is completed, press Return.

If two or more data items are inconsistent, a consistency error message is displayed. The cursor moves to the first field among the inconsistent fields.

- o Press Explain Error for detail on the error.
- o Correct the item if this field is wrong.
- o Press Return to move the cursor to the other inconsistent field(s). Correct the data as necessary.

Note: The cursor continues to move to each field involved in the consistency error until one of the data items is changed. Then the system performs the edits on the new data.

When all the errors are corrected, the cursor moves to ENTER SELECTION.

When the cursor moves to ENTER SELECTION, data is complete and consistent

- With the cursor at ENTER SELECTION, you may select one of the options. If you press Return at this point to store the registration data, the new record is created.

Note: The record is not stored until you have completed all the required fields and have pressed Return when the cursor is at ENTER SELECTION.

When using Registration processing, the PTID Screen is displayed, ready for the next patient registration. If you are in Admission Processing and you press Return after completing the Registration Screen, the Admission Screen will be displayed next to enable you to complete the admission.

4.1.1 DEERS ELIGIBILITY CHECK

When you identify an individual record by using the PTID screen or selecting the patient from the AQCESS Candidate List Screen, a DEERS eligibility check is initiated. After you press Return to leave the Primary Registration Screen or the Admission Screen, the DEERS response will be displayed on the screen.

DEERS uses the following three criteria to search for an individual account: sponsor's Social Security Number (SSN), patient's Date of Birth (DOB), and Family Member Prefix (FMP).

A family eligibility response is returned if DEERS finds a match on the SSN but not on the patient's DOB. The DEERS Candidate List Screen will appear if the specific patient was not found in the DEERS database.

All persons with matching sponsor SSNs are returned on a DEERS Candidate List Screen along with the eligibility status of each person. When duplicate sponsor SSNs and patient DOBs are found, the eligibilities of only the duplicate individuals are returned in the family eligibility response.

The following is a list of the DEERS responses and their meanings:

DEERS ELIGIBILITY NOT AVAILABLE - Either the line is down or is so busy that the request could not be processed before the user finished. If this happens several times in succession, check with your System Manager. The eligibility query will go into a Batch Eligi-

bility Check which will be automatically processed when the DEERS system is available. The responses from these inquiries are printed on the Batch Response From DEERS Report on the A&D Reports Menu.

PROCESSING DEERS REQUEST - This means that the response is still being processed. This is displayed if the user exits from the Registration or Admission Screen before the response comes back from DEERS; the final response from DEERS will be on the Batch Response From DEERS Report on the A&D Reports Menu.

SSN NOT FOUND IN DEERS DATABASE - There is no record with this SSN in the DEERS database.

SSN FOUND - NO DEPENDENTS FOUND IN DEERS DATABASE - The requested dependent was not found in the DEERS database.

DEERS FILES ARE CLOSED - DEERS has closed their files for nightly backup or maintenance. No response was received and the query will go into a batch queue.

PATIENT IS ELIGIBLE - This indicates that the requested patient is eligible for DEERS.

PATIENT IS ELIGIBLE - ELIGIBILITY ENDS XX-XXX-XX - This message is followed by the date on which the patient's DEERS eligibility terminates.

PATIENT IS ELIGIBLE OVERSEAS ONLY - This patient is only eligible for medical care overseas.

PATIENT IS ELIGIBLE OVERSEAS - ELIGIBILITY ENDS XX-XXX-XX - This message is followed by the date on which the patient's overseas DEERS eligibility terminates.

ELIGIBILITY WITH A VALID ID CARD - INCORRECT ELIGIBILITY DATES ON DEERS FILE - This patient must show a valid ID card to receive medical treatment.

ELIGIBILITY WITH A VALID ID CARD - *** - This message is followed by a reason as described in the REASONS section below. The patient is eligible only if he or she has a valid ID card.

ELIGIBILITY OVERSEAS WITH A VALID ID CARD - INCORRECT DATES ON DEERS FILE - The eligibility date on the DEERS file is incorrect but patient is eligible for care overseas with a valid ID card.

ELIGIBLE OVERSEAS WITH A VALID ID CARD - *** - This message is followed by a reason as described in the REASONS section below.

PATIENT NOT ELIGIBLE - NO DIRECT CARE PRIVILEGES - No direct care privileges are specified on the DEERS database.

INELIGIBLE - ELIGIBILITY EXPIRED - *** - This message is followed by a date and a reason as described in the REASONS section below.

INELIGIBLE - SPONSOR IS INACTIVE GUARD/RESERVE - Patient is not eligible for medical care.

INELIGIBLE - LOG A DEPENDENT MISSING FROM AQCESS - The selected dependent is not in the DEERS database. The missing dependent is logged to be researched.

DUPLICATE SPONSOR/SSN FOUND - Displayed at the bottom of the Family Response Screen. More than one sponsor with this SSN was found in the DEERS database.

MULTIPLE DATE OF BIRTH MATCH - Displayed at bottom of the Family Response Screen. More than one family member was found with the same year and month of the DOB.

NO DATE OF BIRTH MATCH - Displayed at the bottom of the Family Response Screen. No family members matched the year and month of the DOB. This will normally be displayed after forcing a new query from the Family Response Screen.

REASONS:

GUARD/RESERVE
REASON UNKNOWN
21st BIRTHDAY
SPONSOR RETIREMENT
DEATH OF SPONSOR/RETIREMENT
ID CARD EXPIRED MORE THAN 120 DAYS
INVALID ENROLLMENT
END OF STUDENT STATUS
DEPENDENT MARRIAGE
INCAPACITATION ENDS
DEPENDENT ON ACTIVE DUTY
ENLISTED CAREER
SPONSOR NOT ON QC MASTER FILE
ESTIMATED ID CARD EXPIRATION
ESTIMATED TERMINATION OF SERVICE
ACTIVE DUTY SEPARATION
DIVORCE (SPOUSE)
NOT PREDICTABLE
1172 NEVER ON MASTER FILE
OTHER
23RD BIRTHDAY

The following messages would appear only on the Batch Response Report.

RECEIVED FAMILY RESPONSE FROM DEERS FOR BATCH QUERY - ????????????????????????????

RECEIVED DISCREPANCY RESPONSE FROM DEERS FOR BATCH QUERY - ????????????????????????????

4.2 OPTIONS

- Once the Registration Screen has been completed and the cursor is at ENTER SELECTION, you can select one of the screen submenu options. You can also call up the Registration Screen for an existing patient and select one of these options. Enter the number of your selection and press Return.

  1 - REGISTRATION PRODUCTS
  2 - VERIFY ESSENTIAL DATA
  3 - VIEW REG HISTORY DATA
  4 - RETURN TO SPONSOR DATA

Note: Some of these options cause different screen segments to replace the sponsor data on the Registration Screen.

4.2.1 TO REQUEST REGISTRATION PRODUCTS - OPTION 1

This segment allows you to request Registration Forms. The number of forms required is specific to your MTF.

- Enter 1 at ENTER SELECTION on the Registration Screen.

The Registration Products Segment is displayed. The cursor is at the first field: NUMBER OF REG FORMS REQUESTED.

- Enter the number of registration forms you are requesting for each registration.

The registration forms will be printed. The cursor moves back to the ENTER SELECTION field.

4.2.2 TO VERIFY ESSENTIAL DATA - OPTION 2

This option allows you to indicate that the patient has verified the data that you have entered and that the fields required for verification are complete. (These requirements are different for each military department.)

- o Enter option 2 and press Return.

When you choose this option, the data will either be verified or not, depending on whether all the necessary data has been entered.

If the required patient information is complete, YES appears in the IS PATIENT REGISTRATION DATA VERIFIED? field and the date verified is displayed. The cursor remains at ENTER SELECTION.

- o Select another option or press Return to store the patient registration.

If the required patient information is not complete, a message is displayed indicating the incomplete required field. The cursor is at ENTER SELECTION.

- Enter the partial name of the field missing information and press Return.

The cursor moves to the field where information must be entered.

- Enter the required data and press Return.

The cursor moves to ENTER SELECTION.

- Enter option 2 again to see if the information is now verified.

- Continue verifying and completing required fields until a YES and data appear after IS PATIENT REGISTRATION DATA VERIFIED?

- Press Return when the cursor is at ENTER SELECTION to store the data.

If you selected Registration from the User Entry Menu, the PTID Screen is redisplayed. If you selected Admission, the Primary Admission Screen is displayed.

4.2.3 TO VIEW REG HISTORY DATA - OPTION 3

This option allows you to review data on a patient's last inpatient episode. This information replaces the sponsor data.

- Enter 3 at ENTER SELECTION and press Return.

The History Data Segment is displayed. The cursor is at ENTER SELECTION. This screen is for viewing only and cannot be updated.

- Enter option 4 to return to the Sponsor Data Segment.

4.2.4 TO REDISPLAY SPONSOR DATA - OPTION 4

When there is a REG HISTORY or REGISTRATION PRODUCTS segment displayed on the screen, use this option to return to the Sponsor Data Screen segment.

4.3 TO VIEW OR UPDATE THE REGISTRATION SCREEN

- Enter R on the User Entry Menu and press Return.

The PTID Screen is displayed. The cursor is at REG NO. Identify the patient whose record you wish to view or update.

NOTE: The registration record of a current inpatient can only be viewed or updated through the admission function.

- o Press Entry Done to move the cursor to SELECTION.

- o Press Return at SELECTION.

Note: A patient must already be registered and admitted to have a REG NO.

The Registration Screen displays data on this patient. The cursor is at ENTER SELECTION.

- o View the record. Select an option to request products or to view Registration History showing the previous admission data.

- o To update a single field, enter all or part of its label. To move the cursor to each field, enter ALL.

- o If you chose to update one field, type the update and press Return. The cursor will go back to ENTER SELECTION.

- o If you entered ALL, update any or all fields and press Return after each one. You can use the Entry Done key at any time to return to ENTER SELECTION.

- o Press Return at ENTER SELECTION to store the update.

The PTID Screen is displayed. The cursor is at REG NO.

- o To return to the User Entry Menu, press the Cancel key.

- o To identify another patient, enter the REG NO.

4.4 POINTS TO REMEMBER

1. To access an existing patient record in Registration processing, enter valid search criteria on the PTID Screen. When a patient's record is identified, the Registration Screen displays the existing patient data.

   View or update this information. Use option 1 to request Registration Forms.

2. When registering any patient who has had a family member previously registered, the sponsor's demographic information is displayed on the Registration Screen.

3. Registration required fields include PATIENT CATEGORY, MARITAL STATUS, RACE, SPONSOR NAME, and RANK plus additional fields depending on the military department and category of the patient.

4. The Registration Screen is displayed when you choose Admission Processing from the User Entry Menu and begin a new patient record. After you have registered the new patient, the Admission Screen is displayed.

5. The data on the PTID Screen can be updated on the Registration Screen. Enter the partial field label for the field to be updated, type over the existing information, and press Return.

6. DEERS eligibility check is initiated when the user selects Registration or Admission Processing and has identified or entered a specific patient. The response from DEERS is returned at the end of the Registration or Admission process or, if by the end of these two processes a response doesn't come back, is put into a Batch Eligibility Report.

4.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 5. ADMISSION

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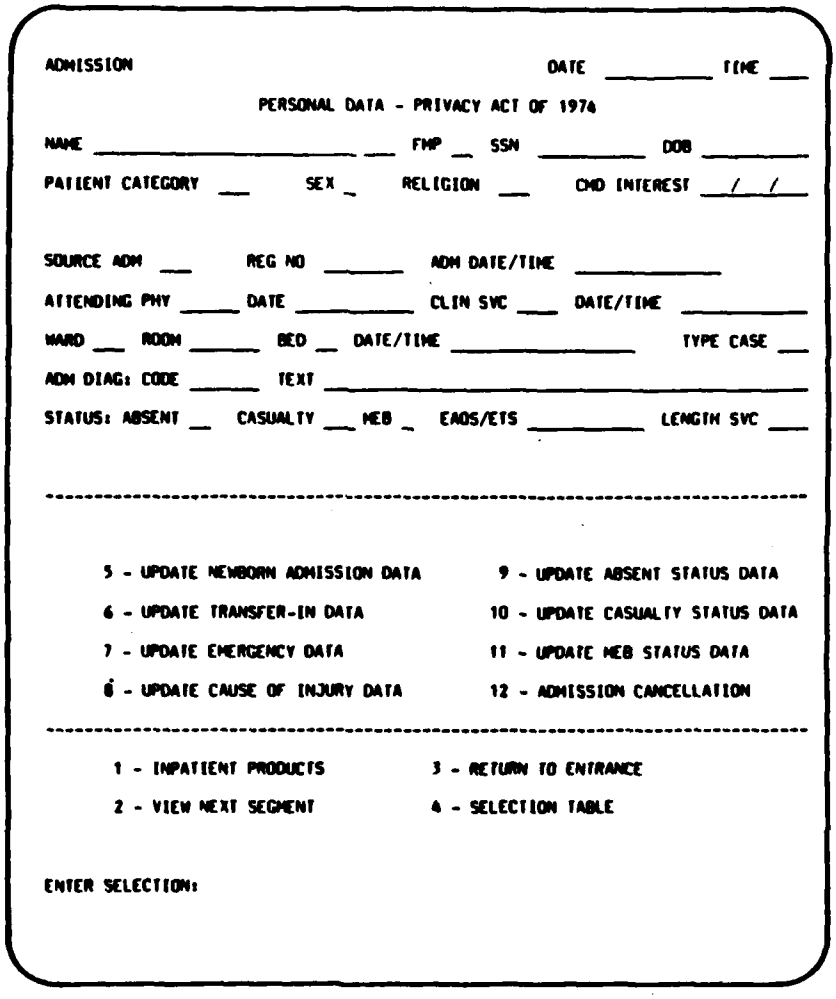


FIGURE 5.1 PRIMARY ADMISSION SCREEN

5. ADMISSION PROCESSING

ACCESS Admission processing is accessed by selecting A, Admission Processing, from the User Entry Menu. The PTID Screen is displayed first to enable creation of a new record or retrieval of existing records using any valid search criteria.

PURPOSE The Admission process enables you to:

1. Collect inpatient episode information necessary to admit a person as an inpatient or as a preadmit.
2. View and update existing patient admission records.
3. Cancel admissions, or change a preadmit to an admission.
4. Request Admission Forms, Index Cards and Embossed Cards.

DESCRIPTION Admission processing uses the Registration Screen to collect demographic information and the Primary Admission Screen to collect episode information. The Primary Admission Screen is made up of two screen segments: Admission Data and

Entrance Data. During the Admission process, the Entrance Data segment of the screen can be replaced by eight alternate screens segments depending on the additional information required to admit a particular patient. These segments are:

- Update Newborn Admission Data
- Update Transfer-In Data
- Update Emergency Data
- Update Cause of Injury Data
- Update Absent Status Data
- Update Casualty Status Data
- Update MEB Status Data
- Admission Cancellation

OPTIONS

1 - INPATIENT PRODUCTS enables you to request additional Registration Forms, Index Cards and Embossed Cards.

2 - VIEW NEXT SEGMENT enables you to display each of the alternate Admission segments one at a time.

3 - RETURN TO ENTRANCE DATA enables you to redisplay the Entrance Data segment when another segment is displayed.

4 - SELECTION TABLE enables you to display a menu of all the Admission segments for selection.

5.1 TO ADMIT A NEW PATIENT

- Enter A on the User Entry Menu and press Return.

The PTID Screen is displayed. The cursor is at REG NO.

- Press Return to move the cursor to the NAME field.

- Enter the patient's name and other identifying information. (Refer to Section 3 on PTID.)

- Enter N at SELECTION for a new patient. An eligibility check is sent to DEERS at this time.

Note: The Candidate List Screen is displayed if any currently or previously registered patient has a similar name, sex, FMP/SSN, or same last name and first four letters of the first name. This is to prevent you from duplicating a record that already exists.

The Registration Screen is displayed. The cursor is at PATIENT ADDRESS.

There are two possible conditions:

1. **If The Patient Is Not Registered:**

Data will be carried over from the PTID Screen. Other data fields may be filled in depending on whether another member of the patient's family has been registered. The cursor will be at PATIENT ADDRESS.

- o Complete the Registration Screen. Refer to Section 4.

2. **If The Patient Is Registered:**

The data fields are filled in if the patient has already been registered. The cursor is at ENTER SELECTION.

- o View the registration information and make sure it is up-to-date.

- o Enter the partial field label of any field you wish to update, or enter ALL to update several fields.
- o Enter the new data in fields as necessary.
- o If you entered ALL, press Entry Done to move the cursor to ENTER SELECTION.
- o With the cursor at ENTER SELECTION, press Return to store the Registration data and display the Admission Screen.

If the DEERS Eligibility response has come back, it will be displayed (see Section 4.1.1 for more detail.)

The Primary Admission Screen is displayed with patient information carried over from the Registration Screen. The cursor is at SOURCE ADM.

Note: If you cancel at this time the Registration data will be stored.

- o Enter the SOURCE ADM code, and press Return.

The cursor moves to the next field: REG NO.

- o If your MTF requires manual assignment of register numbers, complete this field and press Return.

Note: If your MTF has automatic assignment of register numbers, this field will be automatically filled in by the system. To override the REG NO, the system manager must block a group of numbers that can be assigned manually. You will type a blocked number over the system-generated number. (The Air Force manually assigns the mother's REG NO plus a suffix for newborns.)

The cursor moves to the next field: ADM DATE/ TIME.

- o Enter N to default the current date and time.

- o Continue to enter the patient admission information and entrance data required in each field using the Help feature for code tables and field requirements.

Note: If you are unfamiliar with admission diagnosis codes (ADM DIAG:) follow these steps:

- Move to the field labeled TEXT.
- Press Help for a listing.

A list of categories of ICD code is displayed, showing a key word for each category.

- Enter all or part of the key word for the appropriate coding category and press Help.

A list of subgroups within that category is displayed.

- Take note of the 3-digit code that represents the subgroups of ICD codes that seems appropriate.
- Move the cursor back to ADM DIAG CODE.
- Enter the 3-digit code and press Help.

A list of all the codes in that subgroup is displayed.

- Enter the appropriate code in the ADM DIAG CODE field. The corresponding text will automatically be displayed in the TEXT field.

- You can change the wording of the Text by typing over the defaulted text if you wish.

- After the Primary Admission Screen is completed, press Return.

The Entrance Data segment will automatically be replaced with a series of screen segments, depending on what data you entered on the primary screen. The entire list of segments, and the order in which they would appear is:

1. Newborn Admission
2. Transfer-In
3. Emergency Data
4. Cause of Injury
5. Absent Status
6. Casualty Status
7. Medical Evaluation Board (MEB) Status

For example, if the TYPE CASE is injury, the cause of Injury segment will be displayed. If a segment is not applicable to the patient, it will not be displayed.

Note: The Emergency Data segment is displayed for each patient. It may be filled in with data if another member of this family has already been admitted, but you can update this data.

Note: If you admit a patient with an absent status of Bed Occupied, the Absent Status will not be displayed.

- Continue to enter data in each required field of the screen segment.

When you have completed required fields on a screen segment, three things can occur:

1. **You will see a consistency error message.**

If the cursor moves back to a field on any segment and a consistency edit message is displayed, you must correct the information in one of the fields involved in the error.

Note: Some consistency error messages are warnings, which you can override, for example, when the ward assignment does not agree with the clinical service. Enter Y to override these warnings.

- Correct the data.

2. The next segment in the series will be displayed.

   o Continue entering in the information and correct any inconsistent data indicated by a consistency edit.

3. The cursor will go to ENTER SELECTION.

If after completing the last field on the segment the cursor moves to ENTER SELECTION, the admission data is complete.

   o Once the Admission segments are complete, you can select an option from the submenu. Enter the number of the option and press Return.

     1 - Inpatient Products
     2 - View Next Segment
     3 - Return to Entrance
     4 - Selection Table

   o If no options are required at this time, press Return to store the data and to create the admission record. The register number is assigned. One Admission Form and one set of Index Cards are automatically printed if you did not change the default. If you specified an embossed card to be printed, it will also print.

A DEERS Eligibility Response will return stating the eligibility status of the patient (see Section 4.1.1 for greater detail).

Note: The admission record is not stored until you complete all required segments and press Return with the cursor at ENTER SELECTION.

The admission is complete and the PTID Screen is displayed.

- To return to the User Entry Menu, cancel out on the PTID Screen.

- To admit another patient, enter the identification data on the PTID Screen.

5.2 SPECIAL ADMISSIONS

Special admissions include preadmissions, changing a preadmission to an admission, patients who are carded for record only, and emergency room deaths.

5.2.1 TO PREADMIT A PATIENT

You can preadmit a patient by completing the Admission processing screens before the actual admission date.

- o Enter A on the User Entry Menu and Return.

- o Complete the PTID Screen.

- o Enter the preadmission code at SOURCE ADM.

Note: You can enter a future admission DATE/TIME for the projected admission. You can also assign a ward to reserve a bed for this patient.

Absent status is not required for a preadmit.

- o Complete the Admission Screen and the applicable screen segments.

- o Press Return at ENTER SELECTION to store the preadmission.

A DEERS eligibility response is displayed if it has returned from DEERS (see Section 4.1.1 for more detail).

Note: A system-generated register number is not assigned for a preadmit.

Admission products are not generated for pre-admits.

5.2.2 TO CHANGE PREADMISSION TO ADMISSION

- Enter A on the User Entry Menu and press Return.

The PTID Screen is displayed. The cursor is at REG NO.

- Identify the patient on the PTID Screen.

The Registration Screen is displayed. The cursor is at ENTER SELECTION.

- Check the information for accuracy, correct as necessary, then press Return.

The Primary Admission Screen is displayed. The cursor is at SOURCE ADM.

- o Change the code from preadmit to the appropriate admission code, and Return.

The cursor moves to DATE/TIME.

- o Update the current admission date and time.

- o Continue to update the information and to complete any applicable Admission segments.

- o With the cursor at ENTER SELECTION, select one of the options or press Return to store the admission data.

A DEERS eligibility response is displayed or put into a Batch Report.

Note: The register number is now assigned.

5.2.3 TO ADMIT A PATIENT CARDED FOR RECORD ONLY (CRO) OR EMERGENCY ROOM DEATH (ERD)

Note: This type of admission is used only by Army and Air Force MTFs. Navy MTFs can record CRO and ERD patients through the Emergency Service Occurrence Screening Function of the QA subsystem.

- o Enter A on the User Entry Menu and press Return.

The PTID Screen is displayed. The cursor is at REG NO.

- o Identify the patient on the PTID Screen.

The Registration Screen is displayed. The cursor is at PATIENT ADDRESS.

- o Complete the Primary Registration Screen.

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When the Registration Screen is complete and you press Return at ENTER SELECTION, the Admission Screen is displayed. The cursor is at SOURCE ADM.

- Enter the source of admission from a CRO or ERD. Use Help to see a list of codes.
- Enter the approprate CRO codes for clinical service and absent status.
- Complete the Primary Admission Screen and other applicable segments.

The Patient Disposition segment is displayed.

- Complete the disposition segment with the appropriate disposition type and date.
- Press Return at ENTER SELECTION to store the admission and the disposition.

A DEERS eligibility response is displayed. (see Section 4.1.1 for more detail).

5.3 OPTIONS

The cursor is at ENTER SELECTION.

- Type the number of the option selected and press Return.

1 - INPATIENT PRODUCTS
2 - VIEW NEXT SEGMENT
3 - RETURN TO ENTRANCE
4 - SELECTION TABLE

5.3.1 TO REQUEST ADMISSION FORMS, EMBOSSED CARDS, AND INDEX CARDS - OPTION 1

A new admission is automatically issued one set of Index Cards and one Admission Form. Option 1 allows you to request Index Cards and Admission Forms as well as Embossed Cards. Embossed Cards are not generated automatically. These products are not produced until the record is stored.

- Enter option 1 at ENTER SELECTION and press Return.

The Inpatient Products Segment is displayed.

- Type the number of items requested in each field.

- Press Return after typing each request number to enter data and move to the next field.

The cursor moves to ENTER SELECTION.

- Press Return to store the request and the record and return to the PTID Screen.

The requested items will be produced when the admission record and request are stored.

5.3.2 TO VIEW NEXT SEGMENT - OPTION 2

This option allows you to view each of the eight screen segments, including those not required for your patient.

The cursor is at ENTER SELECTION.

- Enter option 2 and press Return to display the first segment in the series. Continue this process to view each screen segment.

- To enter data on any segment, enter the partial field label or ALL.

5.3.3 TO RETURN TO ENTRANCE - OPTION 3

Use this option to display the Entrance Data segment when any other segment is being displayed. Information on the Primary Admission Screen can be updated only when the Entrance Data Segment is displayed.

- Enter 3 and press Return to display the Entrance Data Segment.

Note: To update any field on the Primary Admission Screen, enter the field label at ENTER SELECTION, and press Return.

The cursor will move to the field you identified.

- Change the information in that field and press Return to move the cursor to ENTER SELECTION.

The corresponding Admission segment will be displayed if applicable. The cursor will be at the first field requiring data.

- o Enter data to complete the segment.

When the cursor moves to ENTER SELECTION, the required data has been entered.

- o Press Return at ENTER SELECTION to store the update.

A DEERS Eligibility response will be displayed (see Section 4.1.1 for more detail).

5.3.4 TO DISPLAY SELECTION TABLE - OPTION 4

This option displays an extended list of submenu options which allow you to choose a specific screen segment to update, or to cancel an admission.

- Update Newborn Admission Data
- Update Transfer-In Data
- Update Emergency Data
- Update Cause of Injury Data
- Update Absent Status Data
- Update Casualty Status Data
- Update MEB Status Data
- Admission Cancellation

Choose options 5 through 11 to update any screen segment. Then enter ALL or type part or all of a particular field label to enter your update.

Press Return to store the update, and return to ENTER SELECTION.

5.3.5 TO UPDATE INFORMATION IN THE ADMISSION RECORD - OPTIONS 5 THROUGH 11

These options enable you to update the Admission record and track changes in clinical service, absent status, casualty status, ward, provider, etc.

- Enter A or T on the User Entry Menu.

The PTID Screen is displayed.

- Identify a current record.

The Primary Admission Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the label of the field you wish to update, or type ALL to move to each field, or select a screen segment to update.

The cursor will move to the requested field(s).

Note: The Patient Identification and Registration information (top 3 lines) can be updated only through the Registration process. The Primary Admission Screen can be updated only when the Entrance Data Segment is displayed.

- When you update the ward, absent status, or clinical service, the system will keep track of the old data as well as the update.

If you update TYPE CASE, ABSENT STATUS, CASUALTY STATUS, or MEB STATUS, the corresponding segment is displayed automatically, one at a time.

- When each segment is displayed, enter the information required. Consistency edits will determine whether the updated data is consistent or inconsistent.

Admission Data Consistent

If the cursor moves to ENTER SELECTION, the admission data is complete and consistent.

- Press Return to store the updated information.

A DEERS eligibility response is displayed (see Section 4.1.1 for more detail).

Admission Data Not Consistent

If a consistency error message is displayed, some of the information is inconsistent and must be changed.

- If the cursor is positioned at OVERRIDE, you have the option to leave the data as is. Enter Y to override.
- If there is a consistency error message and the cursor moves to a field on the screen, you must change the information in one of the data fields involved in the error.

- Enter data in at least one of the fields to correct the inconsistency.

When the cursor moves to ENTER SELECTION, the consistency error has been corrected. Press Return to store the admission updates.

5.4 TO CANCEL AN ADMISSION OR PREADMISSION - OPTION 12

This selection enables you to cancel an admission or preadmission, or to change an admission to a preadmission.

Note: You cannot cancel an admission that has just been entered, but not yet stored.

If the patient was admitted, the cursor is at ENTER SELECTION. If the patient is a preadmit, the cursor is at SOURCE ADM.

- For preadmit, use the ENTRY DONE key to go through each screen segment and get to ENTER SELECTION.

- Enter 4 and press Return at ENTER SELECTION to view the selection table.

- Enter 12 and press Return to access the Admission Cancellation segment.

The Admission Cancellation segment is displayed. The cursor is at SOURCE ADM.

- o Type the appropriate code and press Return.

Note: The code depends on whether you are cancelling an admission or pre-admission, or changing an admission to a preadmission.

- o Enter data in the required fields.

- o Press Return when the cursor is at ENTER SELECTION to store the change.

5.5 POINTS TO REMEMBER

Admission Screen Sequence

1. The Admission process uses the following screens and segments:

PTID Screen	enables you to identify the patient's record or to begin to create a new record.
Registration Screen	enables you to enter or update the patient's demographic information.

Primary Admission	enables you to enter information about the admission such as source of admission, type case, absent status, casualty status, and MEB status. Entries in these fields on the Primary Admission Screen will cause the corresponding Admission segments to be displayed.
Entrance Data Segment	enables you to enter data about the admission such as admitting physician and projected disposition type.
Newborn Admission Segment	requires that you enter the mother's register number to link the records together. (Not used by the Air Force.)
Transfer-In Segment	requires information regarding the MTF from which the patient was transferred.
Emergency Data	requires the name, address, and phone number of the next of kin and an emergency contact. This segment is displayed for all Admissions.
Cause of Injury Data	requires information about cause of injury, if the patient has a type case indicating injury.

Absent Status	requires information about the patient's absent status. The Absent Status segment is not displayed if a patient is admitted as a bed occupant.
Medical Evaluation Board Status	requires information on the patient's MEB status, if an MEB status code was entered on the Primary Admission Screen.
Admission Cancellation	allows you to cancel an admission and requires information such as date, authorizing physician and reason for the cancellation.

2. The screens that are displayed after the PTID Screen in Admission processing are determined by the following conditions:

   - o If the patient is not currently registered, the Registration Screen is displayed and must be completed before the Admission Screen.

   - o If the patient has been registered but is not currently admitted, the Registration Screen is displayed and should be reviewed and updated to reflect current demographic information before the Admission Screen is completed.

- o If the patient is currently admitted, the Admission Screen is displayed and can be updated to track changes in status, ward, etc., during the episode.

3. Each time you update a field on any Admission segment, the consistency edits are performed. Any errors resulting from inconsistent data must be corrected before the record can be stored.

4. A mother must be admitted before her newborn can be admitted. Newborns in the Air Force must be manually assigned their mother's register number with a suffix.

5. Once an admission record is stored, you will not have access to the top three lines of data on the Primary Admission Screen. Information on the top two lines can only be changed in Registration. The source of admission and date/time of admission can only be changed in Correction Management. You cannot change the register number through any process.

6. Use the Admission process (or Transfer process) to record changes in a patient's ward, clinical service, or absent status assignment. Use the Correction Management process to correct information entered in error.

7. To update the Admission Screen, first enter updates on the Primary Admission Screen. When you're changing an inpatient's absent status from OUT to IN (bed occupied), use the Primary Admission Screen. This is because you have to enter the ward, the ward date/time, and the new clinical service (if it is changed) in addition to changing the absent status. You can update information on the Primary Admission Screen only when the Entrance Data segment is displayed on the lower portion of the Primary Admission Screen.

8. When you're changing an inpatient's Absent Status from IN to OUT, you can use the Absent Status segment (unless a special Clinical Status is also required). The patient's ward will be cleared automatically.

9. Any backdated change in ward, clinical service, or absent status, or any backdated cancellations of admissions or dispositions will be noted in corrections to A&D text, and will be printed on the following day's A&D Report. To change this text, use the Correction Management function.

10. A DEERS Eligibility Check is initiated when Admission Processing is selected from the Main Menu and a patient has been identified. The response will be displayed when the admission is stored after pressing Return at ENTER SELECTION or after the Primary Registration Screen is complete.

11. Patients admitted after hours on a given day should be entered into AQCESS before the A&D Recap is run for that day so that the patients will not appear as corrections on the Recap report. Patients admitted for a given day but after the running of the Recap report for that day will show as corrections.

5.6 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

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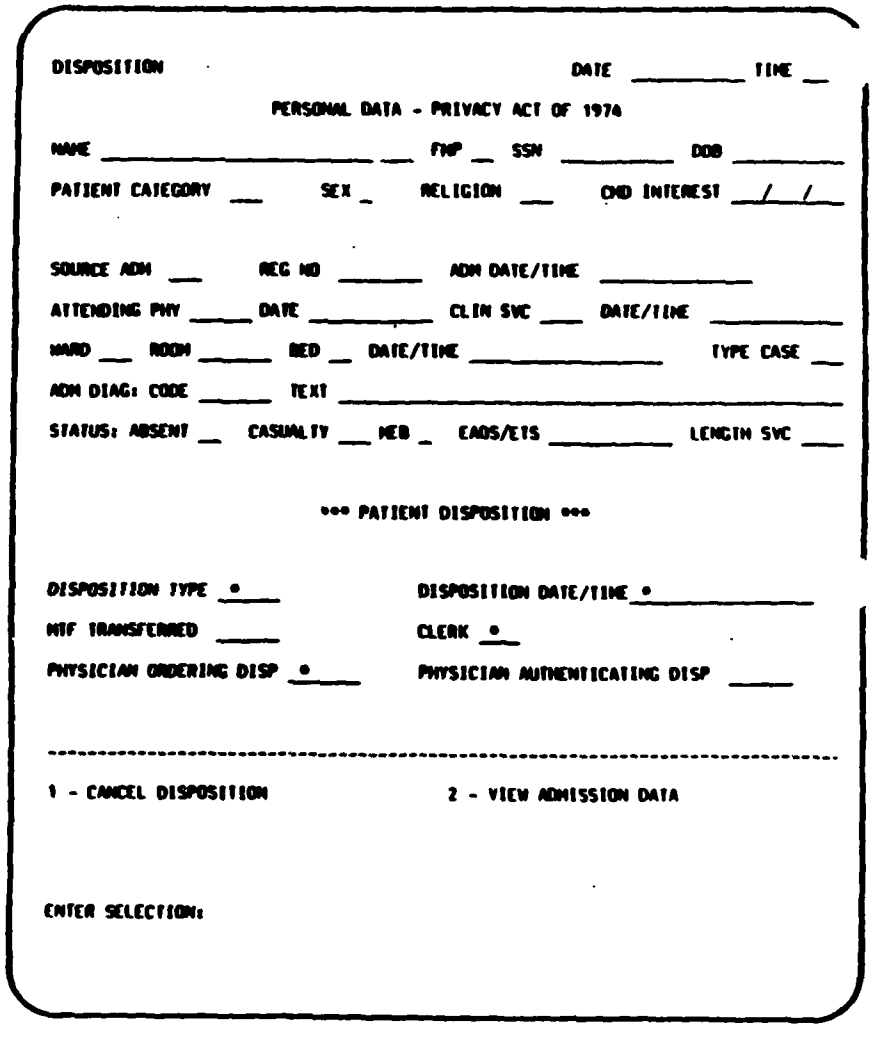


FIGURE 6.1 PRIMARY DISPOSITION SCREEN

6. DISPOSITION PROCESSING

ACCESS Disposition processing is accessed by selecting D (Disposition Processing) from the User Entry Menu Screen. The PTID Screen is displayed first to enable you to identify a patient's record using any valid search criteria.

PURPOSE The Disposition process enables you to:

1. Enter information about the patient's discharge from your MTF.
2. View or update disposition data.
3. Cancel a previous disposition.

DESCRIPTION Disposition processing uses the Primary Disposition Screen, which is made up of two segments: Admission Summary and Patient Disposition. The Admission Summary portion contains the same information that is displayed on the Primary Admission Screen and cannot be updated. To disposition a patient, complete the required fields on the Patient Disposition Segment.

OPTIONS

On the Primary Disposition Segment:

1 - CANCEL DISPOSITION

Enables you to cancel a disposition that has already been entered and stored.

2 - VIEW ADMISSION DATA

Displays the Primary Admission Screen and enables you to print inpatient products and to view, but not update, all the Admission Screen segments.

6.1 TO DISPOSITION A PATIENT

- Enter D on the User Entry Menu Screen and Return.

The PTID Screen is displayed. The cursor is at REG NUMBER.

- Enter the patient's register number or identify the patient using valid search criteria.

- Press Entry Done to move the cursor to ENTER SELECTION. Press Return again to locate the patient's record.

The Primary Disposition Screen is displayed. The cursor is in the Patient Disposition data segment, at the DISPOSITION TYPE field.

Note: A patient cannot be dispositioned from certain out statuses. You must first transfer the patient from an Absent Status to Bed Occupied.

- Enter the disposition type code.

To disposition pay status basics, enter disposition code DPT. This will record the disposition as OTHER DEPENDENTS on the A&D Report.

The cursor moves to the next field.

- Continue to enter data in required fields; correct consistency errors as necessary.

When you complete the disposition press Return at ENTER SELECTION. Two things can happen:

If the PTID Screen is displayed, the disposition is stored and you can disposition another patient.

If the patient is a mother, the Newborn Disposition Screen segment is displayed next. This means the patient had a baby. You must either disposition the baby or put it on pay status when the mother is dispositioned. If you cancel at this point; the mother's disposition will not be stored.

6.2 TO DISPOSITION A NEWBORN

The Newborn Disposition Segment is displayed automatically if you have just dispositioned the baby's mother. This segment has a submenu of options. The cursor is at ENTER SELECTION.

- Enter option 1-Disposition This Newborn.

The cursor moves to the DISPOSITION TYPE field.

- Enter the disposition type and complete the screen segment.

Note: The cursor will skip the date/time of disposition, which is taken from the mother's record.

When the disposition date is complete, the cursor moves to ENTER SELECTION.

- Press Return to store the newborn disposition.

The PTID Screen is redisplayed or, if it was a multiple birth, the Newborn Disposition Segment is repeated.

6.3 TO PUT NEWBORN ON PAY STATUS

If you just dispositioned a mother, the Newborn Disposition Segment and its submenu of options is displayed. The cursor is at ENTER SELECTION.

- If the baby is remaining in the MTF, enter option 2 - Put newborn to pay status and press Return.

A new data field, SOURCE ADM, is displayed on the Newborn Disposition Segment. The cursor is located at SOURCE ADM.

- Enter the appropriate code in the SOURCE ADM field to put the newborn on pay status.

The cursor moves to ENTER SELECTION.

- Press Return to store the information. If there is more than one baby, the Newborn Disposition Segment is redisplayed. Repeat the newborn disposition process until the PTID Screen is displayed.

The PTID Screen is displayed. Continue Disposition processing for the next patient.

6.4 OPTIONS

- Access the Disposition Screen using procedures described on in Section 6.1.

The Primary Disposition Screen is displayed. The cursor is at ENTER SELECTION.

- Type in the number of the option you wish to select and press Return.

1 - CANCEL DISPOSITION
2 - VIEW ADMISSION DATA

6.4.1 TO CANCEL A PATIENT'S DISPOSITION - OPTION 1

This option enables you to cancel a disposition once it has been stored.

- With the cursor positioned at ENTER SELECTION on the Disposition Segment, enter 1.

The Disposition Cancellation Segment is displayed. The cursor is at the WARD field.

- Press Return for the patient to stay in the previous ward assignment, or type the new ward ID code.

- Complete the data required for cancellation.

- After the last field has been completed, press Return.

- Correct any consistency errors.

When you've filled in the required fields accurately and you press Return at ENTER SELECTION to store the data, two things can occur:

1. **The Disposition Will Be Cancelled.**

If the PTID Screen is displayed, the data is stored and you can disposition another patient.

2. **The Newborn Disposition Cancellation Segment will Be Displayed.**

If you have just cancelled the disposition of the mother of a newborn, the Newborn Disposition Cancellation segment is displayed. You can cancel the newborn disposition or leave the newborn as is.

6.4.2 TO CANCEL THE NEWBORN DISPOSITION

The Newborn Disposition Segment is displayed.

- Enter option 1 and press Return.

Note: The cancellation segment will only appear if the newborn was also dispositioned. It is not displayed if the newborn was put on pay status.

The newborn's previous ward, room, and bed information is displayed. The cursor is at the WARD field.

- Change the newborn information as necessary or:
- Press Return to leave the newborn in the same ward, room, and bed.
- Enter the remaining data required for cancellation.
- Press Return until the cursor is at ENTER SELECTION.
- Press Return to store the disposition cancellation.

The newborn's disposition is cancelled. If there is another baby associated with the mother's record, the Newborn Disposition segment is displayed again.

6.4.2.1 TO LEAVE NEWBORN AS IS

The Newborn Disposition Cancellation segment is displayed automatically if you have just cancelled the mother's disposition.

- Enter option 2 at ENTER SELECTION, and press Return.

The newborn remains dispositioned and the PTID Screen is displayed. Or, if there is more than one baby, the Newborn Disposition Cancellation Segment is displayed again. Repeat this process for any additional newborns of this mother. When the cursor moves to ENTER SELECTION and you press Return, the dispositions for the mother and the newborn(s) are cancelled.

Note: If the system goes down or you cancel out before finishing the entire process, neither the disposition of the mother nor the newborn(s) will be cancelled.

6.4.3 TO VIEW ADMISSION DATA - OPTION 2

This option allows you to view the patient's admission data and order inpatient products. You will not be able to update admission data.

The Primary Disposition Screen is displayed. The cursor is at ENTER SELECTION.

- Enter option 2 and press Return.

The Primary Admission Screen is displayed with its Entrance Data Segment. The cursor is at ENTER SELECTION.

- Select one of the following options:

  1 - INPATIENT PRODUCTS
  2 - VIEW NEXT SEGMENT
  3 - RETURN TO DISPOSITION

- For options 1 and 2, follow procedures provided in Sections 5.3.1 and 5.3.2 of The Training Aid.

6.4.4 TO RETURN TO DISPOSITION

This option enables you to return to the original Disposition Screen.

An Admission segment is displayed. The cursor is at ENTER SELECTION.

o Enter option 3 and press Return.

6.5 POINTS TO REMEMBER

1. The newborn record is linked to the mother's record. If the system fails when you are in the process of dispositioning a mother and newborn(s), none of their dispositions will be stored. This ensures that when the mother is dispositioned, her newborn(s) are also either dispositioned or put on pay status (retained).

2. A disposition can be cancelled if necessary. However, if the record has been accessed by Clinical Records, it will first have to be released to A&D.

6.6 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

SECTION 7. TRANSFER

PROCEDURE **PAGE**

7.1 To Track Status Changes.....7-5
7.2 Points to Remember.....7-7
7.3 Checkpoint.....7-8

TRANSFER DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ FMP __ SSN _____ DOB _____

PATIENT CATEGORY ___ SEX _ RELIGION ___ CMD INTEREST __/__/__

SOURCE ADM * REG NO _____ ADM DATE/TIME *_____

ATTENDING PHY * (if BD) DATE * (if BD) CLIN SVC * DATE/TIME _____

WARD * (if BD) ROOM _____ BED __ DATE/TIME * (if BD) TYPE CASE *

ADM DIAG: CODE _____ TEXT _____

STATUS: ABSENT * (if not pre-admit) CASUALTY ___ MEB _ EAOS/ETS A, F (if active duty) LENGTH SVC * (if military)

••• ENTRANCE DATA •••

ADMITTING PHYSICIAN _____ CLERK *

PREVIOUS ADM ___ PROJECTED DISP: TYPE ___ DATE _____

ADM REMARKS _____

MEAL CARD E

HR N OR N SR N PR N OR N PE N

---

1 - INPATIENT PRODUCTS 3 - RETURN TO ENTRANCE

2 - VIEW NEXT SEGMENT 4 - SELECTION TABLE

ENTER SELECTION:

FIGURE 7.1 TRANSFER SCREEN

7. TRANSFER PROCESSING

ACCESS Transfer processing is accessed by selecting T (Transfer Processing) from the User Entry Menu. The record is identified on the PTID Screen and the Transfer Screen is displayed. Transfer processing can also be performed using the Admission Screen. Refer to the Admission Section for more information.

PURPOSE The Transfer process enables you to update admission data during the patient's stay at the MTF. You can enter information such as changes in ward, clinical service, diagnosis, primary provider, absent status, and casualty status.

You can perform the same functions in the Transfer process that you do in the Admission process, with the exception of actually admitting a patient or cancelling an admission.

DESCRIPTION Transfer Processing uses the same screens as Admission processing. All the Admission screen segments, except Admission Cancellation, are available. When any field on the Transfer Screen is updated, the

screen segment associated with that field is automatically displayed. Refer to Admission processing for procedures on updating patient data.

OPTIONS

1 - INPATIENT PRODUCTS enables you to generate additional Admission Forms or Index Cards.

2 - VIEW NEXT SEGMENT enables you to display each of the admission segments.

3 - RETURN TO ENTRANCE DATA enables you return to the Primary Admission Screen.

4 - SELECTION TABLE enables you to display the menu of all the admission segments so that you can select the one needed for processing.

7.1 TO TRACK STATUS CHANGES

- To update the patient's admission record and track changes in clinical service, absent status, casualty status, ward, provider, etc., enter T on the User Entry Menu Screen.

The PTID Screen is displayed. The cursor is at REG NO.

- Identify the patient's record on the PTID Screen using valid search criteria.

The Transfer Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the partial label of the field you wish to update or enter ALL to move the cursor to each field. Press Return.

The cursor moves to the identified field(s).

Note: The patient's identification and Registration information on the top two lines can only be updated through the Registration process. The source of admission can only be updated in Correction Management; you cannot update the register number. The Primary Admission Screen (upper portion) can only be updated when the Entrance Data Segment is displayed.

As information is updated in fields such as ward, bed, attending physician, absent status, casualty status, or MEB status, the corresponding Admission Segment is automatically displayed.

- Enter the additional required information in each field on the segment.

When the required data has been entered, the cursor moves to ENTER SELECTION.

- Press Return to store the updated record.

The PTID Screen is displayed.

Note: Updates on the Admission Screen or the Transfer Screen become part of the history of the inpatient episode. Do not update the Admission Screen or the Transfer Screen to correct erroneous data. Corrections can be made only in Correction Management.

7.2 POINTS TO REMEMBER

1. When you change a ward or clinical service, the DATE/TIME field must also be updated.

2. Updates can be made in both Transfer and Admission processing; however, you cannot admit or cancel an admission in Transfer processing.

3. The Entrance Data Segment in Transfer processing must be displayed in order to update the primary admission data (top portion).

7.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate sections of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 8. R/ADI REPORTS

PROCEDURE		PAGE
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8.2	To Produce a Report.....	8-10
8.3	Options - To Print all Nightly Reports or all Monthly Reports.....	8-12
8.3.1	To Display the Next Page of the Report Menu - Option P2.....	8-13
8.3.2	To Print all Nightly Reports - Option N.....	8-13
8.3.3	To Print all Monthly Reports - Option M.....	8-14
8.4	Points to Remember.....	8-15
8.5	Checkpoint.....	8-16

FIGURE 8.1 REPORTS SELECTION SCREEN

8. R/ADI REPORTS

ACCESS R/ADI Reports Selection Screen is accessed by selecting 1 - R/ADI Reports from the User Entry Menu.

PURPOSE R/ADI Reports enables you to print all reports related to Admission and Disposition processing.

DESCRIPTION R/ADI Reports uses a Reports Selection Screen that lists the titles of all the reports available to you. They are available individually, or you can request all nightly or all monthly reports to be printed. The reports listed vary among military departments.

OPTIONS
N - ALL NIGHTLY REPORTS
M - ALL MONTHLY REPORTS
P2 - DISPLAY NEXT PAGE

8.1 REPORT DESCRIPTIONS

AQCESS provides a number of R/ADT reports, some of which are listed below. These reports differ for each service; examples of all reports are included in the AQCESS User Manual.

1. **A&D REPORT.** Admission and Disposition report describes daily admission activity, disposition activity, change of absent status activity, newborn activity, interward transfers, and correction activity for previous reports.

2. **VSI/SI/SC REPORT.** This report lists, by ward and clinical service, all patients whose casualty status is seriously ill, very seriously ill, terminally ill, or special category.

3. **ALPHA ROSTER.** This report lists all current inpatients in alphabetical order, giving absent status and demographic data on each patient.

4. **WARD NURSING REPORT.** This report alphabetically lists all inpatients assigned to a specific ward at the time the report is run.

5. **DAILY ADMISSIONS BY DIAGNOSIS.** This report lists patients admitted on a specific date according to the admission diagnosis code that was entered at the time of admission.

6. **STATUS OUT ROSTER.** This report lists patients currently out of the hospital and gives their expected return dates.

7. **COMMAND INTEREST REPORT.** This report lists patients who are of special interest to the MTF commander, as indicated by the command interest code(s) entered for these patients.

8. **UCA BED DAYS RECAP.** This report shows the number of bed days by clinical service and ward for the month.

9. **UCA DISPOSITION REPORT.** This report shows the number of patients who have been dispositioned for the month by the UCA Clinical Service code.

10. **A&D RECAP.** This is an Army report that displays current hospital status of admissions, dispositions, and numbers of patients on each status by patient category.

11. **PATIENT STRENGTH REPORT.** This report is used by the Air Force and Navy. It displays the current hospital status of admissions and dispositions with numbers of patients on each status by patient category.

12. **INJURY REPORT.** This report lists each patient with an injury case and pertinent information about the injury and patient.

13. **DEATH REPORT.** This is a listing of all hospital deaths.

14. **ADMISSION NOTIFICATION LETTERS.** An Admission Notification letter is produced on admission for all active duty military personnel. It is used for notifying unit commanders of the date and time of admission. This letter is used for Army and Air Force only.

15. **LONG TERM PATIENT ROSTER.** A roster of all patients who have been in the hospital for the length of time that is specified by your service.

16. **PREADMISSION LIST.** An alphabetical listing of all patients who are currently preadmitted to your MTF.

17. **PROJECTED DISPOSITIONS BY AFSC/MOS.** A roster of all projected dispositions by either military specialty or AFSC.

    Note: AFSC is Air Force Skill Classification, used by the Air Force only. MOS is Military Occupational Specialty and is only used by the Army.

18. **AF235/NAVY OCCUPIED BED DAYS REPORTS.** These reports show bed day occupancy information for the time period specified.

Note: AF235 is used by the Air Force. The NAVY OCCUPIED BEDS DAYS REPORT is the Navy version of this report.

19. **DISPOSITION NOTIFICATION LETTERS.** This output is printed to notify Army unit commanders of any active-duty enlisted in their commands whose dispositions were entered into AQCESS on the report date. Disposition Letters are printed alphabetically by patient name, with one letter per page. They are produced nightly.

20. **DISPOSITION SUMMARY BY NAME.** This report summarizes all dispositions effective in the report month with data in order by name. This product is used only by the Navy, and is printed monthly.

21. **DISPOSITION SUMMARY BY REGISTER NUMBER.** This report summarizes all dispositions effective in the report month with data in order by register number. This product is used only by the Navy, and is printed monthly.

22. **ADMISSION SUMMARY BY NAME.** This report summarizes all admissions effective in the report month with data in order by name. It is used only by the Navy, and is printed month.

23. **ADMISSION SUMMARY BY REGISTER NUMBER.** This report summarizes all admissions effective in the report month with data in order by register number. It is used only by the Navy, and is printed monthly.

24. **REGISTER OF PATIENTS.** This report is a register number assignment log. For each day of the reporting period indicated by the user, the report lists the register numbers assigned and gives summary patient data for each. The data is sorted in chronological order by the date on which the admission was entered in AQCESS and, under each date, data is arranged in ascending order by register number. The Register of Patients is printed on request, and can be used in place of DD739.

25. **MED302.** The MED302 report calculates bed days, sick days, live births, and other monthly statistical data based on information which has been entered into AQCESS. It should be run after all data entry has been completed for the month. Retroactive changes to the data will NOT be added to the figures for the following month and can only be picked up by re-running the report and manually calculating the differences at this time.

    Section II of the MED302 report calculates admissions and bed days by IPDS Clinical Services. If an inpatient record contains a clinical service code for which a corresponding IPDS code is not defined, the report

will abort and display the register number of the patient for which the invalid clinical service code has been entered.

26. **AF234.** The AF235 report includes the following data:

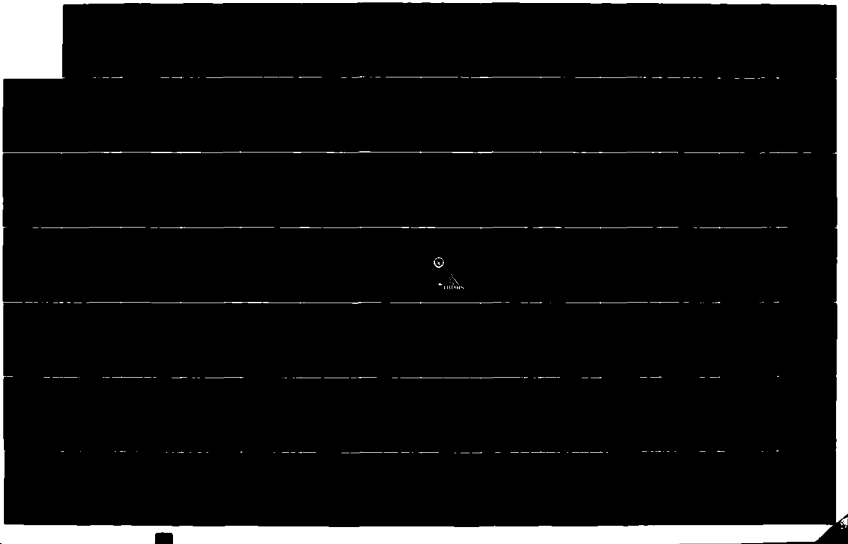
Section IV	Deaths
Section VII	EAD Mil Patients Excused from Duty (non-battle injury breakdown is not available for lines 75, 76, and 77)
Section IX	Miscellaneous Total Sick Days and Normal Days by Branch of Service (lines 118 and 119 not currently available)
Section X	Inpatient Admissions and Inpatient Days
Section XI	Disposition of Inpatients
Section XIII	Live Births

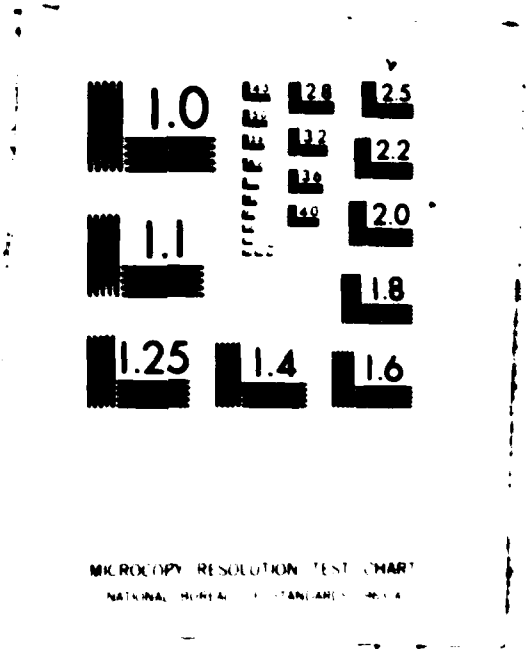
This report will be expanded at some future date.

27. **DEERS BATCH RESPONSES REPORT.** This report, sorted by date and time of query to DEERS, lists all patients who were not checked when the registration or admission screen was complete. The report lists the patient's Name, FMP, Sponsor SSN, Attending Clerk, Duty Address, REG NO, and the DEERS Eligibility Response.

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2.0
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2.8
3.2
3.6
4.0
MICROCOPY RESOLUTION TEST CHART

8.2 TO PRODUCE A REPORT

- Enter 1 and press Return on the User Entry Menu Screen.

The R/ADT Reports Selection Screen is displayed. Titles of all reports available to you are listed. The cursor is at ENTER REPORT NUMBER(S).

- Use option P2 to view page 2 of the Report Menu.

- Enter the number of the report you wish to produce. You can also enter numbers of several reports, separated by commas.

A Report Run-Time Information Screen for each selected report is displayed. Data required to complete the screen will vary, based on the run-time parameters for each report.

- Complete the required fields, which may include report date or range.

- Enter the number of copies at PRINTER COPIES. To reprint a report, enter R, followed by the numbers of copies in the PRINTER COPIES field. To display the report on the screen, press Return without entering the number of copies.

Note: Reprint causes the report last generated to be output again. It takes less time and enables printing of the most recent report.

Most reports can be displayed on the screen. Some reports cannot be displayed because they are too wide to fit on the screen. The Run-Time Information Screen will indicate if the report cannot be displayed on the terminal.

The cursor goes to the SELECTION field.

- You can press Cancel to cancel the request and return to the Report Selection Screen, or

- You can enter all or part of a field label to change some of the run-time information you just entered, or

- You can press Return to run the report.

When you leave the SELECTION field blank, press Return. The report will be displayed or printed, as you requested.

- If you are printing the report, it will print at the printer specified for it. If that printer is busy, it will produce your report when it is free, or you can enter an alternate device.

- If you are viewing the report, press Return to see all pages of it.

- At the last page of the report, press Return at ENTER SELECTION to display the R/ADT Report Menu Selection Screen.

The R/ADT Report Selection Screen is redisplayed.

8.3 OPTIONS = TO PRINT ALL NIGHTLY REPORTS OR ALL MONTHLY REPORTS:

N - ALL NIGHTLY REPORTS
M - ALL MONTHLY REPORTS
P2 - DISPLAY NEXT PAGE

8.3.1 TO DISPLAY THE NEXT PAGE OF THE REPORT MENU - OPTION P2

This enables you to display the next page of report titles.

- Enter P2 at ENTER REPORT NUMBER(S) and press Return.

The next page of report titles is displayed. A new option, P1 - DISPLAY PREVIOUS, enables you to return to the previous page of report titles.

8.3.2 TO PRINT ALL NIGHTLY REPORTS - OPTION N

This enables you to produce all reports generally run at night. The numbers of these reports are given beside this submenu option.

- Enter N at ENTER REPORT NUMBER(S).

- Complete the Report Run-Time Screen for each report, and press Return to run the reports.

Note: You can return to the User Entry Menu at this time and choose another selection, since printing is a background function.

8.3.3 TO PRINT ALL MONTHLY REPORTS - OPTION M

This enables you to produce all reports that are run monthly. The numbers of these reports are shown beside the submenu option.

- Enter M at ENTER REPORT NUMBER(S), and press Return.

- Complete the Report Run-Time Screen for each report and press Return to run the reports.

Note: You can return to the User Entry Menu at this time and choose another selection, since printing is a background function.

8.4 POINTS TO REMEMBER

1. The reports listed on the R/ADT Reports Selection Menu will vary, depending on the military department.

2. Because of their width some reports can only be run on the printer and not displayed on the CRT.

3. Some reports cannot be reprinted.

4. Printing is a "background" job; that is, you are free to continue with other processing while a report is being printed.

5. If a report is in the process of being printed, no other user can run the same report.

6. Each report is assigned a primary output device (printer). If the device is busy, you can queue your request and the report will be printed when the device is free. Or, you can direct the report to be printed on another device. However, you must know the alternative device's number. These are posted on each device in your MTF.

8.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate sections of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

SECTION 9. INPATIENT HISTORY

PROCEDURE PAGE

9.1 To Review a Patient's History.....9-4
9.2 Points to Remember.....9-6
9.3 Checkpoint.....9-7

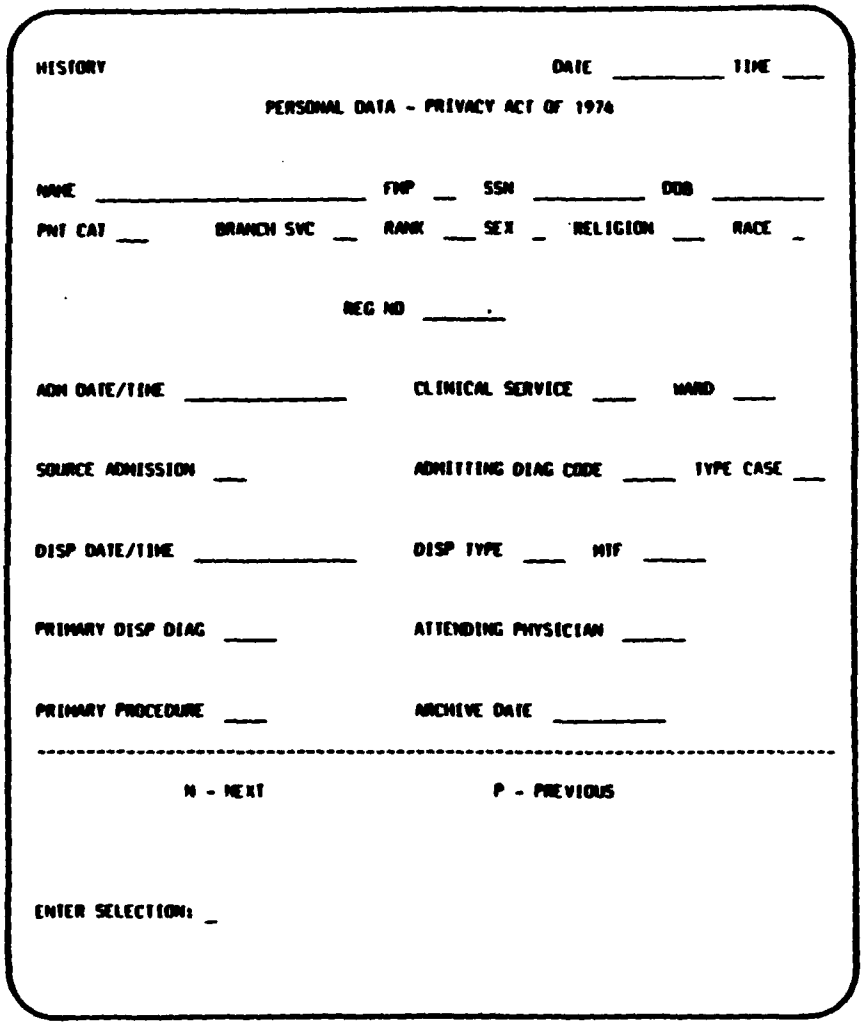


FIGURE 9.1 EPISODE CANDIDATE SCREEN

9. INPATIENT HISTORY

ACCESS Inpatient History is accessed by selecting H (Inpatient History) from the User Entry Menu Screen. The PTID Screen is displayed to enable you to identify a patient's record using valid search criteria. Once the patient record is identified, the Inpatient History Screen is displayed.

PURPOSE Inpatient History allows you to review inpatient episodes of current and dispositioned patients. The Inpatient History data cannot be updated.

DESCRIPTION Inpatient History uses an Episode Candidate Screen and an Inpatient History Screen to display information on previous inpatient episodes. Information about a single episode is displayed on each page.

OPTIONS

P - PREVIOUS PAGE. This option allows you to display past episode information, one page at a time.

N - NEXT PAGE. This option allows you to page forward through the episode pages.

9.1 TO REVIEW A PATIENT'S HISTORY

- Enter H and press Return on the User Entry Menu Screen.

The PTID Screen is displayed. The cursor is at REG NO.

- Enter valid patient identification.

- With the cursor at ENTER SELECTION, press Return. If you input the patient's REG NO., the current history screen is displayed. If you used a valid search criteria, a Candidate List is displayed. Enter the number of the patient whose history you wish to view, and press Return.

If the patient has been admitted to the MTF more than once, an Episode List is displayed listing all the episodes.

- Enter N to view the next page, if appropriate.

- Enter the number of the episode you wish to review and press Return.

Note: If you press Return without selecting an episode, the PTID Screen is displayed.

When you select the episode, the Inpatient History is displayed for the indicated episode. If the patient has only one episode, that one is displayed. The cursor is at ENTER SELECTION.

- To view a summary of an inpatient episode previous to the one being displayed, enter P and press Return.

The summarized information for the previous episode is displayed. If there are no earlier episodes, a message is displayed.

- Continue to enter P and press Return to view all earlier inpatient episode summaries for that patient.

- To view a summary of an episode later than the one bring displayed, enter N and press Return.

The summarized information for a later inpatient episode is displayed. If there is no later episode, a message will be displayed, indicating that this is the last episode.

Note: Use P and N to to page forward or backward through all the episodes.

- To return to the User Entry Menu, press Return at ENTER SELECTION, and then press the Cancel key at the PTID Screen. The User Entry Menu is displayed.

9.2 POINTS TO REMEMBER

1. The Inpatient History Screen allows you to view patient information on previous episodes one episode at a time.

2. If a patient has had more than one episode at the MTF, an Episode List is displayed and you can choose an epidsode to review.

3. To exit the Candidate List Screen or the Episode List Screen, press Return at ENTER SELECTION without entering a selection number.

9.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate sections of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

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ADMISSION AND DISPOSITION TRAINING AID

SECTION 10. PATIENT INQUIRY

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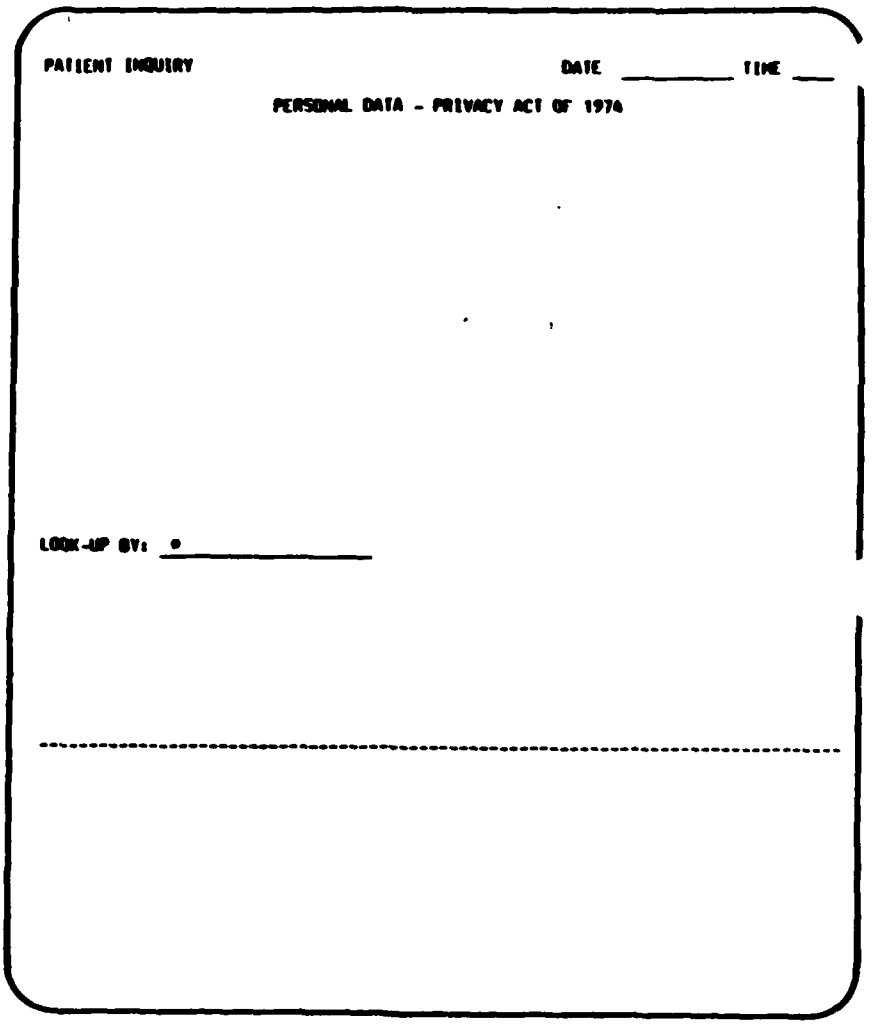


FIGURE 10.1 PATIENT INQUIRY LOOK-UP SCREEN

10. PATIENT INQUIRY

ACCESS Patient Inquiry is accessed by selecting I (Patient Inquiry) on the User Entry Menu Screen.

PURPOSE Patient Inquiry allows you to view lists of current patients who fall within certain categories specified by your MTF, and to view inpatient history related to any patient in the list.

DESCRIPTION Patient Inquiry uses a Patient Inquiry Look-Up Screen to select the category followed by the Candidate List Screen. If desired, the Inpatient History Screen is used to view information on a selected patient.

10.1 TO VIEW A LIST OF PATIENTS BY CATEGORY

- Enter I on the User Entry Menu Screen and press Return.

The Patient Inquiry Look-Up Screen is displayed. The cursor is at LOOK-UP BY:

- Use the HELP key to display your MTF's categories.

Your MTF's categories are displayed below the LOOK-UP field.

- Enter the name of your selected category and press Return.

The cursor moves to the next field where you must enter additional information about your selected category.

- For example, to look up all the patients in a ward, you must enter the ward ID. To look up by attending physician, you must enter the physician's short name.

- Enter information specific to that category and press Return.

The Candidate List Screen is displayed.

- To view additional pages of the Candidate List, type N to view the next page and press Return. You can continue to enter N to view all pages in the list.

10.2 TO VIEW INPATIENT HISTORY

- With the Candidate List Screen displayed, enter the number that appears at the left of the patient's name and press Return.

The patient's Inpatient History summary is displayed. Refer to the Inpatient History Section for information on this screen.

10.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate sections of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

BED MANAGEMENT

PROCEDURES

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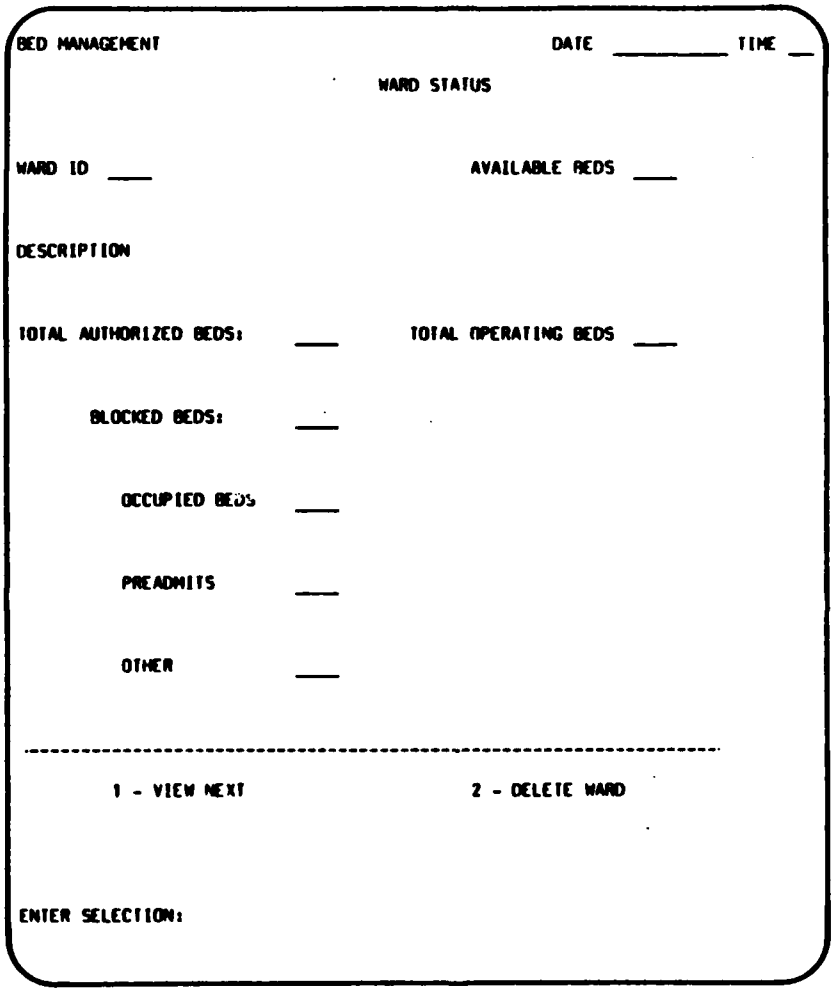


FIGURE 11.1 BED MANAGEMENT ID SCREEN

11. BED MANAGEMENT PROCESSING

ACCESS Bed Management processing is accessed by entering 8 on the User Entry Menu Screen.

PURPOSE The Bed Management process enables you to review and maintain data on the number of beds that are available or occupied on each ward. It enables you to create a ward status record for a ward, which must be done before you can assign patients to that ward. Bed Management also enables you to delete the ward status record for a ward.

DESCRIPTION Bed Management processing uses an ID Screen and a Bed Management Screen. When a ward is identified by ward ID number, the screen displays bed information for that ward.

OPTIONS

1 - VIEW NEXT enables you to page through ward status records.

2 - DELETE WARD enables you to delete a ward.

11.1 TO VIEW TOTAL BED INFORMATION

- Enter B and press Return on the User Entry Menu Screen.

The Bed Management ID Screen is displayed. The cursor is at WARD ID.

- Enter TOT and press Return to view the total bed information for your MTF.

The Bed Management Screen is displayed showing total bed information for your MTF. The cursor is at ENTER SELECTION.

11.2 TO VIEW/UPDATE WARD/BED INFORMATION

- Enter B and press Return on the User Entry Menu Screen.

The Bed Management ID Screen is displayed. The cursor is at WARD ID.

- Enter the ID number or name of the ward for which you wish to view bed information and press Return.

The Bed Management Screen is displayed. The cursor is at ENTER SELECTION.

- To view the next ward, enter 1 and press Return.

- Continue to select VIEW NEXT and press Return to view all the wards in your MTF.

- When the ward information you wish to update is displayed on the screen, enter a partial label for the data field you wish to change and press Return.

- Make any necessary updates.

- When the cursor returns to ENTER SELECTION, press Return to store the changes.

Note: Once you have updated a ward, you must store the record. You may not use option 1 to contiue viewing wards.

11.3 TO DELETE A WARD

- On the Bed Management Screen for the ward you wish to delete and with the cursor at ENTER SELECTION, enter 2 and press Return.

If the ward is not empty, you will not be able to delete it: A message is displayed: CANNOT DELETE WARD - WARD NOT EMPTY.

If the ward is empty, it can be deleted. A message is displayed: ARE YOU SURE YOU WANT TO DELETE?

- Enter Y for Yes and press Return to delete the ward. (Enter N for No if you want to cancel the deletion.)

Note: The ward is not actually deleted from the data base and will still appear in the Help list for the ward table. The system uses the delete date internally to determine if it is valid to assign patients to this ward.

The Bed Management ID Screen is displayed. The ward information is deleted, but the ward ID remains with 0 beds. The deleted ward is no longer a valid entry in the ward field.

11.4 TO CREATE A WARD STATUS RECORD

- Enter B and Return on the User Entry Menu Screen.

The Bed Management ID Screen is displayed. The cursor is at WARD ID.

- Enter the new ward ID and Return. Ward ID may not be all numeric.

The Bed Management Ward Status Screen is displayed. The cursor is at DESCRIPTION.

- Enter the description of the ward and Return.

The cursor moves to TOTAL AUTHORIZED BEDS.

- o Enter the total number of beds authorized under the maximum expanded capacity for the new ward and Return.

The cursor moves to TOTAL OPERATING BEDS.

- o Enter the number of beds normally in use in the ward.

Note: This number can be manually overridden on a per patient basis until the TOTAL AUTHORIZED BEDS figure is reached.

The cursor moves to OTHER.

- o Enter the number of beds that are unavailable for use and Return.

The number of beds you indicated as unavailable appears in the BLOCKED BEDS field, and the remaining available beds appear in the AVAILABLE BEDS field. The cursor is at ENTER SELECTION. The OCCUPIED BEDS and PREADMITS fields will increment as patients are assigned to the ward and will decrement as they are dispositioned.

- Press Return to store the information and create the new ward.

The ward status record for this ward is now created. The Bed Management ID Screen is displayed.

Note: When creating a ward, be sure to store it first by pressing Return at ENTER SELECTION before viewing data on other wards.

11.5 POINTS TO REMEMBER:

1. Only an empty ward can be deleted. Even if there are no inpatients in a ward, the ward cannot be deleted if any beds are blocked.

2. When you are creating a ward status record, the system checks to make sure that no ward with that ID exists. If it does, the Ward Status Screen will display the ward information for the existing ward.

3. For a ward to be valid for a specific clinical service, the system manager must specify the wards which are valid for each clinical service.

11.6 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate sections of the Training Aid, the tutorial, or the packet to gain the understanding you need.

ADMISSION AND DISPOSITION TRAINING AID

SECTION 12. CORRECTION MANAGEMENT

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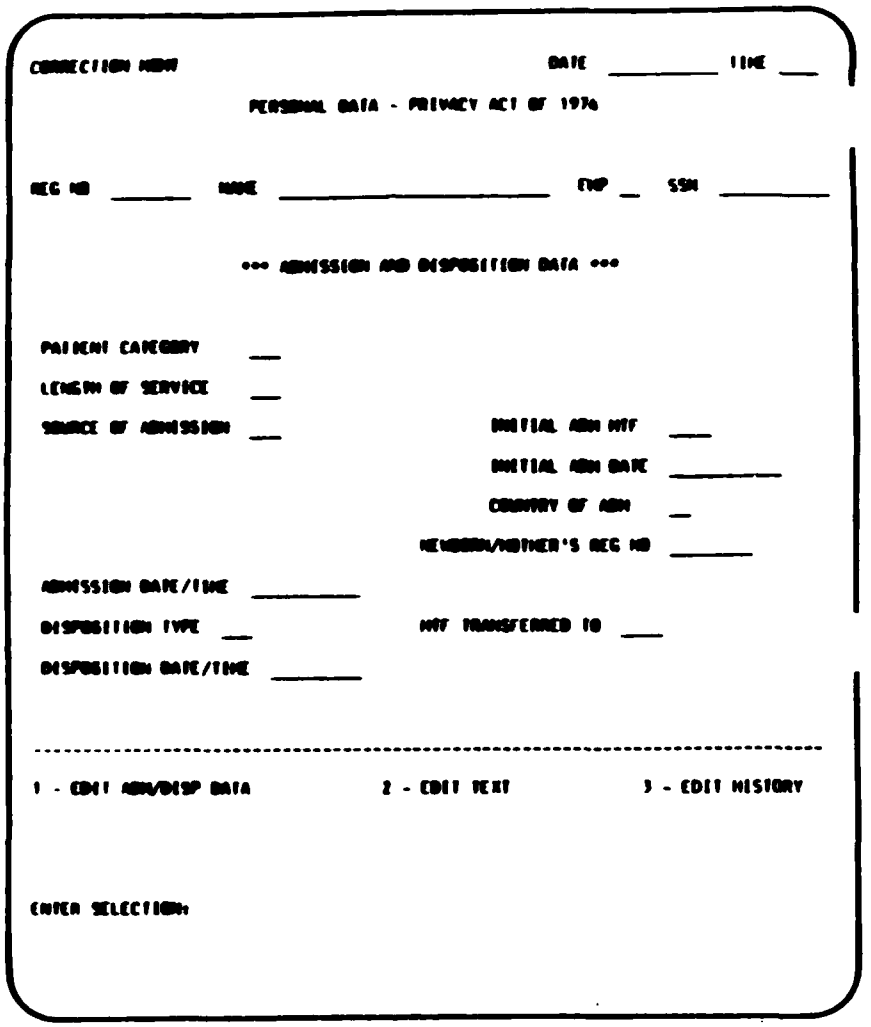


FIGURE 12.1 CORRECTION MANAGEMENT ID SCREEN

12. CORRECTION MANAGEMENT

ACCESS Correction Management is accessed by entering E (Correction Management) on the User Entry Menu Screen.

PURPOSE The Correction Management process enables you to correct errors in the initial admission and disposition data that are not correctable through any other process, such as source of admission and admission date/time. You also use Correction Management to correct text notes that appear on the A&D Report, and to change records of A&D events such as admissions and dispositions.

DESCRIPTION In addition to an ID screen, Correction Management uses three screens that enable you to edit admission and disposition data, edit text, or edit admission and disposition events for a particular inpatient episode.

Note: Correction Management is a powerful tool. Be sure you understand its capabilities thoroughly, and use it with extreme caution.

ADMISSION AND DISPOSITION TRAINING AID

OPTIONS

1 - EDIT ADM/DISP DATA enables you to correct admission or disposition information entered incorrectly.

2 - EDIT TEXT enables you to edit text that will appear on the next A&D Report, or to delete text.

3 - EDIT A&D EVENTS enables you to view or change the record of A&D events such as admissions, dispositions, and changes in absent status and clinical service.

12.1 TO ACCESS A PATIENT'S RECORD FOR CORRECTION

- Enter E and press Return on the User Entry Menu Screen.

The Correction Management ID Screen is displayed. The cursor is at REG NO.

- Enter the patient's register number and press Return.

The patient's name, FMP, and SSN will be displayed. Three options will also be displayed. The cursor will be at ENTER SELECTION.

- Enter the appropriate option for the task you wish to perform.

  1 - EDIT ADM/DISP DATA

  2 - EDIT TEXT

  3 - EDIT A&D EVENTS

12.2 TO EDIT ADM/DISP DATA - OPTION 1

- This option enables you to correct specific information that was entered when the patient was admitted and dispositioned.

- With the Correction Management Menu displayed, enter option 1 and press Return.

The Correction Management Admission and Disposition Data Screen is displayed. The cursor is at PATIENT CATEGORY.

- Make any correction to A&D data by typing over the incorrect data and press Return after each entry.

Note: See Section 12.5 for conditions that affect how you can edit the A&D data.

- With the cursor at ENTER SELECTION, press Return.

A confirmation message is displayed: OK TO FILE (Y/N)?

o Enter Y to confirm the correction.

The system displays a message stating that the system is filing, then the Correction Management ID Screen is redisplayed. The cursor is at REG NO field.

12.3 TO EDIT A&D REPORT TEXT NOTES - OPTION 2

NOTE: This option enables you to correct notes that will appear on the next A&D Report. These notes are generated automatically when information about an event is entered in Admission or Transfer Processing on a day other than when the event occurred.

Example: If a patient were actually admitted to the MTF on one day, but the admission date was not entered into the system until the following day, a note would be displayed; ADMISSION ENTERED ON DATE OTHER THAN ADMISSION DATE.

You can also use this option to add notes for the A&D Report or delete notes from it.

TO EDIT TEXT:

o Enter option 2 and press Return.

The Correction Management A&D Report Text Screen is displayed. The cursor is at ENTER LINE NUMBER.

- To edit, enter the number of the line you wish to delete or change. To add, enter the line number of the next blank line.

Note: You cannot change or delete any note that has already appeared on a report. If you try to access such a note, an error message is displayed: THE A&D REPORT DATE MUST BE TODAY.

The cursor is at the line you selected.

<u>To Change</u>: Enter the new information over the existing EFFECT DATE or TEXT MESSAGE fields.

<u>To Add</u>: Enter the new information on the next blank line in the EFFECT DATE and TEXT MESSAGE fields.

Note: REPORT DATE will be automatically filled in with today's date when the new text note is stored.

To Delete: With cursor positioned at the EFFECT DATE field on the line to be deleted, use the Clear Data key to delete the text.

- Press Return when you have changed, added, or deleted the information.

The cursor moves to ENTER SELECTION. The options are redisplayed.

- Press Return at ENTER SELECTION.

A confirmation message is displayed: OK TO FILE (Y/N)?

- Enter Y to store the data.

The Correction Management ID Screen is displayed. The cursor is at REG NO field.

12.4 TO EDIT A&D EVENTS - OPTION 3

An A&D event is an admission, a disposition, or any change in absent status, clinical service, or ward. Option 3 enables you to view, change, or add data about the admission event.

Note: See Section 12.5 for conditions that affect how you can edit events.

12.4.1 TO CORRECT AN EVENT

- Enter option 3.

The Event Record Screen is displayed. The cursor is at ENTER LINE NUMBER.

- Enter the line number for the line you wish to correct. Or, to add an event, enter the line number of the first blank line.

The cursor is at the EFFECTIVE DATE/TIME field on the line you selected.

- Press Return if the effective date and time are correct or enter a new date/time. The system prompts you to specify the type of event to be created (absent status, clinical services, or ward). If you have entered a valid date/time and event, you can enter the data.

The cursor moves to different fields depending on the type of event. For example, if the event is a transfer between wards, the cursor move to OLD WARD and you can change the old ward and press Return. Then the cursor moves to NEW WARD, which you also can change.

- Enter the correction and press Return. The cursor will return to ENTER LINE NUMBER.

- Press Return to store the correction.

The Correction Management Menu is redisplayed.

12.4.2 TO ENTER AN EVENT

- Enter option 3.

The Event Record Screen is displayed. The cursor is at ENTER LINE NUMBER.

- Enter the number of the first empty line and press Return.

The cursor moves to that line and the EFFECTIVE DATE/TIME field.

- Enter the valid effective date and time of the event you are adding to the history.

The type of events you can enter (absent status, ward and clinical service) are displayed with numbers in the lower right corner of the screen. The cursor is at the end of this line.

Note: You cannot add an absent status, clinical service, or ward change to the end of the patient's history if the patient has not yet been dispositioned.

- Enter the number corresponding to the event you wish to add to the history.

The cursor moves to the indicated event type field on the line on which you entered the date.

- Enter the new event data by completing the fields on that line.

- When the cursor returns to ENTER LINE NUMBER, press Return to store the new event.

Important: A&D event data is very complex and critical to the patient's record. Many different data relationships can exist. You should have a thorough understanding of these events and how they relate to one another before you use this option.

12.5 POINTS TO REMEMBER

1. One user at a time can use Correction Management processing.

2. When you're entering data on the Admission and Disposition Data Screen (option 1), remember:

   - You cannot disposition a patient or cancel a disposition.

- o You cannot enter a CRO, ERD, or pay status code at SOURCE OF ADMISSION.

- o You cannot change a source of admission if it is CRO, ERD, pay status, absent sick, or cancelled.

- o If the source of admission is changed from transfer-in, to direct, the system deletes related transfer-in data.

- o If the source of admission is changed to transfer-in, you must enter related transfer-in data.

3. When you are adding notes (option 2) you will not be able to change the REPORT DATE, which always indicates today's report.

4. When you are editing an event record (option 3), remember:

   - o Two OUT absent statuses may not appear consecutively because patients must be IN before they can be changed to OUT.

   - o If you insert an OUT absent status, you must enter an old ward.

   - o If you insert a change of absent status to Bed Occupied, you must enter a new ward.

- o Changes from an absent status of ON PASS will not result in a new or old ward displayed, since days spent On Pass are counted as bed days.

- o If you insert a change of ward, you must enter an old and a new ward.

5. Fields which default to the same information on the Admission Screen will not default if one is corrected through Corrections Management. For example, the Admission Date/Time and Attending Physician Date/Time will not be the same if the Admission Date/Time is changed in Corrections Management.

12.6 CHECKPOINT

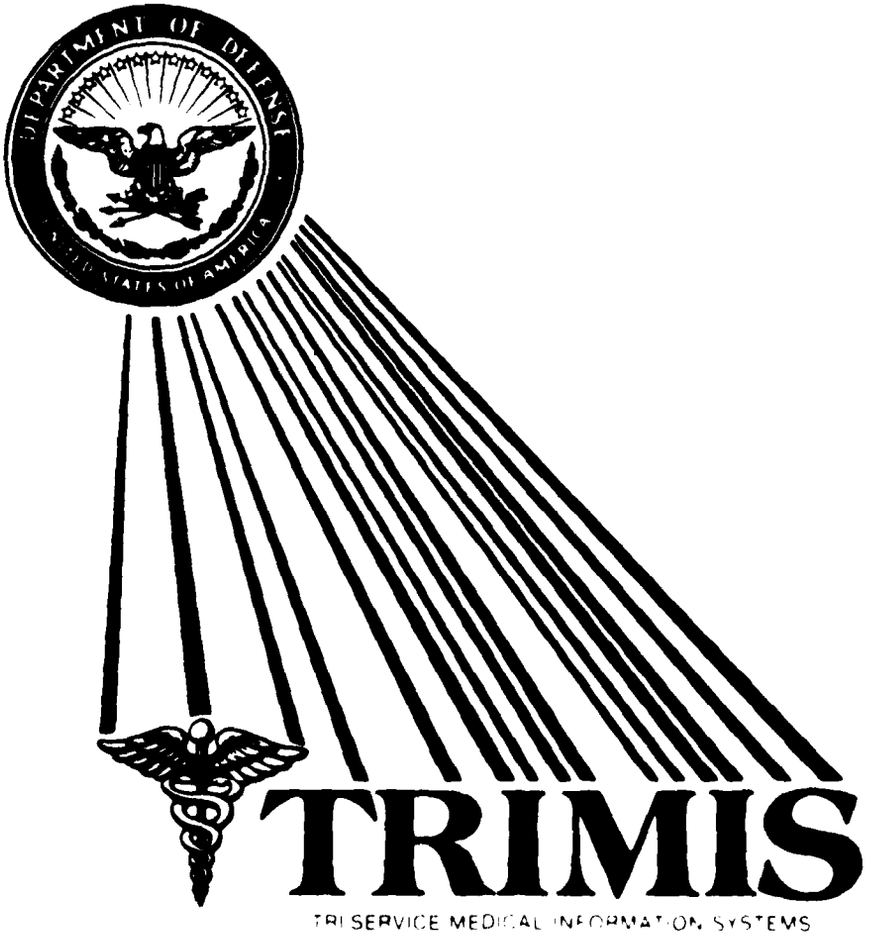
Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

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ADMISSION AND DISPOSITION TRAINING AID

AQCESS

CLINICAL RECORDS TRAINING AID



AQCESS
CLINICAL RECORDS IRAINING AID

Document Issue/Revision History

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When pages of this document are updated, the Document Issue and Revision History Numbers are printed at the bottom of the page (i.e., 1.6, where "1" indicates the Document Issue Number and "6" represents the Document Revision Number), along with the date for the revision's issue. Additionally, a revision bar (or vertical line) identifies specific text, displays, or figures that have been changed. A Documentation Change Notice (DCN) form is provided to identify those pages that must be replaced, added, or deleted in the document.

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DOCUMENTATION CHANGE NOTICE

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DOCUMENT TITLE: ACCESS Clinical Records Training Aid

ISSUE NO.: 1

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THIS NOTICE INFORMS THE RECIPIENTS THAT THE DOCUMENT IDENTIFIED ABOVE HAS BEEN CHANGED. THE PAGES CHANGED BY THIS DCN ARE ATTACHED AND CARRY THE SAME DATE AS THIS DCN. THESE PAGES NEED TO BE INSERTED AND THE INDICATED PAGES REMOVED FROM YOUR DOCUMENT.

PAGES TO REMOVE	PAGES TO INSERT	ACTION* R	A	D
v	v	X		
x	x	X		
1-1 through 1-24	1-1 through 1-24	X		
	1-25 through 1-36		X	
13-9 through 13-10	13-9 through 13-10	X		

* R = REPLACES EARLIER PAGES A = ADDED D = DELETED

PREFACE

Designed for use at 168 DoD hospitals, the Automated Quality of Care Evaluation Support System (AQCESS) is an interactive, menu-driven patient administration and quality assurance computer system. The system is composed of four subsystems, three of which are functional (Admission and Disposition, Clinical Records, and Quality Assurance). These subsystems allow the entry, updating, and display of data, as well as the production of reports for MTF's and higher command. The fourth, System Management, is separate from the functional areas of AQCESS and allows regulation of AQCESS operations and security.

Accompanying installation of AQCESS at your hospital is a fully-developed AQCESS Training Program, which includes several components. These are designed to support you through the formal AQCESS training period and as you continue to learn how to use AQCESS to perform specific processing tasks.

Training Directory	The AQCESS training directory works exactly the same as the live system. You can sign on to the system using a Training User ID and password and perform all of the data entry and processing tasks that you will be performing in the live system. The training system is completely separate from the live hospital database.

AQCESS Training Database	A training database can be loaded into the training directory by the system manager. This database contains sample patient data which can be used to practice the system's information processing capabilities.
TUTOR ME	An online tutorial that consists of lessons that describe the functions and features of AQCESS.
AQCESS User Manual	Appendixes provide detailed information about individual fields, screens, and reports for each subsystem.
AQCESS Training Aids	Provide a self-instructional tool for learning AQCESS. A separate Training Aid is available for each subsystem; each one includes detailed step-by-step procedures for use of the subsystem, "Points to Remember," that highlight key information, and "Checkpoints" that enable you to monitor your learning progress. The Training Aids' introductions are designed for use with TUTOR ME.
AQCESS Packets	Contains practice cases for you to learn the processing functions of the system.

	These are provided by your system manager.
AQCESS A&D Report Packet	Contains a paper or "hard" copy of reports that are generated by AQCESS.
Quick Guide	Provides a means to quickly reference AQCESS processing and data entry features.
AQCESS Trainer Guide	Provides instructions to the trainer for delivering user training. Incorporates the packets and training database.

As an integral component of the AQCESS Training Program, this Training Aid is designed to provide you with general information about AQCESS and detailed procedures that address use of its Clinical Records subsystem.

Section 1 introduces AQCESS, its use, and its features while Section 2 provides an overview of Clinical Records processing.

Sections 3 through 12 present the Clinical Records functions. Each is addressed in a separate, tabbed section. The first page of each tabbed section outlines the function's procedures; this outline is followed by an illustration of the appropriate screen. Facing the screen is an overview of the function which provides access instructions, an outline of its

purpose, and a brief description of the function. Then each procedure related to the function is explained in detail. Actions you take are signified by a bullet; those performed by AQCESS are enclosed in boxes.

"Points to Remember" (which list items of importance) and "Checkpoints" (which help you monitor your progress as you learn AQCESS) are included throughout the Training Aid.

To train yourself to use AQCESS, consult the Admission and Disposition, Clinical Records, and Quality Assurance Training Aids and the online tutorial, TUTOR ME. Use the procedure outlined in Section 1.4 to sign-on to the tutorial. Perform the practice exercises provided in the associated AQCESS Packets (which are available from your system manager) and use the "Checkpoints" provided in each section of the Training Aids to monitor your learning progress. Repeat exercises and review procedures whenever you cannot answer a "Checkpoint" question readily.

AQCESS CLINICAL RECORDS TRAINING AID

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AQCESS CLINICAL RECORDS TRAINING AID

1.0 INTRODUCTION

This section of the Clinical Records Training Aid provides an overview of AQCESS, its use, and its features. Sign-on procedures for the AQCESS tutorial, TUTOR ME, are included.

1.1 INTRODUCTION TO AQCESS

AQCESS, the Automated Quality of Care Evaluation Support System, is a computerized system intended to support quality of care and patient administration processing. This system has three basic objectives:

- To improve the quality and timeliness of the evaluation of health care;
- To support Patient Administration functions;
- To support Clinical Records processing.

AQCESS will make it easier for MTF personnel to keep and process accurate data, and make that data available to system users who need it. Specifically, AQCESS can help MTF personnel:

- Register, admit, and disposition patients;
- Keep track of patients' ward, clinical service, and physician assignments;
- Track patients who are absent from the MTF;

- o Complete the medical record and prepare monthly reports for submission to higher command;
- o Maintains ward status records to manage bed resources;
- o Produce forms and reports for individual patients and for the MTF as a whole;
- o Monitor quality of care indicators, and identify occurrences that could adversely affect the quality of health care;
- o Identify, document, and track quality of care problems;
- o Maintain provider profile and clinical indicator data.
- o Support Accounting Office administrative and reporting functions;
- o Calculate patient charges based on A&D data;
- o Support automated accounting with online payment posting and one-time charge posting;
- o Support recording of Dining Hall monies and reporting of Group Meal Sales;
- o Automatically distribute payments to accounting funds and create cash collection vouchers;

- o Provide automated reporting necessary to manage the accounting function;
- o Provide outpatient clinics with a method of appointing an individual patient to a specific health care provider as opposed to a block-scheduled clinic;
- o Maintain a complete history of a patient's inpatient and outpatient care at the facility; and,
- o Create and maintain unique AQCESS reports.

AQCESS accomplishes its objectives through seven subsystems:

- o Admission and Disposition (A&D)
- o Clinical Records (CR)
- o Quality Assurance (QA)
- o System Management (SM)
- o Medical Services Accounting/Business Office (MSA/Business Office)
- o Appointing and Scheduling Module of the Outpatient Encounter subsystem (A&S)
- o Ad Hoc Report Generator (Ad Hoc).

Figure 1-1 shows the functions related to each AQCESS subsystem.

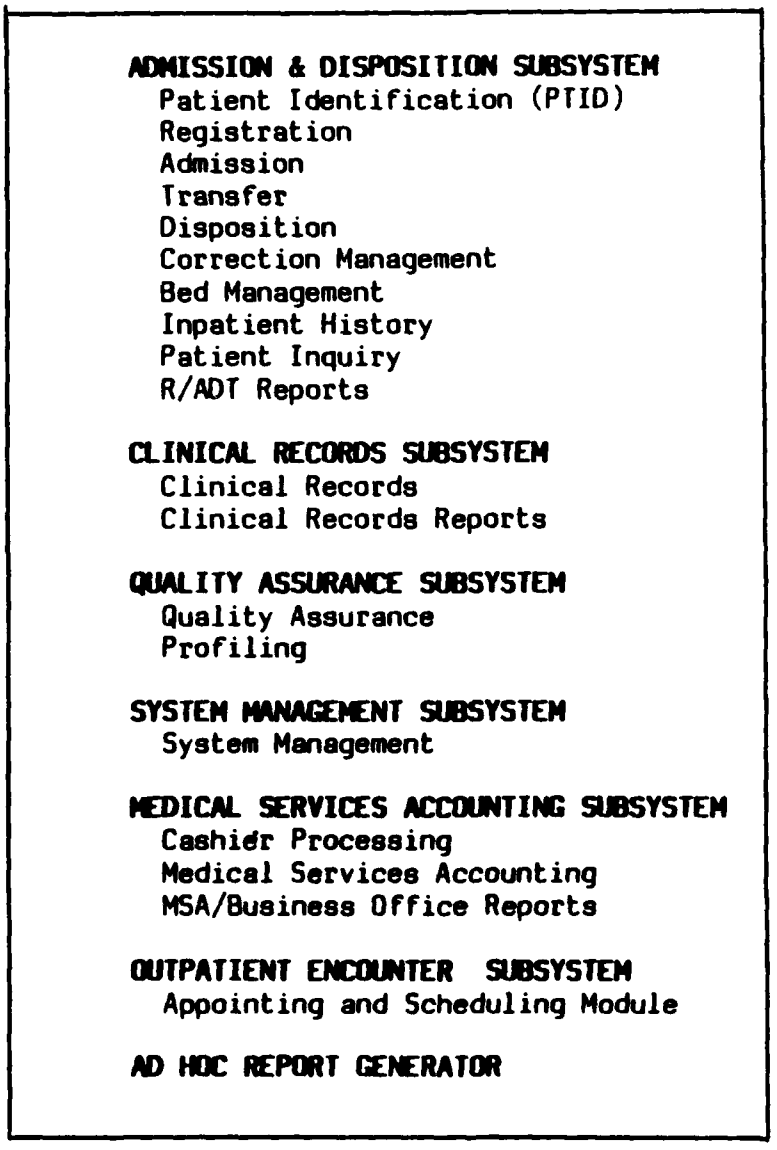


FIGURE 1-1 AQCESS SUBSYSTEMS AND FUNCTIONS

1.2 GUIDE TO AQCESS USE

AQCESS allows online entry, updating, or display of data using a computer terminal. It also provides for paper, or "hard," copy production of data in report format using a printer.

1.2.1 USE OF THE DEC TERMINAL AND PRINTER

A terminal is a tool you use consisting of a keyboard, which looks like a sophisticated typewriter keyboard, and a Cathode Ray Tube (CRT), which resembles a television screen. The particular terminal used for AQCESS is manufactured by Digital Equipment Corporation, so it is referred to as a DEC terminal. The DEC printer, a stand-alone unit, looks like a typewriter without keys. Together these pieces of equipment allow you to use AQCESS.

The **keyboard** is used to type, edit, and store data. In addition to the letter and number keys, this keyboard has other keys that you use to communicate with the computer <u>about</u> the data you type. Figure 1-2 summarizes the use of these keys. For more information, see TUTOR ME, Lesson 2.

The **CRT screen** allows you view data displayed by the system and to see data as you enter it in AQCESS.

The **printer** is used to produce hard copies of the data you see on the CRT screen or data generated by the system.

AQCESS can select and format data and print it in the form of reports for use in your MTF and for submission to higher command. This will eliminate the hours of work involved in manually preparing reports. And since production is faster, reports can be more timely and more useful to MTF staff.

Each terminal is set to default to a printer specified by the system manager. The default printer will print "hard" copies of the screens when you press the control key with P.

For each terminal, reports will be sent to print at a printer specified by the system manager.

Products such as admission forms and cards will also be set to print at a specific printer.

Your system manager is responsible for managing the system and setting up the printers.

Ask your supervisor or system manager to demonstrate how the printer is loaded with paper or forms and to indicate what other procedures are required for using this equipment.

Name & Symbol	Used With	When You Press this Key:
Return		Cursor moves from field to field. Used at the end of a screen, Return transmits the data entered to the system for storage.
Shift	Many Keys	The top character of a two-character key is entered, as on a standard typewriter.
Help		The screen displays information about the data field you are in, such as length, type, and format of the data you can enter. Also displays codes that can be entered in that field.
Explain Error		The screen displays a detailed explanation of the error message that is being displayed.
Back-up		Cursor moves back one field at a time. Cursor must be at the first character of the field when you press Back-up. This key doesn't work at the first field on the screen.
Entry Done		Cursor skips the remaining fields on the screen and moves to ENTER SELECTION at the bottom of the screen.

FIGURE 1-2 SPECIAL FUNCTION KEYS
(PAGE 1 of 2)

Name & Symbol	Used With	When You Press this Key:
ALL	Shift	Cursor moves from bottom of screen to the first accessible field on the screen; you can access any updateable field on the screen and enter data.
Delete DEL		Cursor backs up one space and deletes whichever letter occupied that space. Used to delete typographical errors that were just entered.
Clear Data	Shift	All the data entered in a field is erased. Cursor must be at the first character in a field when this key is pressed.
Cancel	Shift	The system abandons what you have been doing. No data entered immediately before cancelling is stored. You return to the previous processing function or screen.
CTRL	P	The screen being displayed is printed at the printer associated with your terminal.

FIGURE 1-2 SPECIAL FUNCTION KEYS
(PAGE 2 OF 2)

1.2.2 SYSTEM FEATURES

AQCESS enhances the information processing capabilities of your facility with clear, easy-to-use, automated procedures; editing mechanisms that help ensure the accuracy of entered data; and security features that protect the information contained in the system.

1.2.2.1 AQCESS SCREENS

Your CRT displays data in a predetermined format, called a screen. Areas of the screen where data can be typed or displayed are called fields. The cursor is a blinking rectangle that shows you where the first character of data will be entered.

AQCESS screens are designed consistently to facilitate entry of data. The name of the screen is displayed in the upper left corner; the current date and time is displayed in the upper right corner. Screen selections and options are separated from the screen's fields by a dotted line. Messages are displayed at the bottom of the screen.

There are two types of screens: menu screens and data entry screens. Menu screens list functions you can perform and allow you to choose a function by entering the letter or number representing it in a selection field.

Data entry screens are arrangements of fields in which you can enter data or where entered data is displayed. The lower portion of most data entry screens contains a sub-menu listing functions you can perform at this screen.

A screen segment is a group of related data fields that can replace part of a data entry screen. The area in which alternate screen segments can be displayed is called a screen window.

Some fields on screens are required, meaning that you must enter data in them. If data is not entered in a required field, an error message will be displayed. On the other hand, some fields cannot be used because they do not apply to your military department; you will not be able to access these fields.

Examples of AQCESS screens appear throughout this Training Aid, illustrating the Clinical Records functions.

1.2.2.2 ENTERING AND UPDATING AQCESS DATA

Usually, the first time you access a screen, the cursor will be positioned at the first field where you can enter data. You must begin your entry at the first character in the field.

You can update, or change data on a screen by typing over it. To move the cursor to a field you wish to update, you can (1) type the name of that field or part of the name at ENTER SELECTION and press Return. When you have entered the update, the cursor will return to ENTER SELECTION. Or (2) you can type ALL to go to each field on the screen. The cursor will return to ENTER SELECTION after the last field on the screen.

When you have finished an initial data entry or an update, the cursor is at ENTER SELECTION. To store the data you have just entered, press Return. No data is actually stored on the system until you do this.

1.2.2.3 SYSTEM EDITS

As you enter data, AQCESS edits, or checks, it protect the integrity of AQCESS data. There are three types of edits: validity, consistency, and final edits.

Validity edits are performed as you enter data in each field. These edits determine whether the data you enter fits the parameters set up for the individual field. For example, if you enter a date such as March 35th (where the date is greater than 31) or a Social Security Number such as 123-AB-4566 (where letters are included in a field that only allows numbers), validity edits will detect this as an error.

For some fields there is a list of codes that can be entered (this list is called a system table). Validity edits determine whether the code you entered exists in the table.

When you enter invalid data, a beep sounds and an error message, such as INVALID ENTRY, appears at the bottom of the screen along with a description of the kind of data or a list of codes that can be entered. The cursor goes to the beginning of the incorrect field, and you must enter valid data before you can go on. (You can press Return and that field will be redisplayed with the data it contained previously or it will be blank.)

Consistency edits are performed after you have completed data entry on an entire screen. Consistency edits check whether relationships between data entered in different fields are correct, since data entered in one field may be inconsistent with data entered in another field. For example, when you indicate in one field that a patient's status is active duty and in another field that the patient is 12 years old, a consistency edit detect this as an error.

When a consistency error is found, an error message is displayed and the cursor moves to the first field in the inconsistent relationship. If you press Return, the cursor will go to the next field involved in the error. You can change any of the fields involved. When the error is corrected, the cursor returns to ENTER SELECTION.

Usually you must correct a consistency error before you can go on. Occasionally you are given a warning of a condition that may or may not be inconsistent. Warning error messages are followed by the question, OVERRIDE? To override the message and indicate that this data is actually correct, enter Y.

The Clinical Records subsystem also performs edits on completed clinical records. These final edits check the CR data against the A&D data to verify that the information is correct. Errors are indicated on an error list. You must correct any errors either in A&D or CR before the record can be approved.

1.2.2.4 AQCESS SECURITY

Because AQCESS processes highly sensitive data on patient care, a number of provisions have been designed to protect the security of the data in the system. Among these features are user ID and password, time out, predesignated terminal capabilities, and secure reports.

Each user is assigned a private user ID and password, which are used to gain access to the system. Associated with each user ID and password are the system capabilities this user is authorized to perform.

Screens "time out," or are erased from the CRT, if no data is entered or no function key is pressed within a specified length of time. This prevents unattended terminals from being accessed by unauthorized personnel.

The capabilities that can be performed at each terminal are also designated.

Some reports are defined as "secure" reports and may only be printed on the primary printer for the report.

1.3 AQCESS TUTORIAL SIGN-ON PROCEDURE

The preceding sections of this Training Aid provide a general introduction and overview to AQCESS. This section serves to introduce you to the AQCESS tutorial, so you can use TUTOR ME and this Training Aid together to learn AQCESS.

Since you will be using the AQCESS on-line tutorial, TUTOR ME, as a first step in learning the system, you should know how to sign on to the tutorial. Look at the AQCESS terminal screen. You should see the words USER ID and below it, the word PASSWORD. You should also see a retangular blinking block by USER ID. This block is called the cursor and it shows you when you are on the screen. To sign on:

- Type the word TUTOR.
- Find the Return key on the keyboard and press it.
- Type the word ME.
- The screen should look like this:

```
USER ID TUTOR
PASSWORD ME
```

- Press Return.
- You are now signed on to the system in the AQCESS tutorial.

- Press Return again.
- You should see a list of the lessons provided in the AQCESS tutorial. These lessons are as follows:

  1. INTRODUCTION
  2. LEARNING YOUR KEYBOARD
  3. SCREEN PROCESSING
  4. DATA ENTRY AND EDITING
  5. DATA ENTRY SHORTCUTS
  6. SYSTEM FUNCTIONS

You will complete many of these lessons as part of your training program. To see the first tutorial, INTRODUCTION, find the number 1 on your keyboard and press it. Follow the instructions on the screen for completing the tutorial.

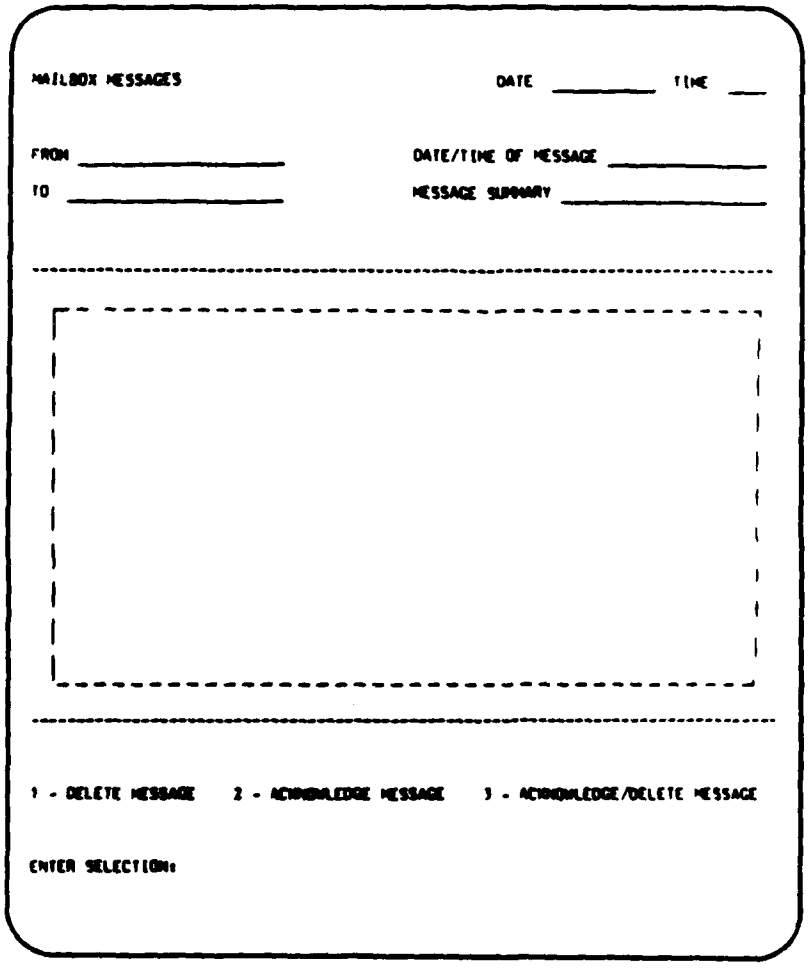


FIGURE 1.3 MAILBOX MESSAGE SCREEN

1.4 THE MAILBOX FUNCTION

ACCESS The Mailbox function is accessed by entering MX on the User Entry Menu.

PURPOSE The Mailbox function enables you to send 'mail' to other users. Messages can be viewed on the screen or printed on paper, acknowledged (returned to sender with or without notation), and deleted.

DESCRIPTION The Mailbox function is comprised of two screens: the Mailbox Message Screen and the Mailbox Candidate Message Screen. The Mailbox Message Screen is used to send, acknowledge, or delete a message. The Mailbox Candidate Message Screen is used to select a particular message from a group of messages for viewing.

OPTIONS On the Mailbox Message Screen:

1 - DELETE MESSAGE enables you to delete a message from your mailbox.

2 - ACKNOWLEDGE MESSAGE enables you to communicate to a sender that you have receive his or her message.

3 - ACKNOWLEDGE/DELETE MESSAGE enables you to acknowledge a message and to delete it from your mailbox.

On the Mailbox Candidate Message Screen:

S - SEND A MESSAGE enables you to send a new message. This option is used to access a blank Mailbox Message Screen.

1.4.1 TO SEND A MESSAGE

- o Enter MX on the User Entry Menu Screen. Press Return.

The Maibox Menu Screen is displayed. The FROM field defaults to your User ID. The DATE/TIME OF MESSAGE field defaults to the current date and time. The cursor is at the TO field.

- o Enter the User ID of the individual who should receive your message. Press Return.

The cursor moves to MESSAGE SUMMARY.

- o Enter a short description of the message. Press Return.

The cursor moves to the first character position of the message box.

- o Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- Press Return to send the message to the receiver.

The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.4.2 TO VIEW A MESSAGE

If you have a message in your mailbox, the system will display the following at the bottom of the User Entry Menu Screen: MAILBOX MESSAGES WAITING - ENTER MX FOR MAILBOX FUNCTION.

- Enter MX at ENTER SELECTION. Press Return.

The Mailbox Candidate Messages Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the number identifying the message you wish to view. Press Return.

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

Note: Only 10 messages can be listed on the Mailbox Candidate Messages Screen at one time. If you have accumulated 10 messages, the system will notallow you to

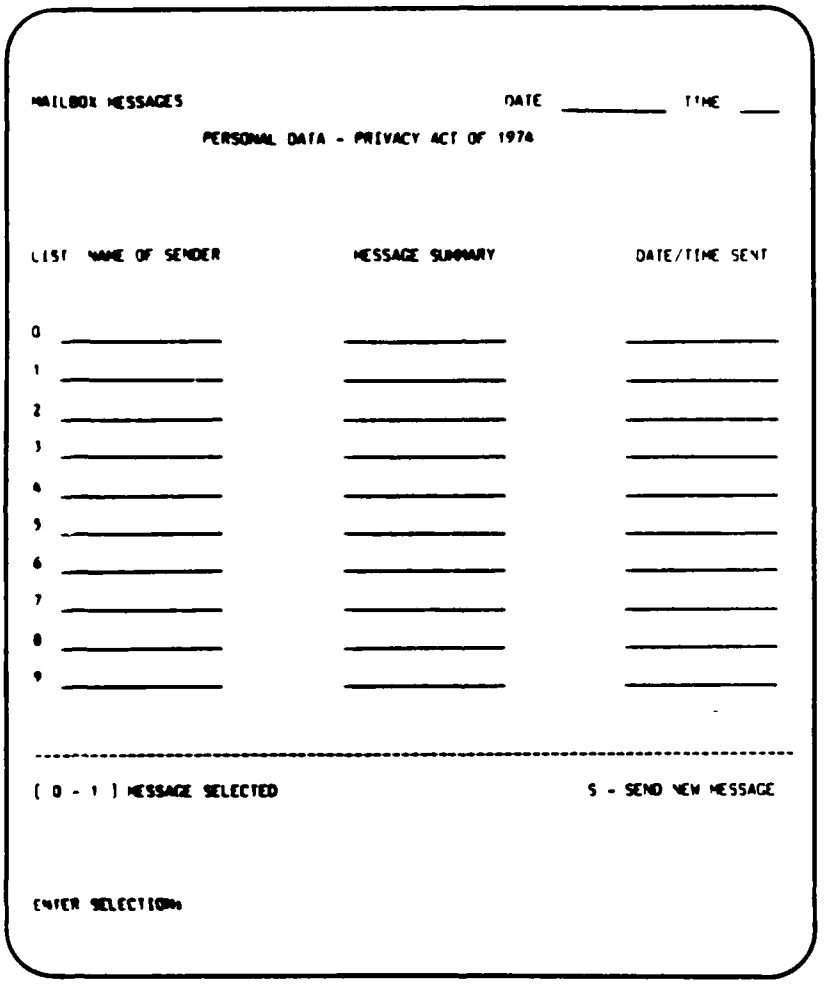


FIGURE 1.4 MAILBOX CANDIDATE MESSAGE SCREEN

send mail. You must delete stored messages to reinstate the capability. Messages which you wish to save can be printed using the CTRL P function at ENTER SELECTION.

To delete a message:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 1 at ENTER SELECTION. Press Return.

The message is deleted. The User Entry Menu is displayed.

To acknowledge a message:

1. If you wish to send an acknowledgment message back to the sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

o Enter ALL. Press Return.

The cursor moves to the TO field.

o Press Return until you move the cursor into the message box. Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send the acknowledgment message to the sender. The User Entry Menu screen is displayed. The cursor is at ENTER SELECTION.

2. If you wish to acknowledge receipt of a message but you do not want to send a new message back to the original sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send an acknowledgment to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.5 GLOSSARY OF TERMS

A&D	Admission and Disposition. The AQCESS subsystem that processes patient administration information.
A&S	Appointing and Scheduling Module of the Outpatient Encounter subsystem.
Ad Hoc	Ad Hoc Report Generator subsystem.
AQCESS	Automated Quality of Care Evaluation Support System.
Character	Any letter, number, symbol, or space in a field.
CR	Clinical Records. The AQCESS subsystem that processes clinical records information.
Codes	Characters which are abbreviations for words. For example, "s" might designate marital status of single.
Computer	A device capable of accepting data (input), applying prescribed processes (program) to the data, and supplying the results of these processes as meaningful information (output).
Computer Hardware	A computer's mechanical, magnetic, electronics, and electrical equipment.

Computer Terminal	The device with which data is input or output. It consists of a keyboard and Cathode Ray Tube (CRT).
CRT	Cathode Ray Tube. The screen or display unit on a computer terminal which resembles a television.
Cursor	The blinking rectangle used on the CRT screen to mark the current position on the screen where data can be entered or a selection made.
Data	A collection of facts or figures.
Database	A collection of data.
Data entry screen	A screen on which data is input.
Default	A selection made automatically by the system when no explicit choice is specified by the user.
DoD	Department of Defense.
Down	The condition in which the computer is not operational.
Edit	Computer activities that check input for validity and consistency.
Enter	The process by which information is transmitted to the computer through a terminal.

Field	The various areas of the screen that always contain the same type of information (e.g., the NAME field.)
Input	The transfer of data into the computer. The data to be processed.
Keyboard	The rows of keys attached to the CRT, used to communicate data to the computer.
Label	The pieces of information on a screen that identify the data to be entered in a field.
Menu Screen	A screen which allows you to select from a list of processing options.
MSA	Medical Services Accounting subsystem.
MTF	Medical Treatment Facility; a military hospital.
Numeric	Pertaining to a character set that contains numbers only.
On-line	The state in which a terminal can be used to send information to or receive information from the computer.
Output	Information produced by a computer in a readable form such as a printed report or information on a display screen.

Password	A confidential code that allows access to the computer system. Passwords are part of a security system that allows only authorized personnel access to the system.
Printer	The equipment used to print messages, forms, labels, and reports.
QA	Quality Assurance. The AQCESS subsystem that processes quality assurance information.
Required field	A field on a screen where data must be entered.
Screen	The display surface of a terminal or the information on the terminal.
Sign-on	The identification process that a user performs to begin work with a computer system. In AQCESS, sign-on consists of a user ID and a password. These are assigned by the system manager.
Software	A set of computer programs, procedures, rules, and documentation recorded in the computer's memory that operates and directs the use of the computer hardware.

Submenu	A menu found on the bottom of a data entry screen that lists the other options for that screen.
Up	The condition in which the computer is operational.
Update	Changing data after it is stored in the system.
User	One who uses the computer system on a day-to-day basis.

1.6 CHECKPOINT

Your reading of Section 1, Introduction, provides a basic understanding of AQCESS. Use the questions listed below to check your progress. If you cannot readily answer a question, review the pertinent subsection. Verify your answers by checking those shown on the next page.

1. List the seven subsystems that process AQCESS information.

   _____

   _____

   _____

2. Generally describe the kind of information that is processed by these subsystems.

   _____

   _____

   _____

3. How does AQCESS use menu and data entry screens to help you organize information that is to be entered?

   _____

   _____

   _____

4. How do you get data in AQCESS?

_____

_____

5. How does AQCESS ensure that entered data is accurate and sensible?

_____

_____

6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

Action	Keys
_____You want to know the valid entries for a field.	a. Clear Data
_____You want to delete information from a field in which it has been stored.	b. Delete c. Entry Done
_____You made a typo and want to correct it.	d. Return e. Explain Error
_____You have finished all required entries on a screen and want to store the information.	f. Help
_____You need additional information to correct an error condition.	

CHECKPOINT ANSWERS

1. List the seven subsystems that process AQCESS information.

   Admission & Disposition, Quality Assurance Clinical Records, System Management, Medical Services Accounting, the Appointing and Scheduling Module of the Outpatient Encounter subsystem, and the Ad Hoc Report Generator.

2. Generally describe the kind of information that is processed by these subsystems.

   patient registration, admission, disposition info; quality of care info; provider profile and performance; resource use.

3. How does AQCESS help you organize information that is to be input?

   Menu screens enable you to choose a particular processing function. Data entry screens and related screen segments collect information for that function in a sequence that is logical and that facilitates information storage and reporting.

4. How does AQCESS acquire its information?

   Information is input into a computer terminal.

5. How does AQCESS ensure that its information is accurate and sensible?

Validity edits check data as it is input. You are notified of an invalid entry by a beep and a message that describe the error condition. Consistency edits check to see that the relationships between data entered in different fields is valid. If an entry in one field is incompatible with an entry in anther field, an error message is displayed.

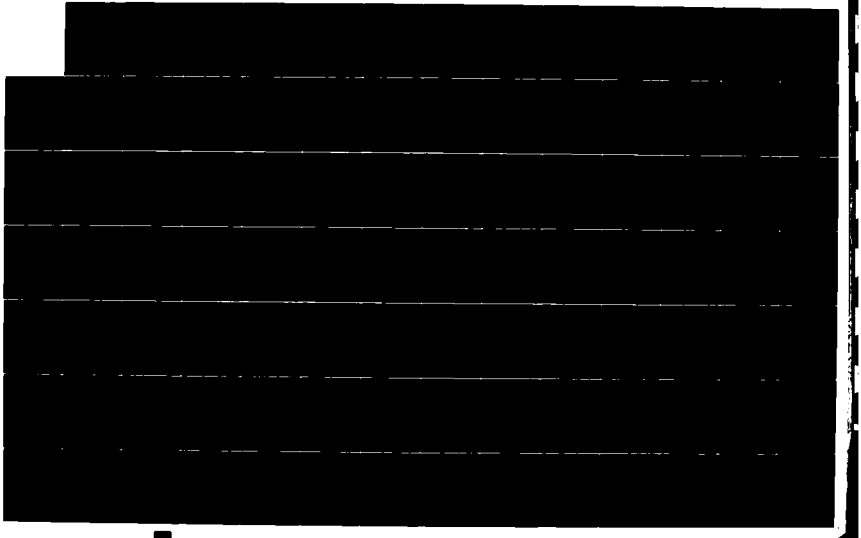
6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

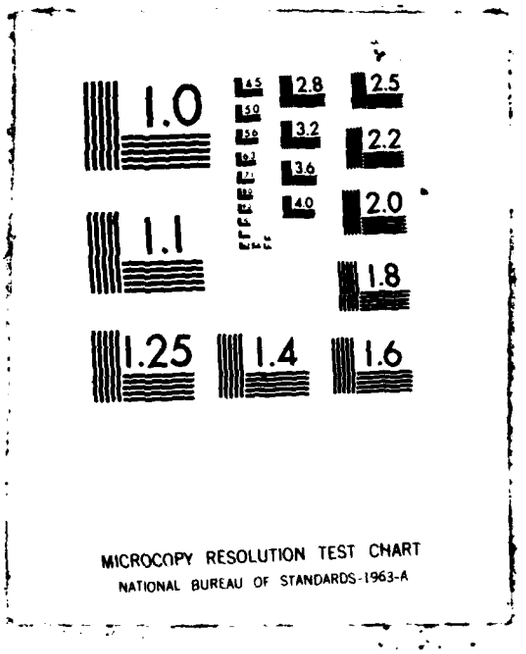
	Action	Keys
f	You want to know the valid entries for a field.	a. Clear b. Delete c. Entry Done d. Return e. Explain Error f. Help
a	You want to delete infomation from a field in which it has been stored.	
b	You made a typo and want to correct it.	
d	You have finished all required entries on a screen and want to store the information.	
e	You need additional information to correct an error condition.	

AQCESS CLINICAL RECORDS TRAINING AID

AD-A178 916 AQCESS (AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM) TRAINING AID. (U) NDC FEDERAL SYSTEMS INC ROCKVILLE MD JAN 87 DOD/SW/MT-87/010A 4/12

UNCLASSIFIED F/G 5/9 NL




1.0
1.1
1.25
1.4
1.6
2.8
3.2
3.6
4.0
2.5
2.2
2.0
1.8
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

2. CLINICAL RECORDS OVERVIEW

This section provides you with a summary of CR Processing, a review of CR Common Data Screen and CR Menu Processes, and a presentation of available options.

2.1 CLINICAL RECORDS PROCESSING

Complete information on a patient's hospital stay is documented in Clinical Records processing. The patient's chart is reviewed after or soon after the patient's disposition; then information from the chart is entered in CR. The record must be complete and correct before it can be approved by the CR Supervisor. Once approved, the data is included in a Coded Transcript Tape and sent to higher command.

The CR Common Data Screen and CR Segments display the following:

- Data that was entered during the patient's admission process.
- Episode history data related to the patient's hospital stay.
- Reports compiled from data.

AQCESS CLINICAL RECORDS TRAINING AID

Using the AQCESS Clinical Records function, you will be able to:

- o Enter or update data on the patient's diagnoses.
- o Enter or update data on procedures performed on the patient.
- o Review clinical services history.
- o Enter or update pertinent medical and administrative data concerning the patient.
- o Enter or update transfer history.
- o Produce printed reports.

As a user, you can access the inpatient record in CR only when:

- o Th patient has been dispositioned.
- o The patient has an absent status of medical hold (Navy only).
- o The patient has been given a projected disposition date.

CR processes that you will be able to perform will vary depending on the patient's status:

- If the patient has been dispositioned or is on medical hold (Navy only), you can perform any CR function.

- If the patient has a projected disposition, you can perform any CR function except to change the record's CR status to W or print final reports on the record.

2.2 CR COMMON DATA SCREEN AND CR MENU PROCESSES

The CR Common Data Screen displays identifying patient information in the top portion and the CR menu in the bottom portion. The CR menu enables you to select the appropriate CR segment to complete processing on a patient's record.

CR processing uses ten segments to make up a single patient's record. These segments are overlayed on the CR Common Data Screen. Thus, patient ID information is always displayed at the top of the screen. The bottom of the screen changes, displaying each of the ten CR segments as appropriate in processing the patient's record. The ten CR segments are:

Diagnosis	Used to review, enter, or update data on the patient's diagnoses.

Procedure	Used to review, enter, or update information on procedures, tests, or operations performed on the patient.
Miscellaneous	Used to enter the attending provider and to update miscellaneous information on transfers-out, causes of injury, cause of death, and the amount of blood transfused.
Transfer History	Used to update information on the patient's transfers from other MTFs before entry into this MTF.
Episode Days by Date	Used to view information on the number of episode days the patient spent on clinical services and absent statuses in chronological order by date. For display only.
Episode Days by Clinical Service	Used to view information on the number of episode days the patient spent on absent status according to each clinical service, with total bed day figures for each clinical service. For display only.
Administrative Data	Used to enter free text remarks, up to seven lines per page on the patient's hospital stay, disposition, or other information not entered in other segments.

Non-procedural Providers — Used to update codes for physicians associated with the patient's stay, but not relating to particular procedures (Navy and Air Force only.)

Record Tracking — Used to mark items missing from the patient's chart, and then to enter or view dates when various items were completed. This is one of the first segments completed in order to monitor the completion of the patient's chart.

Clerk Actions — Used to initiate final edits on the record, to release to A&D or reject for correction of coding errors, to request the Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT) and the Coded Episode Summary, and to mark the record as ready to be included on the Coding Transcript Tape.

These ten CR segments are completed in a logical sequence that correlates with the steps in manual coding of the clinical record. Of course, these screens can be completed in any order appropriate for a given record.

Step 1: Receive the clinical record and review it for completeness. Enter the missing information on the Record Tracking Segment.

Step 2: Determine the Primary/Attending Provider and enter the short name on the Miscellaneous Segment. Enter other miscellaneous information.

Step 3: Enter the transfer history data for a transfer-in patient on the Transfer History Segment.

Step 4: Review Bed Days Information and release the record to A&D for correction, if necessary.

Step 5: Verify that missing items are complete and update the Record Tracking segment.

Step 6: Code diagnoses and enter them on the Diagnosis segment.

Step 7: Code procedures and enter them on the Procedures Segment.

Step 8: Enter the narrative text on the Administrative Data Segment.

Step 9: Change the Record Status to W to print the cover sheet, or print a draft cover sheet and Episode Summary sheet to cause the system to perform final edits on the record.

Step 10: Correct any errors.

Step 11: Change the Record Status to W - Waiting for Supervisor Approval.

Step 12: Supervisor approves the record and the information is included in the output to higher command.

2.3 CLINICAL RECORDS SCREEN OPTIONS

Many CR segments display a submenu of options. You may select the appropriate option to MOVE groups of data, VIEW different pages of the same screen, and DELETE a set of the information.

SECTION 3. CLINICAL RECORDS ID SCREEN

PROCEDURE	PAGE
3.1 To Identify a Patient Record for CR Processing	3-4
3.2 Checkpoint	3-4

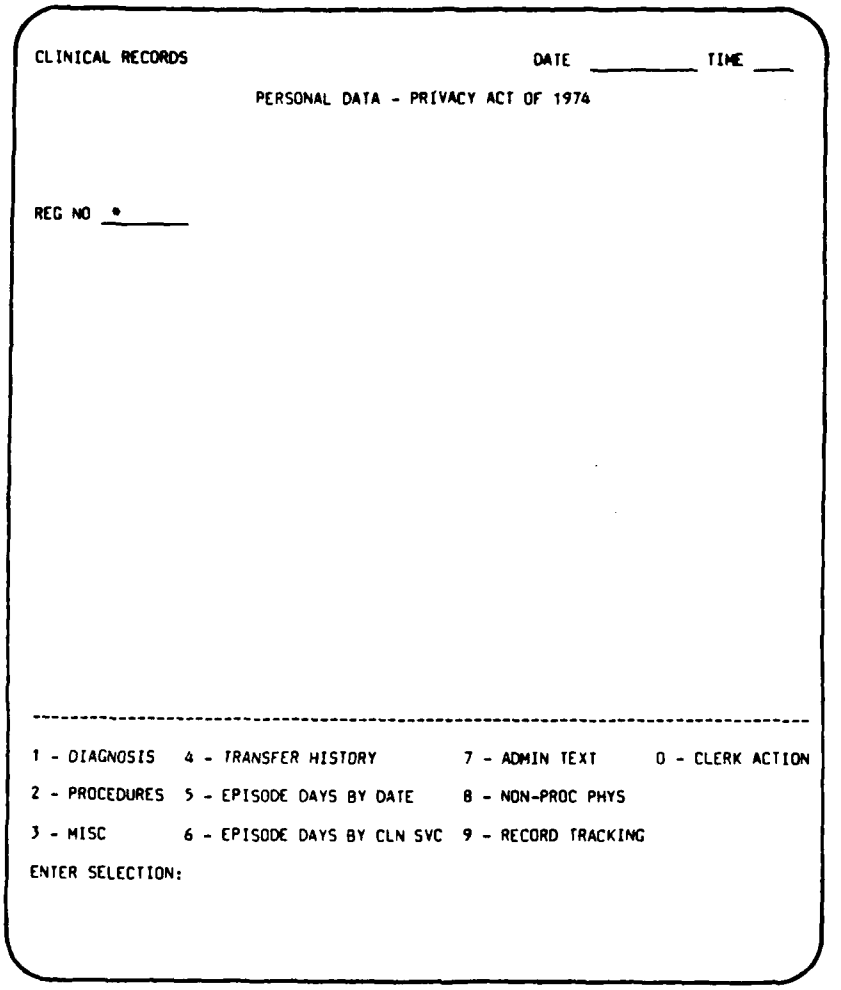


FIGURE 3.1 CLINICAL RECORD IDENTIFICATION (CRID) SCREEN

3. CLINICAL RECORDS ID SCREEN

ACCESS Enter C and Return on the User Entry Menu Screen to display the Clinical Records ID (CRID) Screen.

PURPOSE The CRID Screen enables you to identify the patient's record for processing in CR.

DESCRIPTION The CRID Screen contains one data field, REG NO. A patient record can be accessed in Clinical Records processing by register number only.

OPTIONS There are no options on the CRID Screen. If a register number is not entered, the User Entry Menu is displayed when Return is pressed on the CRID Screen.

3.1 TO IDENTIFY A PATIENT RECORD FOR CR PROCESSING

- o Enter C and Return on the User Entry Menu.

The CRID Screen is displayed. The cursor is at REG NO.

- o Enter the register number of the patient record you wish to process and press Return.

The CR Common Data Screen is displayed containing the patient's admission information.

- o Enter the number corresponding to the CR segment on which you wish to enter data.

3.2 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

SECTION 4. CR COMMON DATA SCREEN

PROCEDURE **PAGE**

4.1 To Begin Coding a Patient's Clinical Record.....4-4
4.2 Points to Remember.....4-7
4.3 Checkpoint.....4-9

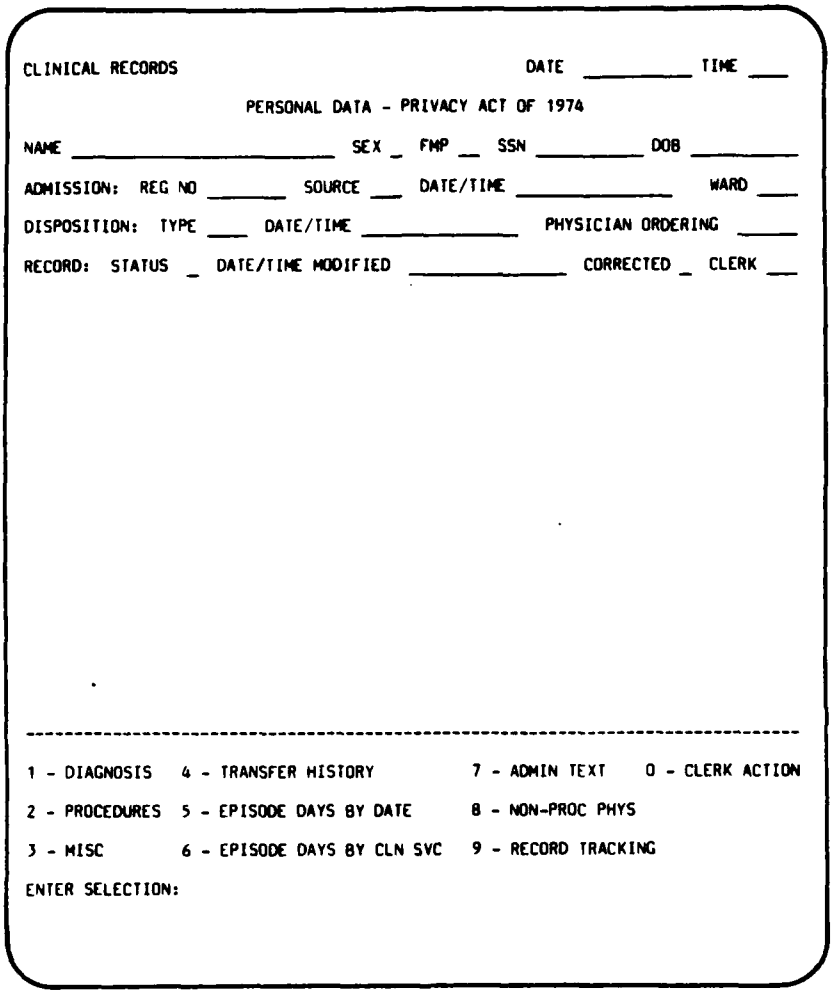


FIGURE 4.1 CR COMMON DATA SCREEN

4. CR COMMON DATA SCREEN

ACCESS Enter C on the User Entry Menu Screen and press Return. The CRID Screen is displayed. Type the patient's register number (REG NO) and press Return. The CR Common Data Screen is displayed.

PURPOSE The CR Common Data Screen enables you to view patient's information on the top portion of the screen and to select the CR segment to be processed from the CR Menu.

DESCRIPTION Once the record is identified by REG NO, the patient information summary is displayed on the CR Common Data Screen with the CR menu. Admission/Disposition patient information is displayed on the top portion of the Common Data Screen.

OPTIONS To complete the patient's clinical record, you will use appropriate CR segments selected from the CR Menu.

4.1 TO BEGIN CODING A PATIENT'S CLINICAL RECORD

- Enter C (Clinical Records) and Return on the User Entry Menu Screen.

The CR Indentification Screen (CRID) is displayed. The cursor is at REG NO.

- Enter the patient's register number, and press Return.

Note: Once a patient record has been identified on the CRID Screen in CR, it is under the control of Clinical Records and cannot be accessed in A&D.

The CR Common Data Screen is displayed with the CR menu. The cursor is at ENTER SELECTION.

Note: The steps that follow refer you to subsequent sections of this training aid. They are placed here only to present an overview of the automated Clinical Records process.

- Verify the Admission and Disposition Data against the chart.

- The first time a record is accessed in CR, the record status must be entered on the Record Tracking Segment. When you've reviewed the record for completeness, select the Record Tracking Segment (#9) to set the record status and begin tracking the missing items. (See Record Tracking section.)

- The first time a record is accessed in CR, the attending provider must be entered on the Miscellaneous Segment (#3). Enter the Attending/Primary Provider's short name on the Miscellaneous Segment.

Note: When you first access a patient record in CR, the start date on the Record Tracking Segment is set. This marks the beginning of CR processing from which the suspense date is set. Providers are delinquent if the record is not complete by the suspense date. The start date can be changed.

- Enter the diagnoses on the Diagnosis Segment. The primary diagnosis must be entered as the first diagnosis set.

- Enter the procedures in the Procedures Segment. (See the Procedures section.)

- View episode day's information to check for errors in recording absent status and transfers. (See Episode Days By Date and Episode Days by Clinical Service sections.)

Note: If this data is not correct, the record must be released to A&D for correction.

- Enter the information regarding episodes at previous MTF's on the Transfer History Segment. (See the Transfer History section.)

- Enter the appropriate action on the Clerk Actions Screen to either print a draft cover sheet, or to change the status to W (Waiting for Supervisor Approval) which automatically causes the final edits and printing of the cover sheet.

- When you've finished entering or viewing information, press Return to store the CR data and cause the cover sheet to be printed.

Note: No data is stored if you cancel out on any CR screen or segment. You must press Return at ENTER SELECTION on the CR Menu to store the record with any updates.

- Correct any errors in the data indicated in the error list at the bottom of the cover sheet.

- Change the record status on the Clerk Actions Screen to Waiting for Supervisor Approval. This causes the cover sheet and coded Episode Summary to be printed.

Note: When the supervisor changes the status of an approved record it is included in the Coded Transcript Tape.

4.2 POINTS TO REMEMBER ABOUT CR SCREENS

1. The CR Menu has ten segments corresponding to different portions of a patient's clinical record. You may choose only one of the segments at a time when the CR Menu is displayed. The first time a record is called up in CR, that record is under the control of CR and cannot be accessed in A&D. At this time it is required that a primary/attending provider is entered and that the record status is entered. Several of the individual segments contain options

(NEXT PAGE, etc.) which allow you to view, update and change, or add additional information to an existing record.

2. Some CR screens are updated differently. On the Miscellaneous Screen, fields are accessed for update by label like other processes. The Diagnosis, Procedure, and Transfer History Screens contain multiple sets of data and are accessed by the data set number to update or enter data.

3. When you have completed entry in a CR segment, press Return at Enter Selection and the second level of edits are performed. If there are consistency errors they will need to be corrected. If there are no errors, the CR Menu will be displayed. No data will have been stored. In CR, the data is stored only when you press Return on the CR Common Data Screen that displays the CR Menu.

4. When you press Return at Enter Selection on the CR Menu, the third level of edits are performed. If there are errors, a message is displayed and you must select the appropriate segment to make correction. If there are no errors, data is stored and the CRID Screen is displayed.

5. Whatever CR segment you select will always be displayed under the patient's basic information (common data). In summary, you have three alternatives when you reach the end of a segment:

   a. Select another segment from the CR Menu to enter additional information for the same patient.

   b. Select another patient record for processing, press Return at the CR Menu to store the data on this patient, then enter the new patient's REG NO on the CRID Screen.

   c. To exit CR, press Return to display the CR Menu, Return again to store the data, and press Return on the CRID Screen to return to the User Entry Menu Screen.

4.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 5. DIAGNOSIS SEGMENT

PROCEDURE **PAGE**

5.1 To Enter a Diagnosis.....5-5
5.2 To Edit Diagnosis Information in an Existing Record.....5-9
5.3 To Move a Diagnosis Data Set.....5-11
5.4 To Delete a Diagnosis Data Set.....5-12
5.5 Points to Remember.....5-13
5.6 Checkpoint.....5-14

CLINICAL RECORDS DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ __ SOURCE ___ DATE/TIME _____ WARD ___

DISPOSITION: TYPE ____ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK __

*** TOTAL DIAGNOSES __ ***

1 ICD CODE: * _____ __ CAUSE (N) (N) OCC REL (N) GROUP NBR (A)
(must have a primary diagnosis)
(ICD CODE associated Text)
_____
(N) (Cause associated Text)
_____

2 ICD CODE: _____ __ CAUSE _ ___ OCC REL _ GROUP NBR __
_____
_____

3 ICD CODE: _____ __ CAUSE _ ___ OCC REL _ GROUP NBR __
_____
_____

N - NEXT PAGE P - PREVIOUS PAGE M - MOVE CODE D - DELETE CODE

ENTER SELECTION:

FIGURE 5.1 DIAGNOSIS SEGMENT

5. DIAGNOSIS SEGMENT

ACCESS Enter 1 and Return on the CR Menu to display the Diagnosis Segment on the lower portion of the Common Data Screen.

PURPOSE The Diagnosis Segment enables you to enter, update, add, view, delete, or reorder multiple diagnosis records and associated codes and causes.

DESCRIPTION The Diagnosis Segment contains several data items that can be entered for each diagnosis. This group of data items is called a data set. Data items that make up the set include ICD codes, the CAUSE of the injury or ailment (Navy only), OCC REL (Navy only), GROUP NBR (Army only), and two lines for text associated with the diagnosis. At the top of the diagnosis portion of the screen, there is a heading labeled TOTAL DIAGNOSES which keeps a running count of the number of diagnoses that have been entered in the patient's file.

OPTIONS NEXT PAGE and PREVIOUS PAGE options enable you to view subsequent and previous pages of data. MOVE CODE enables you to reorder data sets. DELETE CODE enables you to delete an entire data set.

5.1 TO ENTER A DIAGNOSIS

- Enter 1 and press Return on the CR Menu.

The Diagnosis Segment is displayed. The cursor is at ENTER SELECTION.

- Enter the number of the data set you are going to enter. For example, to enter the first diagnosis, type 1, and Return.

- If you are adding another diagnosis to the record, enter the number which is one greater than the TOTAL DIAGNOSES field. For example: If the patient has 2 diagnoses entered, use 3.

The cursor moves to the diagnosis number indicated. The screen will be redisplayed.

- Enter the ICD diagnosis code. Use HELP if necessary.

- If you are unfamiliar with ICD codes follow the subsequent steps to use ICD code HELP.

- o Press Return to the DIAG TEXT field, press HELP.

The high level coding categories (key words) for the ICD structure are displayed on the right side of the screen.

- o Enter the partial key word for the appropriate coding category and press Return.

The specific level of coding categories for the ICD structure are displayed.

- o Select and remember the first two category number(s) of the code you need.

- o Move the cursor back to the ICD CODE: field.

- o Enter the first two beginning numbers for the category and press HELP.

A list of all the codes in the specified category are displayed.

- Enter the appropriate code in the DIAGNOSIS field and press Return.

Text associated with the diagnosis code is displayed. The cursor moves to the next data field. (CAUSE and OCC REL for Navy; GROUP NBR for Army.)

- Enter the appropriate data in each field and press Return.

For Navy users, when the cause is entered, associated text appears in the second line of the diagnosis text. If you wish to change the wording of the text associated with either of the codes, you may type over the displayed text.

- If the physician has worded the diagnosis differently, type over text to change the wording. Press Return after each line of text to enter the changed text.

Note: When you complete a diagnosis set, the cursor moves to the beginning of the next diagnosis set. When three data sets are completed on a page, the next

page of the record is displayed with sequence numbers for the next three data sets.

- To record another diagnosis, repeat this process.

- If you've completed the diagnosis input, press Entry Done to move the cursor to ENTER SELECTION.

- Press Return at ENTER SELECTION to re-display the CR Menu.

Note: No data is stored until you press Return at ENTER SELECTION on the CR Menu. If you cancel out at this point the data is not stored.

- Select another segment at ENTER SELECTION or press Return to store the data.

If the Record Tracking Screen has not been completed, or the Primary/Attending Provider has not been on the Miscellaneous Screen, a message is displayed.

Note: When you press Return to store the data, the system performs the third level edits that require validity and consistency among the CR segments.

- o Complete the information on these two screens.

- o Press Return on the CR Menu to store the data.

5.2 TO EDIT DIAGNOSIS INFORMATION IN AN EXISTING RECORD

- o Enter 1 and Return on the CR Menu.

The Diagnosis Segment is displayed. The cursor is at ENTER SELECTION. You may select the NEXT PAGE option to locate the entry that you wish to change.

- o Type the number of the diagnosis data set that you wish to change. If you are adding another diagnosis to the record refer to the "TO ENTER" procedure of this Training Aid.

Note: If the appropriate page of the Diagnosis Segment is not displayed, it will be displayed when you enter the number of the diagnosis set.

The cursor moves to the beginning of the diagnosis set identified.

- Type over the existing information to change it and press Return after completing each field to move to the next field.

When the data set is completed and you press Return, the cursor moves to ENTER SELECTION.

- Enter the number of the next diagnosis to be changed or updated, if any. Repeat this process.

- Press Return at ENTER SELECTION to display the CR Menu.

- Select another segment at ENTER SELECTION or press Return to store the data.

5.3 TO MOVE A DIAGNOSIS DATA SET

- o Enter 1 and press Return from the CR Menu.

The Diagnosis Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter M - Move Code to display the move code data fields.

Two fields are displayed: MOVE ENTRY #, and BEFORE #. The cursor is at MOVE ENTRY #.

- o Enter the number of the diagnosis set that you wish to move. If the number is less than 10, press Return after entering the number.

The cursor moves to BEFORE #.

- o Enter the number of the diagnosis set that will follow the set you are moving. If the number is less than 10, press Return after entering the number.

The diagnosis sets are reordered. The cursor moves to ENTER SELECTION, and the screen is redisplayed.

5.4 TO DELETE A DIAGNOSIS DATA SET

- Enter 1 and press Return on the CR Menu.

The Diagnosis Segment is displayed. The cursor is at ENTER SELECTION.

- Enter D - Delete Code from the option menu and press Return.

DELETE ENTRY # is displayed. The cursor is at the DELETED ENTRY # field.

- Enter the sequence number of the diagnosis data set you wish to delete. If the number is less than 10, press Return after entering the number.

The data set is deleted, the diagnosis sets are renumbered, the TOTAL DIAGNOSES count is adjusted, and the screen is redisplayed.

5.5 POINTS TO REMEMBER

1. The information entered on each diagnosis is edited on the draft cover sheet requested on the Clerk Actions Screen. Errors made on the Diagnosis Data are listed on the Clinical Records Error List. These errors must be corrected before the record can be approved.

2. The cursor will skip fields of a diagnosis data set which are used by a military department other than your MTF's branch of service.

3. You can change the wording of text associated with ICO codes and CAUSE codes to more accurately reflect the patient's chart. Type over the text to change it.

4. For Navy, the second line of text defaults to the description of CAUSE code. This text can also be changed by typing over it.

5. When you wish to add a diagnosis set to a record, enter the number one greater than the Total Diagnoses count. The cursor moves to the specified diagnosis set number. After you complete the fields in that set, the cursor moves to the next set.

6. When you edit information about a previously recorded diagnosis, enter the number of the diagnosis set to be changed. The cursor moves to the set you've identified. When you've completed the changes or updates on that set, the cursor moves back to ENTER SELECTION.

7. You may elect to edit a diagnosis that is not currently displayed; the respective page of the screen will be displayed automatically upon selection of the diagnosis set number.

8. The primary diagnosis must be entered in the #1 position.

9. The GROUP NO required by the Army is used to organize sets of several diagnoses and procedures when they are printed on the cover sheet.

5.6 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 6. PROCEDURE SEGMENT

PROCEDURE **PAGE**

6.1 To Enter a Procedure in a Patient's Record.....6-4
6.2 To Edit Procedure Information in a Previously Coded Record.....6-6
6.3 To Move a Procedure Data Set.....6-8
6.4 To Delete a Procedure Data Set.....6-9
6.5 Points to Remember.....6-10
6.6 Checkpoint.....6-11

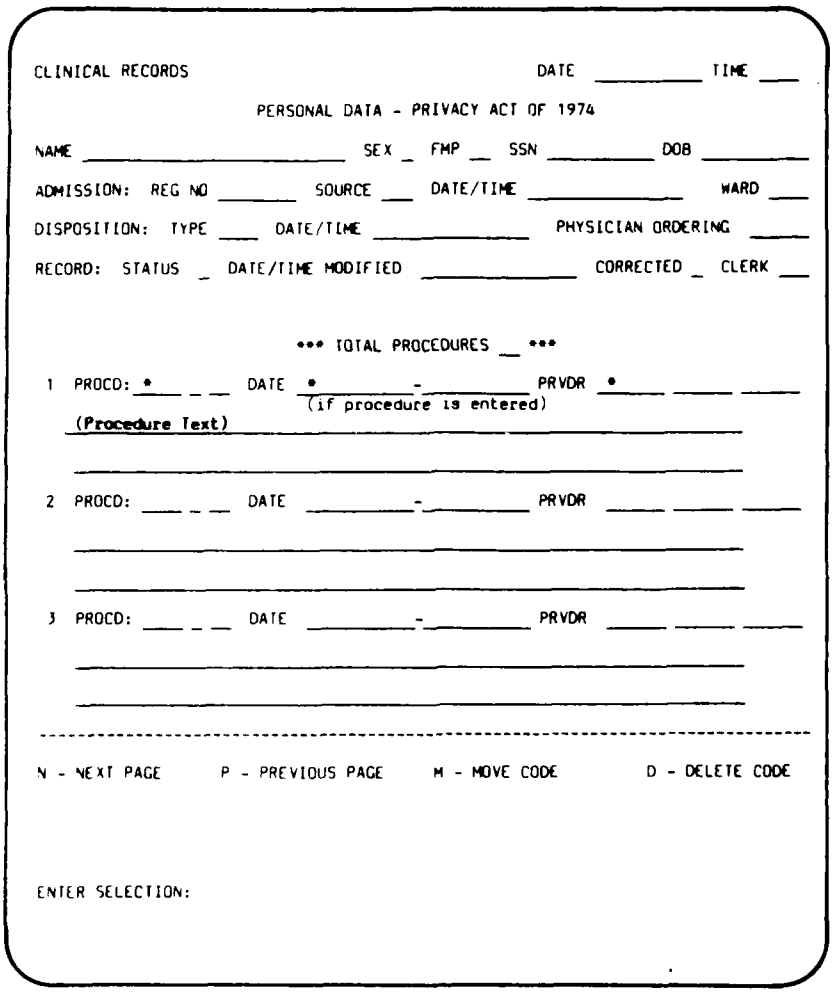


FIGURE 6.1 PROCEDURE RECORD SEGMENT

6. PROCEDURE SEGMENT

ACCESS Enter 2 and press Return on the CR Menu to display the Procedure Segment on the lower portion of the Common Data Screen.

PURPOSE The Procedure Segment enables you to document procedures performed on a patient and record the date(s) and provider(s).

DESCRIPTION Three procedure data sets can be entered on each page. The numbers at the left side of the screen correspond to a complete procedure set. There are four items for each procedure: PROCD, DATE, PRVDR and text. Codes for three care providers can be entered in the PRVDR field. Below the data items are two lines for text associated with the procedure.

At the top of the procedure portion of the screen, there is a field TOTAL PROCEDURES, which keeps a running count of the number of procedures in the patient's file.

OPTIONS NEXT PAGE and PREVIOUS PAGE options enable you to view subsequent and previous pages of data. Move CODE enables you to reorder data sets. DELETE CODE enables you to delete an entire data set.

6.1 TO ENTER A PROCEDURE IN A PATIENT'S RECORD

- o Enter 2 and press Return on the CR Menu.

The Procedure Record Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter the number of the data set you are going to enter. For example, to enter the first diagnosis, enter 1 and press Return.

- o If you are adding another procedure to the record, enter the number which is one greater than the TOTAL PROCEDURES field and press Return.

The cursor moves to the procedure set indicated.

- o Enter the procedure code. Use HELP if necessary.

Text associated with the code is displayed and the cursor moves to the next data field.

- o Continue to enter procedure data in each field.

Note: A single date or range of dates can be entered in the DATE field.

- o If you wish to change the wording of the text associated with the codes, you may type over the displayed text.

- o Press Return at each line of text to move to the next field.

- o To record another procedure, repeat this process.

When you complete a procedure record, the cursor moves to the next procedure set. When three data sets are complete on a page, the next page is displayed with sequence numbers for the next three data sets.

- o If you've completed the procedure input, press Entry Done to move the cursor to ENTER SELECTION.

- o Press Return at ENTER SELECTION to display the CR Menu.

Note: No data is stored until you press Return at ENTER SELECTION on the CR Menu Screen.

- Select another segment or press Return at ENTER SELECTION to store the data and display the CRID Screen.

If the Record Tracking information and the Primary/Attending Provider have not been entered, a message is displayed.

- Select the indicated CR segment and refer to the corresponding section of this Training Aid.

6.2 TO EDIT PROCEDURE INFORMATION IN A PREVIOUSLY CODED RECORD

- Enter 2 and press Return on the CR Menu.

The Procedure Segment is displayed. The cursor is at ENTER SELECTION. (You may select the NEXT PAGE option to locate the entry that you wish to change.)

- Type the number of the procedure set you wish to change. If you are adding

another procedure to the record see the "TO ENTER" procedure of this Training Aid.

Note: If the appropriate page of the Procedure Segment is not displayed, it will be displayed when you enter the number of the procedure set.

The cursor moves to the beginning of the procedure set.

- o Type over the existing information to change it and press Return after completing each field to move to the next field.

When the data set is completed and you press Return, the cursor moves to ENTER SELECTION.

- o Enter the number of the next procedure to be changed or updated, if any. Repeat the process.

- o Press Return at ENTER SELECTION to display the CR Menu.

- Select another segment or press Return at ENTER SELECTION to store the data.

6.3 TO MOVE A PROCEDURE DATA SET

- Enter 2 and press Return on the CR Menu.

The Procedure Segment is displayed. The cursor is at ENTER SELECTION.

- Enter Option M - Move Code, and Return to display the move code data fields.

Two fields are displayed: MOVE ENTRY # and BEFORE #. The cursor is at MOVE ENTRY #.

- Enter the number of the procedure set that you wish to move. If the number is less than 10, press Return after entering the number.

The cursor moves to BEFORE #.

- Enter the number of the procedure set that will follow the set you are moving.

If the number is less than 10, press Return after entering the number.

The procedure sets are reordered. The cursor moves to ENTER SELECTION, and the screen is redisplayed.

6.4 TO DELETE A PROCEDURE DATA SET

- o Enter 2 and press Return on the CR Menu.

The Procedure Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter D - Delete Code from the option menu and press Return.

DELETE ENTRY # is displayed. The cursor is at the DELETE ENTRY # field.

- o Enter the sequence number of the data set you wish to delete. If the number is less than 10, press Return after entering the number.

The data set is deleted, the procedure sets are renumbered, the TOTAL PROCEDURES count is adjusted, and the screen is redisplayed.

6.5 POINTS TO REMEMBER

1. The information that you enter on each procedure is edited on the draft cover sheet requested on the Clerk Actions Screen. Errors made in the procedure data are listed on the Clinical Records Error List. These errors must be corrected before the record can be approved.

2. For a surgical procedure, the first provider is the principal surgeon, the second is the assistant, and the third is a teaching staff physician.

3. For a medical procedure, the first provider is the attending or primary provider, the second is the resident, and the third is any other physician.

4. For procedures not performed in this MTF, the fifth digit of PROCD is used and the provider is not coded. The sixth digit of the ICD code is used to enter the number of times the procedure was performed.

5. When you are adding new procedure sets, the cursor will move to the next procedure set when you complete the fields. When the third procedure set on a page is complete, the next page of the screen will be displayed automatically. To indicate that you have finished entering information, press Entry Done.

6. When you are editing data in a data set, the cursor will automatically move back to ENTER SELECTION. This is because you are in update mode.

7. When you identify a procedure set to be updated, the respective page of the procedure screen is displayed automatically.

6.6 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

SECTION 7. MISCELLANEOUS SEGMENT

PROCEDURE PAGE

7.1 To Enter a Patient's Miscellaneous Information.....7-4
7.2 Points to Remember.....7-5
7.3 Checkpoint.....7-6

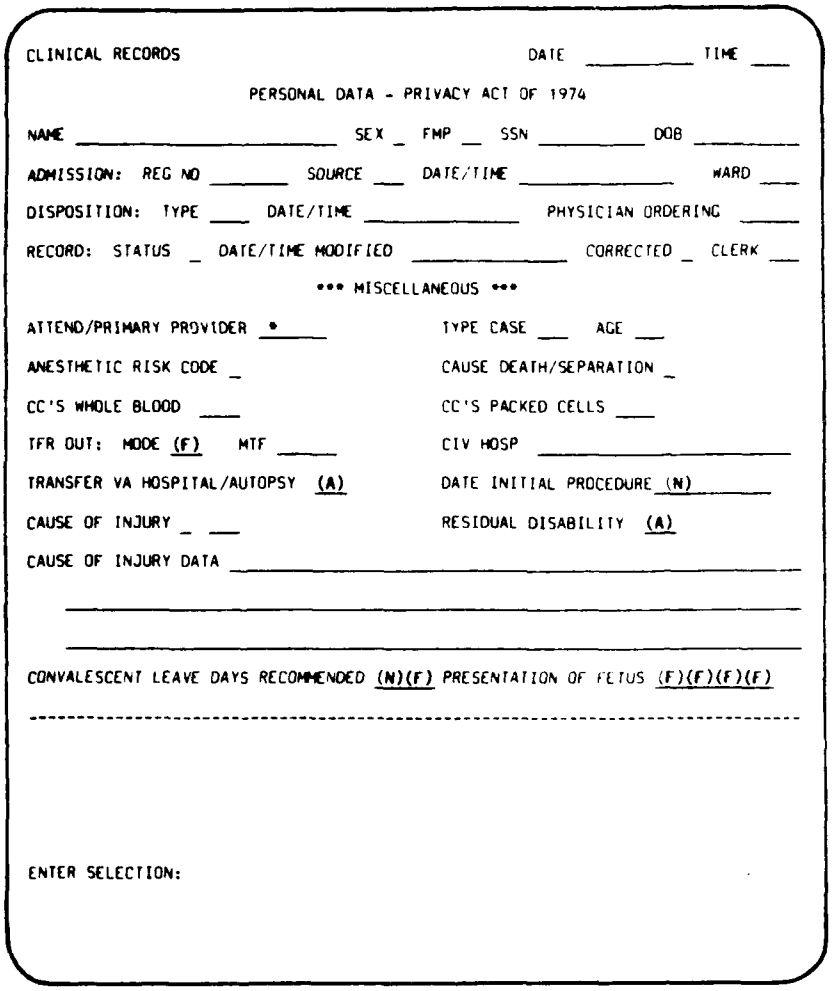


FIGURE 7.1 MISCELLANEOUS SEGMENT

7. MISCELLANEOUS SEGMENT

ACCESS Enter 3 and press Return on the CR Menu to display the Miscellaneous Segment on the lower portion of the Common Data Screen.

PURPOSE The Miscellaneous Segment enables you to review or enter pertinent data collected during a patient's stay at the MTF (The PRIMARY PROVIDER code is required.)

DESCRIPTION This screen segment contains a variety of information not captured elsewhere in Clinical Records, such as data on cause of injury, anesthetic risk code, residual disability, transfer to VA hospital, or autopsy.

OPTIONS You are required to enter the Attending/Primary Provider before storing the record.

Other Miscellaneous data can be entered later.

7.1 TO ENTER A PATIENT'S MISCELLANEOUS INFORMATION

- Enter 3 and press Return on the CR menu.

Note: The first time you call up a record in CR, you must enter the primary/attending provider before you can store the record.

If the record is incomplete, and you have not yet determined the provider, you must cancel out. The record will remain under the control of CR even if you cancel out using the Cancel Key.

The Miscellaneous Segment is displayed. The cursor is at ENTER SELECTION.

- To enter data in all or several of the fields, type the label of the field in which you wish to enter data, or type ALL and press Return to move the cursor to each field on the screen.

The cursor moves to the field you selected or to the first field if you typed ALL. The first field when you type ALL is ATTEND/ PRIMARY PROVIDER.

- o Enter data in the fields as required, pressing Return where necessary.

- o When you have completed the input, press Entry Done to move the cursor to ENTER SELECTION.

- o Press Return at ENTER SELECTION to display the CR Menu.

- o Select another segment or press Return at ENTER SELECTION to store the data.

7.2 POINTS TO REMEMBER

1. You must enter the provider on the Miscellaneous Segment the first time you call up the record in CR. You can cancel out if you can't complete the field at this time, but the record will be locked in CR.

2. Defaulted data in the text field for CAUSE OF INJURY DATA can be changed by typing over it.

3. The patient's age is calculated by the system from DOB and displayed on the Miscellaneous Segment.

   The AGE field can only be changed <u>if the patient is a newborn</u>. Any other AGE entry

must be left as it was calculated by the system based on date of birth. The record may be released to A&D for correction of DOB if necessary.

4. An ANESTHETIC RISK CODE should be entered for patients with surgical procedures. This is important for mortality reporting.

5. Other defaulted data from A&D records includes TFR OUT: MTF for transfer out patients, and CAUSE OF INJURY for injury episode patients.

7.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 8. TRANSFER HISTORY SEGMENT

PROCEDURE **PAGE**

8.1 To Enter a Patient's Transfer History on a New CR Record or to Add Information to an Existing Record.....8-4
8.2 To Edit Information On an Existing Record.....8-5
8.3 To Delete a Line of Transfer History....8-6
8.4 Points to Remember.....8-7
8.5 Checkpoint.....8-8

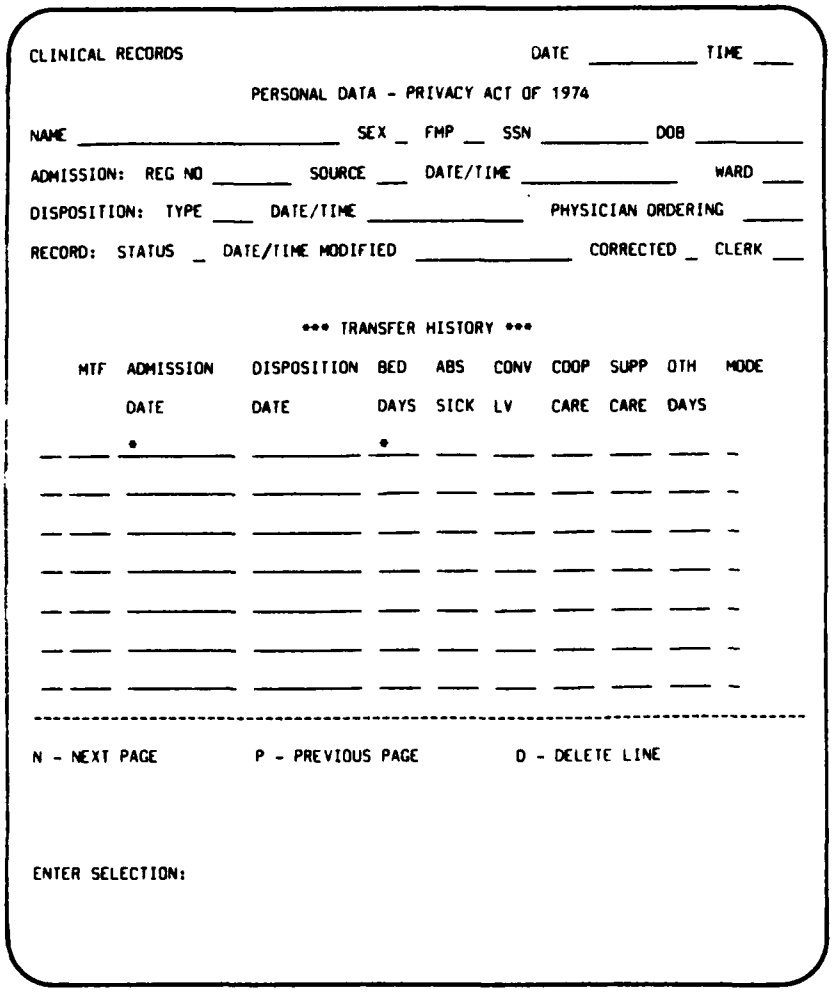


FIGURE 8.1 TRANSFER HISTORY SEGMENT

8. TRANSFER HISTORY SEGMENT

ACCESS Enter 4 and press Return on the CR Menu to display the Transfer History Segment on the lower portion of the Common Data Screen.

PURPOSE The Transfer History Segment enables you to track a patient's stay at other hospitals before transferring to this MTF.

DESCRIPTION This segment displays information from the Transfer-In Segment of the Admission Screen concerning only the hospital from which the patient was transferred to this MTF. You must add the DISPOSITION DATE and the DAYS data concerning this transfer and, if applicable, enter data concerning previous transfers. The transfer history is entered with the most current transfer last. The number of DAYS data must be equal to the number of days from Admission to Disposition. Only one screen segment is used to record this information.

OPTIONS Use the NEXT PAGE and PREVIOUS PAGE options to review subsequent and previous pages of data. Use DELETE LINE to delete an entire line from the record.

8.1 TO ENTER A PATIENT'S TRANSFER HISTORY ON A NEW CR RECORD OR TO ADD INFORMATION TO AN EXISTING RECORD

- o *Enter* 4 and press Return on the CR Menu.

The Transfer History Segment is displayed. The cursor is at ENTER SELECTION.

- o To enter data in all or several of the fields, enter the line number of the set in which you wish to enter data and press Return.

The cursor moves to the identified line number.

- o For each previous MTF enter the MTF code, admission date, disposition date, and number of days spent on each status.

The cursor moves to the next data set.

- o If you've completed the input, press *Entry Done* to move the cursor to ENTER SELECTION.

- o Press Return at ENTER SELECTION to display the CR Menu.

- o Select another segment or press Return at ENTER SELECTION to store the data.

8.2 TO EDIT INFORMATION ON AN EXISTING RECORD

- o Enter 4 and press Return on the CR Menu.

The Transfer History Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter the line number of the set that you wish to change and press Return.

Note: When you enter the line number of the data set you wish to change, the appropriate page of the Transfer Segment is displayed automatically.

The cursor moves to the beginning of the data set identified.

- o Type over the existing information to change it. Press Return where necessary.

When the data set is completed and you press Return, the cursor moves to ENTER SELECTION.

- o To change information in another set, type the number of the data set. Repeat this process.

- o Press Return at ENTER SELECTION to display the CR Menu.

- o Select another segment at ENTER SELECTION or press Return to store the data.

8.3 TO DELETE A LINE OF TRANSFER HISTORY

- o Enter 4 and press Return on the CR Menu.

The Transfer History Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter D - Delete Line from the option menu.

The DELETE # prompt is displayed. The cursor is at DELETE #.

- o Enter the number of the line you wish to delete, and press Return.

The line is deleted and the screen is updated. The cursor is at ENTER SELECTION.

- o Press Return at ENTER SELECTION to display the CR menu.

- o Select another segment at ENTER SELECTION or press Return to store the data.

8.4 POINTS TO REMEMBER

1. Data from the previous admission before transfer to this MTF was entered in the Transfer-In Segment of the Admission Screen and will be automatically displayed on the Transfer History Segment. You must complete DISPOSITION DATE and DAYS data. Enter accurate admission and disposition dates for each previous hospitalization.

2. If the patient transfer to this MTF is indicated in the Transfer-In Segment of the Admission Screen, enter the information on the Transfer History Segment plus any previous transfers from other MTFs.

3. As many as seven lines of transfer data can be entered on each page of this screen segment.

4. Do not confuse the Transfer History Screen with the Transfer Function used to track the events of the patient's stay in the MTF. The Transfer History is generally entered when the cover sheet and chart are received from the previous MTF(s).

5. If additional transfer histories are to be entered, they are entered with the most current transfer last. This requires typing over the defaulted information from the Admission Screen.

8.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

SECTION 9. EPISODE DAYS BY DATE SEGMENT

PROCEDURE **PAGE**

9.1 To View the Episode Days Record for a Patient.....9-5
9.2 Points to Remember.....9-6
9.3 Checkpoint.....9-7

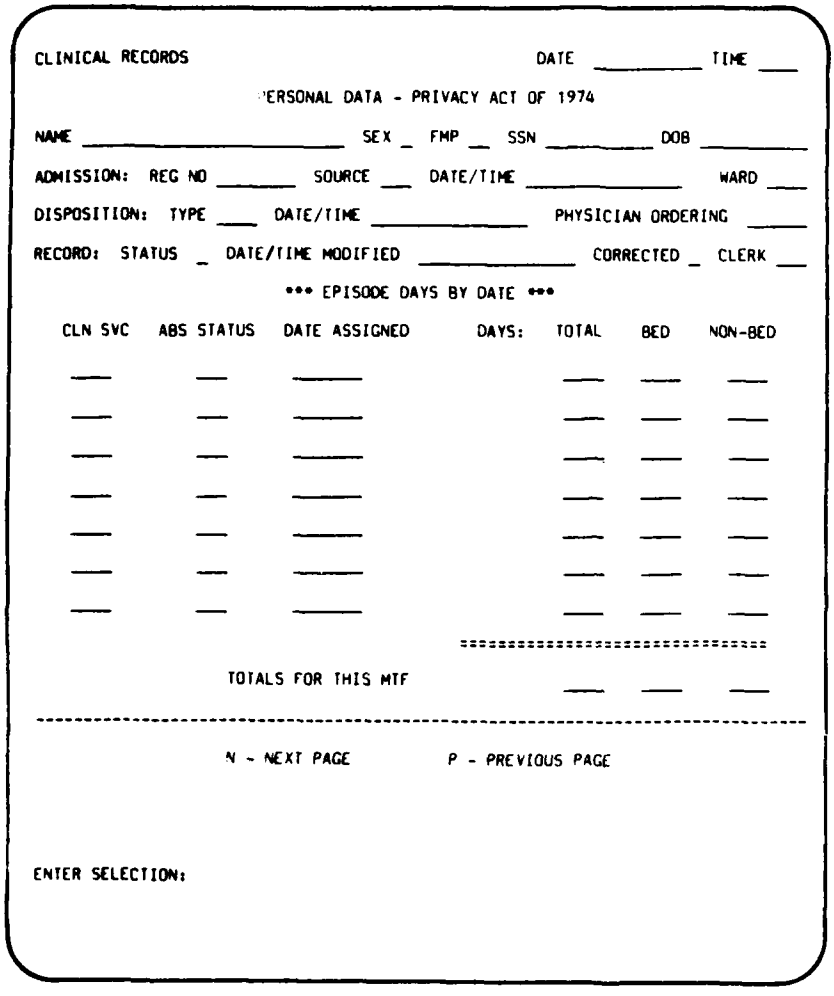


FIGURE 9.1 EPISODE DAYS BY DATE SEGMENT

9. EPISODE DAYS BY DATE SEGMENT

ACCESS Enter 5 and press Return on the CR Menu to display the Episode Days by Date Segment on the lower portion of the Common Data Screen.

PURPOSE The Episode Days by Date Segment enables you to review information on the number of days the patient spent bed-occupied and on absent statuses in order to verify that the transfers in clinical service indicated by the clinical record were entered in A&D. This screen is for display only; it cannot be changed in CR. If it appears that the bed days information reflects an error, you can release the record to A&D for correction. This is done using Clerk Actions.

DESCRIPTION The information displayed on this screen segment is compiled by the system from the admission date, and the dates of the patient's changes in clinical service and absent status. There is one entry for each change.

The Episode Days by Date Segment displays episode days data in chronological order with clinical service and absent status assignment.

OPTIONS

Use the NEXT PAGE and PREVIOUS PAGE options to view pages of the record. If there is no next page of data, INVALID SELECTION will be displayed.

9.1 TO VIEW THE EPISODE DAYS RECORD FOR A PATIENT

- Enter 5 and press Return on the CR Menu.

The Episode Days by Date Segment is displayed. The cursor is at ENTER SELECTION.

- To view data on the following pages, press N.

Note: If there is no next page of data, INVALID SELECTION will be displayed.

The next page is displayed. The cursor is at ENTER SELECTION.

- To view data on the previous page, press P.

Note: If there is no previous page of data, INVALID SELECTION will be displayed.

The previous page is displayed. The cursor is at ENTER SELECTION.

- If you have finished viewing the data, press Return at ENTER SELECTION to display the CR Menu.

- Select another segment or press Return at ENTER SELECTION to exit CR.

9.2 POINTS TO REMEMBER

1. Data on this segment is for display only. It cannot be changed in CR.

2. If the data on this screen appears to be incorrect, the record must be released to A&D for correction, using the Clerk Actions Segment.

3. If there are no additional pages of data, when requesting NEXT on PREVIOUS PAGE options, INVALID SELECTION will be displayed.

9.3 CHECKPOINT

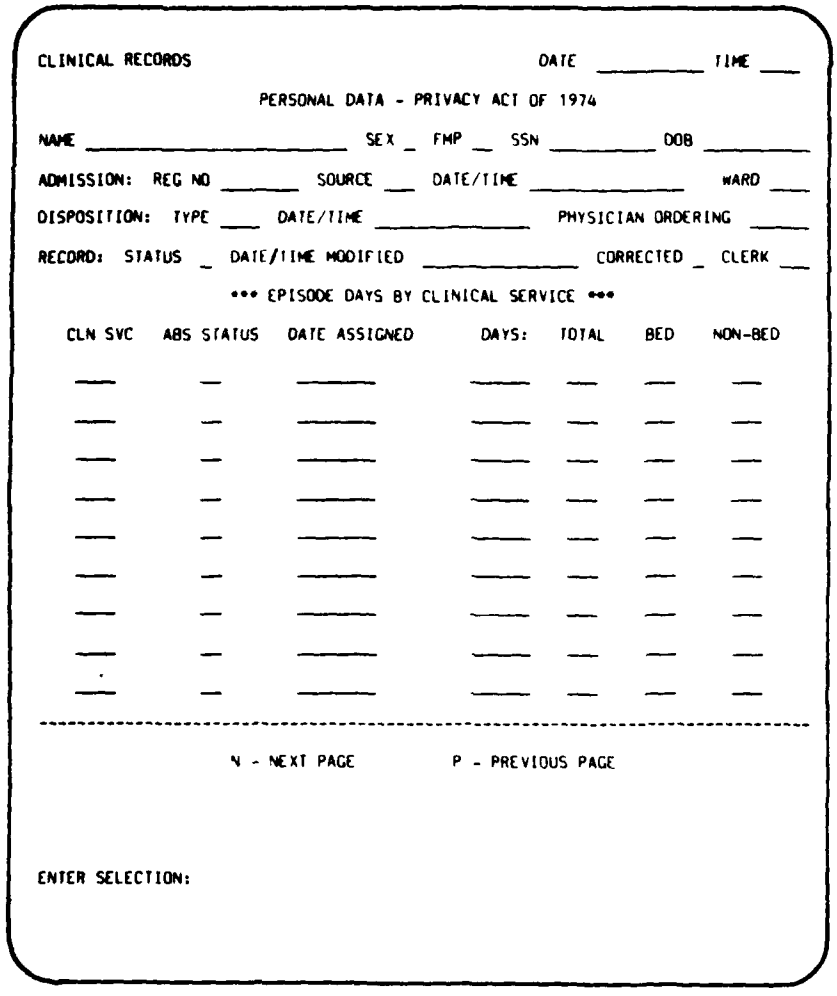
Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 10. EPISODE DAYS BY CLINICAL SERVICE

PROCEDURE **PAGE**

10.1 To View Episode Days by Clinical Service.....10-4
10.2 Points to Remember.....10-5
10.3 Checkpoint.....10-6



CLINICAL RECORDS DATE _____ TIME ____

PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ___

DISPOSITION: TYPE ___ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

••• EPISODE DAYS BY CLINICAL SERVICE •••

CLN SVC	ABS STATUS	DATE ASSIGNED	DAYS:	TOTAL	BED	NON-BED
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___
___	_	_____	_____	___	___	___

N - NEXT PAGE P - PREVIOUS PAGE

ENTER SELECTION:

FIGURE 10.1 EPISODE DAYS BY CLINICAL SERVICE SEGMENT

10. EPISODE DAYS BY CLINICAL SERVICE

ACCESS Enter 6 and press Return on the CR Menu to display the Episode Days by Clinical Service Segment on the lower portion of the Common Data Screen.

PURPOSE The Episode Days by Clinical Service Segment enables you to review information on the number of days spent during an episode in each clinical service, in order to review summary totals by clinical service. This segment cannot be changed in CR. If incorrect episode days information appears to exist, you can release the record to A&D using Clerk Actions.

DESCRIPTION This segment displays episode days grouped by clinical service, with total bed and non-bed days figures for each clinical service.

This information is compiled by the system from the admission episode data and transfer dates.

OPTIONS Use NEXT PAGE and PREVIOUS PAGE to view pages of the record.

10.1 TO REVIEW EPISODE DAYS BY CLINICAL SERVICE

- o Enter 6 and press Return on the CR Menu.

The Episode Days by Clinical Service Segment is displayed. The cursor is at ENTER SELECTION.

- o Enter N and press Return to view the next page.

Note: If there is no next page of data, INVALID SELECTION will be displayed.

The next page of the record is displayed. The cursor is at ENTER SELECTION.

- o Enter P and press Return to display the previous page.

Note: If this is no previous page of data, INVALID SELECTION will be displayed.

The previous page is displayed. The cursor is at ENTER SELECTION.

- o When you have finished viewing the pages of data, press Return at ENTER SELECTION to display the CR Menu.

- o Select another segment at ENTER SELECTION or press Return to exit CR.

10.2 POINTS TO REMEMBER

1. Data on this segment is for display only; it cannot be changed in Clinical Records.

2. If the data on this screen appears to be incorrect, it must be released to A&D for correction, using the Clerk Actions segment.

3. If there are no additional pages of data, when requesting NEXT or PREVIOUS PAGE options, INVALID SELECTION will be displayed.

10.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 11. ADMINISTRATIVE DATA SEGMENT

PROCEDURE **PAGE**

11.1 To Enter Comments in the Patient's Administrative Data Segment.....11-4
11.2 Points to Remember.....11-5
11.3 Checkpoint.....11-6

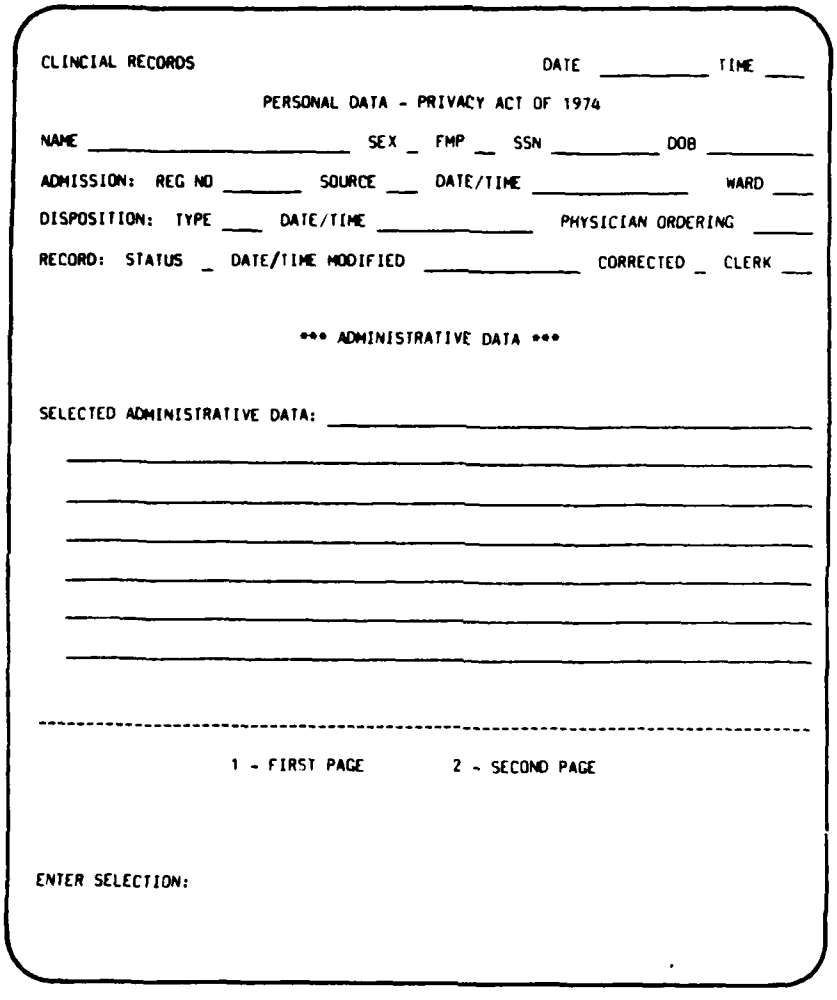


FIGURE 11.1 ADMINISTRATIVE DATA SEGMENT

11. ADMINISTRATIVE DATA SEGMENT

ACCESS Enter 7 and press Return on the CR Menu to display the Administrative Data Segment. This segment is displayed on the lower portion of the Common Data Screen.

PURPOSE The Administrative Data Segment enables you to enter free text information about the patient's hospital stay that is printed on the patient's cover sheet.

DESCRIPTION Administrative Data processing uses a single screen segment.

OPTIONS Use FIRST PAGE and SECOND PAGE to input or view up to two pages of information.

11.1 TO ENTER COMMENTS IN THE PATIENT'S ADMINISTRATIVE DATA SEGMENT

- Enter 7 and press Return on the CR Menu.

The Administrative Data Segment is displayed. The cursor is at ENTER SELECTION.

- To enter comments, type ALL and press Return to move to the first line.

The cursor moves to SELECTED ADMINISTRATIVE DATA.

- Type your comments and press RETURN at the end of each line to move to the next line.

- When you have finished entering comments, press Entry Done to move the cursor to ENTER SELECTION.

The cursor moves to ENTER SELECTION.

- To display page 2, enter 2 - NEXT PAGE at ENTER SELECTION.

Page 2 is displayed. The cursor is at ENTER SELECTION.

- o To continue entering comments, type ALL and press Return at the end of each line.

- o When you have finished entering comments press Entry Done to move the cursor to ENTER SELECTION.

- o At ENTER SELECTION, press Return to display the CR Menu.

- o Select another segment or press Return at ENTER SELECTION to store the data.

11.2 POINTS TO REMEMBER

1. Seven lines of free text may be entered on each of the two pages of this screen segment.

2. Option 2 - NEXT PAGE is not valid if there is no data on page 1.

11.3 CHECKPOINT

Once you have read this section, review lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 12. NON-PROCEDURAL PROVIDERS SEGMENT

PROCEDURE **PAGE**

12.1 To Enter the Patient's Non-Procedural Providers.....12-4
12.2 Points to Remember.....12-5
12.3 Checkpoint.....12-5

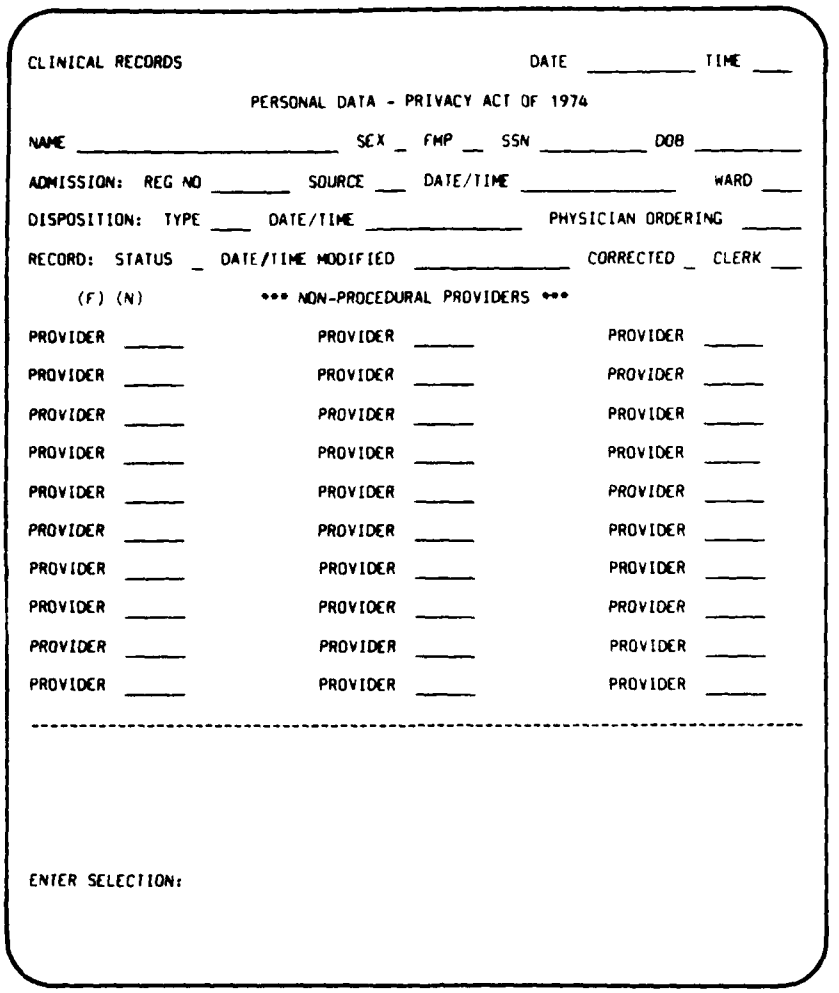


FIGURE 12.1 NON-PROCEDURAL PROVIDERS SEGMENT

12. NON-PROCEDURAL PROVIDERS SEGMENT

ACCESS Enter 8 and press Return on the CR Menu to display the Non-Procedural Providers Segment. This segment is overlaid on the Common Data Screen. This screen is not restricted, but is normally used by the Air Force and Navy only.

PURPOSE The Non-Procedural Providers Segment enables you to enter or change codes for physicians not associated with particular procedures performed.

DESCRIPTION Non-procedural providers processing uses one screen segment to list up to 30 physicians' names.

OPTIONS There are no options on this screen.

12.1 TO ENTER THE PATIENT'S NON-PROCEDURAL PROVIDERS

- Enter 8 and press Return on the CR Menu.

The Non-Procedural Providers Segment is displayed. The cursor is at ENTER SELECTION.

- To enter a provider, type ALL and press Return.

The cursor moves to the first PROVIDER field.

- Enter the physician's short name and press Return.

The cursor moves to the next field.

- Continue entering as many physicians as appropriate.

- When finished entering data, press Enter Done to move the cursor to ENTER SELECTION.

- o At ENTER SELECTION, press Return to display the CR Menu.

- o Select another segment or press Return at ENTER SELECTION to store the data.

12.2 POINTS TO REMEMBER

1. Use this segment to enter or update codes for physicians associated with the inpatient episode but not associated with the particular procedure performed during the episode.

2. Up to 30 providers can be listed.

12.3 CHECKPOINT

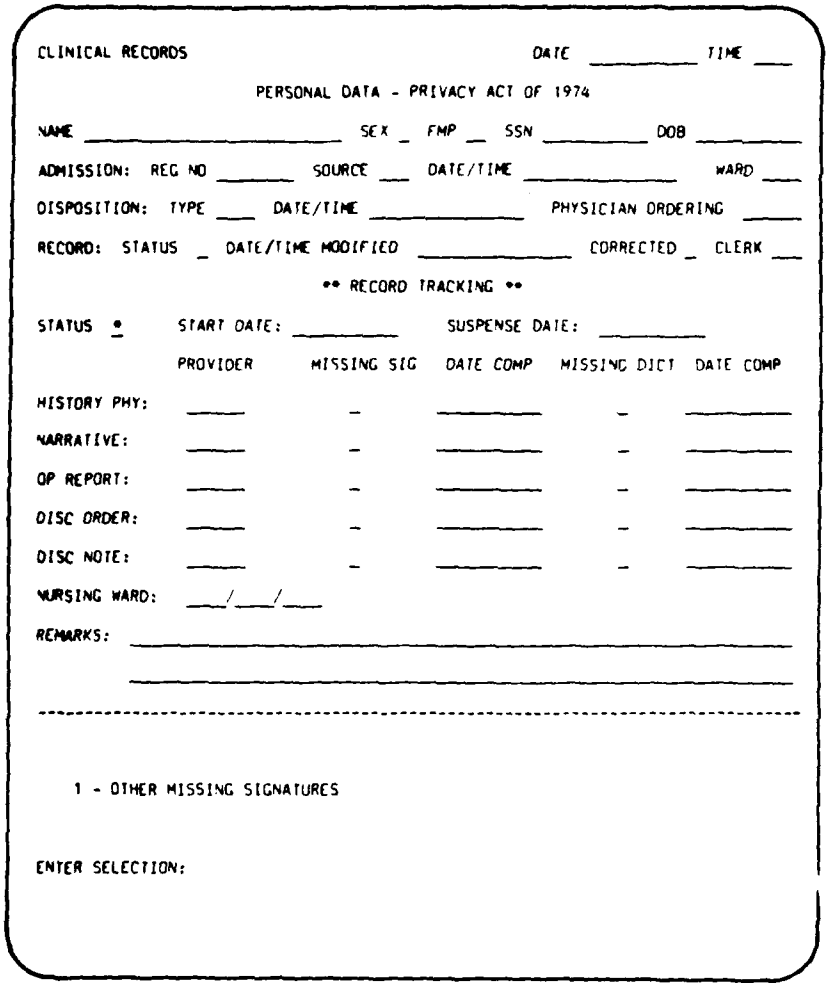
Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

SECTION 13. RECORD TRACKING SEGMENT

PROCEDURE		PAGE
13.1	To Enter Initial Missing Items on a Patient's Record Tracking Segment	13-4
13.2	To Enter Completion Dates on a Patient's Record Tracking Segment	13-6
13.3	To View or Update Other Missing Signatures	13-8
13.4	Points to Remember	13-9
13.5	Checkpoint	13-10



```
CLINICAL RECORDS                                    DATE _____ TIME ___

                    PERSONAL DATA - PRIVACY ACT OF 1974

NAME _____ SEX _ FMP __ SSN _____ DOB _____

ADMISSION: REG NO _____ SOURCE ___ DATE/TIME _____ WARD ___

DISPOSITION: TYPE ___ DATE/TIME _____ PHYSICIAN ORDERING _____

RECORD: STATUS _ DATE/TIME MODIFIED _____ CORRECTED _ CLERK ___

                        ** RECORD TRACKING **

STATUS *    START DATE: _____    SUSPENSE DATE: _____

            PROVIDER    MISSING SIG  DATE COMP  MISSING DICT  DATE COMP

HISTORY PHY:  ____        _          _____      _             _____
NARRATIVE:    ____        _          _____      _             _____
OP REPORT:    ____        _          _____      _             _____
DISC ORDER:   ____        _          _____      _             _____
DISC NOTE:    ____        _          _____      _             _____
NURSING WARD: __/__/__

REMARKS: _____

         _____

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

   1 - OTHER MISSING SIGNATURES

ENTER SELECTION:
```

FIGURE 13.1 RECORD TRACKING SEGMENT

13. RECORD TRACKING SEGMENT

ACCESS Enter 9 and press Return on the CR Menu to display the Record Tracking Segment on the lower portion of the Common Data Screen.

PURPOSE The Record Tracking Segment enables you to enter and review the status of signatures and dictations missing from the patient's record. The dates on which these items are subsequently completed are also entered.

DESCRIPTION The body of the Record Tracking Segment is a matrix of missing items and completion dates, for each provider listed.

OPTIONS Use 1-OTHER MISSING SIGNATURES to view other missing items.

13.1 TO ENTER INITIAL MISSING ITEMS ON A PATIENT'S RECORD TRACKING SEGMENT

Note: When a patient's clinical record is first accessed in CR, the record status must be entered on this screen. Missing signatures and dictation are recorded if the record is incomplete. As items are completed by the physician, the completion date is entered for each missing item.

o Enter 9 and press Return on the CR Menu.

The Record Tracking Segment is displayed. The cursor is at ENTER SELECTION.

o To enter the record status and to record missing or completed signatures and dictations, type ALL and press Return to move the cursor to each field of the screen beginning with the first field, STATUS.

Note: The Record Tracking Status must be changed to C - COMPLETE before finishing the CR processing.

The cursor moves to the STATUS field.

- Enter the record status code.

The cursor moves to START DATE, which is already completed by the system.

Note: The START DATE is calculated by the system but may be updated. If you update the start date, the SUSPENSE DATE (from which delinquencies in completing the record are calculated) will be recalculated and displayed.

- Update the start date, if required, and press Return.

The cursor moves to the first PROVIDER field.

- Enter the provider's short name and press Return.

The cursor moves to the MISSING SIG field.

- If the provider's signature on a report is missing, enter an X; if not, leave field blank and press Return.

- Press Return to skip the DATE COMP field and move to the MISSING DICT field.

- If the provider's dication on a report is missing, enter X; if not, leave the field blank.

- Repeat this process for each procedure that was performed and for which there are items missing in the clinical record.

- When all missing items have been entered, press Entry Done to move the cursor to ENTER SELECTION.

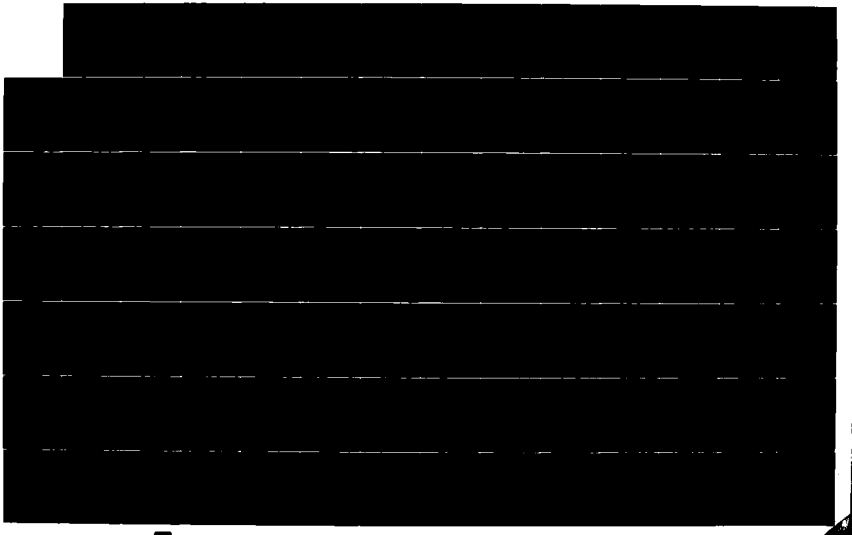
- Press Return at ENTER SELECTION to display the CR Menu.

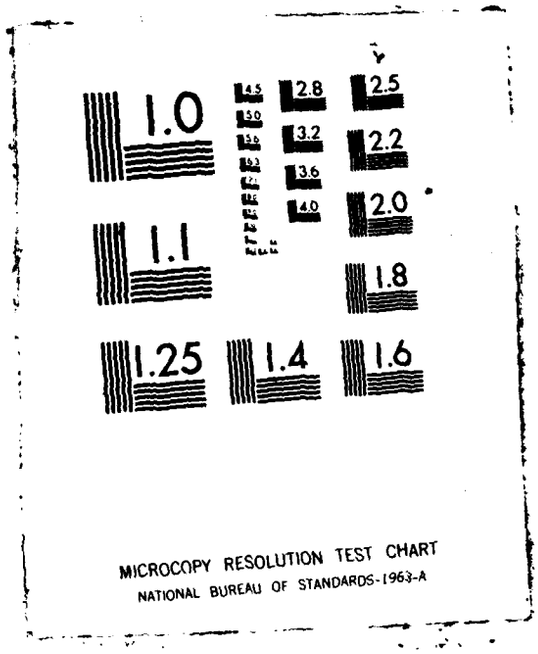
13.2 TO ENTER COMPLETION DATES ON A PATIENT'S RECORD TRACKING SEGMENT

Note: It is extremely important to post items as they are

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UNCLASSIFIED F/G 5/9 NL




1.0
1.1
1.25
1.4
1.6
2.8
3.2
3.6
4.0
2.5
2.2
2.0
1.8
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

completed. If an item is not posted by the suspense date,it will appear on the report as delinquent.

- Enter 9 and press Return on the CR Menu.

The Record Tracking Segment is displayed. The cursor is at ENTER SELECTION.

- Enter ALL and press Return to move the cursor to the PROVIDER field.

- If the signature was previously missing and is now complete, press Return to MISSING SIG. Press RETURN to DATE COMP and enter the completion date.

- Continue entering data as appropriate.

- If you've completed entering information, press Entry Done to move the cursor to ENTER SELECTION.

Note: When all missing signature dates have been completed, the Record Tracking Status must be changed to C - COMPLETE to continue CR processing.

- To change the record status, enter the Partial Field label at ENTER SELECTION.

The cursor moves to RECORD STATUS field.

- Enter the status. (Refer to Points to Remember.)

The cursor moves to ENTER SELECTION.

- At ENTER SELECTION, press Return to display the CR Menu.

- Select another segment at ENTER SELECTION or press Return on the CR Menu to store the data.

13.3 TO VIEW OR CHANGE OTHER MISSING SIGNATURES

- Enter 9 and press Return on the CR Menu.

- Enter 1 - OTHER MISSING SIGNATURES and Return on the Record Tracking Segment.

The list of other missing signatures is displayed. The cursor is at ENTER SELECTION.

- o Enter ALL and press Return.

The cursor is at PROVIDER.

- o Enter the short names of any other providers whose signatures are missing.
- o If you have completed entering all information, press Entry Done to move the cursor to ENTER SELECTION.
- o To redisplay the Record Tracking Screen, press 1 - RETURN TO RECORD TRACKING.

13.4 POINTS TO REMEMBER

1. Use the Record Tracking Segment to enter, update, or review information missing from the record, such as signatures and dictations. These items are tracked to determine deficiencies and delinquencies in the clinical record.

2. If the record is not completed by the suspense date, the delinquency will automatically be posted 14 days later to the respective provider profile. It is important to post completed items each day even though the two week period provides additional time for posting in CR.

3. When all completion dates have been entered, the Record Tracking Status must be changed to C - COMPLETE to continue CR processing.

4. Record Statuses include:

   I - Incomplete
   C - Complete
   W - Waiting for Results
   O - Checked Out

13.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 14. CLERK ACTIONS SEGMENT

PROCEDURE **PAGE**

14.1 To Enter an Action on The Clerk Actions Segment.....14-4
14.2 To Enter a Supervisor Action.....14-5
14.3 To View a Clerk Update List.....14-7
14.4 Points to Remember.....14-8
14.5 Checkpoint.....14-9

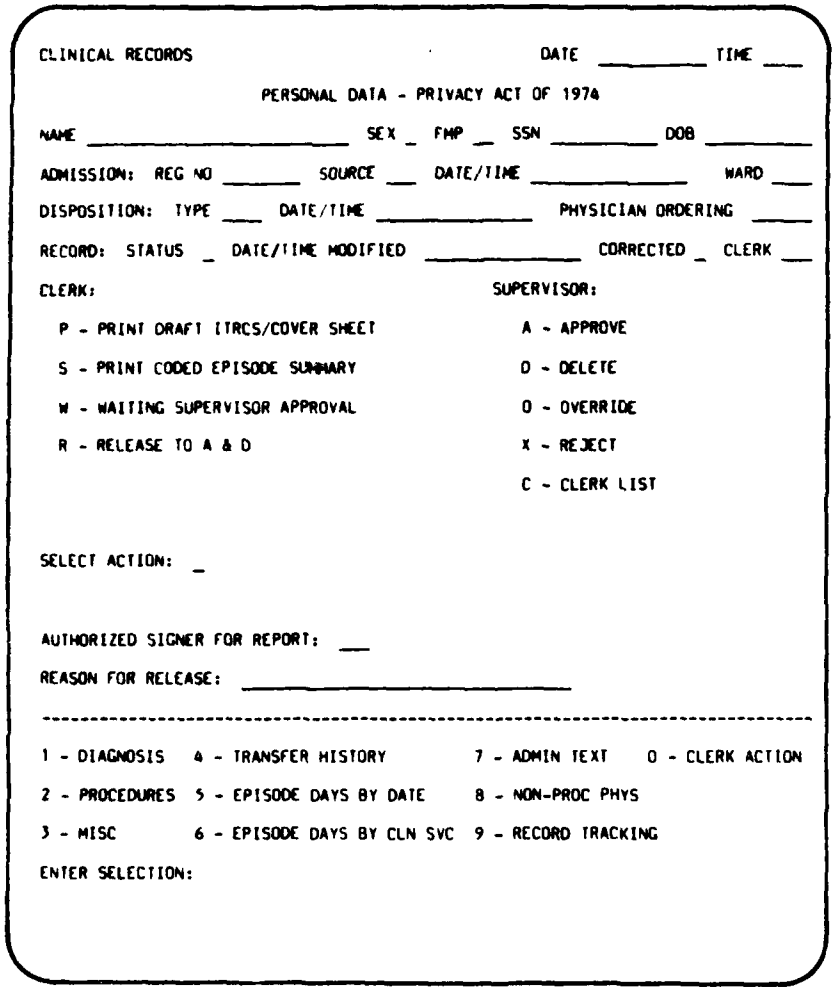


FIGURE 14.1 CLERK ACTIONS SEGMENT

14. CLERK ACTIONS SEGMENT

ACCESS Enter 0 (be sure this is the number 0, not the letter O) and press Return on the CR Menu to display the Clerk Actions Segment on the lower portion of CR Common Data Screen.

PURPOSE The Clerk Actions Segment enables you to specify the next action required to complete processing on a patient's record.

DESCRIPTION The Clerk Actions Segment lists the actions that the clerk and supervisor can take to complete processing on a patient's record. Most of the actions taken on this screen also change the record status which appears on line 6 of the screen.

OPTIONS There are no submenu options on this screen.

14.1 TO ENTER AN ACTION ON THE CLERK ACTIONS SEGMENT

- Enter 0 (the number 0, not the letter O) and press Return on the CR Menu.

The Clerk Actions segment is displayed. The cursor is at SELECT ACTION.

- To enter an action, type in the letter that corresponds to the desired action.

CLERK ACTIONS P - PRINT DRAFT ITRCS/COVER SHEET S - PRINT CODED EPISODE SUMMARY W - WAITING SUPERVISOR APPROVAL R - RELEASE TO A&D If P, S, or W is selected, final edits are performed and CR products printed.

- Press Return to move the cursor to the REG NO screen and to start the printing action.

Note: If select R is used, the REASON FOR RELEASE field must have an entry.

- o Enter required data and press Return.

- o Enter the register number to begin processing another record or press Return to exit CR.

14.2 TO ENTER A SUPERVISOR ACTION

- o Enter O and press Return on the CR Menu.

The Clerk Action Segment is displayed. The cursor is at SELECT ACTION.

- o To enter an action, type in the letter that corresponds to the desired action.

SUPERVISOR ACTION A - APPROVE D - DELETE O - OVERRIDE X - REJECT C - CLERK LIST If A is selected, final edits are performed and the record status is changed. If O or X is selected the record status is changed to I-Incomplete and additional clerk action must be performed.

The cursor moves to the SUPERVISOR USER CODE.

- o Enter a valid user code.

- o The cursor moves to PASSWORD. Enter a valid password.

Note: For Army only, when approving the record the cursor will move to AUTHORIZED SIGNER FOR REPORT. Enter the initials of the authorizing person. This record remains locked while the cover sheet/RIPT and Coded Episode Summary are printed. You are free to process another record.

- o Press Return to move the cursor to the REG NO screen and to start the printing action.

Note: When a record has been approved to be included on the CTT, it can be rejected for corrections. If the record is subsequently corrected, it can be reapproved. If it is not to be retransmitted with CTT, the action should be set to D for delete.

14.3 TO VIEW A CLERK UPDATE LIST

- Enter O and press Return on the CR Menu.

The Clerk Action Segment is displayed. The cursor is at SELECT ACTION.

- To view the Clerk Update List, enter C - Clerk List.

The cursor is at SUPERVISOR USER CODE.

- Enter a valid user code.

The cursor is at PASSWORD.

- Enter a valid password.

The Clerk Update List is displayed. The cursor is at ENTER SELECTION.

- o When finished viewing the data, press Return at ENTER SELECTION to display REG NO Screen.

- o Select another segment at ENTER SELECTION or press Return to exit CR.

14.4 POINTS TO REMEMBER

1. The RECORD STATUS field on the Clerk Actions Screen displays the code indicating the current status of the record. The status of a record is I - Incomplete when CR processing is initiated. The Record Statuses are:

   I = CR processing has begun on this record but is incomplete

   W = Waiting for supervisor's approval

   A = Approved for inclusion on the Coding Transcript Tape (CTT)

   D = Deleted from CR processing; cannot be accessed and does not appear on reports

   P = Projected disposition

   X = Record is erroneous and has been rejected for correction in CR

   R = Released to A&D for correction or changes

   T = Transmitted to higher command

2. If you enter a Clerk Action of P, S, or W, the final edits are performed and CR products are printed with a list of errors.

3. When you enter an action that causes a final Clinical Record Edit and printing of the cover sheet/RIPT, the REG NO (patient record) will be locked during the edit process and during printing of the final cover sheet and Coded Episode Summary. The CRID Screen is displayed and you are free to process another patient.

14.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

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SECTION 15. CLINICAL RECORDS PRODUCTS

PROCEDURE	PAGE
15.1 To Print Clinical Records Products	15-4
15.2 Checkpoint	15-5

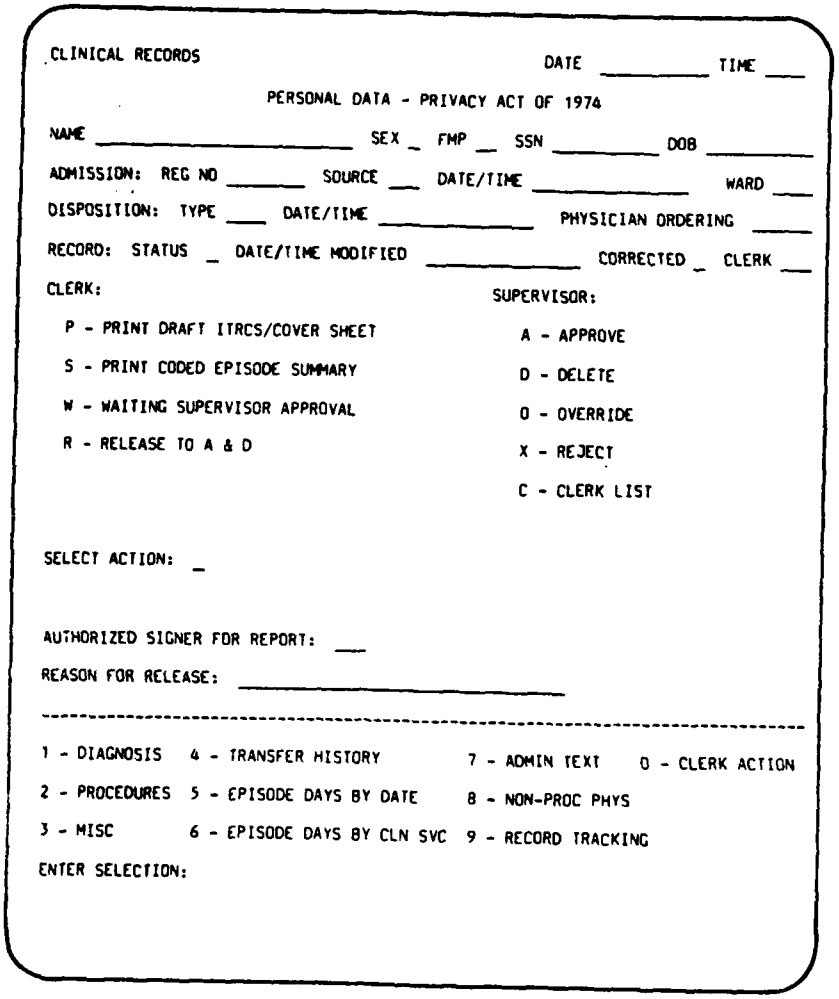


FIGURE 15.1 CLERK ACTIONS SEGMENT

15. CLINICAL RECORDS PRODUCTS

ACCESS Enter 0 (the number 0, not the letter O) and press Return on the CR Menu to display the Clerk Actions Segment.

PURPOSE Clinical Records Products are printed automatically when you enter a patient's record status as W-Waiting for Supervisor's Approval. Products can also be printed on request by entering P - PRINT DRAFT ITRCS/COVER SHEET or S - PRINT CODED EPISODE SUMMARY.

There are three Clinical Records Products:

1. **Coded Episode Summary (CES)** - The Coded Episode Summary is a printout of the data on the Coding Transcript Tape (CTT); The CES is different for each military department.

2. **Inpatient Treatment Record Cover Sheet (ITRCS) or Record of Inpatient Treatment (RIPT)** - The RIPT is used by the Navy and Air Force; the ITRCS is used by the Army. These products provide a summary of the patient's treatment at the MTF.

3. **Error List** - The Error List is printed following each draft ITRCS/RIPT or CES. Any errors will be listed. The edit logic and messages will be different for each military department.

DESCRIPTION The Cover Sheet and Error List are the tools you will use to correct the errors that are indicated after final edits have been initiated.

15.1 TO PRINT A CR PRODUCT

- Enter 0 (the number 0, not the letter O) and press Return on the CR Menu.

The Clerk Actions Segment is displayed. The cursor is at ENTER SELECTION.

Note: CR Products are printed automatically when you enter a patient's record status as W.

- To request printed products enter P - PRINT DRAFT ITRCS/COVER SHEET or S - PRINT CODED EPISODE SUMMARY.

The product that you selected is printed.

Note: These products cannot be displayed on the screen.

15.2 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

SECTION 16. CLINICAL RECORDS REPORTS SCREEN

PROCEDURE **PAGE**

16.1 To Print a CR Report.....16-4
16.2 Checkpoint.....16-7

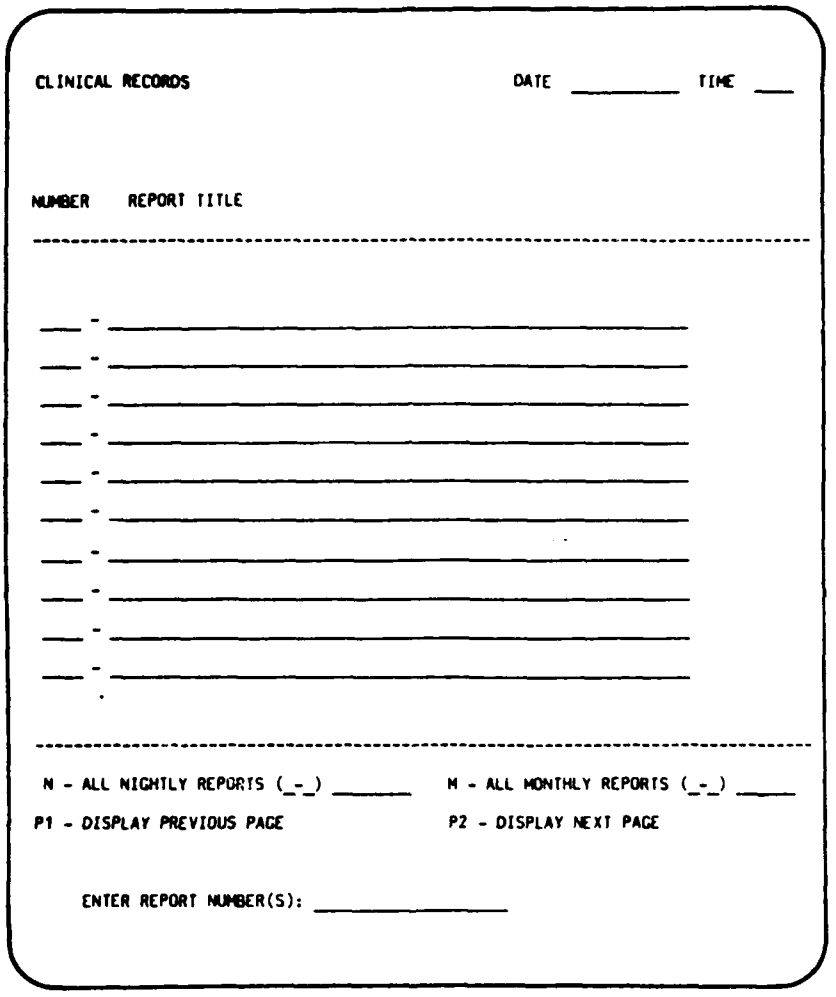


FIGURE 16.1 SAMPLE CLINICAL RECORDS REPORTS SCREEN

16. CLINICAL RECORDS REPORTS SCREEN

ACCESS The Clinical Records Reports Screen is displayed when you enter option 2 and press RETURN on the User Entry Menu. A different Clinical Record Screen is used by each service; a sample is shown in Figure 16.

PURPOSE The Clinical Records Reports Screen enables you to select the CR reports you wish to print. These CR reports are described on the following pages.

DESCRIPTION Three report types are displayed on the screen: Coded Transcript Tape (different for each service), Roster of Delinquent Records, and Clinical Records Released to A&D. The Navy also has an end-of-month Summary Report. Each report uses a Run-Time Information Screen to enable you to specify the parameters of the report.

OPTIONS There are no submenu options on the reports. However, you can print a hard copy or view the report on the screen depending upon the information specified on the Run-Time Information Screen.

CLINICAL RECORDS REPORTS

Clinical Records Reports are printed upon request. To access this function, enter 2 and press Return on the *User Entry Menu*. The Clinical Record Reports Selection Screen is displayed. Reports are selected by entering the number to the left of the Report. For each report selected, a run-time information screen is displayed, which enables you to specify run-time parameters.

CR reports include the following:

1. **Roster of Delinquent Records.** This report lists records that have not been completely processed in Clinical Records within the time limit set by the MTF, and which are therefore delinquent.

2. **Clinical Records Released to A&D.** This report lists records that have been returned to A&D for processing.

Samples of these reports, and others, are shown in the AQCESS Trainer Guide.

16.1 TO PRINT A CR REPORT

- Enter 2 and press Return on the User Entry Menu Screen.

The Clinical Records Report Selection Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the number of the report you wish to print or view and press Return.

The Report Run-Time Information Screen for the report you selected is displayed. The cursor is at the first field required to specify the report parameters.

- To print the report, enter the number of copies you wish to print at the PRINTER COPIES field.

Note: To regenerate the previous (last printed) report, enter R followed by the number of copies.

- To display the report on the screen, leave the PRINTER COPIES field blank, and press Return.

The cursor moves to the next field for you to specify parameters.

- Continue to complete the report specifications.

Note: These specifications may include report date, or starting date and ending date to specify a time period.

When all applicable fields are complete the cursor moves to ENTER SELECTION.

- Press Return at ENTER SELECTION to print or display the report.

The report is either displayed on the screen or printed.

- If displayed on the screen, press Return to view each subsequent page of the report.

- Press Return on the last page of the report to redisplay the CR Report Selection Screen.

16.2 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS CLINICAL RECORDS TRAINING AID

send mail. You must delete stored messages to reinstate the capability. Messages which you wish to save can be printed using the CTRL P function at ENTER SELECTION.

To delete a message:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 1 at ENTER SELECTION. Press Return.

The message is deleted. The User Entry Menu is displayed.

To acknowledge a message:

1. If you wish to send an acknowledgment message back to the sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter ALL. Press Return.

The cursor moves to the TO field.

- o Press Return until you move the cursor into the message box. Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send the acknowledgment message to the sender. The User Entry Menu screen is displayed. The cursor is at ENTER SELECTION.

2. If you wish to acknowledge receipt of a message but you do not want to send a new message back to the original sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send an acknowledgment to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.5 GLOSSARY OF TERMS

A&D	Admission and Disposition. The AQCESS subsystem that processes patient administration information.
Ad Hoc	Ad Hoc Report Generator subsystem.
A&S	Appointing and Scheduling Module of the Outpatient Encounter subsystem.
AQCESS	Automated Quality of Care Evaluation Support System.
Character	Any letter, number, symbol, or space in a field.
CR	Clinical Records. The AQCESS subsystem that processes clinical records information.
Codes	Characters which are abbreviations for words. For example, "s" might designate marital status of single.
Computer	A device capable of accepting data (input), applying prescribed processes (program) to the data, and supplying the results of these processes as meaningful information (output).

Computer Hardware	A computer's mechanical, magnetic, electronics, and electrical equipment.
Computer Terminal	The device with which data is input or output. It consists of a keyboard and Cathode Ray Tube (CRT).
CRT	Cathode Ray Tube. The screen or display unit on a computer terminal which resembles a television.
Cursor	The blinking rectangle used on the CRT screen to mark the current position on the screen where data can be entered or a selection made.
Data	A collection of facts or figures.
Database	A collection of data.
Data entry screen	A screen on which data is input.
Default	A selection made automatically by the system when no explicit choice is specified by the user.
DoD	Department of Defense.
Down	The condition in which the computer is not operational.

Edit	Computer activities that check input for validity and consistency.
Enter	The process by which information is transmitted to the computer through a terminal.
Field	The various areas of the screen that always contain the same type of information (e.g., the NAME field.)
Input	The transfer of data into the computer. The data to be processed.
Keyboard	The rows of keys attached to the CRT, used to communicate data to the computer.
Label	The pieces of information on a screen that identify the data to be entered in a field.
Menu Screen	A screen which allows you to select from a list of processing options.
MSA	Medical Services Accounting subsystem.
MTF	Medical Treatment Facility; a military hospital.
Numeric	Pertaining to a character set that contains numbers only.

On-line	The state in which a terminal can be used to send information to or receive information from the computer.
Output	Information produced by a computer in a readable form such as a printed report or information on a display screen.
Password	A confidential code that allows access to the computer system. Passwords are part of a security system that allows only authorized personnel access to the system.
Printer	The equipment used to print messages, forms, labels, and reports.
QA	Quality Assurance. The AQCESS subsystem that processes quality assurance information.
Required field	A field on a screen where data must be entered.
Screen	The display surface of a terminal or the information on the terminal.

Sign-on	The identification process that a user performs to begin work with a computer system. In AQCESS, sign-on consists of a user ID and a password. These are assigned by the system manager.
Software	A set of computer programs, procedures, rules, and documentation recorded in the computer's memory that operates and directs the use of the computer hardware.
Submenu	A menu found on the bottom of a data entry screen that lists the other options for that screen.
Up	The condition in which the computer is operational.
Update	Changing data after it is stored in the system.
User	One who uses the computer system on a day-to-day basis.

1.6 CHECKPOINT

Your reading of Section 1, Introduction, provides a basic understanding of AQCESS. Use the questions listed below to check your progress. If you cannot readily answer a question, review the pertinent subsection. Verify your answers by checking those shown on the next page.

1. List the seven subsystems that process AQCESS information.

   _____

   _____

   _____

2. Generally describe the kind of information that is processed by these subsystems.

   _____

   _____

   _____

3. How does AQCESS use menu and data entry screens to help you organize information that is to be entered?

   _____

   _____

   _____

4. How do you get data in AQCESS:

_____

_____

5. How does AQCESS ensure that entered data is accurate and sensible?

_____

_____

_____

6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

	Action	Keys
____	You want to know the valid entries for a field.	a. Clear Data
____	You want to delete information from a field in which it has been stored.	b. Delete c. Entry Done
____	You made a typo and want to correct it.	d. Return e. Explain Error
____	You have finished all required entries on a screen and want to store the information.	f. Help
____	You need additional information to correct an error condition.	

CHECKPOINT ANSWERS

1. List the seven subsystems that process AQCESS information.

   Admission & Disposition, Quality Assurance, Clinical Records, System Management, Medical Service Accounting, the Appointing and Scheduling Module of the Outpatient Encounter, and the Ad Hoc Report Generator.

2. Generally describe the kind of information that is processed by these subsystems.

   patient registration, admission, disposition info; quality of care info; provider profile and performance; resource use.

3. How does AQCESS help you organize information that is to be input?

   Menu screens enable you to choose a particular processing function. Data entry screens and related screen segments collect information for that function in a sequence that is logical and that facilitates information storage and reporting.

4. How does AQCESS acquire its information?

   Information is input into a computer terminal.

5. How does AQCESS ensure that its information is accurate and sensible?

Validity edits check data as it is input. You are notified of an invalid entry by a beep and a message that describe the error condition. Consistency edits check to see that the relationships between data entered in different fields is valid. If an entry in one field is incompatible with an entry in another field, an error message is displayed.

6. Identify the terminal "Keys" listed on the right that should be used to accomplish the "Action" listed at the left. Mark your answer in the space provided.

	Action	Keys
f	You want to know the valid entries for a field.	a. Clear Data b. Delete c. Entry Done d. Return e. Explain Error f. Help
a	You want to delete infomation from a field in which it has been stored.	
b	You made a typo and want to correct it.	
d	You have finished all required entries on a screen and want to store the information.	
e	You need additional information to correct an error condition.	

QUALITY ASSURANCE TRAINING AID

2. OVERVIEW

The Quality Assurance process enables the quality of care indicators of treatment provided at the MTF to be monitored. Much of the information required to do this is collected through Admission and Disposition on Clinical Records.

The QA function has seven processes:

O INPATIENT OCCURRENCE SCREENING

Inpatient Occurrence ID Screen - used to enter valid register number identifying the patient to be screened.

Inpatient Occurrence Screening Checklist - used to answer all the questions in the checklist on inpatient occurrences for each patient record.

Inpatient Screening Audit - used to enter information concerning the review of the case and to track the review and record the recommendations and actions taken.

E EMERGENCY SERVICES OCCURRENCE SCREENING

Emergency Service PTID Screen - used to identify the Emergency Service patient episode to be screened.

Emergency Service Candidate List Screen - used to identify the patient whose emergency room data you wish to review.

Emergency Service Episode List Screen - used to identify list of emergency room episodes for the selected patient.

Emergency Service Occurrence Screening Checklist - used to collect the answers to the screening checklist questions.

Emergency Service Screening Audit - used to enter information concerning the review of the case, to track the review, and to record the recommendations and the actions taken.

I INCIDENT REPORTING

Incident ID Screen - used to enter valid log number identifying the incident to be processed.

Incident Log Screen - used to enter, update, or review information on the incident.

P PROBLEM AUDIT TRACKING

Problem ID Screen - used to enter a valid problem number identifying the problem to be processed.

Problem Audit Screen - used to enter, update, or review data on the problem.

M OCCURRENCE SCREENING QUESTION MAINTENANCE

Question Maintenance ID Screen - used to indicate whether the Inpatient or Emergency Services Checklist is to be changed.

Occurrence Screening Question Maintenance Screen - used to enter the number of the question to be added or changed, and to perform these changes, if applicable.

A AUTO EDIT FOR APPROVED CR RECORDS/BATCH POST MEDICAL RECORD DELINQUENCIES - used to initiate an edit of records that have been processed in QA Occurrence Screening but that have not been approved in Clinical Records. At the same time, Medical Record Delinquencies are posted to the provider profiles. (No screen is displayed.)

R REPORTS - used to choose and print QA reports.

QUALITY ASSURANCE TRAINING AID

QUALITY ASSURANCE TRAINING AID

SECTION 3. QUALITY ASSURANCE MENU SCREEN

PROCEDURE	PAGE
3.1 To Access Quality Assurance Processes	3-4
3.2 Checkpoint	3-5

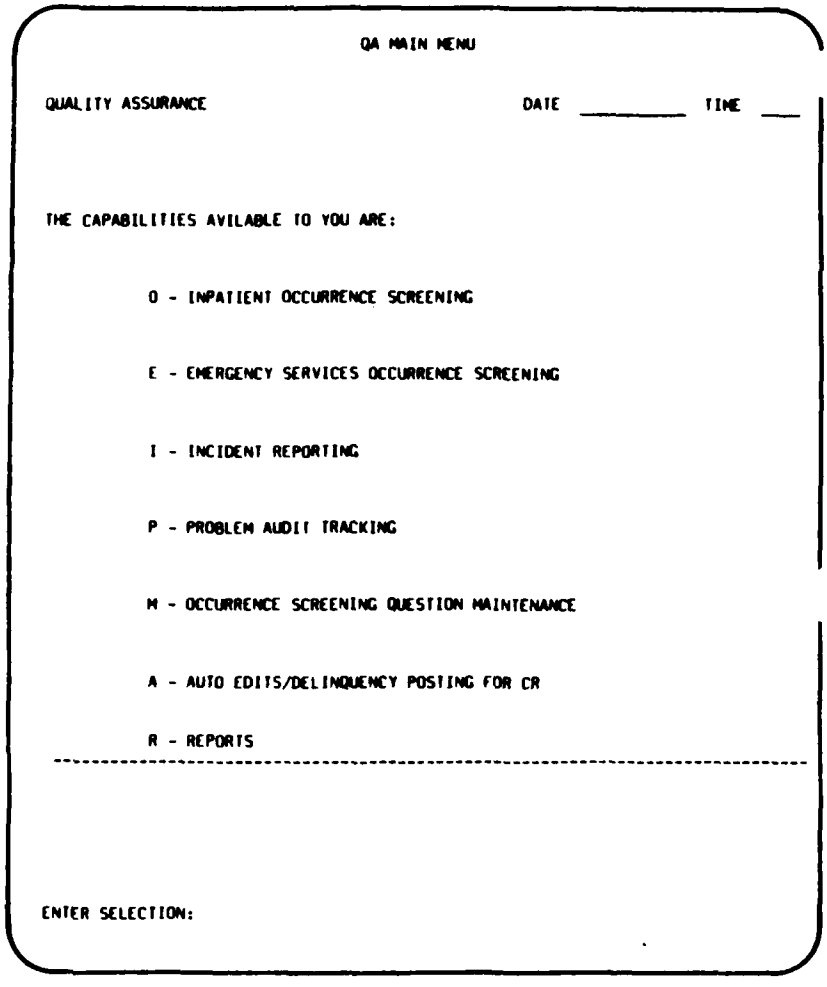


FIGURE 3.1 QUALITY ASSURANCE MENU SCREEN

3. QUALITY ASSURANCE MENU SCREEN

ACCESS Enter Q (Quality Assurance) and press Return on the User Entry Menu Screen to display the Quality Assurance Menu Screen.

PURPOSE The QA Menu Screen allows you to select and access QA processes.

DESCRIPTION The screen lists the selection of QA processes:

O - Inpatient Occurrence Screening

E - Emergency Services Occurrence Screening

I - Incident Reporting

P - Problem Audit Tracking

M - Occurrence Screening Question Maintenance

A - Auto Edit/Delinquent Posting for CR

R - Reports

OPTIONS Select any process listed on the menu by entering the corresponding letter. When Return is pressed without making a selection, the User Entry Menu is displayed.

3.1 TO ACCESS QUALITY ASSURANCE PROCESSES

- Enter Q - Quality Assurance on the User Entry Menu and press Return.

The QA Menu Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the desired selection. Press Return.

The selected QA screen is displayed.

Note: If you select A, no screen will be displayed because this is an edit function.

- Refer to the subsequent sections of this Training Aid for detailed procedures and information on each of the QA processes.

3.2 CHECKPOINT

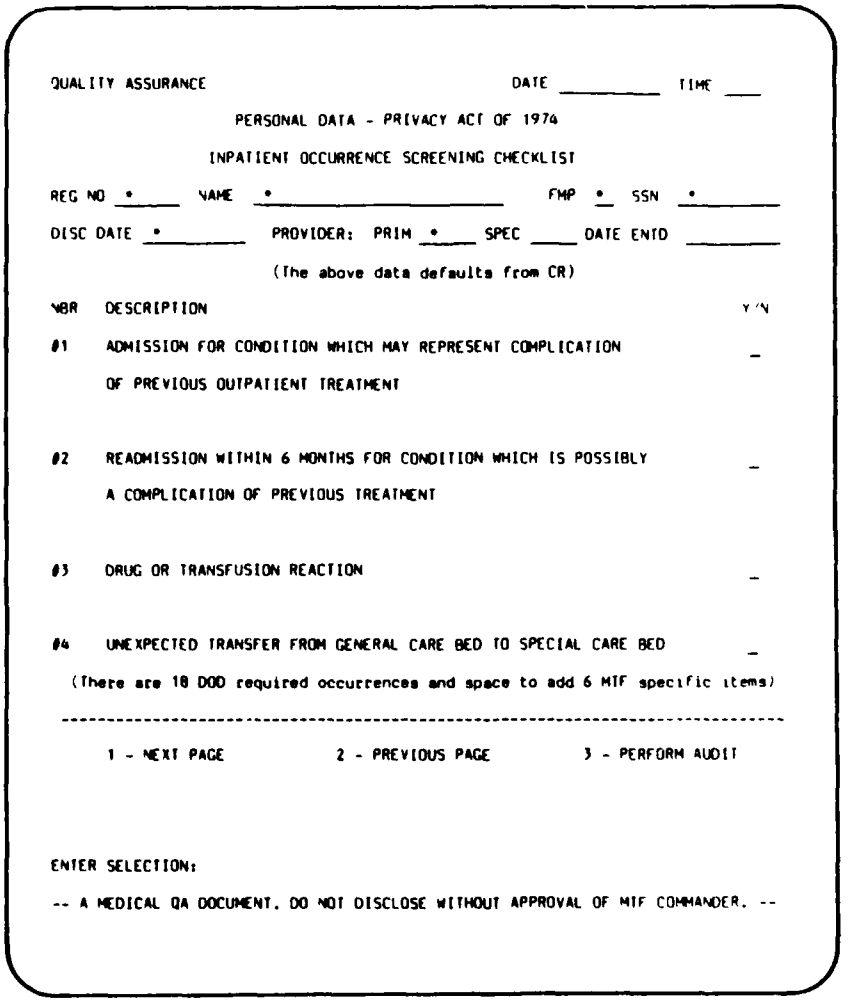
Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

QUALITY ASSURANCE TRAINING AID

SECTION 4. INPATIENT OCCURRENCE SCREENING

PROCEDURE		PAGE
4.1	To Complete Inpatient Occurrence Screening Checklist for a Patient Episode	4- 5
4.2	To Review or Update the Occurrence Screening for an Existing Inpatient Episode	4- 9
4.3	To Perform an Audit on All "Yes" Occurrences	4-11
4.4	To Complete the Audit Information after Review	4-15
4.5	To View or Change Audit Information	4-19
4.6	Points to Remember	4-22
4.7	Checklist	4-22



QUALITY ASSURANCE DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO * ____ NAME * _____ FMP * SSN * _____

DISC DATE * _____ PROVIDER: PRIM * ____ SPEC ____ DATE ENTD _____

(The above data defaults from CR)

NBR	DESCRIPTION	Y/N
#1	ADMISSION FOR CONDITION WHICH MAY REPRESENT COMPLICATION OF PREVIOUS OUTPATIENT TREATMENT	_
#2	READMISSION WITHIN 6 MONTHS FOR CONDITION WHICH IS POSSIBLY A COMPLICATION OF PREVIOUS TREATMENT	_
#3	DRUG OR TRANSFUSION REACTION	_
#4	UNEXPECTED TRANSFER FROM GENERAL CARE BED TO SPECIAL CARE BED	_

(There are 18 DOD required occurrences and space to add 6 MTF specific items)

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 4.1 INPATIENT OCCURRENCE SCREENING CHECKLIST

4. INPATIENT OCCURRENCE SCREENING

ACCESS Select O on the QA Menu Screen to access the Inpatient Occurrence Screening process. Press Return.

PURPOSE Inpatient Occurrence Screening enables you to enter the physician's response to each affirmative occurrence included in the Inpatient Occurrence Screening Checklist. These occurrence items must be answered for patient episode. Once the checklist is completed, all positive occurrences must be sent for review. The Inpatient Occurrence Screening Checklist Screen enables you to select the Perform Audit option and display the Audit screen (Figure 4-2). The Audit screen enables you to track the review process and document actions taken. If the variation is provider related it will be posted to the provider. The checklist can be completed while the patient is still in the hospital and the review process can be initiated. The checklist contains a set of standard MTF occurrence questions and may include additional questions specific to your MTF.

QUALITY ASSURANCE TRAINING AID

DESCRIPTION Inpatient Occurrence Screening uses three screens: the Inpatient Occurrence ID Screen, the Inpatient Occurrence Screening Checklist, and the Inpatient Screening Audit.

OPTIONS Use NEXT PAGE and PREVIOUS PAGE to display pages of the checklist for viewing or updating. Use PERFORM AUDIT to display the audit screens.

4.1 TO COMPLETE INPATIENT OCCURRENCE SCREENING CHECKLIST FOR A PATIENT EPISODE

- Select O on the QA Menu. Press Return.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- Enter the patient's REG NO. Press Return.

The Inpatient Occurrence Screening checklist is displayed. The PROVIDER: PRIM field is defaulted from the Primary Admission data or the Clinical Record. If the patient is dispositioned, the DISC DATE field will be filled. The cursor is positioned at SPEC.

- If the provider has only one clinical specialty, the SPECIALTY field is filled in and should be appropriate for the patient's clinical service. Press Return to move to the next field.

- If the provider has more than one specialty, the SPECIALTY field will be blank. With the cursor at SPECIALTY,

press HELP to display the clinical specialties that are listed for the provider. Enter the appropriate clinical specialty code for this patient's clinical service. Press Return.

Note: If the Clinical Record is approved, the answer field for each occurrence question will be defaulted to N, except for occurrence questions that are defaulted to Y based on CR data.

o Enter the short name of the secondary provider. Press Return.

The cursor moves to the first item in the checklist.

Note: To complete the checklist, transfer the responses from the completed manual Occurrence Screening Checklist.

o Type Y to each question that warrants a "Yes" answer. Press Return to confirm the default N for each answer that is "No."

Note: Use the HELP feature to display the exceptions to yes answers for each question for which there is exception criteria.

Once an answer is entered, the cursor moves automatically to the next question.

- Continue entering Y or N in response to each question on the screen.

Note: Any Y response will cause the record to appear on the audit pull list.

- When you have entered a response to all of the checklist questions on the page, press Return to move the cursor to ENTER SELECTION.

If you have answered N to every question on this page:

The system displays the message ALL QUESTIONS ANSWERED NEGATIVE. ENTER Y IF CORRECT:

- o Enter Y to default the answers to the questions listed on the following pages of the Screening Checklist to N.

- o Enter N if there are questions listed on the remaining pages of the checklist that require a Y answer.

If you have answered Y to any of the questions or answered N to the system message described above:

- o Enter 1 at ENTER SELECTION to access the next page of checklist questions.

Note: Use Options 1 and 2 to page back and forth through the checklist.

After the last question, the cursor moves to ENTER SELECTION.

- o Press Return to store the checklist data.

The Inpatient Occurrence Screening ID screen is displayed. The cursor is positioned at REG NO.

- o If you wish to screen another patient, enter the patient's register number.

- o To view the QA Menu, press Return.

4.2 TO REVIEW OR UPDATE THE OCCURRENCE SCREENING FOR AN EXISTING INPATIENT EPISODE

- o Enter O from the QA Menu. Press Return.

The Inpatient Occurrence ID screens displayed. The cursor is at REG NO.

- o Enter the REG NO to identify the record. Press Return.

The Inpatient Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- o AT ENTER SELECTION, enter 1 and Return to view each page of the Occurrence Screening Checklist.

- To update a response, enter number sign and then the number (e.g., #14) of the occurrence question for which you wish to enter a response. (Or enter ALL to move to each question.)

The cursor moves to the answer field of the question you have selected.

- Enter the updated answer (Y/N). Press Return.

Note: Yes answers defaulted from CR cannot be changed to No.

When the update is made, the cursor moves to ENTER SELECTION.

- Press Return to store the update.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- Press Return to view the Quality Assurance Menu.

4.3 TO PERFORM AN AUDIT ON ALL "YES" OCCURRENCES

- Enter O on the QA Menu. Press Return.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

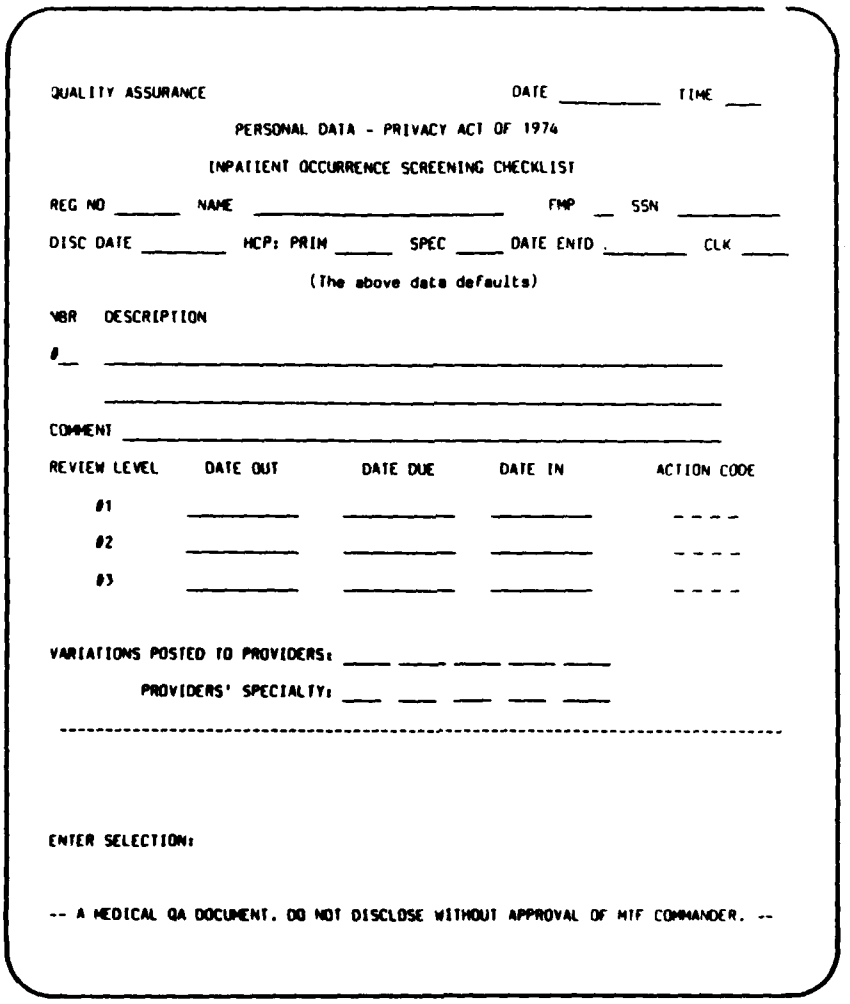
- Enter the REG NO to identify the record. Press Return.

The Inpatient Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- Enter 3 to select PERFORM AUDIT. Press Return.

The Inpatient Screening Audit segment is displayed. The NBR DESCRIPTION field displays the text of the first question in the checklist that was answered Yes. The cursor is at the COMMENT field.

- Enter free text further specifying the occurrence as it relates to the patient. Press Return.



QUALITY ASSURANCE DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

INPATIENT OCCURRENCE SCREENING CHECKLIST

REG NO _____ NAME _____ FMP __ SSN _____

DISC DATE _____ HCP: PRIM _____ SPEC ____ DATE ENTD _____ CLK ____

(The above data defaults)

VBR DESCRIPTION

0__ _____

_____

COMMENT _____

REVIEW LEVEL	DATE OUT	DATE DUE	DATE IN	ACTION CODE
01	_____	_____	_____	- - - -
02	_____	_____	_____	- - - -
03	_____	_____	_____	- - - -

VARIATIONS POSTED TO PROVIDERS: ___ ___ ___ ___ ___

PROVIDERS' SPECIALTY: ___ ___ ___ ___ ___

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 4.2 AUDIT SCREEN

The cursor moves to the REVIEW LEVEL #1 DATE OUT field.

- o Enter the date the record is being sent to the review committee and press Return.

The cursor moves to DATE DUE.

- o Enter the date the review is due and press Return.

Note: The DATE DUE cannot be prior to the DATE OUT.

The cursor moves to DATE IN.

Note: DATE IN cannot be completed until the record is reviewed and returned to the QA office.

- o Press Return to move the cursor to the next field: ACTION CODE.

The cursor moves to the first field of the four digit ACTION CODE.

Note: The ACTION CODE is made up of four separate one-character fields. Use HELP for descriptions of the field requirements.

- Enter the first digit of the code indicating where the record is to be sent for review. Use HELP.

The cursor moves to the second field of the ACTION CODE.

Note: The remaining three fields that make up the ACTION CODE cannot be completed until the record is back from review.

- Enter Entry Done to move the cursor to ENTER SELECTION.

- Press Return to display the next audit question in the NBR DESCRIPTION field.

The NBR DESCRIPTION field displays the next Yes question to be audited. The cursor is at Review Level #1 DATE OUT.

- o Repeat this process for each Yes occurrence.
- o When you've completed audit information for each Yes occurrence, press Return at ENTER SELECTION.

The Inpatient Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- o Press Return to store the data.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- o Press Return to view the QA Menu.

4.4 TO COMPLETE THE AUDIT INFORMATION AFTER REVIEW

- o Enter O on the QA Menu. Press Return.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- Enter the patient's REG NO. Press Return.

The Inpatient Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- Enter option 3 to Perform Audit. Press Return.

The Inpatient Screening Audit Segment is displayed with the first Yes question from the checklist displayed in the NBR DESCRIPTION field. The cursor is at ENTER SELECTION.

- To complete the DATE IN field, enter the REVIEW LEVEL # and press Return to move the cursor to DATE IN.

- Enter the date that the record was returned.

Note: The DATE IN cannot be prior to the DATE OUT. Press Return.

The cursor moves to the first field of the ACTION CODE. The first field of the ACTION CODE is completed.

- Press Return to move the cursor to the next field.

- Enter the code for provider-related decision as indicated by the review of the record.

Note: If the record was reviewed but the outcome is not clear, or no decision was reached, the record must be sent to the next appropriate review level. Complete the REVIEW LEVEL #2 fields.

The cursor moves to the third field of the ACTION CODE: Recommendation.

- Enter the code for the measures taken as indicated by the review.

The cursor moves to the last field of the ACTION CODE: Post to Provider Profile.

- Enter the code to indicate whether or not the occurrence is to be entered in the provider's profile.

NOTE: If you enter Y, you must specify the provider(s) whose profile is to be updated. This variation is to be posted to the profile.

- Press Return repeatedly to move the cursor to the VARIATIONS POSTED TO PROVIDER field. Enter the provider to whose profile the variation is to be posted. Up to five providers can be entered. As you press Return after each provider is entered, the specialty code will be displayed on the line directly below the provider <u>if</u> that provider has only <u>one</u> specialty.

  If the provider has two or more specialties, the specialty code must be entered for each provider on the line directly below the provider. Use HELP to display the specialty codes for each provider.

When all of the occurrences have been completed on the Audit Screen, the Inpatient Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- Press Return to store the completed audit information and post validated variations to the Provider Profiles as indicated.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- To complete the audit for another patient occurrence, enter the register number.

- To return to the QA Menu, press Return at REG NO on the Inpatient Occurrence ID Screen.

4.5 TO VIEW OR CHANGE AUDIT INFORMATION

- Enter 0 on the QA Menu Screen and press Return.

The Inpatient Occurrence ID Screen is displayed. The cursor is at REG NO.

- o Identify the patient occurrence by REG NO and press Return.

The Inpatient Occurrence Checklist Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 3 - PERFORM AUDIT. Press Return.

The Audit Screen from the first audited Yes answer is displayed. The cursor is at ENTER SELECTION.

- o Press Return to display subsequent audit pages corresponding to each Yes occurrence. The cursor remains at ENTER SELECTION.

- o To change or update information, type #, followed by the REVIEW LEVEL number (e.g., #2). Press Return.

The cursor moves to the DATE OUT field in the selected Review Level.

- o Press Return to move the cursor to the field you wish to update.

- Enter the new information. Press Entry Done to move the cursor to ENTER SELECTION.

The information is updated.

- Press Return to store the updated information.

The cursor is at ENTER SELECTION.

- Press Return to view the Quality Assurance Menu.

The cursor is at REG NO.

- To return to the QA Menu, press Return.

4.6 POINTS TO REMEMBER

1. If the discharge DISC DATE field is blank on the Inpatient Occurrence Screening Checklist, the patient is not dispositioned. The clinical record has not been approved. The checklist can be started and the audit can be initiated for any Yes occurrence. However, even though you have entered data in the checklist and completed the audit, the occurrence will not appear on the Occurrence Screening Summary until the clinical record is approved.

2. If a date appears in the DATE ENTD field and the cursor is at ENTER SELECTION, the occurrence checklist has been previously accessed and stored.

4.7 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 5. EMERGENCY SERVICE OCCURRENCE SCREENING

PROCEDURE		PAGE
5.1	To Complete the Emergency Services Checklist for an Emergency Room Episode	5- 5
5.2	To Initiate an Audit Review for Each Question Answered "Yes" on the Screening Checklist	5-11
5.3	To Update Audit Information and Track the Review Process	5-14
5.4	To Review or Update Occurrence Screening and Audit Tracking Information for Previous Emergency Room Episodes	5-19
5.5	Points to Remember	5-22
5.6	Checkpoint	5-22

QUALITY ASSURANCE DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ HCP _____ CLK ___

NBR	DESCRIPTION	Y/N
01	PATIENT SEEN IN ER WHO HAS EITHER BEEN HOSPITALIZED OR SEEN IN ER WITHIN THE PAST 48 HOURS	_
02	PATIENT TREATMENT BY NONPHYSICIAN HEALTH CARE PROVIDER IS NOT REVIEWED BY A PHYSICIAN WITHIN 8 HOURS OF TREATMENT	_
03	PATIENT ARRIVES DOA OR DIES IN THE ER	_
04	PATIENT LEAVES WITHOUT BEING SEEN OR LEAVES AGAINST MEDICAL ADVICE	_

---

1 - NEXT PAGE 2 - PREVIOUS PAGE 3 - PERFORM AUDIT

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 5.1 EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

5. EMERGENCY SERVICE OCCURRENCE SCREENING

ACCESS Enter E on the QA Menu Screen to access the Emergency Service Occurrence Screening Process.

PURPOSE Emergency Service Occurrence Screening enables you to complete the Emergency Service Occurrence Screening Checklist. This is done by entering a physician's response to a list of occurrence questions regarding an emergency service episode. When an occurrence is indicated as positive in the checklist, a review must be performed. The Emergency Service Occurrence Screening Checklist Screen enables you to select the option Perform Audit to display the Audit Screen (Figure 5-2). This feature enables the tracking of the audit process and the automatic posting to the provider profile when the variation is determined to be provider related. Also, patient episode histories, occurrence checklists, and review of previous occurrences can be viewed.

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DESCRIPTION The checklist contains a set of standard MTF occurrence questions and may contain numerous additional questions specific to your MTF. The Emergency Service Occurrence Screening process uses five screens: the Emergency Service PTID Screen; the Emergency Service Candidate List Screen; the Emergency Service Episode List Screen; the Emergency Service Occurrence Screening Checklist; and the Emergency Service Screening Audit.

OPTIONS On the Emergency Service Occurrence Checklist, use NEXT PAGE and PREVIOUS PAGE to locate a response to a particular checklist item. Use PERFORM AUDIT to display the audit screens so that you can initiate and track the review process.

5.1 TO COMPLETE THE EMERGENCY SERVICES CHECKLIST FOR AN EMERGENCY ROOM EPISODE

- o Enter E on the QA Menu Screen. Press Return.

The Emergency Service PTID Screen is displayed. The PATIENT NAME, FMP, and SSN must be entered on the PTID Screen to register an emergency episode. The cursor is at ER LOG NO.

Note: When creating a new record, do not enter the ER LOG NO on the PTID Screen.

- o Press Return to move to the NAME field.
- o Enter the patient's name.
- o Press Return to move the cursor to the next field: FMP.
- o Enter the patient's FMP.

The cursor moves to the next field: SPONSOR'S SOCIAL SECURITY NUMBER (SSN).

- o Enter the sponsor's social security number. Press Return.

The cursor moves to SELECTION.

- o Enter N at SELECTION to create a new patient record. Press Return.

The Emergency Service Occurrence Screening Checklist is displayed. The cursor is at ER LOG NO.

- o Enter the ER LOG NO if the MTF uses a manual system.

Note: The ER LOG NO will be displayed here if the MTF uses an automatic system.

- o Press Return to move to the next field.

The cursor moves to the next field: DATE/TIME OF TREATMENT.

- Enter the date and time. Press Return.

The cursor moves to the next field: PRVDR ID

- Enter the provider's short name or code. Press Return.

The cursor moves to the first question in the checklist. The occurrence questions are all defaulted to N for No.

Note: The system does not default to N for MTF-specific occurrence questions.

- Press Return to accept the default or enter Y if the answer should be Yes.

Once an answer is entered, the cursor moves automatically to the next question.

- Continue entering Y or N in response to each question on the screen.

- When you have entered a response to all of the checklist questions on the page, press Return to move the cursor to ENTER SELECTION.

If you have answered N to every question on this page:

The system displays the message ALL QUESTIONS ANSWERED NEGATIVE. ENTER Y IF CORRECT:

- Enter Y to default the answers to the questions listed on the following pages of the Emergency Service Occurrence Screening Checklist to N.

- Enter N if there are questions listed on the remaining pages of the checklist that require a Y answer.

If you have answered Y to any of the questions or answered N to the system message described above:

- Enter 1 at ENTER SELECTION to access the next page of checklist questions.

Note: Use Options 1 and 2 to page back and forth through the checklist.

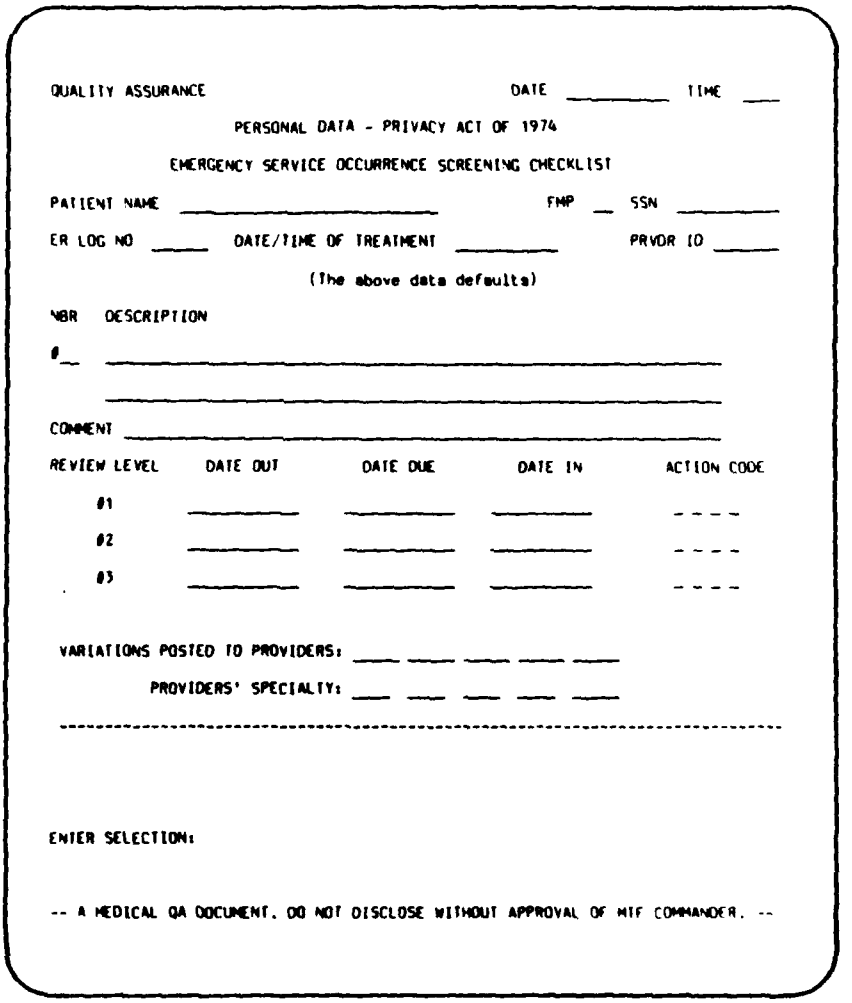
After the last question the cursor moves to ENTER SELECTION.

- Press Return at ENTER SELECTION to store the information.

The Emergency Service PTID Screen is displayed. The cursor is at ER LOG NO.

- To enter another ER episode, complete the Emergency Service PTID screen and repeat the above procedure.

- To return to the QA Menu, press Entry Done and Return.



QUALITY ASSURANCE DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

EMERGENCY SERVICE OCCURRENCE SCREENING CHECKLIST

PATIENT NAME _____ FMP __ SSN _____

ER LOG NO _____ DATE/TIME OF TREATMENT _____ PRVDR ID _____

(The above data defaults)

NBR DESCRIPTION

#__ _____

_____

COMMENT _____

REVIEW LEVEL	DATE OUT	DATE DUE	DATE IN	ACTION CODE
#1	_____	_____	_____	- - - -
#2	_____	_____	_____	- - - -
#3	_____	_____	_____	- - - -

VARIATIONS POSTED TO PROVIDERS: ___ ___ ___ ___ ___

PROVIDERS' SPECIALTY: ___ ___ ___ ___ ___

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 5.2 AUDIT SCREEN

5.2 TO INITIATE AN AUDIT REVIEW FOR EACH QUESTION ANSWERED 'YES' ON THE SCREENING CHECKLIST

- o Enter E on the QA Menu Screen and press Return.

- o Enter the ER LOG NO on the ES PTID Screen and press Return.

The Emergency Occurrence Screening Checklist is displayed. The Cursor is at ENTER SELECTION.

- o Enter 3 to perform an audit on Yes occurrences. Press Return.

The Emergency Service Screen Audit is displayed. The first occurrence question from the checklist that was answered YES is displayed in the NBR DESCRIPTION field. The cursor is at the COMMENT field.

- o Enter free text to further specify the comment as it relates to this patient. Press Return.

The cursor moves to REVIEW LEVEL #1 DATE OUT.

Note: REVIEW LEVEL # indicates the number of times the record has been reviewed. The first review is level #1. If a decision is not reached, the record will be sent to

another review, and this information will be recorded at Review Level #2.

- Enter the date the record is to be sent for review.

The cursor moves to DATE DUE.

- Enter the date the record is due back. Press Return.

Note: The DATE DUE cannot be prior to the DATE OUT.

The cursor moves to DATE IN. This field is completed when the record comes back from review.

- o Press Return to move the cursor to the first field of the ACTION CODE.

- o Enter the code to indicate who is reviewing the record. Use the HELP Function.

The cursor moves to the next field of the ACTION CODE. The remaining three fields of the ACTION CODE are completed after review of the record.

- o Press Entry Done to move the cursor to ENTER SELECTION.

The text of next Yes occurrence to be reviewed is displayed in the NBR DESCRIPTION field. The cursor is at REVIEW LEVEL #1 DATA OUT field.

- o Repeat the above process to enter audit information for each occurrence question answered Yes.

Note: The Emergency Service Occurrence Screening Audit Segment is automatically displayed

for each subsequent Yes occurrence question until audit information for all of the questions is completed.

When the Audit Screen is completed for the last Yes occurrence, the cursor moves to ENTER SELECTION.

- To complete Emergency Service Screening for another emergency room episode, press Return to display the Emergency Service ID Screen.

- To exit *Emergency Service Screening*, cancel out on the Emergency Service ID Screen.

5.3 TO COMPLETE THE AUDIT INFORMATION AFTER THE REVIEW PROCESS

- Enter E on the QA Menu Screen.

Quality Assurance Emergency Service PTID Screen is displayed. The cursor is at ER LOG NO.

- o Enter the ER LOG NO and press Return.

- o Press Entry Done.

The cursor is at SELECTION.

- o Press Return.

The Emergency Service Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- o Enter 3 - PERFORM AUDIT to update the audit information. Press Return.

The Audit Segment is displayed. The first Y question is displayed in the NBR DESCRIPTION field. The cursor is at ENTER SELECTION.

- o Enter # followed by the number of the Review Level to be updated (e.g., #1).

The cursor moves to the DATE OUT field.

- o Press Return twice to move to DATE IN.

- o Enter the date that review was returned to QA. Press Return.

Note: The DATE IN cannot be prior to the DATE OUT.

The cursor moves to the first field of the ACTION CODE.

Note: Use the HELP function for assistance in the ACTION CODE fields.

- o Press Return to move to the second field of the ACTION CODE.

- o Enter the PROVIDER-RELATED CODE to indicate review decision. Press Return.

The cursor moves to third field of the ACTION CODE.

- o Enter the recommendation for action. Press Return.

The cursor moves to the fourth field of the ACTION CODE.

- If the occurrence was provider-related, enter Y to post the occurrence to the provider profile.

If Y was entered, a message is displayed: SPECIFY PROVIDER.

- Press Return repeatedly to move to VARIATIONS POSTED TO PROVIDERS.

- Enter the providers (up to 5) to whose profile the variation is to be posted. Press Return.

Note: N indicates the profile will not be posted.

If more than one question on the checklist was answered Y, the next audit screen is displayed. The cursor is at ENTER SELECTION.

- To enter the audit information on additional occurrences, repeat the above process.

If there are no more Yes occurrences, the Emergency Service Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- Press Return to store the information and to post the variation to the provider's profile.

The Emergency Services PTID Screen is displayed. The cursor is at ER LOG NO.

- To enter audit review tracking information on another patient, type the ER LOG NO.

- To return to the QA Menu Screen, press Cancel at ER LOG NO on the Emergency Service PTID Screen.

Note: The variation is posted immediately in the provider profile.

5.4 TO REVIEW OR UPDATE OCCURRENCE SCREENING AND AUDIT TRACKING INFORMATION FOR PREVIOUS EMERGENCY ROOM EPISODES

- o Enter on the QA Menu and press Return.

- o Enter the information required on the EMERGENCY SERVICE PTID Screen to identify the patient.

If the patient has only one episode, the Emergency Services checklist is displayed.

If the patient has had several episodes, the Episode List is displayed to enable you to select the episode.

- o Enter the number of the episode you wish to view or screen.

If the information required does not identify a single patient to the system, the Candidate List Screen is displayed. The cursor is positioned at ENTER SELECTION.

- Select the correct patient. Enter the number of a patient from the Candidate List and press Return.

The Emergency Service Episode List Screen is displayed. The list includes all previous emergency room episodes for this patient. The cursor is positioned at ENTER SELECTION.

- To view information on an episode from the Episode List, enter the number appearing to the left of the desired episode. Press Return.

The Emergency Services Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- Press 1 and Return to view each page of the Emergency Service Checklist for the episode that you've selected.

- To view audit information on that episode, enter 3 and press Return at ENTER SELECTION.

The Emergency Service Occurrence Screening Checklist Audit Segment is displayed. The first occurrence question from the checklist that was answered "Yes" is displayed in the NBR DESCRIPTION field.

- To view the audit information for each subsequent Yes occurrence, press Return to display the next audit screen.

Note: Audit information can be updated.

After you press Return on the last audit screen, the Emergency Service Occurrence Screening Checklist is displayed. The cursor is at ENTER SELECTION.

- To exit the patient's record, press Return at ENTER SELECTION.

- To view another emergency service episode for that patient, enter the ER LOG NO, or press Cancel to view the Quality Assurance Menu.

5.5 POINTS TO REMEMBER

1. Inpatient Occurrence Screening can be initiated while the patient is still an inpatient. In this case the DISC DATE field is blank, indicating that the patient is not dispositioned. Therefore, the clinical record has not been approved. The variation is posted to the provider but will not appear on reports until the clinical record is approved.

2. Emergency Services is not connected to the inpatient records.

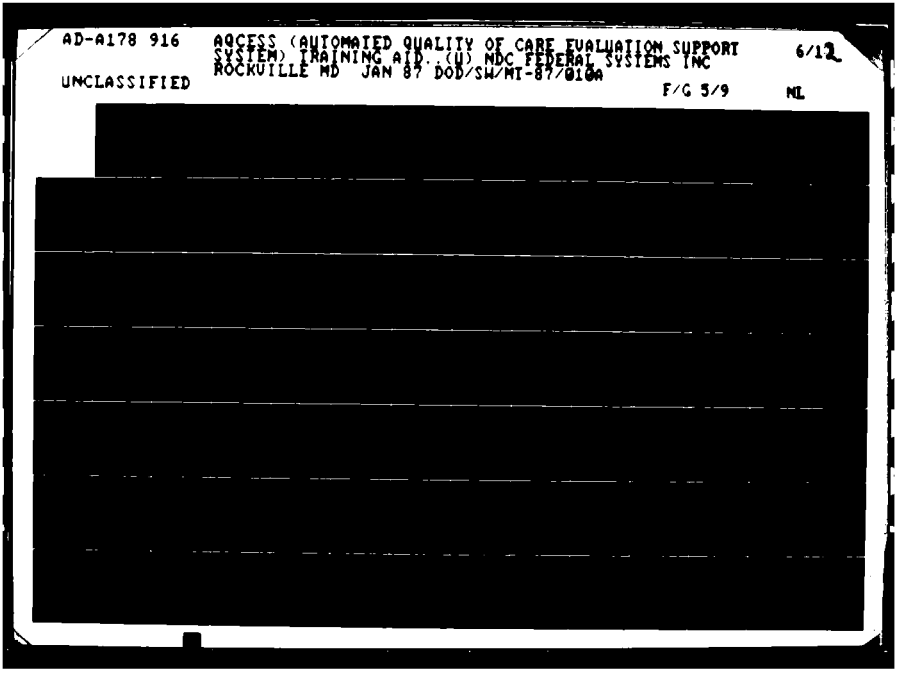
5.6 CHECKPOINT

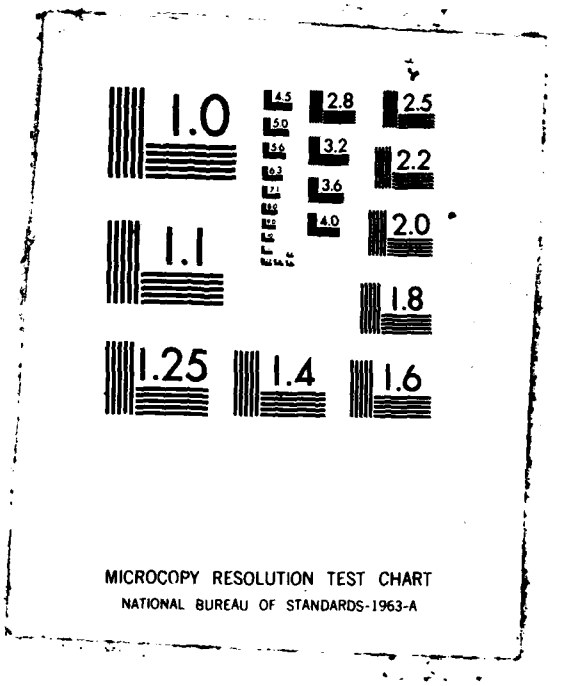
Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

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QUALITY ASSURANCE TRAINING AID

SECTION 6. INCIDENT REPORTS

PROCEDURE		PAGE
6.1	To Complete a Report on an Incident	6-4
6.2	To Update Information on an Incident Report	6-10
6.3	Points to Remember	6-14
6.4	Checkpoint	6-14

QUALITY ASSURANCE DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

INCIDENT REPORT

LOG NO _____

DATE/TIME OF INCIDENT _____

PERSON INVOLVED TYPE _____ NAME _____

FMP ___ SSN _____ REG NO ___

INCIDENT TYPE: _____ LOCATION _____

COMMENT _____

PERSONNEL INVOLVED _____ PERSONNEL REPORTING _____

RESULT OF INCIDENT _

DATE REVIEWED BY RISK MANAGER _____

JAG REVIEW _ DATE SENT TO JAG _____

DATE OF ACTION _____ ACTION CODE _ _ _

DATE OF ACTION _____ ACTION CODE _ _ _

DATE OF ACTION _____ ACTION CODE _ _ _

INCIDENT POSTED TO PROVIDERS _____ _____ _____ _____

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 6.1 INCIDENT LOG SCREEN

6. INCIDENT REPORTS

ACCESS Enter I on the QA Menu Screen to access the Incident Reporting Process.

PURPOSE The Incident Reporting Process enables you to complete a report on incidents that occur within the MTF, for example, accidents. These incidents are not necessarily related to patients. The purpose of incident reporting is to help identify problems by collecting information on similar incidents. Information to document the incident is entered, and can be viewed and updated.

DESCRIPTION The Incident Reporting Process uses two screens: the Incident ID Screen and the Incident Log Screen.

OPTIONS There are no options in this process.

6.1 TO COMPLETE A REPORT ON AN INCIDENT

- Enter I on the QA Menu Screen. Press Return.

The Incident ID Screen is displayed. The cursor is positioned at LOG NO.

- To enter information on a new incident, type NEW. Press Return.

The Incident Log Screen is displayed. The LOG NO is automatically assigned and displayed by the system. The cursor is at DATE/TIME OF INCIDENT.

- Write the LOG NO on the hard copy of the incident report for future reference.

- Enter the date and time the incident occurred. Press Return.

The cursor moves to PERSON INVOLVED: TYPE.

NOTE: Several fields allow you to enter multiple responses or free text in single quotes.

- Enter the code for the person type. Press Return.

Note: If the person involved is an inpatient you will need the register number.

The cursor moves to NAME.

- Enter the name of the person involved. Press Return.

The cursor moves to the FMP field.

- Enter the Family Member Prefix of the person involved. Press Return.

The cursor moves to SSN.

- Enter the Social Security Number of the person involved. Press Return.

The cursor moves to REG NO.

- Enter the Registration Number of the person involved. Press Return.

The cursor moves to INCIDENT TYPE.

- Enter one or more 1-character incident codes, separated by commas, or up to 70 characters of free text enclosed in single quotes describing the incident. Press Return.

The cursor moves to LOCATION.

- Enter one or more 1-character codes separated by commas, or 25 characters of free text enclosed in single quotes to indicate the location of the incident. Press Return.

The cursor moves to COMMENT.

- Enter a comment of up to 70 characters to further describe the incident. Press Return.

The cursor moves to PERSONNEL INVOLVED.

- Enter one or more 1-character codes indicating the job classification of the MTF personnel involved in the incident, separated by commas, or up to 15 characters of text enclosed in single quotes. Press Return.

The cursor moves to PERSONNEL REPORTING.

- Enter one or more 1-character codes indicating the job classification of the MTF personnel who reported the incident, separated by commas, or enter up to 15 characters of text enclosed in single quotes. Press Return.

The cursor moves to RESULT OF INCIDENT.

- Enter Y(Yes) or N(No) to indicate whether injury resulted from this incident.

The cursor moves to DATE REVIEWED BY RISK MANAGER.

- Enter 11 characters indicating the date of review. Press Return.

The date is formatted and the cursor moves to JAG REVIEW.

- Enter Y(Yes) or N(No) to indicated whether this incident will be reviewed by the Judge Advocate General.

The cursor moves to DATE SENT TO JAG.

- Enter the 11-character date when record of this incident was sent to the Judge Advocate General's office. Press Return.

The date is formatted and the cursor moves to DATE OF ACTION.

- Enter the 11-character date when action was taken regarding this incident. Press Return.

The date is formatted and the cursor moves to ACTION CODE.

- Enter up to three 1-character codes for each action, separated by a comma.

  The first code indicates the job classification of the person or committee that the review was assigned to.

  The second code indicates the result of the review.

  The third code indicates whether this variation is to be posted to the provider's profile; answer Y(Yes) or N(No).

The cursor moves to INCIDENT POSTED TO PROVIDERS.

- Enter the short names of the providers (up to 4) who should have the incident posted to their profile.

When the Incident Report Screen is completed and you press Return, the Incident ID Screen is displayed. The cursor is at LOG NO.

- To complete another incident report, type NEW and repeat the above process.

- To exit the Incident Reporting process, press Cancel.

The QA Menu is displayed.

6.2 TO UPDATE INFORMATION ON AN INCIDENT REPORT

For example: You must complete the review information when the record is returned by the reviewer.

- Enter I on the QA Menu Screen to display the Incident ID Screen. Press Return.

- Enter the LOG NO on the Incident ID Screen to identify the Incident Report. Press Return.

The Incident Report Screen is displayed showing the completed information on the incident. The cursor is at ENTER SELECTION.

- To update the incident review information, type DATE OF ACTION and press Return to move the cursor to that field.

The cursor is positioned at DATE OF ACTION.

- Enter the date on which the record was returned. Press Return.

The cursor moves to ENTER SELECTION.

- Enter the partial field label for ACTION CODE.

The cursor moves to the first field of the ACTION CODE. This field indicates who reviewed the report.

- Press Return to move to the next field of the ACTION CODE.

- o Enter the code indicating the result of the review. Press Return.

The cursor moves to the next field of the ACTION CODE.

- o If the incident was provider-related, enter Y to post the incident to the provider profile.

If Y was entered:

The cursor moves to the INCIDENT POSTED TO PROVIDERS field.

- o Enter the providers (up to 4) who should have the incident posted to their profile.

When you have completed entering the providers, the cursor moves to ENTER SELECTION.

Note: Incident information in the other fields of this screen can be changed. Type the field label to move the cursor to any field. Type the update over the old information and press Return.

When the field(s) you have selected are completed, the cursor moves to ENTER SELECTION.

- Press Return to store the updates.

The Incident ID Screen is displayed. The cursor is positioned at LOG NO.

- To process another incident, type the log number or NEW and press Return.
- To return to the QA Menu Screen, press Return at LOG NO.
- To exit QA, press Return at ENTER SELECTION on the QA Menu Screen.

6.3 POINTS TO REMEMBER

Incident Reports are accessed by the incident log number which is automatically assigned by the system based on the data entered in the INCIDENT DATE/TIME field. If you cancel the screen, the number will be reused for the next incident. Once the number is assigned, it cannot be changed even if the DATE/TIME field is changed.

6.4 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

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SECTION 7. PROBLEM AUDIT TRACKING

PROCEDURE		PAGE
7.1	To Record a Problem.....	7- 4
7.2	To Update Information on an Existing Problem Record.....	7- 7
7.3	Points to Remember.....	7-10
7.4	Checkpoint.....	7-10

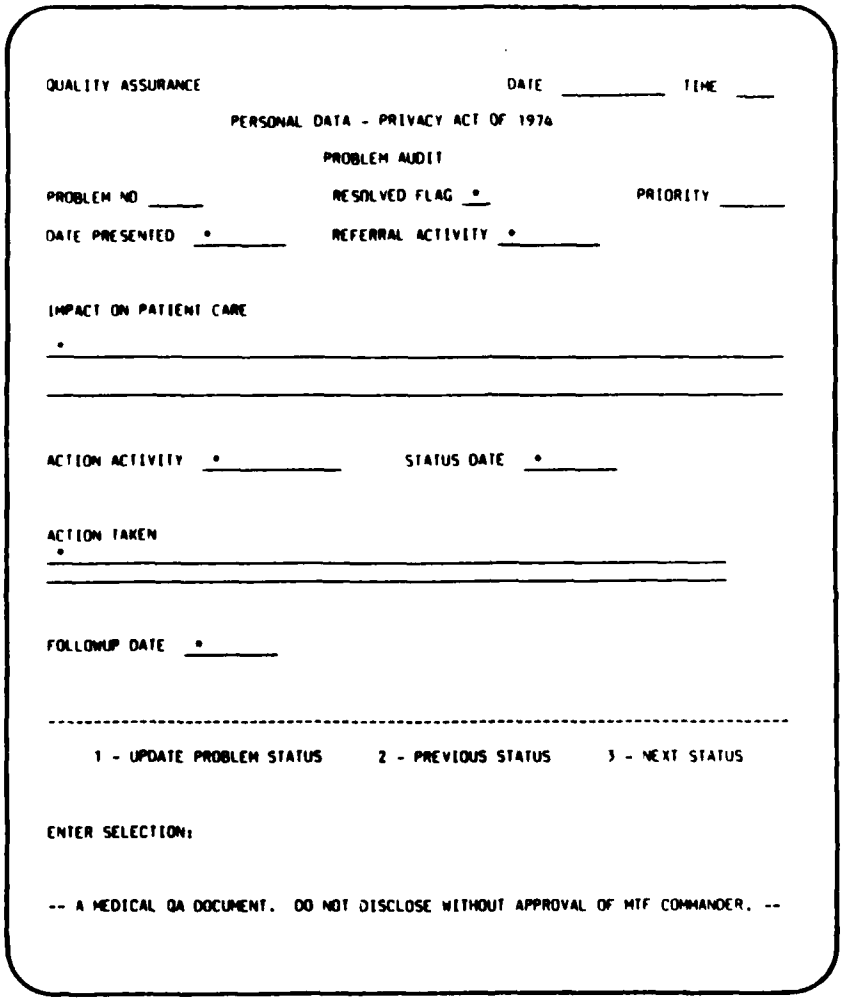


FIGURE 7.1 PROBLEM AUDIT SCREEN

7. PROBLEM AUDIT TRACKING

ACCESS Enter P on the QA Menu Screen to access the Problem Audit Tracking Process. The Problem ID Screen is displayed to allow you to access a particular problem record or create a new problem record.

PURPOSE Problem Audit Tracking allows you to document quality of care problems, and to track review of problems as well as the solutions to these problems.

DESCRIPTION The Problem Audit Tracking Process uses two screens: the Problem ID Screen and the Problem Audit Screen.

OPTIONS There are no submenu options on the screen.

7.1 TO RECORD A PROBLEM

- o Enter P on the QA Menu Screen. Press Return.

The Problem ID Screen is displayed. The cursor is at PROBLEM NO.

- o Enter NEW in the PROBLEM NO field. Press Return.

The Problem Audit Screen is displayed. The system assigns the next sequential problem number. The cursor moves to the RESOLVED FLAG field.

- o Enter Y or N to indicate resolution.

The cursor moves to the PRIORITY field.

- o Enter a number specifying the priority of the problem on a scale of 1 (high) to 10 (low). Press Return.

The cursor moves to DATE PRESENTED.

- o Enter the appropriate date. Press Return.

The cursor moves to REFERRAL ACTIVITY.

- o Enter name or committee. Press Return.

The cursor moves to IMPACT ON PATIENT CARE.

- o Enter appropriate comments. (Type up to two lines of comments.) Press Return.

The cursor moves to ACTION ACTIVITY.

- o Enter the appropriate action being taken. Press Return.

The cursor moves to STATUS DATE.

- Enter the date of the status. Press Return.

The cursor moves to ACTION TAKEN.

Note: Action taken is completed after the report is returned from the current review activity.

The cursor moves to FOLLOW UP DATE.

- Enter the date on which the action should be followed up. Press Return.

The cursor moves to ENTER SELECTION.

- Press Return to store the record.

The Problem ID Screen is displayed. The cursor is at PROBLEM NO, ready to process another problem.

7.2 TO UPDATE INFORMATION ON AN EXISTING PROBLEM RECORD

- o Enter P from the QA Menu Screen. Press Return.

The Problem ID Screen is displayed. The cursor is at PROBLEM NO.

- o Enter the problem number. Press Return.

The Problem Audit Screen is displayed. The cursor is at ENTER SELECTION.

- o To update PROBLEM STATUS, enter 1.

The cursor moves to the RESOLVED FLAG field.

- o Enter N for not resolved, or update the Resolved Flag if the problem is resolved. Press Return.

The cursor moves to ACTION ACTIVITY.

- o Enter the person or group who took the action that is being described on this screen. Press Return.

The cursor moves to STATUS DATE.

- o Enter the effective date of the information entered on this screen. Press Return.

Note: When entering new status data on this problem, the status date cannot be earlier than the previous date entered in this field.

The cursor moves to ACTION TAKEN.

- o Enter the action taken on the problem. Two lines of text are available. Press Return.

The cursor moves to FOLLOWUP DATE.

- o Enter the date on which any followup activity occurred. Press Return.

The cursor moves to ENTER SELECTION.

Note: Problem information can be updated in the fields of the Problem Audit Screen. At ENTER SELECTION, type the label of the field you wish to change and press Return. Type over existing data to change it. Press Return to continue.

- After the last update, the cursor is at ENTER SELECTION. Press Return to store the update.

The Problem ID Screen is displayed. The cursor is at PROBLEM NO.

- To process another problem, type the problem number and press Return.
- To return to the QA Menu Screen, press Return at PROBLEM NO on the Problem ID Screen.
- To exit QA, press Return at ENTER SELECTION on the QA Menu Screen.

7.3 POINTS TO REMEMBER

Problem numbers are automatically assigned by the system based on the data entered in the PROBLEM DATE field. If you cancel the screen, this number is assigned to the next problem entered. Once the number is assigned it cannot be changed even if the PROBLEM DATE is changed.

7.4 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

SECTION 8. OCCURRENCE SCREENING QUESTION MAINTENANCE

PROCEDURE		PAGE
8.1	To Add an MTF-Specific Question to the Occurrence Screening Checklist.....	8-4
8.2	To Reword Occurrence Question Text for MTF-Specific Items in the Inpatient Occurrence Screening Checklist or the Emergency Services Checklist.....	8-5
8.3	To Delete All Previously Collected Data on a Question and Replace the Question with a New MTF-Specific Question.....	8-8
8.4	Points to Remember.....	8-9
8.5	Checkpoint.....	8-9

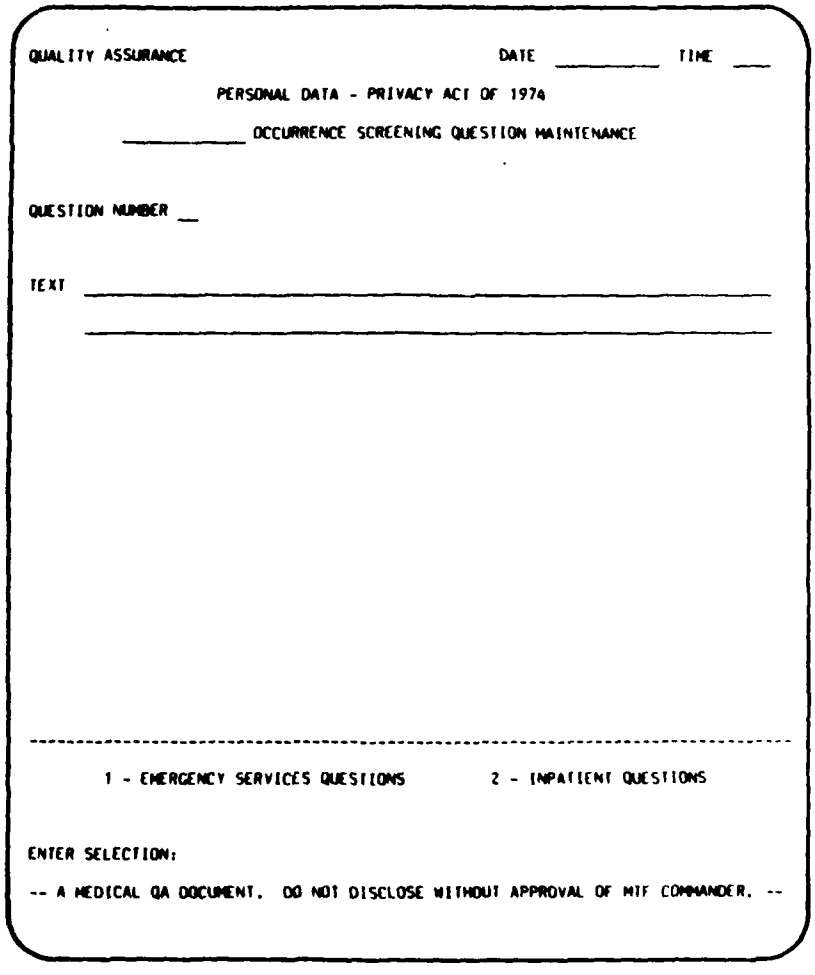


FIGURE 8.1 OCCURRENCE SCREENING QUESTION MAINTENANCE

8. OCCURRENCE SCREENING QUESTION MAINTENANCE

ACCESS Enter M on the QA Menu Screen to access the Occurrence Screening Question Maintenance process.

PURPOSE Occurrence Screening Question Maintenance allows you to edit, replace, or add questions to the MTF-specific portion of the Inpatient Occurrence Screening Checklist and the Emergency Services Checklist.

The Inpatient Occurrence Screening Checklist accepts MTF-specific questions for Items 19 through 24. The Emergency Services Checklist accepts MTF-specific questions for Items 10 through 24.

DESCRIPTION The Occurrence Screening Question Maintenance , process uses two screens: the Question Maintenance ID Screen, and the Occurrence Screening Question Maintenance Screen.

8.1 TO ADD AN MTF-SPECIFIC QUESTION TO THE OCCURRENCE SCREENING CHECKLIST

- Enter M on the QA Menu Screen. Press Return.

The Occurrence Screening Question Maintenance ID Screen is displayed. The cursor is at ENTER SELECTION.

- Select Option 1 - Emergency Services Checklist or Option 2 - Inpatient Occurrence Checklist. Press Return.

Note: The procedure for adding an MTF-specific question is the same for either checklist.

The Occurrence Screening Question Maintenance ID Screen is displayed. The cursor is at QUESTION NO.

- To add an MTF-specific question, enter a number which is one greater than the number of questions that are now in your checklist.

The QUESTION NO and TEXT fields are displayed. The cursor is at the beginning of the field.

- o Enter the text of the new MTF-specific question. Press Return.

- o With the cursor at ENTER SELECTION, press Return to store the new question.

Note: The question is added to the checklist and will be displayed the next time an Occurrence Screening Checklist is displayed.

8.2 TO REWORD OCCURRENCE QUESTION TEXT FOR MTF-SPECIFIC ITEMS IN THE INPATIENT OCCURRENCE SCREENING CHECKLIST OR THE EMERGENCY SERVICES CHECKLIST

- o Enter M on the QA Menu Screen. Press Return.

The Question Maintenance ID Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 1 to select the Emergency Services Checklist (Option 1) or enter 2 to select

the Inpatient Checklist (Option 2). Press Return.

Note: The procedure for changing either checklist is the same.

The Occurrence Screening Question Maintenance ID Screen for that option is displayed. The cursor is at QUESTION NO.

- To change an existing question, type the number of the question.

Note: The screening questions which are required by the DoD cannot be changed or deleted. Only MTF-specific questions can be changed or deleted.

If there is a question, the text of the question is displayed. The cursor is at the beginning of the text.

- Enter the reworded text over the existing text. You must enter the complete question text, then press Return.

The cursor moves to ENTER SELECTION.

- Press Return to store the new text.

This message is displayed regarding the previously collected data for the question: "You have changed the text of the occurrence screening question. If this is now a different question you must delete the old data. Enter Y to delete all previous data for this question number."

- Enter N to change the wording of the text. This is the same question; all data is kept.

Note: Entering Y means that you are replacing the question and that you want to delete all data collected previously.

The Question Maintenance ID Screen is displayed. The text of the question is changed. The data is kept. This is not a new question. This cursor is at ENTER SELECTION.

8.3 TO DELETE ALL PREVIOUSLY COLLECTED DATA ON A QUESTION AND REPLACE THE QUESTION WITH A NEW MTF-SPECIFIC QUESTION

- o Enter M on the QA Menu and complete the procedure to change the text of a occurrence question.

When the new text has been entered, a message is displayed: YOU HAVE CHANGED THE TEXT OF THIS QUESTION. DO YOU WANT TO DELETE.

- o Enter Y to indicate that this question is replacing the old question.

A confirmation message is displayed: ARE YOU SURE THAT YOU WANT TO DELETE.

- o Enter Y to delete all data previously collected on that question number. No data will be saved.

Note: Be careful!

- o To return to the QA Menu, cancel out at ENTER SELECTION.

- To exit QA, press Return at ENTER SELECTION on the QA Menu.

8.4 POINTS TO REMEMBER

1. Only MTF-specific questions can be edited or deleted.

2. When the question is edited to clarify the wording but the data collected on that question is to be saved, respond N to the prompt: HAVE YOU CHANGED THE TEXT OF THIS QUESTION.

3. When deleting a question, all data associated with that question is deleted.

4. Data from MTF-specific questions does not automatically default to provider's profiles.

8.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

QUALITY ASSURANCE TRAINING AID

SECTION 9. AUTO EDIT DELINQUENCY POSTING FOR CR

PROCEDURE		PAGE
9.1	To Initiate an Auto Edit and Post Delinquencies to Providers.....	9-4
9.2	Checkpoint.....	9-5

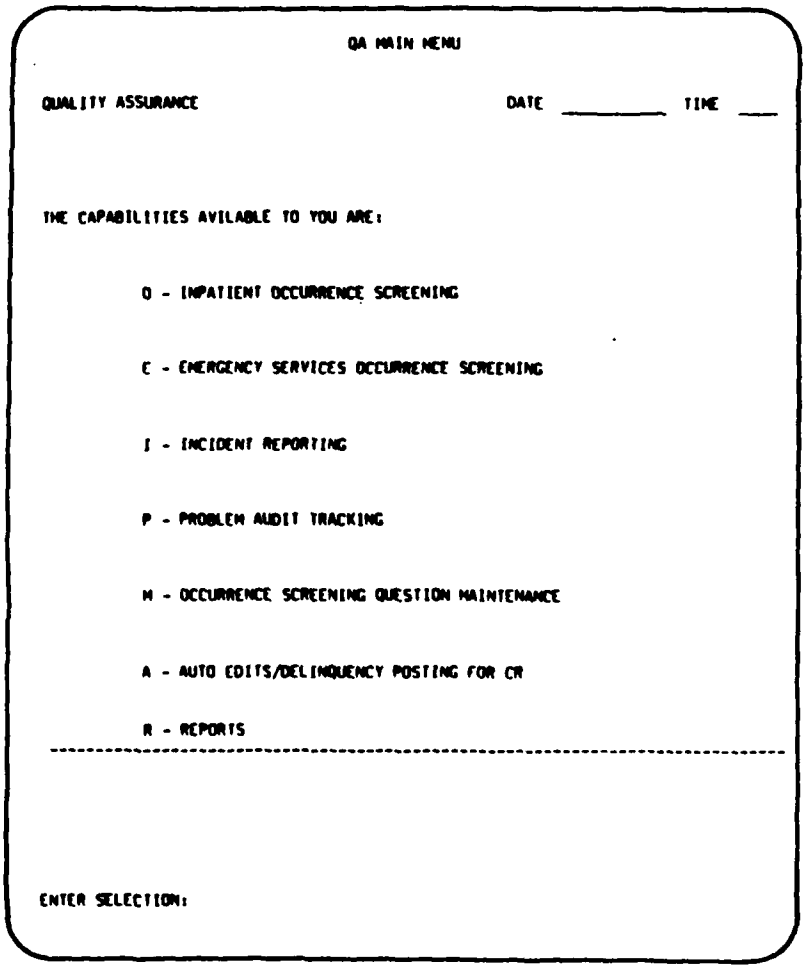


FIGURE 9.1 QUALITY ASSURANCE MENU SCREEN

9. AUTO EDIT DELINQUENCY POSTING FOR CR

ACCESS Enter A on the QA Menu Screen to initiate an edit of records processed in Occurrence Screening.

PURPOSE The Auto Edit enables you to compare records for which the Inpatient Occurrence Screening Checklist has been indicated in QA but which were later approved in CR. If questions answered "no" on the QA checklist are defaulted to "yes" through this edit process, these records are listed on a pull list so that the new "yes" occurrence can be audited.

Delinquency Posting is done at the same time. Any provider who has not submitted the required items (signatures and dictations) to complete the clinical record by the suspense date receives a delinquency.

DESCRIPTION No screen is displayed by this selection.

9.1 TO INITIATE AN AUTO EDIT AND POST DELINQUENCIES TO PROVIDERS

- Enter A on the QA Menu Screen.

The Auto Edit and Delinquency Posting are performed.

AUTO EDIT:

No screen is displayed. The system edits the records that have been processed in Occurrence Screening but have not yet been changed to an approved CR. If any of the checklist occurrence questions default to Y through this edit, the question will be listed on a pull list for review in QA.

DELINQUENCY POSTING:

Delinquency is calculated from the start date on the CR Record Tracking Screen. The start date is used to calculate the suspense date. Any item missing as of the suspense date will result in a delinquency posted to the provider. The delinquencies are posted after a two week period that gives Clinical Records time to post the completions. It does not give physicians extra time to complete the record.

9.2 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

QUALITY ASSURANCE TRAINING AID

QUALITY ASSURANCE TRAINING AID

SECTION 10. REPORTS

PROCEDURE		PAGE
10.1	Report Descriptions.....	10- 4
10.2	To Produce a Report.....	10-13
10.3	Checkpoint.....	10-17

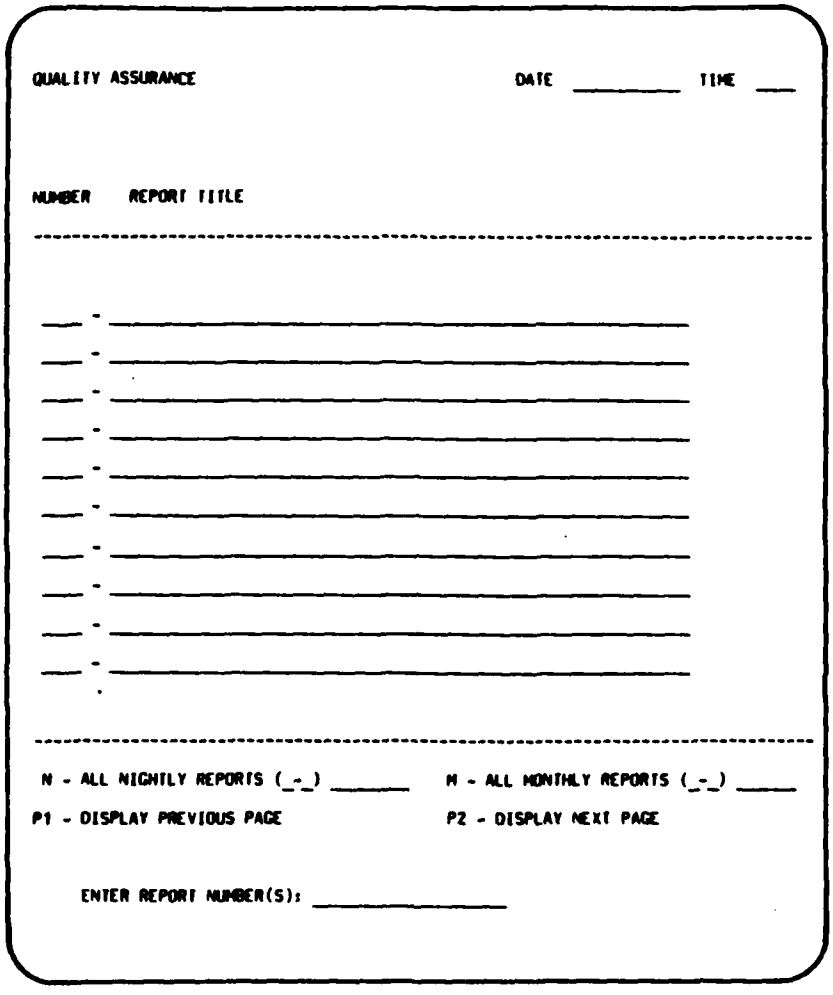


FIGURE 10.1 REPORTS SCREEN

10. REPORTS

ACCESS Enter R on the QA Menu Screen to display the QA Reports Menu Screen.

PURPOSE The reports selection enables you to request printed copies of QA reports, or to view report information on the screen.

DESCRIPTION Reports Processing uses the Report Menu Screen and a Report Run Time Specification Screen on which you can provide run time information for each report. You will use the specification screens to indicate parameters of the report, e.g., the number of copies, inclusion dates, and other required information which is dependent on the report selected.

OPTIONS
N - ALL NIGHTLY REPORTS (NONE)
M - ALL MONTHLY REPORTS
P2 - DISPLAY NEXT PAGE
P1 - DISPLAY PREVIOUS PAGE

10.1 REPORT DESCRIPTIONS

The reports shown in this section are representative of those available in Quality Assurance processing. Examples of all reports are included in the AQCESS User Manual.

1. **OCCURRENCE SCREENING PULL LIST - INPATIENT.** This report identifies the records of patients involved in inpatient occurrence screening discrepancies, enabling those records to be pulled for further review. The report provides the FMP/SSN and register number of the patient, and the occurrence criterion that needs review. It is produced monthly or on demand.

2. **OCCURRENCE SCREENING PULL LIST - EMERGENCY SERVICES.** This report identifies the records of patients involved in emergency service occurrence screening discrepancies, listing those records to be pulled for further review. The report provides the FMP/SSN and log number of the patient episode, and the occurrence criterion that needs review. It is produced monthly or on demand.

3. **DELINQUENT OCCURRENCE SCREENING LIST.** This report includes all patients whose Inpatient Occurrence Screening Checklist is not completed within a certain number of days after disposition. (The number of days is specified by the MTF on the MTF Profile.) The

report lists a discharge date, register number, and FMP/SSN for each patient.

4. **BLOOD UTILIZATION PULL LIST.** This report summarizes blood product utilization by care provider, over a specified period of time. It lists records that are to be reviewed by the Blood Utilization Review Committee. It shows the dates of the reporting period. The report lists the care provider, then gives the following information for each of that physician's patients who had blood transfusions: register number, FMP/SSN, and discharge date.

5. **INCIDENT SUMMARY BY INCIDENT DATE/TIME.** This report provides a summary listing of all or selected incidents, sorted by specified criteria over specified periods of time. It shows the report period. The body of the report includes the incident date/time, log number, injury code, action codes, type of person involved, type and location of incident, the category of reporting, and the personnel involved. It is produced on demand.

6. **PROBLEM AUDIT.** This report provides a list of all or selected QA problems and their status. It includes the problem number, referral and action activity, status, follow-up, action taken and the impact on patient care. It is produced weekly or on demand.

7. **OCCURRENCE SCREENING AUDIT - EMERGENCY SERVICES BY PROVIDER.** This report lists action taken on exceptions to the emergency service standards. It shows the provider ID, the period of the report, the patient's FMP/SSN, and the date and time of treatment. The body of the report gives the number of the checklist question, the text of the question, review level, date out, date in, and the action code. It is produced monthly or on demand.

8. **OCCURRENCE SCREENING AUDIT - INPATIENT BY PROVIDER.** This report lists actions taken on exceptions to the inpatient occurrence standards. It shows the provider's ID, the period of the report, the patient's register number, and discharge date. The body of the report gives the number of the checklist question, the text of the question, review level, date out, date in, and the action code.

9. **OCCURRENCE SCREENING SUSPENSE LIST - EMERGENCY SERVICES.** This report lists emergency service occurrence screening open items which are due for follow-up. It shows the patient FMP/SSN, date of treatment, review level, date out (date the review was assigned), and action code. The report is produced daily.

10. **OCCURRENCE SCREENING SUSPENSE LIST - INPATIENT.** This report lists inpatient occurrence screening open items which are due for follow-up. It shows the patient's register number, discharge date, review level, date out (date the review was the review was assigned), and action code. The report is produced daily.

11. **OCCURRENCE SCREENING SUMMARY - EMERGENCY SVC BY PROVIDER.** Summarizes information about exceptions to the emergency service occurrence criteria (checklist) for individual providers specified in the facility, for a specified period. It shows the period of the report, the name of the provider involved, the number of records screened, and the total occurrences. The body of the report gives the number of exceptions to each checklist question.

12. **OCCURRENCE SCREENING SUMMARY - INPATIENT BY PROVIDER.** Summarizes information about exceptions to the inpatient occurrence criteria (checklist) for individual providers specified in the facility, for a specified period. It shows the period of the report, the name of the provider involved, the number of records screened, and the total occurrences. The report gives the number of exceptions to each checklist question.

13. **OCCURRENCE SCREENING SUMMARY - EMERGENCY SVC FACILITY.** Summarizes information about exceptions to the emergency service occurrence criteria (checklist) for every provider in the facility, for a specified period. It shows the period of the report. The report gives the provider's code, the number of records included in the report, the total number of occurrences listed on the report, and the number of exceptions to each checklist question.

14. **OCCURRENCE SCREENING SUMMARY - INPATIENT SPECIALTY.** This report summarizes, by specialty, exceptions to the inpatient occurrence screening criteria identified for each provider within the specialty, for a specified time period. It shows the specialty and the report period. The body of the report shows the provider name, the number of records, the total occurrences reported for that provider, and the number of exceptions for each checklist question.

15. **OCCURRENCE SCREENING SUMMARY - INPATIENT FACILITY.** Provides a summary of all the affirmative inpatient checklist responses for the period specified. The data is sorted by the provider's specialty. The report provides totals of the number of records screened and the number of affirmative checklist responses per specialty. It also includes the total number of "yes" responses to the basic items on the Inpatient Occurrence Screening Checklist, and the total number of "yes" responses to the Inpatient Checklist items that were devised by the MTF.

16. **SURGICAL OPERATIONS REPORT.** Provides information on all surgical procedures performed in the MTF during the reporting period specified by the user. To be included on the report, a record must have a disposition date that falls within the reporting period, and must have a Clinical Record status of A or T. The report contains the ICP code and the descriptive title of the procedure, the number of times the indicated procedure was the principle procedure, the personnel category of the patient for whom the procedure was the principal procedure performed, the age range of the patients, and the number of times the indicated procedure was the associated operation for the patient.

17. **DISPOSITION BY DIAGNOSIS.** Lists all diagnoses from the MTF during the period specified. To be included on this report, a record must have been accessed, but not necessarily approved, in Clinical Records. The report contains the following information: the diagnosis code, the age ranges of patients having this diagnosis, whether the diagnosis indicated was the primary diagnosis for these patients, the total number of patients who had each diagnosis, the personnel category of the patients having the indicated diagnosis as their primary diagnosis, the number of bed days at this MTF for patients having the indicated diagnosis as their primary diagnosis, and the amount of blood transfused to these patients.

18. **DIAGNOSIS INDEX BY PROVIDER.** Provides information on diagnoses entered in Clinical Record, by provider of care. It lists patient deaths and patients whose length of stay was outside the range considered normal for the diagnosis. You can specify the name of a particular doctor or request a report on all providers. The report includes the ICD code and the description of the diagnosis, the total number of cases with this diagnosis, the total number of variations found for cases with this diagnosis, the average range of stay for patients with this diagnosis, and provides data for any individual death or length-of-stay variation occurring among patients with the diagnosis.

19. **SURGICAL INDEX BY PROVIDER.** Provides information on the surgical procedures performed during the reporting period. You have the option to report on an individual provider or on all the providers. The report contains the following information: the ICD code for the procedure, the name of the operation, the number of times the specified provider performed the indicated procedure during the reporting period, the number of times the specified provider was the primary provider, the number of times he or she was the assisting provider, and the number of deaths associated with the performance of the indicated procedure.

20. **INCIDENT SUMMARY BY INCIDENT TYPE/LOCATION.** This report provides a summary listing of all or selected incidents, sorted by specified criteria over specified periods of time. It shows the report period. The body of the report includes the incident date/time, log number, injury code, action codes, type of person involved, type and location of incident, the category of reporting, and the personnel involved. It is produced on demand.

21. **PROMPT REPORTS.** Prints all the records' pull lists identifying the records necessary for the Peer Review of Military Patient Treatment (PROMPT). Each list is related to a specific task of PROMPT. Each of the 35 reports prints a list of the patient records to be pulled for review. The Multi-Patient-Task Listing prints at the end of the report run. The data reported for each report varies from list to list as required for the specific task of PROMPT.

    Examples of the Quality Assurance reports are included in the AQCESS Users Manual.

22. **EMERGENCY ROOM LOG.** This report provides information about emergency room patient visits for the time period requested. The body of the report includes the date of the visit, the log number, patient name, rank, age, sex, time and mode of arrival, disposition type and time, relevant provider, the discharge diagnosis, if any, and any command interest code entered at registration.

23. **EMERGENCY ROOM TRACKING REPORT.** This report gives basic information about patients admitted to the emergency room, and includes the Tracking Item codes for each patient visit as recorded on the Encounter Data Screen. The body of the report includes the date of the visit, the log number, the patient name, social security number and family member prefix, and any Tracking Item codes entered in the Encounter Data Screen.

24. **AUTOMATED SF558, DRAFT, FINAL, PATIENT COPY.** This standard form is printed automatically the first time entrance data is stored for the patient. The top and bottom portions of the form contain patient information from the registration and ER visit entrance data screens. The middle of the form is a worksheet used to gather clinical data during the ER visit. The final and patient copy of these forms are made up of data included on the draft copy.

10.2 TO PRODUCE A REPORT

- Enter R on the QA User Menu Screen. Press Return.

The QA Report Selection Screen that lists all the reports is displayed. The cursor is at ENTER REPORT NUMBER(S).

- Enter the number that appears to the left of the title of the report(s) you wish to produce. Several reports can be selected at the same time by entering a list of report numbers at ENTER REPORT NUMBER(S), or select the appropriate option:

  M - MONTHLY REPORTS.

Note: There are no nightly reports for Quality Assurance.

The Report Run-Time Information Screen is displayed.

- Enter the required parameters.

Note: Depending on the report requested, a different set of parameters will be required.

When you have entered specific parameters, the cursor will move to the PRINTER COPIES: field.

- If you want the report printed on paper, enter the number of copies you wish to print, or enter R followed by the number to reprint the last report produced.

Note: If you are reprinting, you can also reprint to the screen rather than regenerating the report.

- If you do not want the report printed, but wish to view the report on the screen, press Return, leaving this field blank.

The cursor moves to the next field: SELECTION.

- o If you do not wish to change the report specifications you entered, press Return to store the information and run the report.

- o If you wish to change the specification, type ALL or the partial label of the field you want to change. With the cursor at the field you identified, change the information, and press Return.

The cursor moves back to ENTER SELECTION.

- o Press Return to store the information and run the report(s).

Note: The cursor moves to the bottom left corner of the screen indicating the report is being processed. If the report is being printed to the printer, you are free to use the terminal to enter or view other information.

The report will either appear on the screen (if you left the PRINTER COPIES field blank), or the QA Report Selection Screen will be displayed when the report has been printed (if you completed the PRINTER COPIES field).

- If the report is displayed on the screen, press Return to page through the report to the end.

- On the last page of the report, press Return to display the QA Report Selection Menu.

QA REPORT SELECTION SCREEN OPTIONS

Option P2 - DISPLAY NEXT PAGE: This option enables you to display the next page of report titles. Enter P2 at ENTER REPORT NUMBER(S).

P1 - DISPLAY PREVIOUS PAGE. This option enables you to return to the previous page of report titles. Enter P1 at ENTER REPORT NUMBER(S).

Option M - ALL MONTHLY REPORTS. Enter M at ENTER REPORT NUMBER(S): Complete the Run-Time Information Screen for each report.

10.3 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

QUALITY ASSURANCE TRAINING AID

11. QUALITY ASSURANCE PROFILING

The QA Profiling Process maintains physician profile information and assists the Credentials Committee in formulating their recommendations regarding the privileges to be granted to care providers. This process is only available to personnel designated by the MTF Commander -- normally the Credentials Committee Chairman and the Credentials Committee Secretariate.

When QA Profiling is selected from the User Entry Menu, the QA Profiling Menu displays three choices:

- Provider Profile
- Batch Posting to Provider Profile
- Reports

Each of these are discussed separately in this section.

The Provider Profile Screen enables you to enter information into the profile of individual providers at the MTF.

Batch Posting to Provider Profile enables you to post information to several or all providers by entering the information on one screen instead of entering it directly into each provider profile.

REPORTS

The Credentials Pull List enables you to print or view a report listing information pertinent to credentials review and renewal.

The Provider Procedure Summary Screen enables you to print or view a report showing mortality rate by procedure for each provider.

The Provider Procedures/Mortality Summary enables you to print or view a report summarizing procedure and mortality rate for a provider in each of 26 categories of procedure codes.

Examples of Quality Assurance reports are included in the AQCESS User Manual.

QUALITY ASSURANCE TRAINING AID

SECTION 11.1 PROFILING MENU SCREEN

PROCEDURE		PAGE
11.1	To select the appropriate Process or Report from the QA Profiling Menu.....	11- 5

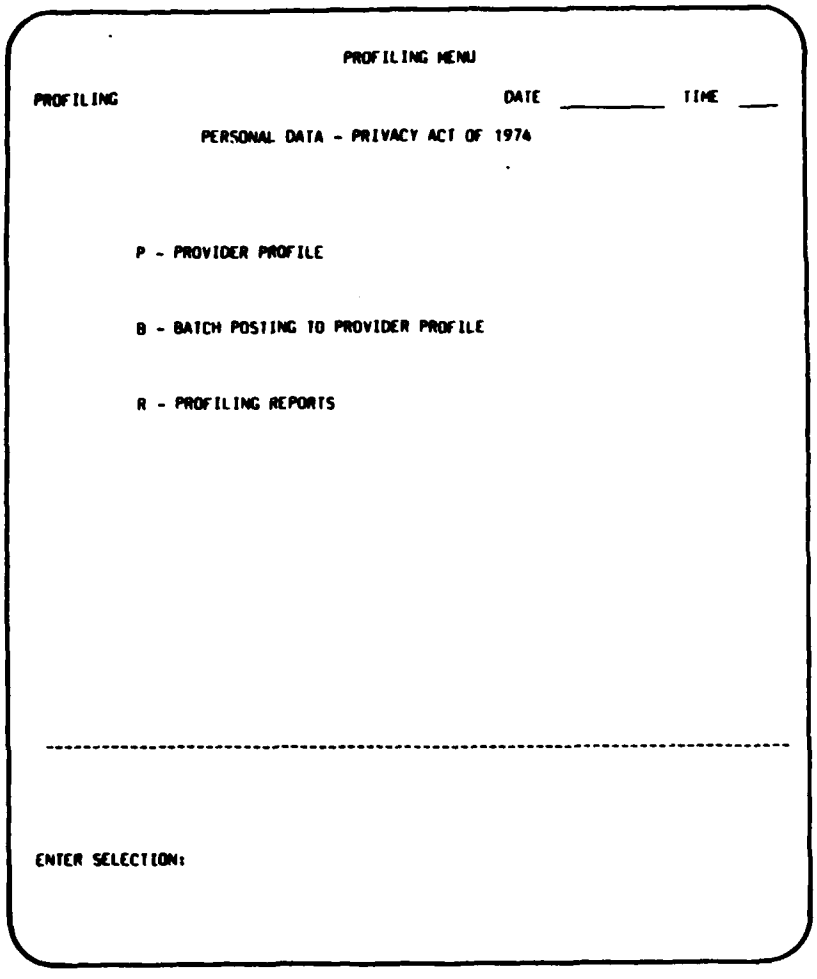


FIGURE 11.1 PROFILING MENU SCREEN

11.1 PROFILING MENU SCREEN

ACCESS Enter P on the User Entry Menu Screen to display the QA Profiling Menu Screen. Only authorized user IDs will be provided access.

PURPOSE The Profiling Menu Screen enables you to select and access QA Profiling processes by which you can enter information, view information, or generate reports, all related to providers.

DESCRIPTION The QA Profiling Menu Screen lists these QA Profiling processes:

P - Provider Profile
B - Batch Posting to Provider Profile
R - Profiling Reports

SECTION 11.2 PROVIDER PROFILE

PROCEDURE		PAGE
11.2.1	To Create a Provider Profile for a New MTF Physician.....	11-10
11.2.2	To Update a Physician Profile...	11-15
11.2.3	To View or Update Previous Six Month Periods of the Clinical Practice Indicators.....	11-17
11.2.4	Points to Remember.....	11-18

PROFILING DATE _____ TIME ___

PERSONAL DATA - PRIVACY ACT OF 1974

PROVIDER ID _____ NAME _____ SPEC _____

QA ID CODE _____ CONT ED (YY/HHH) __/___ __/___ __/___ ASGN DTE _____

DATE OF: CPR TRAINING _____ ACLS CERT _____ ATLS CERT _____

CREDENTIALS RENEWAL _____

LICENSE RENEWAL _____ STATE OF LICENSE __

---- CLINICAL INDICATOR TOTALS FOR A MONTH PERIOD BEGINNING _____----

PROCEDURES PERFORMED _____ PATIENTS DISCHARGED _____

MALPRACTICE CLAIMS FILED _____ MED RECORD DEFICIENCIES _____

MED RECORD DELINQUENCIES _____

VALIDATED: ANTIBIOTIC VARIATIONS _____ COMPLAINTS _____ INCIDENTS ____

NORMAL SURGICAL TISSUE _____ TRANSFUSIONS _____

SCREENING VARIATIONS: IP ___ ER ___ TOTAL DEATHS: IP ___ ER ___

---

1 - PREVIOUS 6 MONTH PERIOD 2 - NEXT 6 MONTH PERIOD

ENTER SELECTION:

-- A MEDICAL QA DOCUMENT. DO NOT DISCLOSE WITHOUT APPROVAL OF MTF COMMANDER. --

FIGURE 11.2 QA TRAINING AID/REPORTS PROVIDER PROFILE

11.2 PROVIDER PROFILE

ACCESS Enter P on the QA Profiling Menu to access the Provider Profile Process.

PURPOSE The QA Provider Profile Process enables you to enter or update all information on file for a specific physician.

DESCRIPTION Provider Profiling uses two screens. The Provider ID Screen enables you to identify the physician whose record you wish to access.

The Provider Profile Screen enables you to view or update information in the record.

OPTIONS The Provider Profile Screen has two options: Option 1 enables you to view or update information from the previous six month period. Option 2 enables you to return page-by-page to the current information.

11.2.1 TO CREATE A PROFILE FOR A PHYSICIAN

- Enter P on the QA Profiling Menu Screen. Press Return.

The Provider ID Screen is displayed. The cursor is at PROVIDER ID.

- Enter the physician's short name. Press Return.

Note: Air Force - the 6-digit QA ID Code must have been entered in order to establish a profile.

The ASGN DTE field is highlighted. A message is displayed: PLEASE CONFIRM THE MTF ASSIGNMENT date for this provider. It is essential that this date is correct. Once clinical data is posted to this record, the assignment date cannot be changed. Enter Y if correct. If it is not correct, press Return and contact your system manager.

Note: Verify that the ASGN DTE is correct. This is the date the physician was assigned to this MTF. The initial six month reporting period is determined from this date.

The cursor moves to the CONT ED field.

- Enter the continuing education credit hours completed by this provider for the last three years. Press Return.

The cursor moves to CPR TRAINING.

- Enter the date that the provider completed training in cardiopulmonary resuscitation (CPR). Press Return.

The cursor moves to ACLS CERT.

- Enter the date that the provider was certified in Advanced Cardiac Life Support (ACLS). Press Return.

The cursor moves to ATLS CERT.

- Enter the date that the provider was certified in Advanced Trauma Life Support (ATLS). Press Return.

The cursor moves to CREDENTIALS RENEWAL.

- o Enter the date that the provider's credentials for this MTF are due to be renewed by the Credentials Committee. Press Return.

The cursor moves to LICENSE RENEWAL.

- o Enter the date that the provider's license to practice is due to be renewed by the state licensing board. Press Return.

The cursor moves to STATE OF LICENSE.

- o Enter the 2-character abbreviation for the state that the provider is licensed to practice in. Press Return.

Note: The values for the PROCEDURES PERFORMED and the PATIENTS DISCHARGED fields are defaulted from data contained in other AQCESS files.

The cursor moves to MALPRACTICE CLAIMS.

- Enter the number of claims filed against this provider. Press Return.

The cursor moves to MED RECORDS DEFICIENCIES.

- Enter the number of medical records considered deficient because this provider had not supplied all chart items within the time limit set by the MTF (e.g., history/physical, signatures, etc.). Press Return.

Note: The value for the MED REC DELINQUENCIES field is calculated from CR data when option A on the QA Menu Screen is selected, and reflects the number of records not completed within the time limit set by the MTF.

The cursor moves to VALIDATED: ANTIBIOTIC VARIATIONS.

- Enter the number of occurrences related to antibiotic use for which the provider has received a "failed" audit result. Press Return.

The cursor moves to COMPLAINTS.

- o Enter the number of validated patient complaints lodged against this provider. Press Return.

Note: The value for the INCIDENTS field is defaulted from the ACTION CODE of the Incident Log screen.

The cursor moves to NORMAL SURGICAL TISSUE.

- o Enter the number of occurrences related to normal surgical tissue that the provider has received a "failed" audit result. Press Return.

The cursor moves to TRANSFUSIONS.

- o Enter the number of occurrences related to transfusions that the provider has required a "failed" audit result. Press Return.

Note: The values for the SCREENING VARIATIONS and TOTAL DEATH fields are posted automatically as a result of Inpatient and Emergency Service reviews.

The cursor moves to ENTER SELECTION.

- o Update the field(s) as necessary.
- o Press Return at ENTER SELECTION to store the data.

Note: The profile is set up as soon as you store the information. Information can now be posted to the profile through other functions.

11.2.2 TO UPDATE A PHYSICIAN PROFILE

- o Enter P on the QA Profiling Menu Screen. Press Return.

The Provider ID Screen is displayed. The cursor is at PROVIDER ID.

- Enter the physician short name or QA ID Code to identify the physician whose profile is to be processed. Press Return.

The Provider Profile Screen is displayed. The cursor is at ENTER SELECTION.

- To enter information in the profile, type ALL or the partial field label. Press Return.

Note: You will be unable to modify those fields whose values are posted to the profile from other system files.

When you have completed the update, the cursor moves to ENTER SELECTION.

- Press Return to store the updates.

The Provider ID Screen is displayed. The cursor is at PROVIDER ID.

- To update another physician's profile, type the provider ID (short name or QA ID Code). Press Return.

- To return to the QA Profiling Menu, press Return twice when the cursor is at ENTER SELECTION.

- To exit QA Profiling, press Return at ENTER SELECTION on the QA Profiling Menu.

11.2.3 TO VIEW OR UPDATE PREVIOUS SIX MONTH PERIODS OF THE CLINICAL PRACTICE INDICATORS

- Enter P on the User Entry Menu.

- Identify the provider on the Provider ID Screen.

- Enter option 1 in the provider profile to update and view information page by page for the previous six month period. Option 2 allows you to return page-by-page to the current information.

NOTE: The information input is stored for six month periods, beginning with January 1 or July 1, for three years.

- To update one field, type the partial name of the field or type ALL to move the cursor to each field of the screen.

- Enter information in the fields as required. If the field label was entered to identify a specific field, the cursor returns to ENTER SELECTION when the update is entered. If ALL was entered, use Entry Done to move the cursor to ENTER SELECTION.

- Press Return at ENTER SELECTION to store the update.

The Provider ID Screen is displayed.

11.2.4 POINTS TO REMEMBER

1. Only indicators that are not calculated based on approved Clinical Records or QA audit action codes can be updated manually.

2. The clinical practice indicators are accumulated in six month periods for three years in addition to the current six month period.

3. Credential renewal data is used to create a pull list of providers with reviews coming up in a specified time period.

4. PATIENTS DISCHARGED and PROCEDURES PERFORMED are automatically posted from approved Clinical Records data. Medical record delinquencies are posted seven days after the record becomes delinquent. SCREEN VARIATIONS and TOTAL DEATHS are posted automatically after the QA review indicates that they are to occur.

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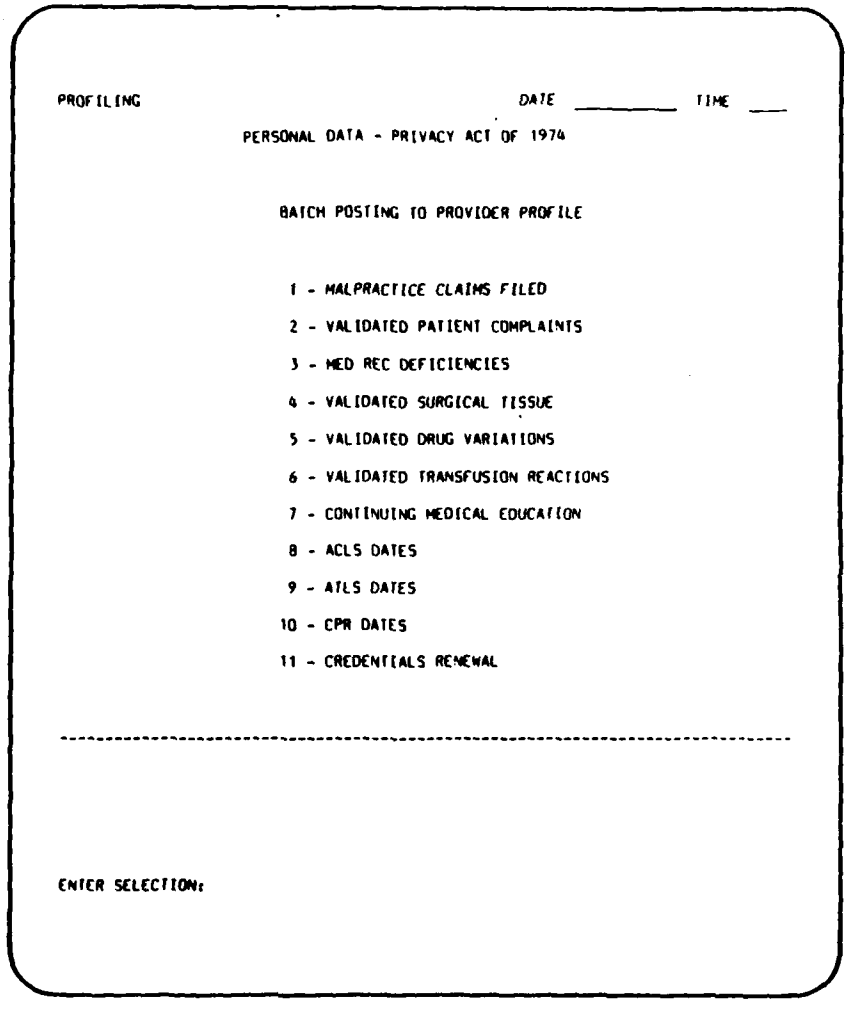


FIGURE 11.3 PROFILING-BATCH POSTING MENU SCREEN

11.3 BATCH POSTING

ACCESS Enter B on the Profiling Menu to access the Batch Posting Selection Menu.

PURPOSE The Batch Posting Process enables you to post data to providers' profiles without accessing each profile. For example, it is used when a group of providers have attended a continuing education course or CPR certification renewal.

DESCRIPTION The Batch Posting Process uses a Batch Posting Selection Menu from which the profile field to be posted to is selected. Then all the providers are entered on a single batch posting screen that collects data appropriate to that particular entry, along with the effective date.

11.3.1 TO BATCH POST TO PROVIDERS' PROFILES

- o Enter P on the User Entry Menu.

- o Enter B on the Profiling Menu.

The Batch Posting Selection Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter the number that appears to the left of the profile field to which you wish to post.

The Batch Posting Screen for the specific profile field is displayed. The cursor is at the EFFECTIVE DATE field.

- o Enter the effective date. This date will be used as the effective date for posting unless a specific date is entered for an individual provider.

- o Enter the appropriate information in each field specifying provider, effective date, and other data as required for the specific profile data being posted.

- When all of the providers have been entered, press Entry Done to return to ENTER SELECTION.

- Press Return at ENTER SELECTION to post to the providers' profiles.

The Batch Posting Selection Screen is displayed. The cursor is at ENTER SELECTION.

- To return to the Profiling Menu, press Return.

- To return to the User Entry Menu, press Return on the Profiling Menu.

QUALITY ASSURANCE TRAINING AID

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SECTION 11.4 PROFILING REPORTS

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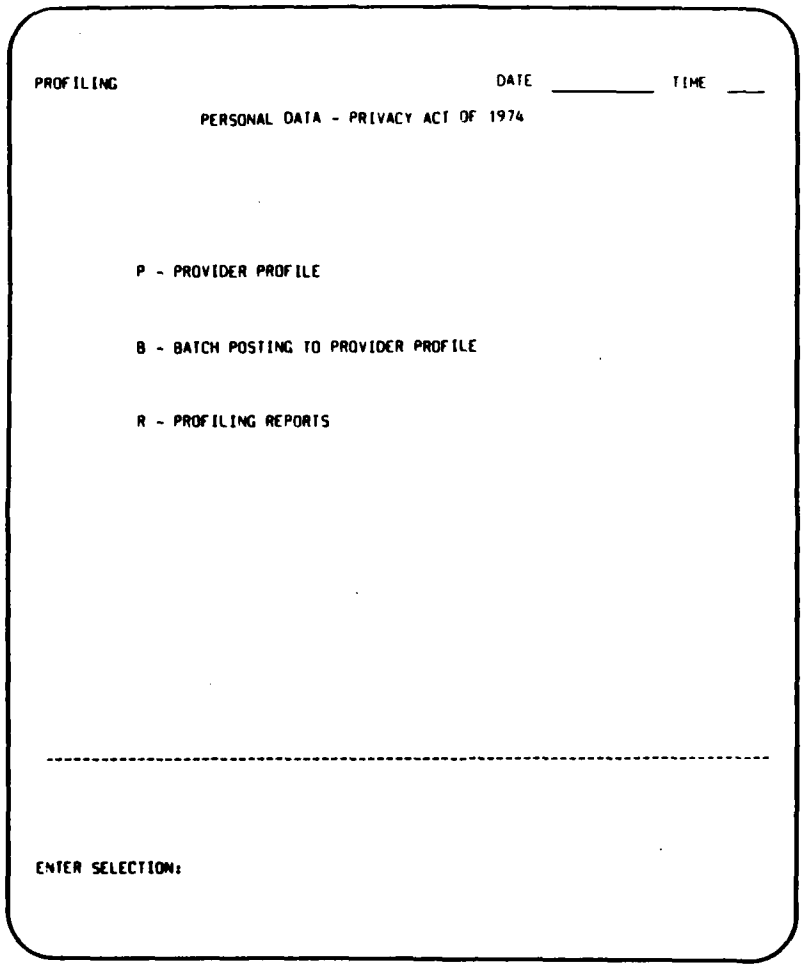


FIGURE 11.4 PROFILING MENU

11.4 PROFILING REPORTS

ACCESS/PRINT The Profiling Report Selection Screen is accessed by entering R on the Profiling Menu.

PURPOSE The Profiling Report Process enables you to print the reports, summarizing the quality assurance information related to providers in the facility. These reports are described at the end of this section.

DESCRIPTION The Profiling Report Selection Menu lists the reports available. Once a report is selected from the menu, the Report Run-Time Information Screen is displayed. Profiling Reports can be printed or displayed on the screen.

1 - Credentials Pull List. This report lists providers by specialty to facilitate pulling the provider's credential file and performing credential review. It shows the date of the reporting period. The body of the report lists the provider's name, specialty, and the dates for CPR and ACLS certifications, credential renewal, and license renewal. It is produced monthly or on demand.

2 - Provider Procedure Summary. This report gives the mortality rate by procedure for providers in the MTF. It shows the provider at the top. The body of the report includes the procedure code with text, procedures performed, the number of deaths, mortality rate, and the anesthesia risk code.

3 - Provider Procedures Mortality Summary. This report summarizes, for a specified period of time, the procedure and mortality rate for a provider for each of the 26 categories of procedure codes that are reportable to the DoD. It includes procedure text, procedures performed, deaths, mortality rate, rate criterion, and anesthesia risk codes. It is produced quarterly or on demand.

4 - Provider Insufficient Continuing Education. This report lists the providers whose continuing education credits are insufficient.

11.4.1 TO PRODUCE A PROFILING REPORT

- Select the report from the Profiling Reports Menu Screen:

  1 - Credential Pull List
  2 - Provider/Procedure Mortality Summary
  3 - Provider Procedure Summary

- Enter the selection number or list of reports and press Return.

The Report Run-Time Information Screen for the selected report is displayed. The cursor is at the first required field.

- Enter the required information to specify the parameters of the report; e.g., Provider, Start Date, End Date.

Note: Depending on the report requested, a different set of parameters will be required.

When you have entered specific parameters, the cursor moves to the PRINTER COPIES: field.

- Enter the number of copies, if you wish the report to be printed. Press Return. If you are reprinting, enter R followed by the number of copies, then press Return.

- If you do not want to print the report but wish to display the report on your terminal, leave this field blank and press Return.

The cursor moves to the next field: SELECTION

- If you do not wish to change the report specifications you entered, press Return to store the information and run the report.

- If you wish to change the specifications, enter ALL or the partial field label of the field you want to change, and press Return. With the cursor at the field you identified, change the information and press Return.

The cursor moves back to SELECTION.

- Press Return to store the information and run the report.

The cursor moves to the bottom left corner of the screen indicating the report is being processed. The report will appear on the screen if you left the PRINTER COPIES: field blank. Or, the Profiling Menu Screen is displayed if if you completed the PRINTER COPIES: field.

- If the report is displayed on the screen, use the Next Page option to page through the report.

- Press Return at ENTER SELECTION on the last page of the report to redisplay the Report Selection Screen.

The Report Selection Screen is displayed.

11.5 CHECKPOINT

Once you have read this section, review Lesson 6, System Functions of TUTOR ME. Then perform the exercises provided in your packet and answer associated questions.

If at any point you are unable to answer a question, review the appropriate section of the Training Aid, the tutorial, or the packet to gain the understanding you need.

AQCESS SYSTEM MANAGEMENT
TRAINING AID

Document Issue/Revision History

Document Issue No.	Document Revision No.	Date
1	0	SEP 1985
2	0	AUG 1986
2	1	JAN 1987

When pages of this document are updated, the Document Issue and Revision History Numbers are printed at the bottom of the page (i.e., 1.6, where "1" indicates the Document Issue Number and "6" represents the Document Revision Number), along with the date for the revision's issue. Additionally, a revision bar (or vertical line) identifies specific text, displays, or figures that have been changed. A Documentation Change Notice (DCN) form is provided to identify those pages that must be replaced, added, or deleted in the document.

When the entire document is reissued, the Document Issue and Revision History Numbers are printed at the bottom of the page (i.e., 2.0, where "2" represents the Document Issue Number and "0" indicates reissue rather than revision), along with the date of the document's reissue. No DCN form is provided, since the entire document is to be replaced.

DOCUMENTATION CHANGE NOTICE

ORIGINATOR: NDC/FSI DATE: January 1987

DOCUMENT TITLE: ACCESS System Management Training Aid

ISSUE NO.: 2

REVISION NO.: 1

THIS NOTICE INFORMS THE RECIPIENTS THAT THE DOCUMENTS IDENTIFIED ABOVE HAVE BEEN CHANGED. THE PAGES CHANGED BY THIS DCN ARE ATTACHED AND CARRY THE SAME DATE AS THIS DCN. THESE PAGES NEED TO BE INSERTED AND THE INDICATED PAGES REMOVED FROM YOUR DOCUMENT.

PAGES TO REMOVE	PAGES TO INSERT	ACTION* R	A	D
i through vi	i through vi	x		
ix and x	ix and x	x		
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3-11 and 3-12	3-11 and 3-12	x		
3-17 through 3-20	3-17 through 3-20	x		
5-1 through 5-8	5-1 through 5-8	x		
5-21 through 5-24	5-21 through 5-24	x		
	5-25 and 5-26		x	
7-21 and 7-22	7-21 and 7-22	x		
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Hardware Maintenance				
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25-7 and 25-8	25-7 and 25-8	x		

* R = REPLACES EARLIER PAGES A = ADD D = DELETE

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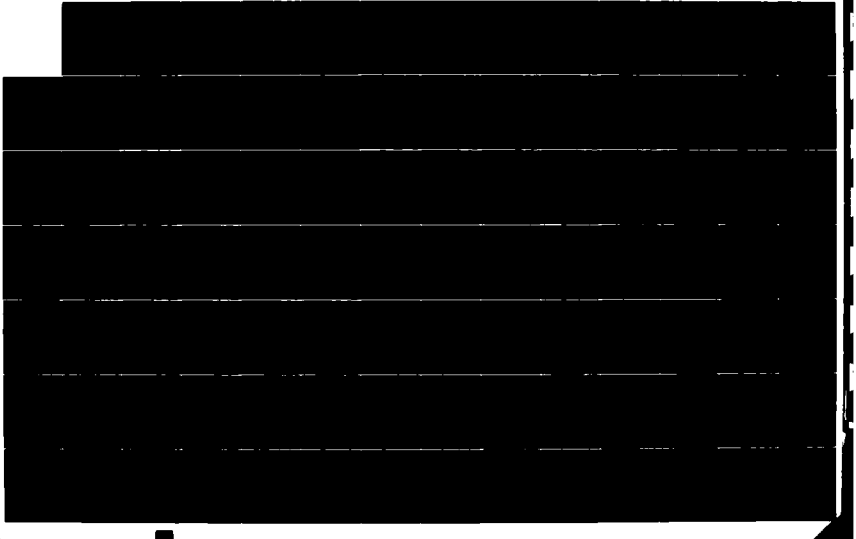
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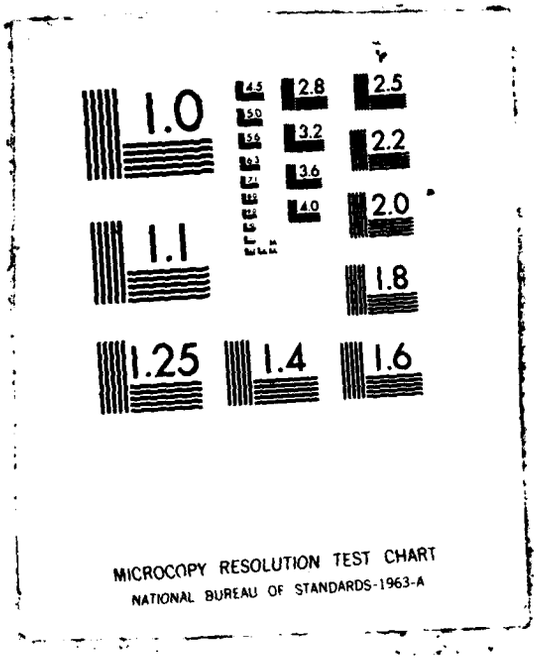

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AQCESS SITE SUPPORT PROCEDURES

AQCESS Customer Support Group recommends that the following procedures be used at each installation when questions or problems arise regarding the AQCESS system.

The AQCESS toll-free telephone customer support number is 800-368-3325, or local Maryland access 301-258-9200. This access number should be used by the facility point of contact from 7:00 a.m. until 11:00 p.m. EST, Mondays through Thursdays and from 7:00 a.m. until 8:00 p.m. Fridays.

When contacting AQCESS Customer Service, the facility point of contact should identify himself to the operator by name, give the facility name, say that the call is regarding the AQCESS system, and give a telephone number that the customer service representative can use to return the call if necessary. The operator will route the telephone call to an AQCESS customer service representative who will log the call and assist in resolving the problem.

All written correspondence should be mailed to the following address:

AQCESS Customer Support
1300 Piccard Drive, Suite 101
Rockville, Maryland 20850

SYSTEM MANAGEMENT TRAINING AID

1. INTRODUCTION

This Training Aid is intended to give you the basic information necessary to perform System Management functions at your facility. Section 1 introduces you to AQCESS in general, describing many of the features common to the system as a whole. It also provides an overview of the functions you perform through System Management.

Part 2 of this Training Aid describes the System Management functions related to the AQCESS software, giving general information on each function, then detailing the procedures involved. The procedure sections list each step necessary to perform the function. Each action you take is signified by a bullet (o); each action performed by the system appears enclosed in a box.

Part 3 addresses hardware operations, giving an overview of each procedure and detailing the steps to be followed to perform it. Again, actions you take are bulleted. Section 21 of this part describes the configuration of the hardware you will be using. Sections 22 through 24 describe power up, power down, start up, and shut down procedures. These procedures are also summarized on a card, accompanying this document, which can be attached to the operator's console.

A glossary of terms related to AQCESS is included in Appendix A at the end of this volume.

1.1 INTRODUCTION TO AQCESS

AQCESS, the Automated Quality of Care Evaluation Support System, is a computerized system intended to support quality of care and patient administration processing. This system has six basic objectives:

- To improve the quality and timeliness of the evaluation of health care;
- To support Patient Administration functions;
- To support Clinical Records processing;
- To support the Medical Services Accounting Office;
- To support Outpatient Appointing and Scheduling Functions;
- To provide Ad Hoc Reporting capability.

AQCESS will make it easier for MTF personnel to keep and process accurate data, and make that data available to system users who need it. Specifically, AQCESS can help MTF personnel:

- Register, admit, and disposition patients;
- Keep track of patients' ward, clinical service, and physician assignments;
- Track patients who are absent from the MTF;

- o Complete the medical record and prepare monthly reports for submission to higher command;
- o Maintain figures on resource use, like bed days;
- o Produce forms and reports for individual patients and for the MTF as a whole;
- o Monitor quality of care indicators, and identify occurrences that could adversely affect the quality of health care;
- o Identify, document, and track quality of care problems;
- o Maintain provider profile and clinical indicator data;
- o Calculate patient charges based on A&D data;
- o Support automated accounting with on-line payment posting and one time charges posting;
- o Support recording of Dining Hall monies and reporting of Group Meal Sales;
- o Automatically distribute payments to accounting funds and create cash collection vouchers;
- o Provide automated reporting to manage the accounting function;

- o Provide outpatient clinics with a method of appointing individual patients to a specific HCP and Clinic;

- o Create and maintain unique AQCESS reports.

AQCESS accomplishes its objectives through seven subsystems:

- o Admission and Disposition (A&D)
- o Clinical Records (CR)
- o Quality Assurance (QA)
- o System Management (SM)
- o Medical Services Accounting (MSA)
- o Ad Hoc Report Generator (Ad Hoc)
- o Appointing and Scheduling Module of the Outpatient Encounter Subsystem (A&S)

These subsystems are made up of functions or processes, as shown on the next page.

ADMISSION & DISPOSITION SUBSYSTEM
- Patient Identification (PTID)
- Registration
- Admission
- Transfer
- Disposition
- Correction Management
- Bed Management
- Inpatient History
- Patient Inquiry
- R/ADT Reports

CLINICAL RECORDS SUBSYSTEM
- Clinical Records
- Clinical Records Reports

QUALITY ASSURANCE SUBSYSTEM
- Quality Assurance
- Profiling

SYSTEM MANAGEMENT SUBSYSTEM
- System Management

MEDICAL SERVICES ACCOUNTING SUBSYSTEM
- Cashier Processing
- Medical Services Accounting
- MSA/Business Office Reports

AD HOC REPORT GENERATOR

OUTPATIENT ENCOUNTER SUBSYSTEM
- Appointing & Scheduling Module

AQCESS SUBSYSTEMS AND FUNCTIONS

Training Yourself to Use AQCESS

The following sections give you an overview of various features of using AQCESS. For more detailed information, you can consult the A&D, Clinical Records, Quality Assurance, Medical Services Accounting, Outpatient Encounter Appointing & Scheduling, and Ad Hoc Report Generator Training Aids, and the AQCESS online Tutorial. The Tutorial consists of lessons on how to use the system. It also allows you to use the system in training mode to see how AQCESS operates, without interfering with "real" MTF data.

1.1.1 USING AQCESS

What makes AQCESS run is the data you enter into it. You enter and update data on the system by means of a DEC terminal, which consists of a keyboard that looks like a sophisticated typewriter keyboard, and a Cathode Ray Tube Screen (CRT) that resembles a television screen.

The Keyboard

You use the keyboard to type in data that will go into the system. In addition to the letter and number keys, this keyboard has other keys that you use to communicate with the computer <u>about</u> the data you type in. The chart on the following page summarizes the use of these keys. For more information, see the AQCESS Tutorial, Lesson 2.

Name & Symbol	Used With	When You Press this Key:
Return		Cursor moves from field to field. Used at the end of a screen, Return transmits the data entered to the system for storage.
Shift	Many Keys	The top character of a two-character key is entered, as on a standard typewriter.
Help		The screen displays information about the data field you are in, such as length, type, and format of the data you can enter. Also displays codes that can be entered in that field.
Explain Error		The screen displays a detailed explanation of the error message that is being displayed.
Back-up		Cursor moves back one field at a time. Cursor must be at the first character of the field when you press Back-up. This key doesn't work at the first field on the screen.
Entry Done		Cursor skips the remaining fields on the screen and moves to the bottom of the screen.

SPECIAL FUNCTION KEYS (page 1)

Name & Symbol	Used With	When You Press this Key:
ALL		Cursor moves from bottom of screen to the first accessible field on the screen; you can access any updateable field on the screen and enter data.
Delete DEL		Cursor backs up one space and deletes whatever letter occupied that space. Used to delete typographical errors that were just entered.
Clear Data		All the data entered in a field is erased. Cursor must be at first character in a field when this key is pressed.
Cancel		The system abandons what you have been doing. No data entered immediately before cancelling is stored. You return to the previous processing function or screen.
CTRL	P	The screen being displayed is printed at the printer associated with your terminal.

SPECIAL FUNCTION KEYS (page 2)

The Screen

A screen is a display that appears on your CRT in a certain format. An area of the screen where data can be typed is called a field. The cursor is a blinking rectangle that shows you where the first character of data will be entered.

There are two types of screens: menu screens and data entry screens. Menu screens list functions you can perform and allow you to choose a function by entering the letter or number representing it in a selection field.

Data entry screens are arrangements of fields in which you can enter data. The lower portion of most data entry screens contains a submenu, listing functions you can perform at this screen.

A screen segment is a group of related data fields that can replace part of a data entry screen. The area in which alternate screen segments can be displayed is called a screen window.

Some fields on screens are required, meaning that you must enter data in them. If data is not entered in a required field, an error message will be displayed. On the other hand, some fields cannot be used because they do not apply to your military department; you will not be able to access these fields.

Examples of AQCESS screens appear throughout this Training Aid, illustrating the System Management functions.

Entering Data

Usually, the first time you access a screen, the cursor will be positioned at the first field where you can enter data. You must begin your entry at the first character in the field.

You can update, or change data on a screen by typing over it. To move the cursor to a field you wish to update, you can (1) type the label of that field, or part of the label, at ENTER SELECTION, and press Return. When you have entered the update, the cursor will return to ENTER SELECTION. Or (2) you can type ALL to go to each field on the screen. The cursor will return to ENTER SELECTION after the last field on the screen.

When you have finished an initial data entry or an update, the cursor is at ENTER SELECTION. To store the data you have just entered, press Return. No data is actually stored on the system until you do this.

Errors and Edits

AQCESS checks data as you enter it. This checking process is called editing. There are two types of edits: validity and consistency editing.

Validity Edits

Validity edits are performed as you enter data in each field. They check to see whether the data you enter fits the parameters set up for the individual field. For example, if you enter a date of March 35th or a Social Security Number like 123-AB-4566, validity edits will detect this as an error.

For some fields there is a list of the codes that can be entered (this list is called a system table). Validity edits determine whether the code you entered exists on the table or not.

When you enter invalid data, a beep sounds and an error message, like INVALID ENTRY, appears at the bottom of the screen, along with a description of the kind of data or a list of codes that can be entered. The cursor goes to the beginning of the incorrect field, and you must enter valid data before you can go on. (You can press Return, and that field will redisplay what it contained before, either previous data, or a blank.)

Consistency Edits

Consistency edits are performed after you have completed data entry on an entire screen. Consistency edits check whether relationships between data entered in different fields are correct. Data entered in one field may be incompatible with data entered in another field on the screen, for example, when you indicate in one field that a patient is active duty and in another field that the patient is 12 years old. Consistency edits would detect this as an error.

When a consistency error is found, an error message is displayed and the cursor moves to the first field in the inconsistent relationship. If you press Return, the cursor will go to the next field involved in the error. You can change any of the fields involved. When the error is corrected, the cursor returns to ENTER SELECTION.

Warnings

Usually you must correct a consistency error before you can go on. Occasionally you are given a warning of a condition that may or may not be inconsistent. Warning error messages are followed by the question, OVERRIDE? To override the message, and indicate that this data is actually correct, enter Y.

AQCESS Reports

Not only does AQCESS edit and store data and make it available to those who need it, AQCESS can also manipulate data. It can select and format data and print it in the form of reports for use in your MTF and for submission to higher command. This will eliminate the hours of work involved in manually preparing reports. And since production is faster, reports can be more timely and more useful to MTF staff.

System Security

Because AQCESS processes highly sensitive data on patient care, a number of provisions have been designed to protect the security of the system. Among these features are the following:

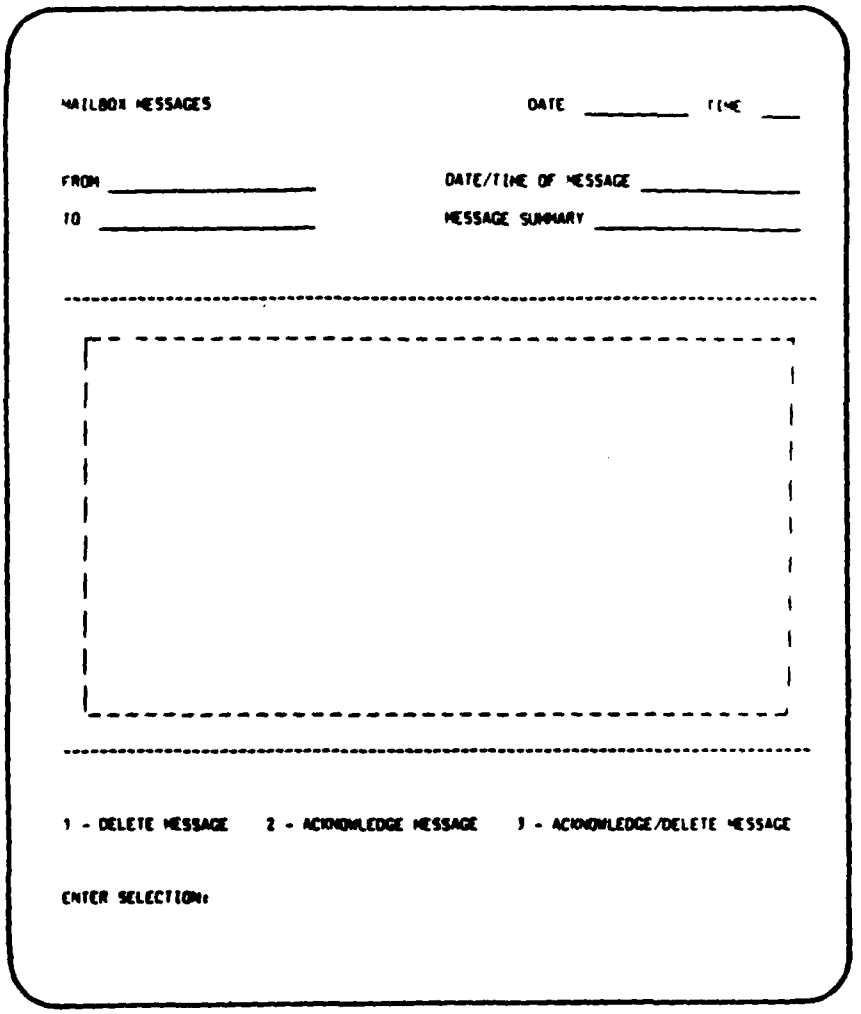
- Each user is assigned a private user ID and password, which are used to gain access to the system. Associated with each user ID and password are the system capabilities this user is authorized to perform. Also associated with each user ID and password are the Clinic capabilities this user is authorized to book into, view only, or neither book nor view.

- Screens time out, or are erased from the CRT, if no data is entered or no function key is pressed within a specified

length of time. This prevents unattended terminals from being accessed by unauthorized personnel.

- The capabilities that can be performed at each terminal are also designated.

- Some reports are defined as "secure" reports and may only be printed on the primary printer for the report.



MAILBOX MESSAGE SCREEN

1.1.2 THE MAILBOX FUNCTION

ACCESS The Mailbox function is accessed by entering MX on the User Entry Menu.

PURPOSE The Mailbox function enables you to send 'mail' to other users. Messages can be viewed on the screen or printed on paper, acknowledged (returned to sender with or without notation), and deleted.

DESCRIPTION The Mailbox function is comprised of two screens: the Mailbox Message Screen and the Mailbox Candidate Message Screen. The Mailbox Message Screen is used to send, acknowledge, or delete a message. The Mailbox Candidate Message Screen is used to select a particular message from a group of messages for viewing.

OPTIONS On the Mailbox Message Screen:

1 - DELETE MESSAGE enables you to delete a message from your mailbox.

2 - ACKNOWLEDGE MESSAGE enables you to communicate to a sender that you have receive his or her message.

3 - ACKNOWLEDGE/DELETE MESSAGE enables you to acknowledge a message and to delete it from your mailbox.

On the Mailbox Candidate Message Screen:

S - SEND A MESSAGE enables you to send a new message. This option is used to access a blank Mailbox Message Screen.

1.1.2.1 TO SEND A MESSAGE

- Enter MX on the User Entry Menu Screen. Press Return.

The Maibox Menu Screen is displayed. The FROM field defaults to your User ID. The DATE/TIME OF MESSAGE field defaults to the current date and time. The cursor is at the TO field.

- Enter the User ID of the individual who should receive your message. Press Return.

The cursor moves to MESSAGE SUMMARY.

- Enter a short description of the message. Press Return.

The cursor moves to the first character position of the message box.

- Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- Press Return to send the message to the receiver.

The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

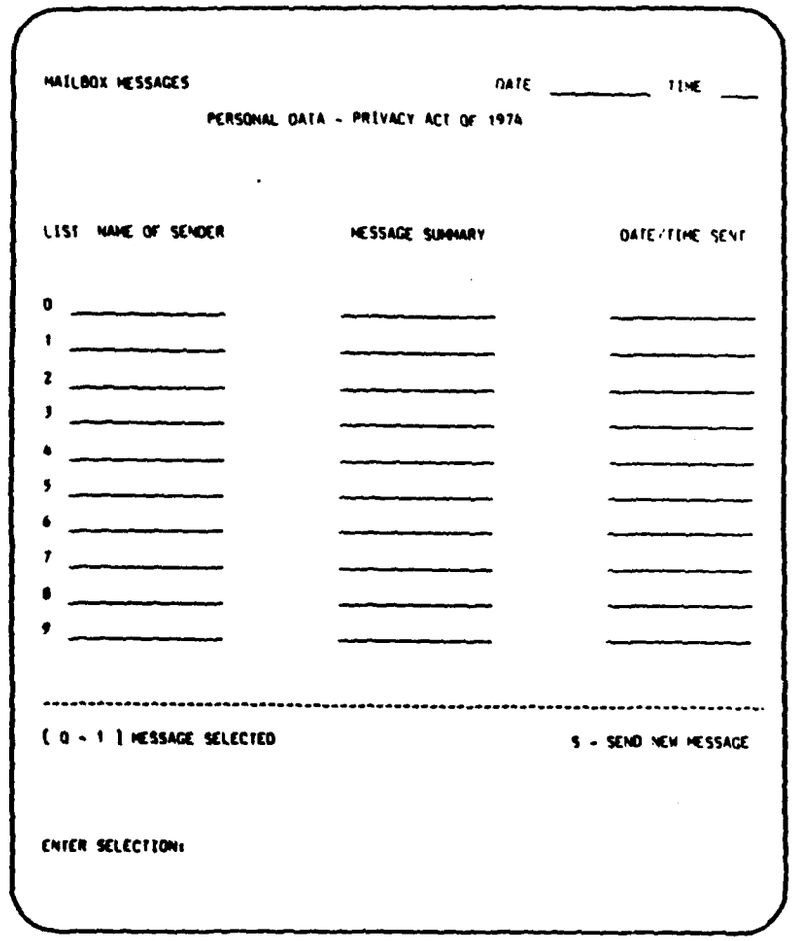


FIGURE 1.4 MAILBOX CANDIDATE MESSAGE SCREEN

1.1.2.2 TO VIEW A MESSAGE

If you have a message in your mailbox, the system will display the following at the bottom of the User Entry Menu Screen: MAILBOX MESSAGES WAITING - ENTER MX FOR MAILBOX FUNCTION.

- Enter MX at ENTER SELECTION. Press Return.

The Mailbox Candidate Messages Screen is displayed. The cursor is at ENTER SELECTION.

- Enter the number identifying the message you wish to view. Press Return.

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

Note: Only 10 messages can be listed on the Mailbox Candidate Messages Screen at one time. If you have accumulated 10 messages, the system will notallow you to

send mail. You must delete stored messages to reinstate the capability. Messages which you wish to save can be printed using the CTRL P function at ENTER SELECTION.

To delete a message:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter 1 at ENTER SELECTION. Press Return.

The message is deleted. The User Entry Menu is displayed.

To acknowledge a message:

1. If you wish to send an acknowledgment message back to the sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

- o Enter ALL. Press Return.

The cursor moves to the TO field.

- o Press Return until you move the cursor into the message box. Enter the message. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send the acknowledgment message to the sender. The User Entry Menu screen is displayed. The cursor is at ENTER SELECTION.

2. If you wish to acknowledge receipt of a message but you do not want to send a new message back to the original sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

o Enter 2 at ENTER SELECTION. Press Retur

Note: If you wish to acknowledge the message and also delete it from your mailbox, enter 3 at ENTER SELECTION.

The system will send an acknowledgment to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

1.2 INTRODUCTION TO SYSTEM MANAGEMENT

System Management consists of two areas of responsibility: regulating the functioning of the AQCESS software at your MTF and regulating the operations of the hardware on which AQCESS runs.

Through the System Management subsystem referred to in Section 1.1, you can perform functions that govern some aspects of AQCESS software functioning. You access the System Management subsystem through the system's User Entry Menu. On its screens you enter, update, or view data that, for example, controls the assignment of register numbers to patient records. The System Management subsystem and the System Management screens are described in detail in the second part of this Training Aid.

AQCESS hardware operations at your MTF are controlled through use of procedures that are listed on the operations Main Menu that is displayed on the system console. This menu lists such functions as saving the training database or listing the current status of all active jobs on the system. These functions are described in detail in the third part of this Aid. This third part also describes the system's hardware configuration, and the procedures for powering up, powering down, starting up, and shutting down the AQCESS hardware at your MTF.

The following lists the responsibilities of the System Manager for ongoing management of the AQCESS software and hardware.

Software-Related Functions

- Maintaining the system tables that are specific to your MTF; especially, assigning reports to printers, adding codes for physicians, updating information on clinical services, setting the length of time before time-out for each system function, and setting up and maintaining the clinic.
- Maintaining MTF Profile data, such as the MTF name and code, the number of days before medical records are considered delinquent, and the automatic or manual assignment of register numbers to records.
- Reserving blocks of register numbers for manual assignment to records.
- Assigning user IDs, passwords, and system privileges to AQCESS users, and freeing locked user IDs; assigning clinic capabilities to user IDs and passwords.
- Assigning system capabilities to AQCESS terminals, and freeing locked terminals.

Hardware-Related Functions

- Powering up, powering down, starting up, and shutting down the hardware running at your MTF.
- Obtaining a system status of all currently active jobs on the system.
- Producing the listing of software errors that have occurred.
- Setting up devices, when adding or moving terminals or printers.
- Verifying the integrity of system data (usually in case of an abnormal shutdown).
- Saving (or copying) and loading the training database.
- Broadcasting messages to system terminals.
- Backing up the system (i.e., saving the information on disk to a backup tape).
- Producing Clinical Records monthly reporting to higher commands (i.e., the Coding Transcript Tapes).
- Listing a summary of disk space usage (the Tally Disk Blocks Report).

SYSTEM MANAGEMENT TRAINING AID

- Starting up and shutting down the DEERS interface.
- Archiving records to tape.
- Managing the Caretaker utilities.
- Setting the system date and time.
- Updating AQCESS software and viewing status utilities.
- Creating the System Manager's user ID and password.

2. THE SYSTEM MANAGEMENT FUNCTION

ACCESS

To access the System Management function, enter S on the User Entry Menu Screen and press Return. The System Management Menu Screen will be displayed.

PURPOSE

The System Management function enables you to enter and update data that regulates how AQCESS operates and maintains system security. Specifically, through System Management you can:

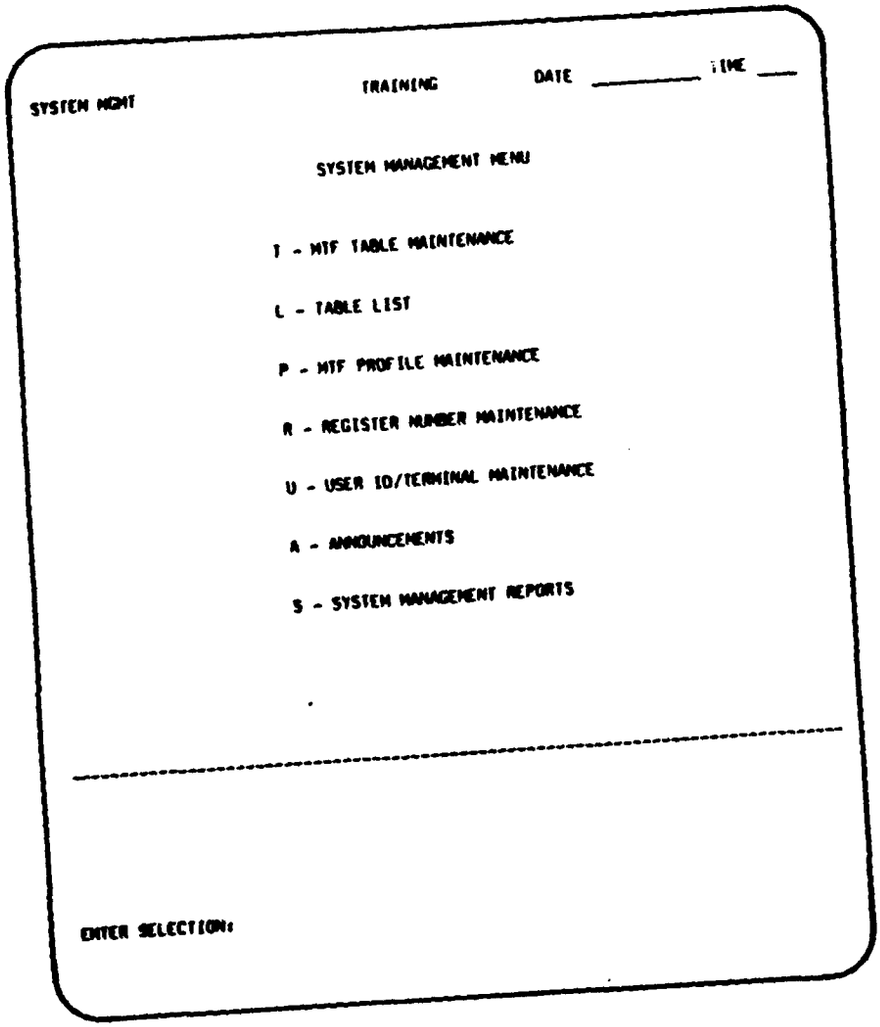
- o Modify, view, or print system tables
- o Maintain hospital profile data
- o Manage the assignment of register numbers
- o Maintain user ID/terminal security.

OPTIONS

The System Management Menu Screen lists the functions you can perform through System Management. These functions are:

T - MTF TABLE MAINTENANCE enables you to change, add, or delete entries on system tables.

L - TABLE LIST enables you to view a list of all system tables and print out hard copies of the tables.



SYSTEM MANAGEMENT MENU SCREEN

P - MTF PROFILE MAINTENANCE enables you to enter and update data that regulates some aspects of AQCESS functioning at your MTF (e.g., whether register numbers are to be assigned automatically or manually).

R - REGISTER NUMBER MAINTENANCE enables you to reserve or release blocks of patient register numbers.

U - USER ID/TERMINAL MAINTENANCE enables you to maintain system security by assigning and maintaining user ID and terminal capability profiles.

To access one of these functions, select the letter to the left of the entry on the Menu and press Return.

NOTE: Since the modifications you make in System Management may impact other users, be sure to use System Management only when no one else is signed on to the system.

NOTE: Only one person at a time can be signed on to System Management.

SYSTEM MANAGEMENT TRAINING AID

3. T - MTF TABLE MAINTENANCE

ACCESS — To display the Table Maintenance Screen, enter T on the System Management Menu Screen and press Return.

PURPOSE — Using Table Maintenance you can view or change individual items on system tables, or add items to tables.

DESCRIPTION — On the Table Maintenance Screen you choose whether to change, add, or view information on a table item. Then you identify the table and enter the code of the item you want to change, add, or view.

OPTIONS — C - CHANGE EXISTING enables you to modify information related to an existing table item.

A - ADD NEW ITEM enables you to add items to a table.

V - VIEW EXISTING ITEM enables you to look at a table item and the information about it.

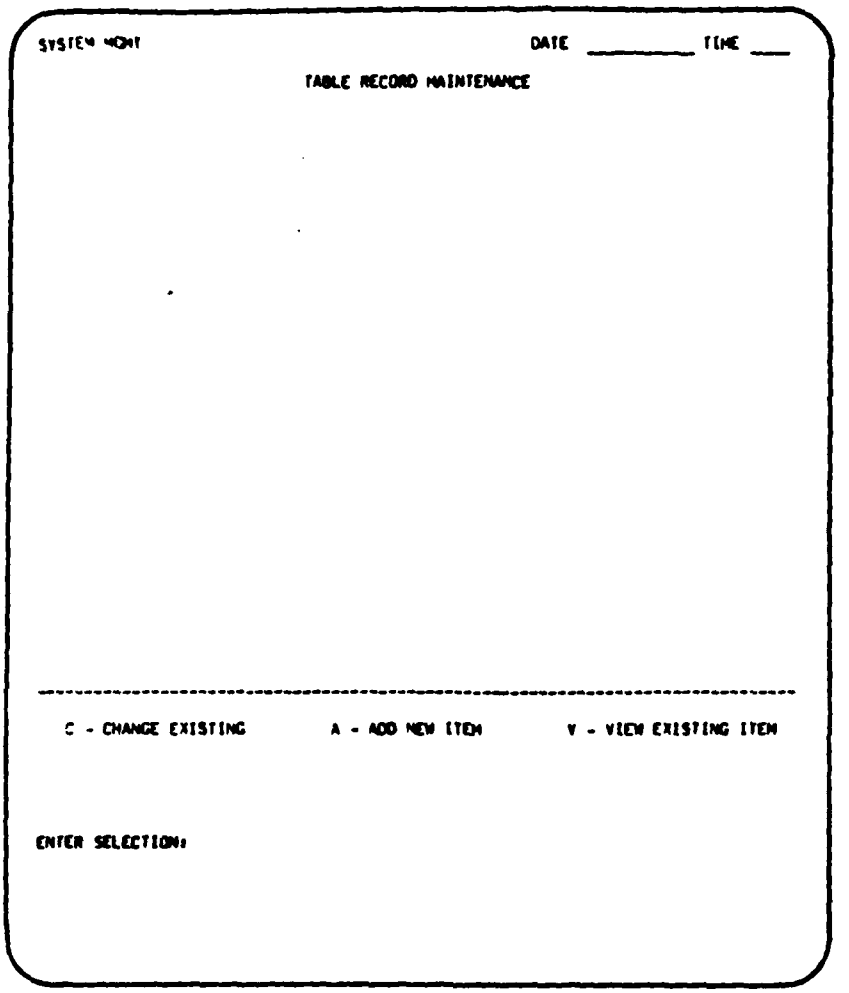


TABLE MAINTENANCE SCREEN, SUBMENU

3.1 MORE INFORMATION ABOUT SYSTEM TABLES

Through Table Maintenance, you can change, add, or view a table item's code and description, and other information or edit flags associated with the item.

The code is how the item is entered on the screen. The description is what the code stands for. For example, one code on the Religion Table is CAT, and its description is "Roman Catholic."

In addition to the code and description, a table item can have a number of pieces of information associated with it. These types of information vary depending on the table. For example, the Primary Provider Table also includes the physician's Social Security Number and medical specialty.

Many tables have service flags, which specify the military department for which each table item is valid (A = Army, F = Air Force, and N = Navy).

Table items can also have edit flags associated with them. An edit flag is a number that categorizes the code for editing and other processing. (See the AQCESS Tutorial and Section 1 of this Training Aid for more information about edits.)

For example, on the Disposition Type Table, each code has an edit flag that specifies that the code is either for:

1 - Military only
2 - Civilian only
3 - Both.

A disposition type such as DUTY may have an edit flag of 1, meaning that DUTY can be entered for a military patient only. If you enter a disposition type of DUTY for a civilian patient, the AQCESS edits will detect this as an error.

NOTE: You can only change or add items to system tables that contain information specific to your MTF, such as adding the code for a new physician on your staff. If you try to modify a table that is not specific to your MTF alone (e.g., the Rank Table), an error message will be displayed.

The following sections tell you how to change, add, or view a table item.

3.2 TO CHANGE AN EXISTING TABLE ITEM

- o On the System Management Menu Screen, enter T and press Return.

The Table Maintenance Screen is displayed.

- o Enter C and press Return.

The TABLE ID field is displayed.

- o Enter the number of the table you want. (If you don't know the table number, use Help to see a list of the system tables and their numbers.) Press Return.

The title of the table is displayed, and a blank CODE field appears.

- o Enter the code of the item you want to change. (If you don't know the code, use Help to see a list of all the codes in this table.) Press Return.

```
SYSTEM MGMT                                        DATE _________ TIME ___

                        TABLE RECORD MAINTENANCE

   TABLE ID             2005          TITLE   CLINICAL SVC (table)

   CLINICAL SVC/MTF CODE  AAA
   DESCRIPTION          INTERNAL MEDICINE
   FLAGS                0000

      1=NURSERY
      2=PEDIATRICS
      3=OB/GYN

      ENTER FLAG 1      0

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

  C - CHANGE EXISTING        A - ADD NEW ITEM        V - VIEW EXISTING ITEM


ENTER SELECTION: C
```

TABLE MAINTENANCE SCREEN
CHANGING AN EXISTING ITEM

The description of this code is displayed; the cursor is under the first letter of the description.

- To change the description of this code, type another description and press Return.
- To leave the description as is and have the next piece of information or edit flag displayed, just press Return.
- Continue to press Return to see each piece of information in turn, and update as necessary.

The FLAGS field displays a list of edit flags for this item, if any (e.g., 33112). The screen also displays the short table that defines the first flag, and the prompt, ENTER FLAG 1.

NOTE: If an edit flag is zero, none of the definitions on the short table applies to it.

- To change the first edit flag, type in another number from the short table, and press Return. (To change an edit flag to zero, use the Clear Data key.)

- To leave the first edit flag as is and see the next flag, just press Return.
- Continue this procedure for each of the edit flags that apply for this item.

When all the edit flags for this table have been displayed in turn, the FLAGS field will show the list of edit flags as you updated them.

- Continue to view or update the information that applies to this table item, and press Return after each.

When all the information for the table item has been displayed (and updated) you will see the message, IS EVERYTHING CORRECT?

- Enter Y to store the updates you have just entered. Nothing will be stored unless you enter Y here.

The cursor will return to a blank CODE field.

- To change another code on this table, enter it here and press Return. Or press Return only to return to the TABLE ID field.
- At the TABLE ID field, you can enter the number of another table to be changed. Or press Return to move to ENTER SELECTION and choose another option from the Table Maintenance Menu.

3.3 TO ADD A NEW TABLE ITEM

- On the System Management Menu Screen, enter T and press Return.

The Table Maintenance Screen is displayed.

- Enter A and press Return.

The TABLE ID field is displayed.

- Enter the number of the table you want. (If you don't know the table number, use Help to see a list of the system tables and their numbers.) Press Return.

The title of the table is displayed, and a blank CODE field appears.

- Enter the code or number of the item you want to add to the table.

```
SYSTEM MGMT                                        DATE _________ TIME __

                        TABLE RECORD MAINTENANCE

    TABLE ID                1000          TITLE   PRIM CARE PROVIDER (table)

    PRIM CARE PROVIDER CODE  JONESF
    DOCTOR NAME              JONES,FRED R DR  CAPT
    SSN                      837-73-9012
    DATE ASSIGNED TO MTF     01 APR 85
    SPECIALTY                PEDIATRICS
    CLINIC                   FAM
    AF ID CODE
    DELETE DATE
    PROVIDER PRIVILEGES

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

  C - CHANGE EXISTING        A - ADD NEW ITEM        V - VIEW EXISTING ITEM


ENTER SELECTION: A
```

TABLE MAINTENANCE SCREEN
ADDING A TABLE ITEM

If this code is already on the table, an error message is displayed, and the cursor returns to the CODE field, where you can enter another code. If the code is not already on the list, the DESCRIPTION field is displayed.

- Enter the description for this item and press RETURN.

The screen will prompt you to enter the next applicable piece of information or edit flag.

- Enter the information needed and press Return.

  For example, if you are adding a physician code to the Primary Provider Table, you will see the prompt SPECIALTY. Enter the medical specialty of the physician you are adding and press Return.

NOTE: Remember to use Help if you don't know what to enter in the information fields.

NOTE: Some of these fields require you to enter data; an error message will be displayed if you do not. Other fields are not required.

- If you do not wish to make an entry, leave the field blank. If you leave an edit flag blank, a zero will appear in the FLAGS field.

- Continue entering all the necessary information about this new item, pressing Return after each entry.

When you have finished entering this information, you will see the message, IS EVERYTHING CORRECT?

- Enter Y to store the new item on the table. (Nothing will be stored if you don't enter Y.)

The cursor will return to a blank CODE field.

- You can enter another code to be added to this table, or press Return to go to the TABLE ID field.

- At the TABLE ID field, you can enter the number of another table to which you want to enter an addition. Or press Return to move to ENTER SELECTION and choose another option from the Table Maintenance Menu.

3.4 TO VIEW AN EXISTING TABLE ITEM

- On the System Management Menu Screen, enter T and press Return.

The Table Maintenance Screen is displayed.

- Enter V and press Return.

The TABLE ID field is displayed.

- Enter the number of the table you want. (If you don't know the table number, use Help to see a list of the system tables and their numbers.) Press Return.

The title of the table is displayed, and a blank CODE field appears.

- Enter the code of the item you want to view information on. (Use Help if you don't know the code.) Press Return.

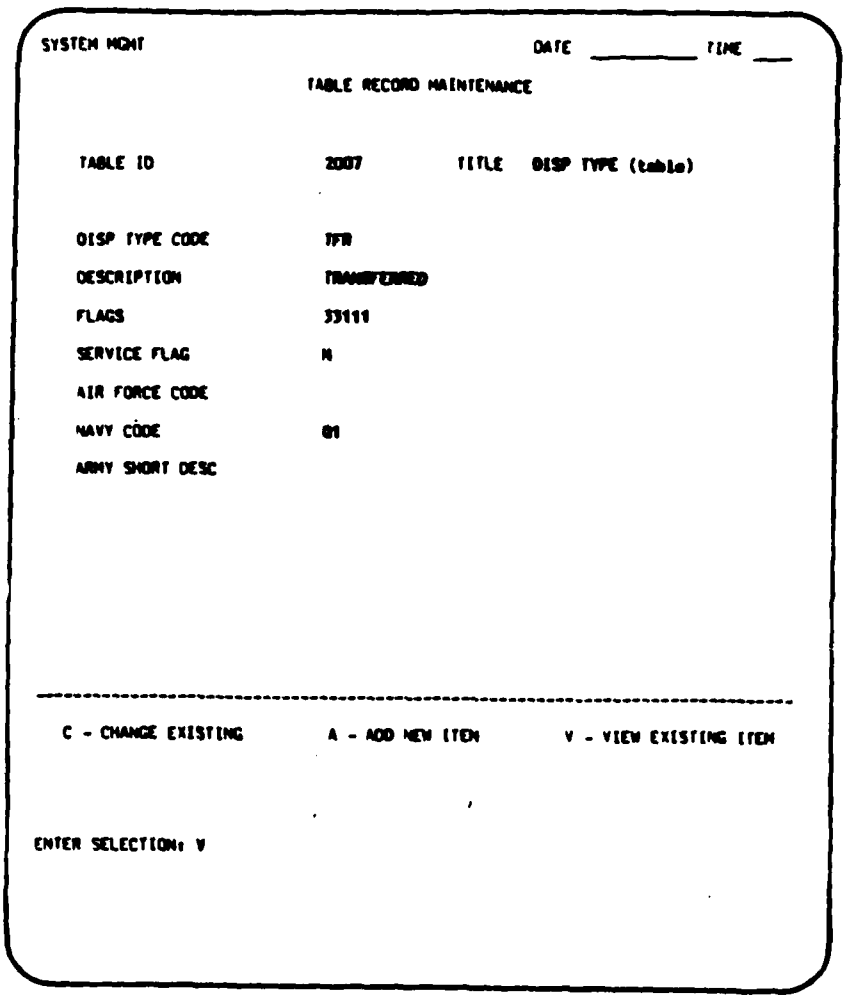


TABLE MAINTENANCE SCREEN
VIEWING AN EXISTING ITEM

The description and all the information associated with this code are displayed. The cursor moves to ENTER SELECTION.

- When you have reviewed the information on this item, you can enter another option from the Table Maintenance Menu or press Return to go back to the System Management Menu.

3.5 TO ADD A PHYSICIAN TO THE PRIMARY CARE PROVIDER TABLE

Information on a health care provider must be entered on the Primary Care Provider Table in order for that physician to be recorded in any of the provider fields on the AQCESS screens, and in order for a Provider Profile to be created on that physician.

To add a provider to this table, use the Add option on the Table Maintenance Menu (see Section 3.3 for a general explanation of this procedure). To update data on a provider, use the Change option (Section 3.2).

The following chart describes the particular information that can be entered or updated on the provider table (Table 1004).

NOTE: Required fields are indicated by an asterisk.

*TABLE ID: 1004
*PRIM CARE PROVIDER CODE: Enter up to 6 letters of the alphabet to represent the physician. Normally, these are the first 5 letters of the last name, and the first letter of the first name.
(Continued on the next page)

*DOCTOR NAME: Enter the provider's full name in the format LAST NAME,FIRST NAME, MI. The name can be followed by title and rank. This name will be printed as a signature on the final Cover Sheet and is displayed in the Help list of provider names. This entry can be up to 27 characters long and must be all alphabetical.

*SSN: Enter the provider's 9-digit Social Security Number, with or without hyphens.

*DATE ASSIGNED TO MTF: Enter the date when this physician was assigned to your MTF. See the AQCESS Tutorial for the formats in which dates can be entered (see Lesson 5). This date is important to the functioning of the QA subsystem.

SPECIALTY: Enter the UCA code for the provider's clinical specialty. Use Help if you don't know this code. You can enter multiple codes, separating them with semicolons.

CLINIC: Enter the Provider's Main Clinic for Outpatient Appointing and Scheduling. Press Help to display all valid entries.

AF ID CODE: For the Air Force, enter the 6-digit code assigned to this provider (numerical only). This field is not required, but a profile cannot be established in an Air Force MTF if it is not entered.

(Continued on next page)

DELETE DATE: Enter the date when this provider code can no longer be entered on the AQCESS screens. This field is not required.

PROVIDER PRIVILEGES: Enter the duties assigned to the HCP. This entry may be 1-10 characters in length.

*It is extremely important that these are entered correctly. Once the provider is profiled, these cannot be changed.

3.6 TO ADD OR CHANGE ON THE CLINICAL SERVICE TABLE

On the Clinical Service Table you can enter information on clinical services at your MTF, including the ward assignment that is normal for each service. If a patient is assigned to a ward that is not the normal assignment for the patient's clinical service, the screen displays a warning message (which can be overridden).

To add a new clinical service, use the Add option described in Section 3.3; to update this information, use the Change option described in Section 3.2.

The following chart describes the information that can be entered for clinical services.

TABLE ID: 2005
CLINICAL SVC/MTF CODE: If you don't know the code you want to change, use Help to see a list of the codes and their definitions.
DESCRIPTION: The definition of the clinical service code can be from 3 to 44 characters long.
FLAGS: This field lists all the numerical flags for this table item. Possible entries for these flags, and their definitions are listed on the next page. Zero
(Continued on the next page)

means that none of the definitions shown applies to this table item. To change a flag to zero, use the Clear Data key.

FLAGS (continued)

1ST FLAG	2ND FLAG
1 - Nursery 2 - Pediatrics 3 - OB/GYN	1 - Military only
3RD FLAG	**4TH FLAG**
1 - Absent sick 2 - CRO 3 - ERD 4 - Quarters	1 - May change to after admit

VALID WARDS: Here you enter or update the IDs for the normal wards that are assigned for this clinical service, separated by semi-colons.

ARMY CODE: This is the 2-character IPDS Army code for this item.

ITRCS SHORT DESCRIPTION: Enter or update the short description of this clinical service, as it will appear on the Army Admission Cover Sheet and the ITRCS (from 2 to 12 characters long).

SERVICE FLAGS: Enter or update the codes for the military departments for which this is a valid clinical service code (A = Army, F = Air Force, and N = Navy).

DELETE DATE: Special Care MSR CSV CODE.

3.7 TO ADD AN OUTPATIENT APPOINTMENT CANCEL REASON

Reasons for outpatient appointment cancellations must be entered into the table to cancel appointments.

To add a cancel reason to the table, use the Add option on the Table Maintenance Menu (see Section 3.3 for a general explanation of this procedure). To update data on a cancel reason, use the Change option (see Section 3.2).

The following chart describes information that can be entered for a cancellation reason.

TABLE ID: 1600
CANCEL CODE: Enter up to 3 letters of the alphabet to represent the cancel reason.
DESCRIPTION: The definition of the cancel reason can be 3 to 30 characters long.

3.8 TO ADD AN APPOINTMENT TYPE

Before appointments can be scheduled, the Appointment Type Table has to be built. These appointment types are site specific and can be added or updated when necessary.

To add a new appointment type, use the Add option described in Section 3.3; to update this information, use the Change option described in Section 3.2.

The following chart describes the information that can be entered for appointment types.

TABLE ID: 1602
NAME: Enter up to 3 letters of the alphabet to represent the type of appointment.
DESCRIPTION: The definition of the appointment type can be 3 to 30 characters long.
BOOKABLE: Enter a "Y" or "N" to specify if this appointment type can be booked.

3.9 TO ADD OR CHANGE A HOLIDAY

Holidays can be added, deleted, or updated to reflect the specific MTF's needs. Holiday messages will appear in the Outpatient Appointing & Scheduling Module.

To add a holiday to the Holiday Table, use the Add option described in Section 3.3; to update this information, use the Change option described in Section 3.2.

The following chart describes the information that can be entered for holidays.

TABLE ID: 1603
NUMBER: Enter a number that corresponds to a holiday. Press Help to see what number was last used.
DESCRIPTION: The definition of the holiday can be up to 30 characters long.
DATE: Enter the date of the holiday.

3.10 TO ADD A CLINIC

The number and types of clinics that a hospital has is site specific. Therefore the MTF needs to add, delete, or update its clinic data when necessary.

To add a clinic to the Clinic Table, use the Add option described in Section 3.3; to update clinic information, use the Change option described in Section 3.2.

The following chart describes the information that can be entered for outpatient clinics.

TABLE ID: 1604
NAME: Enter up to 3 characters to represent the clinic name.
DESCRIPTION: The definition of the clinic can be 10 to 30 characters long.
DEPARTMENT: Enter up to 30 characters describing the department in which this clinic is found.
CONTACT: Enter the name of the contact for this clinic.
PHONE: Enter the clinic's phone number.
(Continued on the next page)

APPT COMMENT: Enter any text to be shown.

SCHED ADV DAYS: Enter the number of days in advance that an HCP must have an open schedule.

FROZEN DAYS: Enter the number of days that a schedule may be frozen.

OPEN ON SATURDAY: Enter a "Y" or "N" to indicate if the clinic is open on Saturdays.

OPEN ON SUNDAY: Enter a "Y" or "N" to indicate if the clinic is open on Sundays.

SECURE ?: Enter a "Y" or "N" to indicate if this clinic is secure so that booked appointments cannot be visible.

3.11 TO ADD A MEDICAL RECORD TYPE

The medical record types need to be entered into the system in order to retrieve a record for review before a booked appointment.

To add medical record types to the table, use the Add option described in Section 3.3; to update this table, use the Change option described in Section 3.2.

The following chart describes the information that can be entered for medical record types.

TABLE ID: 1605
NUMBER: Enter the number of medical record type.
DESCRIPTION: Enter the name of the medical record type. Use 5 to 20 characters.

3.12 TO ADD A MEDICAL RECORD LOCATION

The location where specific medical records are stored is vital in retrieving and tracking the medical records when they are needed for review by the Health Care Providers.

To add a Medical Record Location to the table, use the Add option described in Section 3.3; to update this information, use the Change option described in Section 3.2.

The following chart describes the data elements that can be entered for medical record locations.

TABLE ID: 1606
NAME: Enter a 4-character code for the medical record location.
DESCRIPTION: Enter up to 20 characters describing the location of the record.
PRINTER DEVICE: Enter the Product Device (Table 1021) located in the medical record location.

3.13 TO SPECIFY PRINTERS ON THE DEVICE TABLE

On the Product Device Table you enter the device number of the printer that is to be used for each AQCESS product and report. To do this, you use the Change option described in Section 3.2.

Device numbers for the printers that produce the AQCESS products are specified in Table 1021, as described in this section.

Reports work differently from products. Each report is associated with a printer name, e.g., A&D1. When the system is installed, there are four printers defined: A&D1, CR1, QA1, and CONSOLE. If more printers are added to the configuration to be used as report printers, additional printers would be defined, such as A&D2. Reports and their corresponding printer names are specified on Table 5002 (A&D reports), Table 5003 (QA reports), Table 5004 (Clinical Records reports), and Table 5005 (System Management Reports), Table 5007 (MSA reports) and Table 5008 (A&S reports). Printer names are, in turn, associated with the physical devices that produce the reports, as specified on Table 1021.

Thus you can perform two functions when you modify the Device Table (1021). You can change the device number that produces each product, and you can change the device number associated with the printer name for specific types of reports.

The chart that follows shows the specific information you enter for this table.

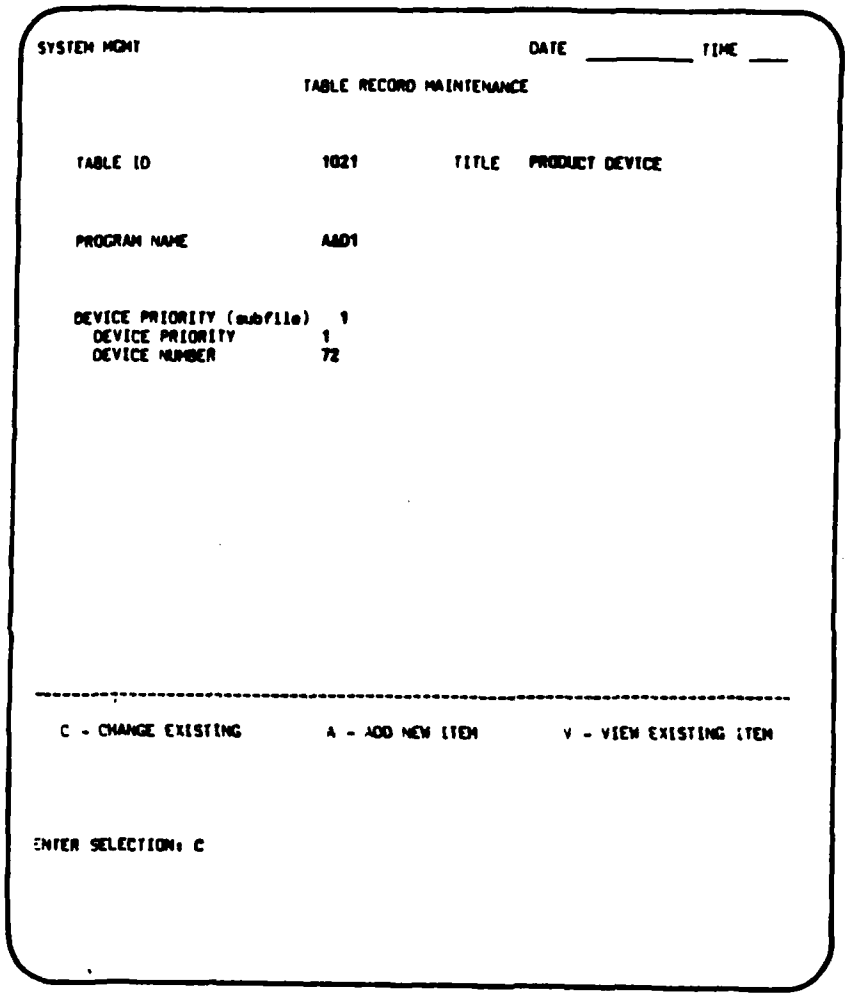


TABLE MAINTENANCE SCREEN
CHANGING THE PRODUCT DEVICE TABLE

TABLE ID: 1021

PROGRAM NAME: For products, enter the type of product. For reports, enter the printer name associated with the report. If you do not know these codes, use Help and the following list will be displayed:

A&D1	- A&D Reports
A&S1	- Appointment & Scheduling Reports
ATCOVER	- Admission Cover Sheets
ATCRD	- Index Cards (3x5 or 5x8 Cards)
ATNIR	- Navy Admission Cover Sheets
CONSOLE	- the system console
CR1	- Clinical Records reports
CRCES	- Coded Episode Summaries
CRDFT	- Draft Cover Sheets/Record of Inpatient Treatments
CRFIN	- Final Cover Sheets/Record of Inpatient Treatments
DD1131	- Cash Collection Voucher
DD139	- Pay Adjustment Authorization
I&R	- Invoice & Receipt
MSA1	- MSA Report - Narrow Paper
MSA2	- MSA Report - Wide Paper
MSCON	- Consent Form
QA1	- Quality Assurance reports
RGEMB	- Embosser
RGFORM	- Registration Forms
SF1049	- Public Voucher for Refund
SYTLS	- System Management Table Lists

(Continued on next page)

DEVICE PRIORITY (subfile) - Enter 1 to indicate whether the device number you are about to enter is the number of the primary device at which the output(s) should print. If this is a product, and there is a printer with the same type of paper loaded, you can enter 2 to indicate that this is the secondary device, etc. If this is a report only a primary device can be entered.

DEVICE PRIORITY - This field will show the priority number that you just entered. If you are viewing this table instead of changing it, this field will show the first priority that was previously entered for the output(s), if any.

DEVICE NUMBER - Enter the device number for the printer at which you want the output(s) to print. You can use the same device for more than one product or report as long as the correct paper or form is loaded.

If you are viewing this table instead of changing it, this field will show the device number that has already been entered for this output at this priority.

NOTE: When a user requests printing of a product, the system will check the printer that is designated in the Product Device Table as the primary device. If that printer is busy, the system will check the secondary device, if any.

When a user requests printing of a report, the system will check the status of the primary device. If it is busy, the system will ask if the user wants to queue the print request and wait. If not, it will ask if the user wants to specify an alternate device. The user can specify as an alternate any device that is defined in Table 1019 as a terminal with no capabilities.

3.14 TO ADD A REPORT TO A REPORT MENU

Reports that are generated by Ad Hoc Report Generator and additional reports that are released in software updates can be added to the Report Menus in either A&D, CR, QA, Profiling, MSA, or Outpatient A&S. These report menus are found in Tables 5002 through 5008 in System Management. Once a report is assigned to a menu it must also be assigned a Product Device (Table 1021).

To add a report to the table, use the Add option on the Table Maintenance Menu described Section 3.3.

The following chart describes the information that can be entered for the report menus.

TABLE ID: 5002 - 5008
REPORT NUMBER: Enter the number assigned to this report.
REPORT DESCRIPTION: Enter the name of the report that will appear on the menu. Up to 60 characters are allowed.
REPORT TYPE: Enter N for nightly, M for Monthly, or S for Special Case to identify the report type. This might rearrange the order of your present menu.
(Continued on next page)

SERVICE FLAG: Enter A for Army, F for Air Force, and/or N for Navy to define the services for which this report is available.

PRIMARY PRINTER ID: Enter the product device (Table 1021) on which the report will print.

DELETE DATE: Enter the date on which the report will no longer appear on the menu.

3.15 TO CHANGE A REPORT FROM ONE FUNCTIONAL MENU TO ANOTHER FUNCTIONAL MENU

At times the MTF might want a particular report to be available in more than one menu, or to be moved from one menu to another.

The available report menus are as follows:

5002	R/ADT Reports Menu File
5003	QA Reports Menu File
5004	CR Reports Menu File
5005	System Management Reports Menu File
5006	Profiling Reports Menu File
5007	MSA Reports Menu File (Army and Air Force Only)
5008	OP Appointing & Scheduling Reports Menu File

To add a report to a particular menu, follow the directions in Section 3.3.

To change a report from one menu to another, first add the report to the new menu (Section 3.3), and then set the DELETE DATE field for the report in the original menu. Directions for setting the delete date are as follows:

- Select S from the Main Menu and press Return.

The System Management Menu is displayed.

- Select option T, MTF Table Maintenance from the Sub-Menu and press Return.

The Table Record Maintenance Screen is displayed.

- Select option C, Change Existing, from the Menu and press Return.

  The cursor is at TABLE ID.

- Enter the Table ID from which the report should be removed.

The title of the specific Table ID is displayed and the cursor is at the REPORT NUMBER field.

- Enter the Report Number and press Return.

The Report Description is displayed.

- Press Return four times until the DELETE DATE field is displayed.
- Enter today's date and press Return.
- At the IS EVERYTHING CORRECT? Prompt, press "Y" for yes.
- Press Cancel to exit from the menu.

3.16 POINTS TO REMEMBER

1. You can change or add items to system tables that are specific to your MTF. The system will not allow you to change or add items to tables that are not just specific to your MTF.

2. Different tables have different pieces of information associated with their entries. Also, the information you are able to view, change, or add to a given table may vary, depending on which function you are performing.

3. An edit flag is a single-digit number that stands for a piece of information that is important to AQCESS edits. Edit flags are associated with the codes on some, but not all, system tables. Only the edit flag numbers, not the descriptions, are displayed when you use the View option in Table Maintenance.

4. Service flags indicate the military department for which the code is valid.

4. L - TABLE LIST

ACCESS — To display the Table List Screen, enter L on the System Management Menu Screen and press Return.

PURPOSE — The Table List process enables you to view a list of all tables in the system by table number and title, print a selected table, or print all tables.

DESCRIPTION — The Table List Menu Screen displays the titles of all tables in the system and their four-digit table numbers. These numbers are used to select a table to be printed.

On the Table List Screen you can view the titles of all system tables, but not items on the tables. To view table items, you use the Table Maintenance process.

OPTION — N - VIEW NEXT PAGE enables you to view the complete table list, page by page. The screen can display 20 titles per page. Enter N to view each subsequent page of table titles.

P - VIEW PREVIOUS PAGE enables you to return to previous pages of the table list that have already been

displayed. This option allows you to scroll backward through the list of tables.

S - SELECT TABLE NUMBER TO PRINT enables you to print any table you select. Remember, the individual items in the table won't be displayed on this screen.

A - PRINT ALL TABLES enables you to print hard copies of most system tables. (The tables contents are not displayed on this screen.)

CAUTION: PRINTING ALL TABLES IS A VERY TIME-CONSUMING PROCESS. ONCE YOU CHOOSE THIS OPTION YOU CANNOT CANCEL THE PRINTOUT, AND NO OTHER ITEMS CAN BE PRINTED ON THE PRINTER ASSOCIATED WITH THIS TERMINAL UNTIL ALL TABLES HAVE BEEN PRINTED.

FOR THIS REASON, THE EXTREMELY LARGE DIAGNOSIS AND PROCEDURE TABLES WILL NOT BE PRINTED USING THIS OPTION.

SYSTEM MGMT DATE _____ TIME ___

TABLE LIST MENU

TABLE NO	TITLE	TABLE NO	TITLE
1000	RELIGION CODE	1019	TERMINAL CAPABILITIES
1002	PATIENT CATEGORY	1020	FUNCTION TABLE
1004	PRIMARY CARE PROVIDER	1021	PRODUCT DEVICE
1005	MTF (MEDICAL TREATMENT FAC)	1023	BRANCH OF SERVICE
1006	RANK CODE	1024	RANK CODE
1012	FMP (FAMILY MEMBER PREFIX)	1025	ZIP CODE TABLE
1013	UNIT/ID SHIP	1028	CAPABILITY PROFILES
1014	FLYING STATUS	1029	MILITARY SPECIALTY
1015	STATE/COUNTRY CODES	2001	SOURCE OF ADMISSION
1016	COMMAND INTEREST	2002	ABSENT STATUS

S - SELECT TABLE NUMBER TO PRINT P - VIEW PREVIOUS PAGE

A - PRINT ALL TABLES N - VIEW NEXT PAGE

ENTER SELECTION:

TABLE LIST SCREEN

4.1 TO USE THE TABLE LIST SCREEN

- To use any of the options described in this section, enter L on the System Management Menu Screen and press Return.

The first page of the Table List is displayed. The cursor is at ENTER SELECTION.

- You can perform any of the procedures described in the Sections 4.2-4.5.

4.2 TO VIEW THE NEXT PAGE OF THE TABLE LIST

- Enter N on the Table List Screen and press Return.

The next page of the table list is displayed.

4.3 TO VIEW THE PREVIOUS PAGE OF THE TABLE LIST

- Enter P on the Table List Screen and press Return.

The previous page of the list is displayed.

4.4 TO SELECT TABLE NUMBER TO PRINT

- Enter S on the Table List Screen and press Return.

The TABLE NUMBER field is displayed.

- Enter the number of the table you wish to print. You can only enter one table number at a time. Then press Return.

The table will be printed at the printer associated with the SYTLS product (see Section 3.7).

NOTE: You can enter S and select another table to print, and continue to select individual tables to print. They will all be printed when you press Return and leave the Table List function.

4.5 TO PRINT ALL TABLES

- Enter A on the Table List Screen and press Return.

All of the tables that can be printed at your facility will be printed. This does not include the Diagnosis and Procedure tables.

CAUTION: PRINTING ALL TABLES IS TIME-CONSUMING AND TIES UP THE PRINTER. ALSO, ONCE YOU SELECT THIS OPTION, THE PRINTOUT CANNOT BE CANCELLED.

4.6 POINTS TO REMEMBER

1. The Table List Menu is a quick reference to identify system table codes and names.

2. Hard copies of individual tables can be printed using option S.

3. Option A allows you to print all system tables. However, some tables, such as the Diagnosis and Procedure Tables, cannot be printed using this option. Printing the tables using this option is very time-consuming and ties up the printer associated with your terminal. This function cannot be cancelled once it is requested; use it with care.

SYSTEM MANAGEMENT TRAINING AID
Table List Procedures

5. P - MTF PROFILE MAINTENANCE

ACCESS — To access the Profile Maintenance function, enter P on the System Management Menu Screen and press Return.

PURPOSE — The MTF Profile Maintenance process enables you to change the information that regulates functions of the system that are specific to your MTF.

DESCRIPTION — Information you can change through MTF Profile Maintenance includes data that identifies your MTF on system reports and products, delinquency periods for various CR and QA reports, and whether the MTF uses automatic or manual assignment of register numbers.

OPTIONS — 1 - CR PARAMETERS and 2 - QA PARAMETERS enable you to display screen segments with MTF information specific to Clinical Records and Quality Assurance, respectively.

3 - RETURN TO PAD PARAMETERS enables you to redisplay the patient administration segment of the screen.

4 - OP PARAMETERS enables you to display a screen segment with fields specific to Outpatient Appointing & Scheduling.

```
SYSTEM MGMT                                        DATE _________ TIME ___
                        MTF PROFILE MAINTENANCE

MTF CODE ___              MTF NAME ____________________
SERVICE (A,F,N) _         TRAINING FLAG (Y/N) _    TRAINING DATE _________
SOFTWARE VERSION NO ___   INVALID ATTEMPTS BEFORE LOCKOUT __

                    ---------- PAD PARAMETERS ----------

AUTO REGISTER NUMBER (Y/N) _          INDEX CARDS (0 PER SET) __  WAR (Y/N) _
PAD BLDG/ROOM DESIGNATION _______
MTF ADDRESS: CITY ____________________ STATE __ ZIP CODE _______
PAD SIGNATURE BLOCK: LINE 1 ____________________________
                     LINE 2 ____________________________
                     LINE 3 ____________________________
PAD OFFICE SYMBOL _________

--------------------------------------------------------------------------------
  1 - CR PARAMETERS      2 - QA PARAMETERS      3 - RETURN TO PAD PARAMETERS


ENTER SELECTION:
```

MTF PROFILE MAINTENANCE SCREEN
SHOWING PAD PARAMETERS SEGMENT

5 - ER PARAMETERS enables you to display a screen segment with information specific to the Emergency Room.

5.1 TO USE THE MTF PROFILE MAINTENANCE SCREEN

- To display the MTF Profile Maintenance Screen, enter P on the System Management Menu and press Return.

The Profile Maintenance Screen is displayed, showing the PAD PARAMETERS segment. The cursor is at ENTER SELECTION.

- You can perform any of the procedures described in Sections 5.2-5.5.

5.2 TO UPDATE MTF PROFILE DATA AND PAD PARAMETERS

- With the Profile Maintenance Screen displaying the PAD Parameters segment, you can enter ALL to update all fields on the screen, or enter the partial field label of the field you wish to update. Then press Return.

- To update a field, type over the existing information and press Return. Use Help for explanations of any of these fields.

- If you entered ALL and do not want to update a particular field, just press Return.

If you enter ALL:

The cursor moves to MTF Code.

- Enter the code assigned to your MTF. Press Return.

The cursor moves to MTF Name.

- Enter the name of the MTF. This name will print on all reports and display on the Sign-On Screen. Press Return.

The cursor moves to Training Date.

- Enter the date to be used on the Training database. Press Return.

The cursor moves to INVALID ATTEMPTS BEFORE LOCKOUT.

- Enter the number of times a user should be allowed to attempt a sign-on with an incorrect sign-on name and password. The system will lock the user out when this number of attempts is reached. Press Return.

The cursor moves to DEERS Site Code.

- Enter the DEERS site code provided by DEERS for your MTF. Press Return.

The cursor moves to RESTRICT REPORT START TIME _____ TO _____.

- Enter the time after which restricted reports can begin printing. Press Return. Enter the time at which they will again become unprintable. Press Return.

The cursor moves to the Auto Register Number field in the PAD Parameters portion of the screen.

- To return to ENTER SELECTION, press Entry Done.

To update the PAD Parameters:

- Enter Y for Yes to assign register numbers automatically at the time of Registration. Press Return.
- Enter N for No if register numbers are to be assigned manually. Press Return.

The cursor moves to INDEX CARDS (# PER SET).

- Enter the number of index cards to be issued as a set at the time of admission.

The cursor moves to WAR (Y/N).

- Enter Y for Yes if wartime conditions prevail. Press Return.
- Enter N for No to indicate peacetime. Press Return.

The cursor moves to EMBOSSER TYPE.

- Enter the code representing the type of embosser at the MTF:

  1 - Addressograph Farrington 177.001
  2 - Addressograph Farrington 3.002
  3 - National Business System
  4 - Addressograph Farrington without interface box.

  Press Return.

The cursor moves to CARD SIZE CR

- Enter 50 if the embossed card measures 3 3/8" X 1 1/2".

- Enter 80 if the embossed card measures 3 3/8" X 2 1/2".

The cursor moves to PAD BLDG/ROOM DESIGNATION.

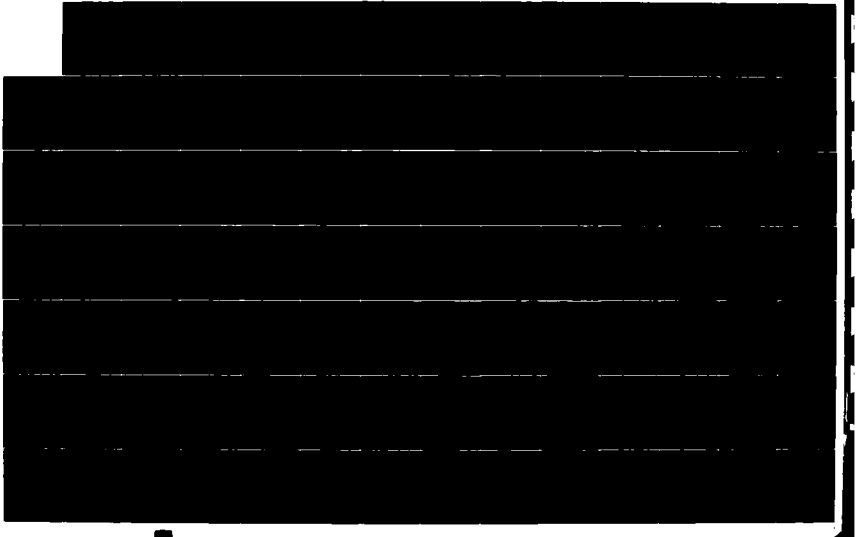
- Enter the Building and/or Room designation of the PAD office. Press Return.

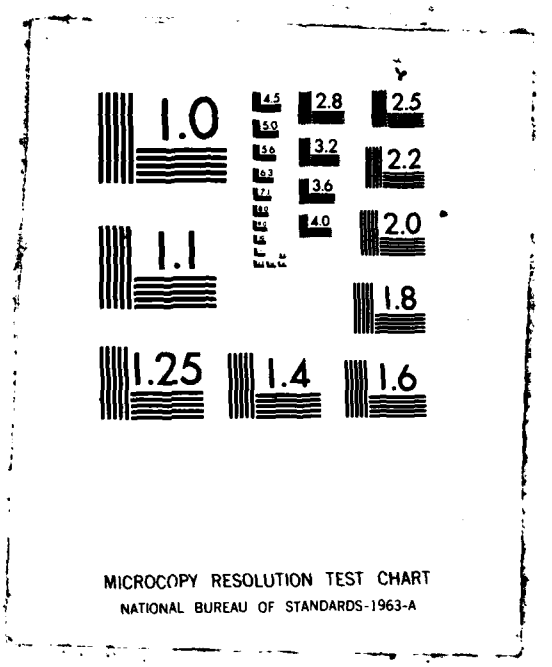
The cursor moves to MTF AREA CODE

- Enter the area code of the MTF [illegible] number.

AD-A178 916 AQCESS (AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM) TRAINING AID..(U) MDC FEDERAL SYSTEMS INC ROCKVILLE MD JAN 87 DOD/SW/MT-87/010A 8/12

UNCLASSIFIED F/G 5/9 NL




1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
4.5
5.0
5.6
6.3
7.1
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

The cursor moves to OCONUS.

- Enter Y if the MTF is outside the continental U.S.
- Enter N if the MTF is within the continental U.S.

The cursor moves to MTF ADDRESS: CITY.

- Enter the name of the city in which the MTF is located. Press Return.

The cursor moves to STATE.

- Enter the state abbreviation for the state in which the MTF is located.

The cursor moves to ZIP CODE.

- Enter the ZIP CODE of the MTF address. ZIP+4 codes can be entered with or without the hyphen. The system will insert the hyphen when you press Return.

The cursor moves to PAD SIGNATURE BLOCK LINE1, LINE2, LINE3.

- o Enter the signature block of the PAD officer. Press Return to move from one line to the next as needed.

The cursor moves to PAD Office Symbol.

- o Enter the PAD Office Symbol as it should appear on correspondence. Press Return.
- o When the cursor returns to ENTER SELECTION, press Return to store the updated data.

NOTE: With this option you can choose to have register numbers assigned to patient records either manually or automatically. If you have chosen automatic assignment and need to reserve some numbers to be assigned manually, use the Register Number Maintenance function described in Section 6, which follows. DO NOT simply change this flag to "N" to "turn off" the automatic register feature once it is in use.

NOTE: When the automatic register number feature is initially activated, a confirmation message is displayed. You must confirm that no users are currently on the system. The system will determine the highest number already assigned. The next sequential number will be the beginning number that the computer will automatically assign to the next record.

NOTE: The new parameters go into effect at any terminal where the user signs on after you store the change.

5.3 TO UPDATE CR PARAMETERS

- To display the CR Parameters segment, enter 1 on the MTF Profile Maintenance Screen (PAD Parameters segment), and press Return.

The CR Parameters segment of the screen is displayed, with the cursor at ENTER SELECTION.

- Enter ALL to update all fields on the CR segment, or enter the partial field label of the field you wish to update. Then press Return.

NOTE: You cannot update the top three lines of the screen using this option.

- To update a field, type over the existing information and press Return. Use Help for explanations of any of these fields.

- If you entered ALL and do not want to update a particular field, just press Return.

If you enter ALL:

The cursor moves to DELINQUENCY DAYS (CODING).

- Enter the number of days after disposition by which CR coding should be complete. Records processed after the time indicated will be considered delinquent. Press Return.

The cursor moves to TAPE TO ARCHIVE MONTHS.

- Enter a number indicating the number of months a completed record should be on-line prior to archiving. Press Return.

The cursor moves to DELINQUENCY DAYS (MED REC COMPLETE).

- Enter the number of days after which a provider will be considered delinquent if a medical record is incomplete.

NOTE: This number must be less than 30.

- When the cursor returns to ENTER SELECTION, press Return to store the updated data.

NOTE: The new parameters go into effect at any terminal where the user signs on after you store the change.

SYSTEM MANAGEMENT TRAINING AID
MTF Profile Maintenance Procedures

```
SYSTEM MGMT                                    DATE _________ TIME ___

                    MTF PROFILE MAINTENANCE.

MTF CODE ___          MTF NAME _____________________

SERVICE (A,F,N) _     TRAINING FLAG (Y/N) _   TRAINING DATE _________

SOFTWARE VERSION NO ___   INVALID ATTEMPTS BEFORE LOCKOUT ___

DEERS SITE CODE _______

                  --------- CR PARAMETERS ---------


DELINQUENCY DAYS (CODING) ___

TAPE TO ARCHIVE MONTHS ___

DELINQUENCY DAYS (MED REC COMPLETE) ___

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

 1 - CR PARAMETERS     2 - QA PARAMETERS     3 - RETURN TO PAD PARAMETERS
 4 - OP PARAMETERS

ENTER SELECTION:
```

MTF PROFILE MAINTENANCE SCREEN
SHOWING CR PARAMETERS SEGMENT

5.4 TO UPDATE QA PARAMETERS

- To display the QA Parameters segment, enter 2 on the MTF Profile Maintenance Screen (PAD Parameters segment) and press Return. Use Help for explanations of the QA Parameters.

The QA Parameters segment of the screen is displayed, with the cursor at ENTER SELECTION.

- Enter ALL to update all fields on the QA segment, or enter the partial field label of the field you wish to update. Then press Return.

NOTE: You cannot update the top three lines of the screen using this option.

- To update a field, type over the existing information and press Return. Use Help for explanations of any of these fields.

- If you entered ALL and do not want to update a particular field, just press Return.

If you enter ALL:

The cursor moves to DELINQUENCY DAYS FOR INPATIENT CHECKLIST.

- o Enter the number of days following disposition within which the Inpatient Occurrence Screening Checklist should be complete. Press Return.

The cursor moves to Auto ER Log No (Y/N).

- o Enter Y for Yes if ER Log numbers are to be assigned automatically.
- o Enter N for No if ER Log numbers are to be assigned manually.

The cursor moves to MINM PROMPT PULL PERCENT.

- o Enter the minimum percentage of records to be pulled for the PROMPT review committee. Press Return.

The cursor moves to SYSTEM INSTALL DATE.

- o Enter the date on which AQCESS was installed at the site. Press Return.

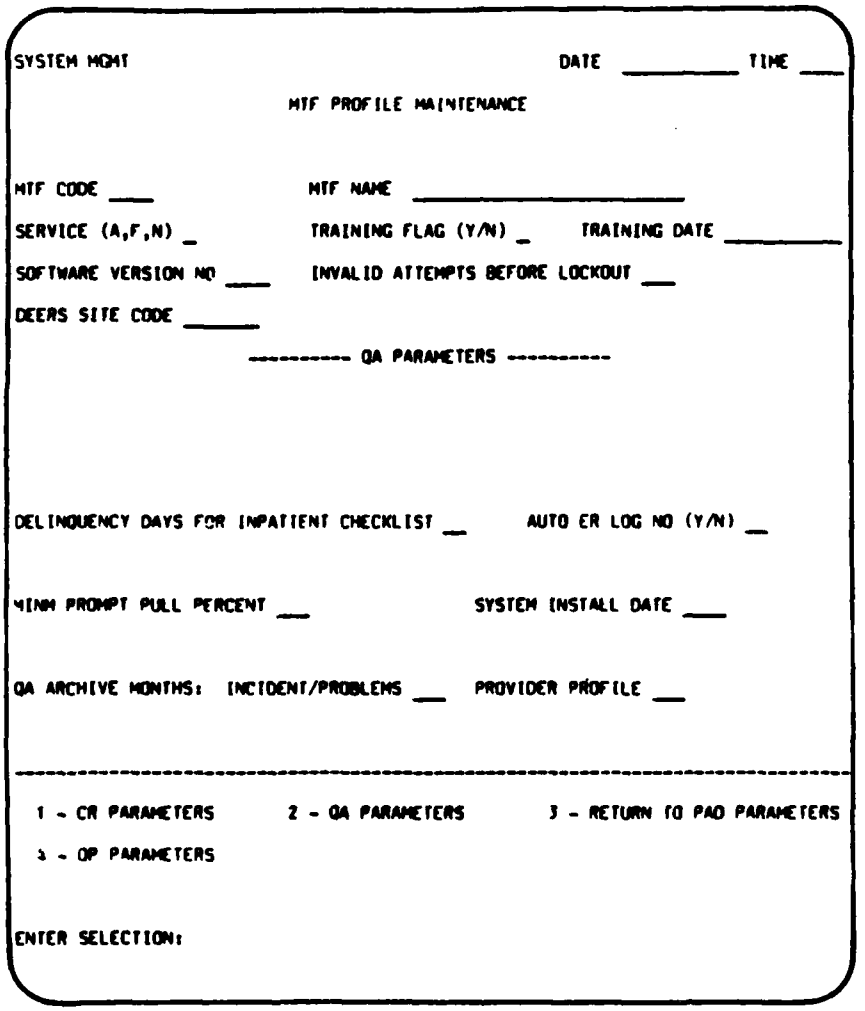
The cursor moves to QA ARCHIVE MONTHS: INCIDENT/PROBLEMS

- o Enter a number indicating the number of months a completed QA incident or problem should be on-line prior to archiving. Press Return.

The cursor moves to PROVIDER PROFILE.

- o Enter a number indicating the number of months a provider profile should be inactive prior to archiving.
- o When the cursor returns to ENTER SELECTION, press Return to store the update.

NOTE: The new parameters go into effect at any terminal where the user signs on after you store the change.



MTF PROFILE MAINTENANCE SCREEN
SHOWING QA PARAMETERS SEGMENT

5.5 UPDATE OP PARAMETERS

- To display the Outpatient Parameters segment, enter 4 on the MTF Profile Maintenance Screen and press Return. Use Help for explanations of the OP parameters.

The OP Parameters segment of the screen is displayed, with the cursor at ENTER SELECTION.

- Enter ALL to update all fields on the OP segment, or enter the partial field label of the field you wish to update. Then press Return.
- To update a field, type over the existing information and press Return. Use Help for explanations of any of these fields.
- If you enter ALL and do not want to update a particular field, press Return.

If you enter ALL:

The cursor moves to MINIMUM APPT GAP.

- Enter the minimum spacing allowed between patient appointments. Press Return.

Note: This number must be a multiple of 5 minutes.

The cursor moves to AUTOMATIC ROUTING CARD.

- o Enter Y for Yes if a routing card is to be created automatically for each medical record to be pulled for a patient's appointments.
- o Enter N for No if routing cards will be requested manually as needed.

The cursor moves to PULL DAYS

- o Enter a number indicating the number of days required for actual record pull time. Press Return.

The cursor moves to 3 X 5 Card

- o Enter Y for Yes if the size of the automatic routing card is to be 3 X 5.
- o Enter N for No if the size of the automatic routing card is to be 8.5 x 11.

The cursor moves to NO. AUTO CARDS PRINTED.

- o Enter the number of cards to be printed for each patient when automatic routing cards are printed.
- o When the cursor returns to ENTER SELECTION, press Return to store the update.

NOTE: The new parameters go into effect at any terminal where the user signs on after you store the change.

```
SYSTEM MGMT                                        DATE _________ TIME __

                      MTF PROFILE MAINTENANCE

MTF CODE ___              MTF NAME ____________________
SERVICE (A,F,N) _         TRAINING FLAG (Y/N) _    TRAINING DATE ________
SOFTWARE VERSION NO ___   INVALID ATTEMPTS BEFORE LOCKOUT __
DEERS SITE CODE ___

                ---------- OUTPATIENT PARAMETERS ----------


   MINIMUM APPT GAP __                    AUTOMATIC ROUTING CARD __

         PULL DAYS __                                '3 X 5' CARD __

                                        NO. AUTOMATIC CARDS PRINTED __


--------------------------------------------------------------------------------
1 - CR PARAMETERS        2 - QA PARAMETERS      3 - RETURN TO PAD PARAMETERS
4 - OP PARAMETERS

ENTER SELECTION:
```

MTF PROFILE MAINTENANCE SCREEN
SHOWING OUTPATIENT PARAMETERS

5.6 TO UPDATE ER PARAMETERS

- To display the Emergency Room Parameters, enter 5 on the MTF Profile Maintenance Screen and press Return.

The ER Parameters segment is displayed; the cursor is at ENTER SELECTION.

- Enter ALL to update all fields on the ER segment, or enter a partial field label of the field you wish to update. Press Return. If you enter ALL and do not want to update a particular field, press Return.

The cursor moves to AUTO ER LOG NUMBER.

- Enter Y if ER log numbers are to be automatically generated by the system.
- Enter N if ER log numbers are to be assigned manually.

NOTE: Manually assigned numbers begin with 1 each day for the first patient of the day. The system differentiates each day's patients based on the Visit Date.

5.7 TO RETURN TO THE PAD PARAMETERS SEGMENT

- If the CR, QA, or OP, or ER segment is being displayed, enter 3 and press Return.

The PAD Parameters segment will be redisplayed.

5.8 POINTS TO REMEMBER

1. You can only change the top three lines of the Profile Maintenance Screen when the PAD Parameters Segment is displayed. You cannot update these fields when the CR, QA, OP, or ER Parameter segments are displayed.

2. If automatic register number assignment has been selected on the PAD Parameters segment and you need to set aside some numbers for manual assignment, use the Register Number Maintenance function described in the following section. DO NOT change the Auto Register Number flag to "turn off" the automatic register feature once it is in use.

3. When automatic register number assignment feature is initially activated, the system will determine the highest number already assigned. The next sequential number will be the beginning number that the computer will automatically assign to the next record.

4. To store updates to the MTF Profile, press Return when the cursor is at ENTER SELECTION. Profile updates go into effect at any terminals where users sign on to the system after you store the updates.

5. Manually assigned ER Log Numbers are re-started at 1 each day. The system can distinguish the patient data based on the Visit Date. To search for a specific episode by Log Number, the Visit Date must also be entered.

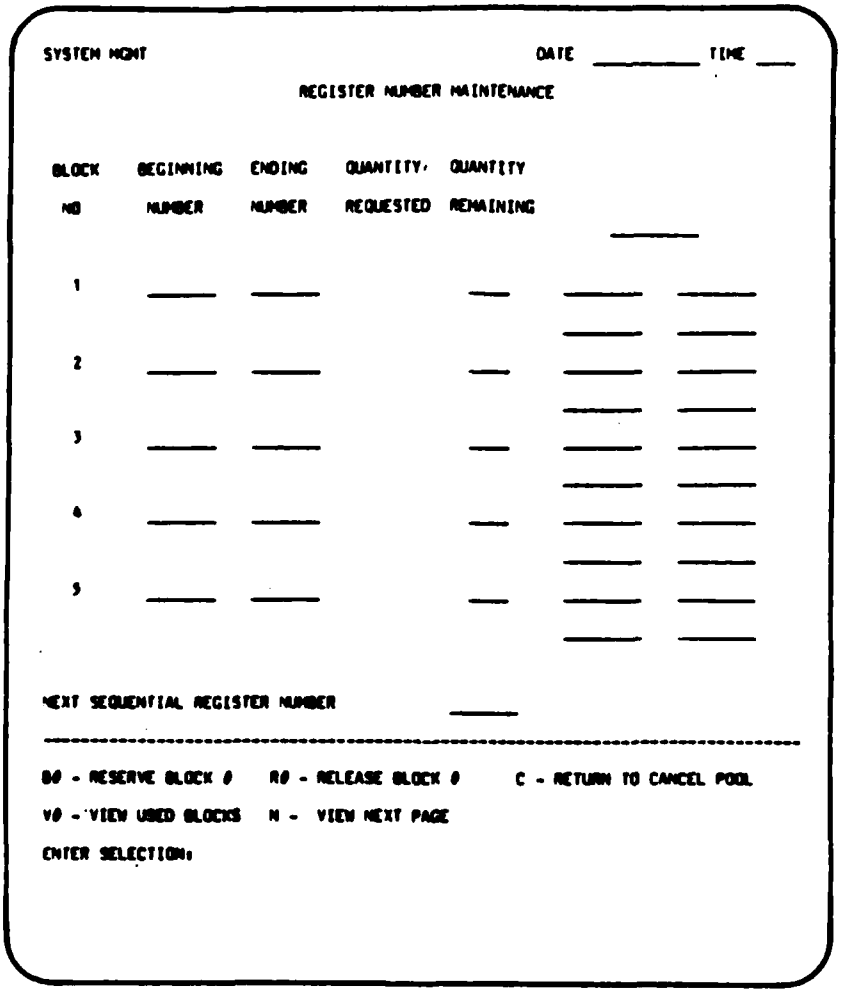
6. R - REGISTER NUMBER MAINTENANCE

ACCESS — To access the Register Number Maintenance function from the System Management Menu, enter R and press Return.

PURPOSE — Your MTF may choose to have register numbers assigned to patient records either automatically or manually (via the MTF Profile Maintenance). If automatic assignment is in use, you can reserve blocks of numbers to be assigned manually by using the Register Number Maintenance option on the System Management Menu. As many as five blocks of register numbers can be reserved. This process also enables you to release previously reserved blocks.

DESCRIPTION — On the Register Number Maintenance Screen you define the block of register numbers that is to be reserved. You can also view the blocks of numbers reserved, or release blocks so that they are again available for automatic assignment to records.

The screen displays a Cancel Pool, which contains numbers that were initially assigned to records



REGISTER NUMBER MAINTENANCE SCREEN

but were not used (i.e., the admission was cancelled), as well as numbers that were reserved and then released.

OPTIONS

CAUTION: Do not use options B and R, Reserve and Release Block Numbers, while other A&D users are on the system.

B# - RESERVE BLOCK # enables you to reserve numbers for manual assignment.

R# - RELEASE BLOCK # enables you to release a previously reserved block.

V# - VIEW USED BLOCK enables you to look at the numbers in a reserved block that have been assigned manually.

N - VIEW NEXT PAGE enables you to look at subsequent pages of Cancel Pool or Used Block numbers.

C - RETURN TO CANCEL POOL enables you to redisplay previous pages of Cancel Pool or Used Block numbers.

6.1 TO RESERVE A BLOCK OF NUMBERS

- Enter R on the System Management Menu Screen and press Return.

The Register Number Maintenance Screen is displayed.

- At ENTER SELECTION, enter B followed by the number of the block you wish to use (e.g., B1). Press Return.

The cursor moves to QUANTITY REQUESTED, on the same line as the block number you selected.

- Enter the quantity of numbers you want to reserve, up to 999, and press Return.

NOTE: The first number in the reserved block will be the next sequential register number, which is displayed on the screen.

A confirmation message: SAVE NUMBERS ___ THRU ____ IN BLOCK ____? is displayed.

- To confirm that you wish to reserve this block, enter Y. (If you do not want to confirm, enter any other key, and the cursor will return to ENTER SELECTION.)

If you confirm, the cursor moves to ENTER SELECTION.

The BEGINNING NUMBER field displays the first number in the reserved block (this was the next sequential register number).

The ENDING NUMBER field displays the last number in the block. The system calculated this number by adding the quantity you requested to the next sequential number.

- Press Return to redisplay the System Management Menu.

The System Management Menu is displayed. The numbers in the reserved block can now only be assigned manually.

6.2 TO RELEASE A BLOCK OF REGISTER NUMBERS

NOTE: Numbers in the Cancel Pool may not be blocked. Make sure you have used all the necessary numbers in a block before you release it.

- Enter R on the System Management Menu Screen and press Return.

The Register Number Maintenance Screen is displayed.

- At ENTER SELECTION, enter R followed by the number that you wish to release. Press Return.

A confirmation message is displayed: RELEASE BLOCK _____ TO CANCEL POOL?

- To confirm that you wish to release this block, enter Y. (If you do not want to confirm, press any other key, and the cursor will return to ENTER SELECTION.)

If you confirm, the cursor moves to ENTER SELECTION. All register numbers that had been reserved are now released, except those that were already used. The released numbers appear in the Cancel Pool; they are now available for automatic assignment to records.

6.3 TO VIEW USED NUMBERS

- Enter R on the System Management Menu Screen and press Return.

The Register Number Maintenance Screen is displayed.

- At ENTER SELECTION, enter V followed by the number of the reserved block whose used register numbers you wish to view.

Numbers in that reserved block that have already been manually assigned are listed on the right hand side of the screen in place of the Cancel Pool. If none of the numbers in that block have been assigned, this area will be blank.

6.4 TO REDISPLAY THE CANCEL POOL

- When the right side of the Register Number Maintenance Screen is displaying the Used Block Numbers segment, enter C to redisplay the Cancel Pool. Press Return.

The Cancel Pool is displayed.

6.5 TO VIEW NEXT PAGE

- The Cancel Pool or Used Block Numbers segments can display as many as 20 register numbers on a page. To see subsequent pages of either segment, enter N at ENTER SELECTION on the Register Number Maintenance Screen.

The next page of Cancel Pool numbers or Used Block numbers is displayed. The rest of the screen is unchanged.

6.6 POINTS TO REMEMBER

1. To use Register Number Maintenance, the AUTO REGISTER NUMBER field on the MTF Profile Maintenance Screen must be set to Y (i.e., automatic assignment of register numbers must be in effect).

2. Because register numbers are constantly being assigned when other users are using the A&D subsystem, you should not reserve or release blocks of register numbers when other A&D users are on the system (options B and R).

3. After register numbers are released to the CANCEL POOL they can not be blocked again. AQCESS will automatically assign register numbers from the Cancel Pool to new admissions until the cancel pool is empty. When the Cancel Pool is empty, the next register number to be assigned automatically will be the next sequential register number.

SYSTEM MANAGEMENT TRAINING AID
Register Number Maintenance Procedures

7. U - USER ID/TERMINAL MAINTENANCE

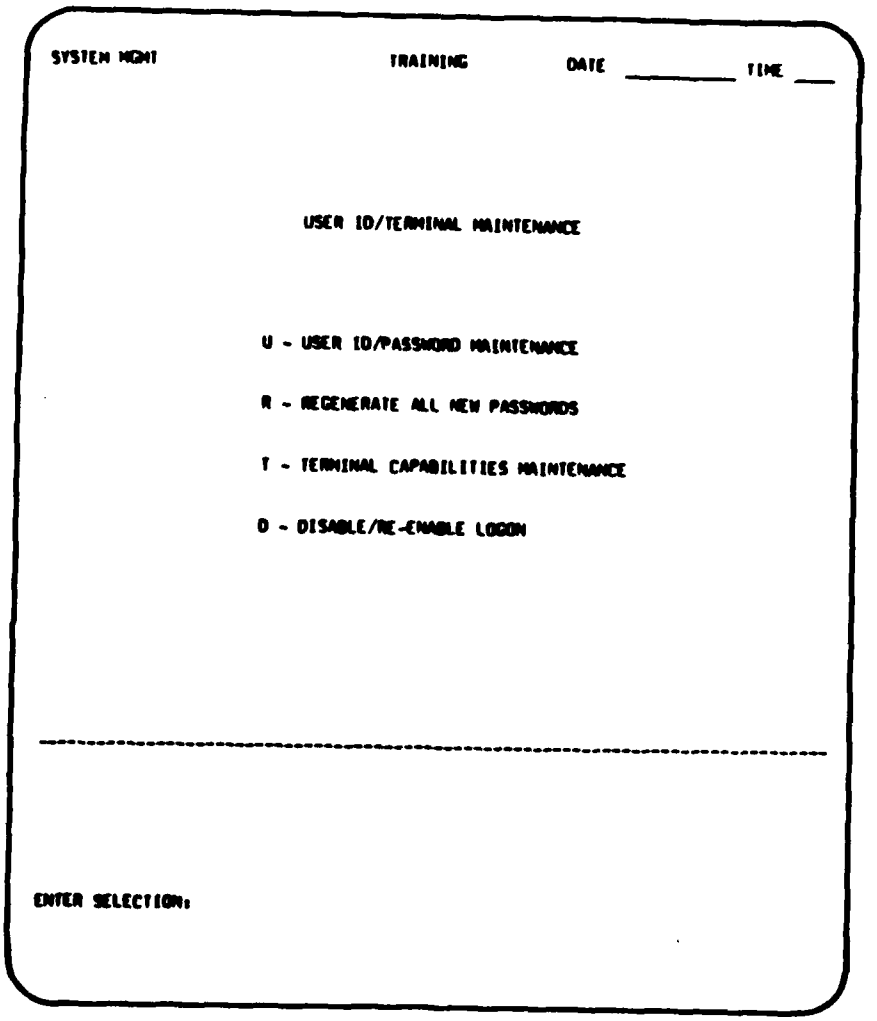
ACCESS — To display the User ID/Terminal Maintenance Menu, enter U on the System Management Menu and press Return.

PURPOSE — The User ID/Terminal Maintenance process enables you to assign and delete user passwords, and assign system privileges to individuals and terminals. These functions are essential to system security; they control who can do what at which terminal.

DESCRIPTION — The User ID/Terminal Maintenance Menu displays the functions you can perform, which are:

U - USER ID/PASSWORD MAINTENANCE enables you to assign new passwords to system users, update information on each user ID, view passwords and delete user ID codes, and unlock locked-out users.

R - REGENERATE ALL NEW PASSWORDS automatically assigns new passwords to all users except those identified with the System Manager Flag. This can be done periodically, or as necessary for security purposes.



USER ID/TERMINAL MAINTENANCE MENU

T - TERMINAL CAPABILITIES MAINTENANCE enables you to assign system capabilities to different AQCESS terminals, to assign a default printer for each CRT, and to unlock locked-out terminals.

D - DIS ABLE/RE-ENABLE LOGON allows the system manager to disable all signed-on terminals and prevent additional users from signing-on. Sign-on is re-enabled from this option as well.

7.1 U - USER ID/PASSWORD MAINTENANCE

ACCESS — To display the User ID/Password Maintenance Screen, enter U on the User ID/Terminal Maintenance Menu and press Return.

PURPOSE — User ID/Password Maintenance enables you to enter and update information about user IDs and passwords. Specifically, you can:

- o Assign, view, or delete user IDs.
- o Update other user ID information.
- o Unlock a locked-out user.
- o Lock out a user.

OPTIONS — The options listed on this screen's submenu are as follows:

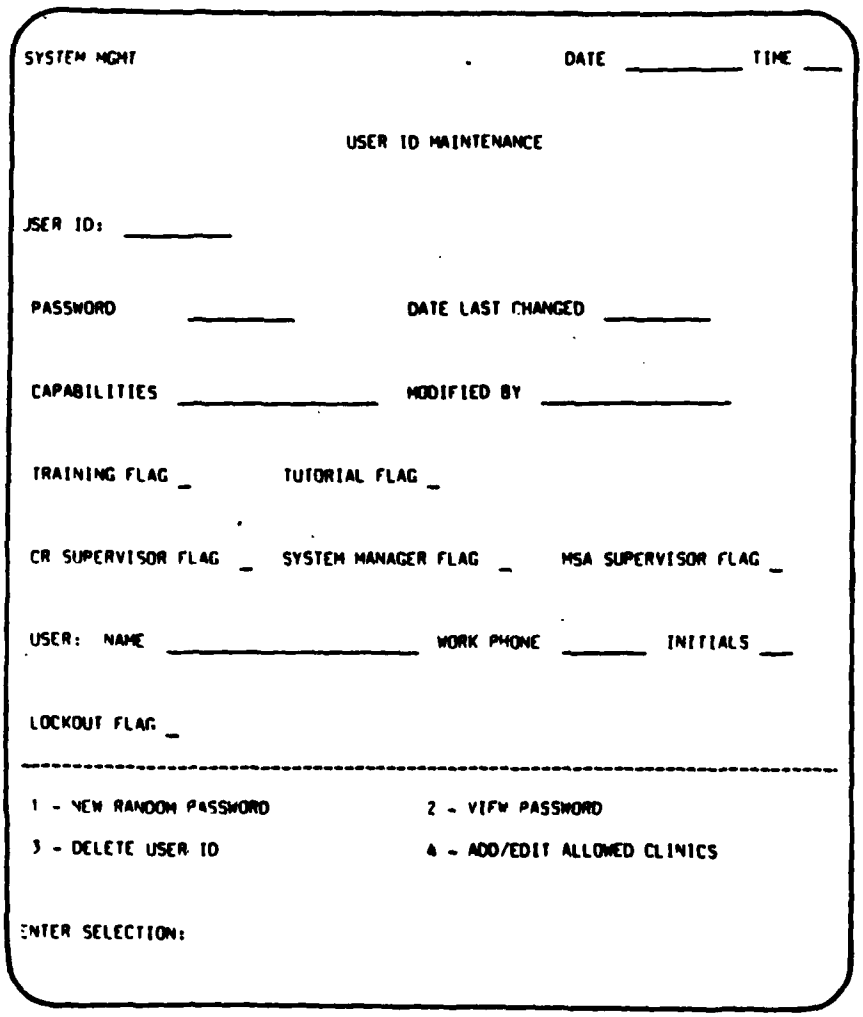
1 - NEW RANDOM PASSWORD automatically generates a new random password for an individual user.

2 - VIEW PASSWORD displays the password for an individual user.

3 - DELETE USER ID enables you to remove a user ID from the system.

4 - ADD/EDIT ALLOWED CLINICS enables you to provide a second level of security by specifying which clinics are available to the user and whether they can book, display, or not view the appointments in that clinic.

5 - EDIT EXTENDED SCREEN SECURITY allows you to control the Appointing and Scheduling menu selections which are available to each user.



USER ID MAINTENANCE SCREEN

7.1.1 TO USE THE USER ID/PASSWORD MAINTENANCE PROCESS

- To access User ID/Password Maintenance, enter U on the User ID/Terminal Maintenance Menu and press Return.

A blank USER ID field is displayed.

- To modify an existing user ID/password, enter the user ID and press Return. (To view a list of all current user IDs and passwords, use the List Current Passwords option described in Section 7.3, below.)

- To create a new user ID and password, enter the new user ID and press Return. Remember, each user ID must be unique.

The User ID Maintenance Screen is displayed. (1) If you entered an existing user ID, the data on that ID is displayed, and the cursor is at ENTER SELECTION. (2) If you entered a new user ID, only the user ID is displayed, and the cursor is at the first field where you can enter data.

- The procedures you can perform on this screen are described in Sections 7.1.2 through 7.1.6 below.

7.1.2 TO CREATE A NEW USER ID OR UPDATE INFORMATION ON AN EXISTING USER ID

The following chart describes the data you enter to create the new user ID and password, and to update information on an existing user ID. When you have completed entering or updating data on this screen, press Return to store the data and make it available to the system.

PASSWORD: You can enter a new password for this user (from 2 to 6 characters long), or, if this is a new user ID, leave this field blank and a new random password will be automatically generated by the system. An automatically assigned password will not be displayed here until you return to ENTER SELECTION. If you are updating an existing user ID, use option 1 to have a new random number automatically assigned.

CAPABILITIES: Here you enter the system capabilities authorized to the user with this ID and password. There are two ways of doing this.

(1) Enter the letter or number that represents each system function to be allowed.

Or (2) enter the profile name for the type of user, enclosed in single quotes, and predetermined capabilities authorized to this type of user will be assigned to this

(Continued on next page)

user ID. You can use Help to see a list of these profiles. For example, the code 'A&D' stands for A&D clerk. If you enter this code, the functions allowed to A&D clerks will be authorized for this user. When you press Return and move to the next field, those functions will be displayed in the CAPABILITIES field.

MODIFIED BY: In this field you can add or subtract from the capabilities authorized to this user. Enter + followed by the letters of the functions to be added, and enter minus (-) followed by the letters of the functions to be subtracted. It is not necessary to use spaces or commas. For example, enter +AD-S to allow this user to use Admission and Disposition and to disallow the System Management function.

TRAINING FLAG: Enter Y if the person with this user ID is to be restricted to the training database. Otherwise, leave blank.

TUTORIAL FLAG: Enter Y if the person with this user ID is to be restricted to tutorial mode. Otherwise, leave blank. (If the tutorial flag is Y, the training flag must also be Y.)

CR SUPERVISOR FLAG: Enter Y to indicate that this user is authorized as the Clinical Records supervisor.

(Continued on next page)

SYSTEM MANAGER FLAG: Enter Y to indicate that this user is authorized as the System Manager.

MSA SUPERVISOR FLAG: Enter Y to indicate that this user is authorized as the Medical Services Accounting Supervisor.

USER NAME: Enter the name of the user who will have this user ID and password. This is a required field.

WORK PHONE: Enter the work phone number of this user.

INITIALS: Enter the initials of this user (up to three). This is a required field.

LOCKOUT FLAG: Enter zero (0) to indicate that this user is not locked out of the system. To lock out the user ID, enter 1.

CAUTION: When modifying the capabilities assigned to the System Manager (you), do not remove the System Management function from your list of authorized functions. You may be the only user authorized to use System Management.

7.1.3 TO VIEW A PASSWORD

NOTE: When the User ID Maintenance Screen is displayed, showing data on an existing user ID, the screen does not display the password unless you specifically request it, using this option.

The User ID Maintenance Screen is displayed, with the cursor at ENTER SELECTION. The screen displays data on the user ID, but does not display the password.

- To have the password associated with an ID displayed, enter 2 and press Return.

The password is displayed in the PASSWORD field. The cursor is at ENTER SELECTION.

7.1.4 TO ASSIGN A NEW RANDOM PASSWORD TO AN EXISTING USER ID

NOTE: Through this function you request that the system automatically assign a new random password to the user ID. You can also update the PASSWORD field by entering a specific new password.

CAUTION: Be careful not to change the System Manager's (your) password without knowing the new one.

The USER ID Maintenance Screen is displayed, filled in with data on a user ID, and the cursor is at ENTER SELECTION.

- To have a new random password generated for this user ID, enter 1 and press Return.

The new password is displayed. The cursor is at ENTER SELECTION.

- Press Return to assign the new password to the user ID. The new password will not be assigned unless you press Return.

NOTE: Since this procedure affects a user's access to the system, use it with caution.

7.1.5 TO DELETE A USER ID

CAUTION: Be careful not to delete the user ID of the System Manger (you). You may be the only user authorized to use the System Management functions.

The User ID Maintenance Screen is displayed, showing data on the user ID you want to delete. The cursor is at ENTER SELECTION.

- Enter 3 and press Return.

The screen displays the message, ARE YOU SURE YOU WANT TO DELETE THIS USER ID?

- Enter Y to confirm. (If you don't want to confirm, enter any other key, and the cursor moves to ENTER SELECTION.)

If you confirmed the deletion, the screen displays the message, USER ID WILL BE DELETED WHEN YOU HIT RETURN TO STORE THE TRANSACTION.

- Press Return to delete the user ID from the system. (If you decide not to delete, press the Cancel key.)

7.1.6 TO LOCK OUT OR UNLOCK A USER ID

CAUTION: Do not lock out the System Manager's (your) user ID, since this may be the only ID with access to the System Management function.

The User ID Maintenance Screen is displayed, showing data on the user ID you want to lock or unlock. The cursor is at ENTER SELECTION.

- Enter part of the label for the LOCKOUT FLAG field (e.g., enter LOC) and press Return.

The cursor moves to the LOCKOUT FLAG field.

- To lock out a user ID, enter 1.
- To unlock a user ID, enter 0 (zero).

The cursor moves to ENTER SELECTION.

- Press Return to store the change.

NOTE: A terminal will lock if the user ID and password are entered incorrectly more than the allowed number of times in succession. The System Manager will have to unlock the terminal before anyone can use it to access the system again.

Both the user ID and the terminal will lock if the user ID is entered correctly but the password is entered incorrectly more than the allowed number of times in sequence. The System Manager will have to unlock both the user ID and the terminal.

See Section 7.4 for information on unlocking terminals.

7.1.7 TO ASSIGN CLINIC CAPABILITIES

The User ID Maintenance Screen is displayed, showing data on the user ID to which you want to assign clinic capabilities.

- o Enter 4 and press Return.

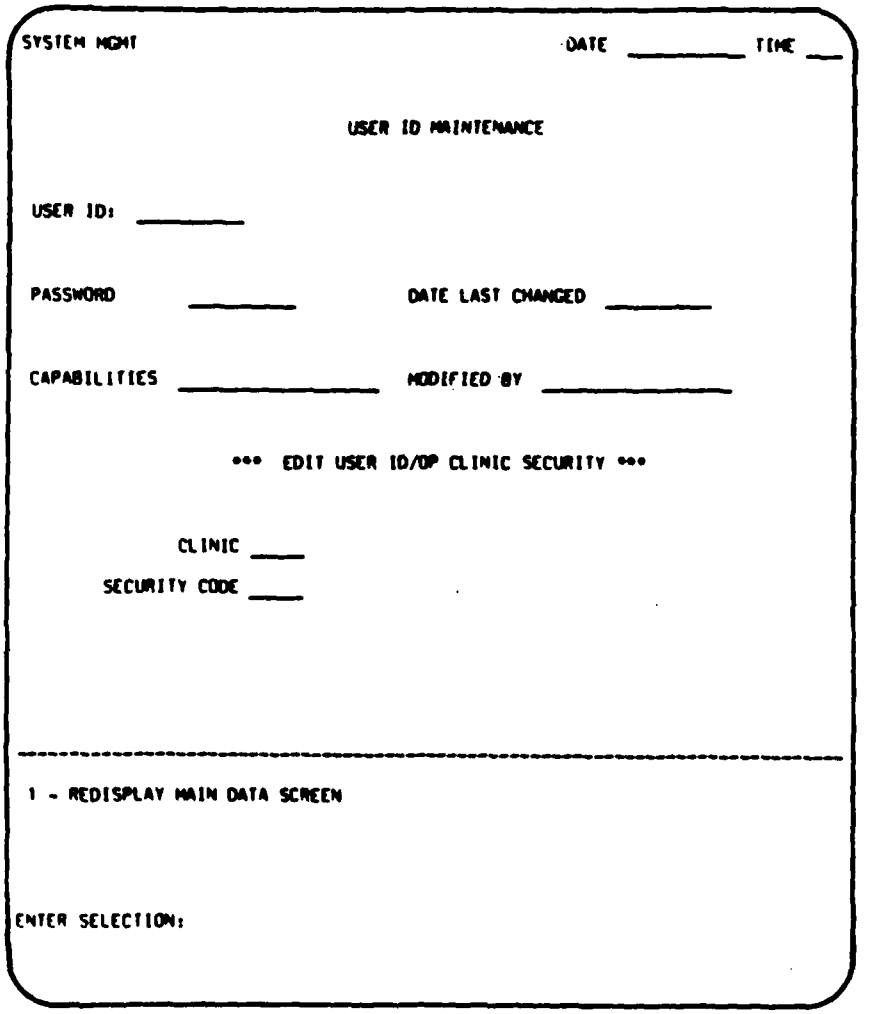
The Edit User ID/OP Clinic Security Screen is displayed with the cursor at CLINIC.

- o Enter the Clinic short name. Use Help to view the available clinics.

- o Enter the Security Code:
  A = Available for Booking & Display
  N = Not Available for Booking (Display Only)
  S = Secure - No Booking or Display

The cursor moves to ENTER SELECTION.

- o Press Return to store the data.



USER ID MAINTENANCE SCREEN SHOWING
OP CLINIC SECURITY PARAMETERS

The cursor is at the Clinic field.

- o Update or Edit another clinic by repeating the previous instructions OR

- o Press Entry Done and enter 1 at ENTER SELECTION.

The User ID Maintenance Main Data Screen is displayed.

7.1.8. *TO EDIT EXTENDED SCREEN SECURITY*

Note: This option only controls user access to Appointing and Scheduling functions.

The User ID Maintenance Screen is displayed showing data about the user ID you wish to edit.

- o Enter 5 at ENTER SELECTION and press Return.

The system displays the A&S Main Menu and the message "Please enter valid menu selections for this usercode".

- o Enter the letter(s) representing all menu options which are to be available to this user. No spaces or punctuation are entered between the letter(s). Press Return.

Note: If no options are to be allowed, press Return at ENTER SELECTION.

The system displays the A&S Scheduling Menu and the extended security edit message.

- Enter the letter(s) representing all menu options which are to be available to this user. No spaces or punctuation are used. Press Return.

The system displays the A&S Reports Menu and the extended security edit message.

- Enter the number(s) representing all Report Menu options to be available to this user. No spaces or punctuation are used. Press Return.

The system displays the A&S Check-In Menu and the extended security edit message.

- Enter the letter(s) representing all Check-In Menu options to be available to this user. No spaces or punctuation are used. Press Return.

The system displays the A&S Modify Schedules Menu and the extended security edit message.

- Enter the letter(s) representing all Modify Schedules Menu options to be available to this user. No spaces or punctuation are used. Press Return.

The security edit is complete. The User ID Maintenance Screen is displayed.

7.1.9 POINTS TO REMEMBER

1. The System Manager's user ID and password can also be modified, but BE CAREFUL:

   - Do not lock out the System Manager's ID.
   - Do not remove System Management (S) from the list of the System Manager's authorized capabilities.
   - Do not change the System Manager's password without knowing the new one.

2. When the User ID Maintenance Screen is displayed for an existing user ID, the password will not be displayed unless you specifically request it using option 2. When the NEW RANDOM PASSWORD option is used to generate a new password, the new password (a random series of three letters and three numbers) is displayed in the PASSWORD field.

3. The user ID will be locked out if the ID is entered correctly but the password is entered incorrectly more than the allowed number of times in succession. When this happens, both the user ID and the terminal will be locked. The System Manager will have to unlock both the user ID and the terminal before either can be used to access the system again.

4. An Assistant System Manager can be created by entering '%' in the CAPABILITIES field of the User ID Maintenance Screen, through the AQC directory. This assistant will be able to perform system startup, shutdown, and system backup functions on the Operator's Console. The user will not be able to perform any other System Management functions.

7.2 R - REGENERATE ALL NEW PASSWORDS

ACCESS — To perform this function, enter R on the User ID/Terminal Maintenance Menu and press Return.

PURPOSE — This option enables you to create new passwords for all user IDs except the System Manager's. Since this affects entry into the system by all other users, be very careful when using this process.

TO REGENERATE ALL NEW PASSWORDS

- Enter R on the User ID/Terminal Maintenance Menu Screen and press Return.

The system ID will display the following:
YOU ARE ABOUT TO REGENERATE NEW PASSWORDS FOR ALL USER IDS (EXCEPT THE SYSTEM MANAGER). ENTER Y TO REGENERATE NEW PASSWORDS.
The cursor is positioned at the end of this message.

- To regenerate all new passwords, enter Y. To avoid regenerating, enter any other key.

The User ID/Terminal Maintenance Menu Screen remains displayed.

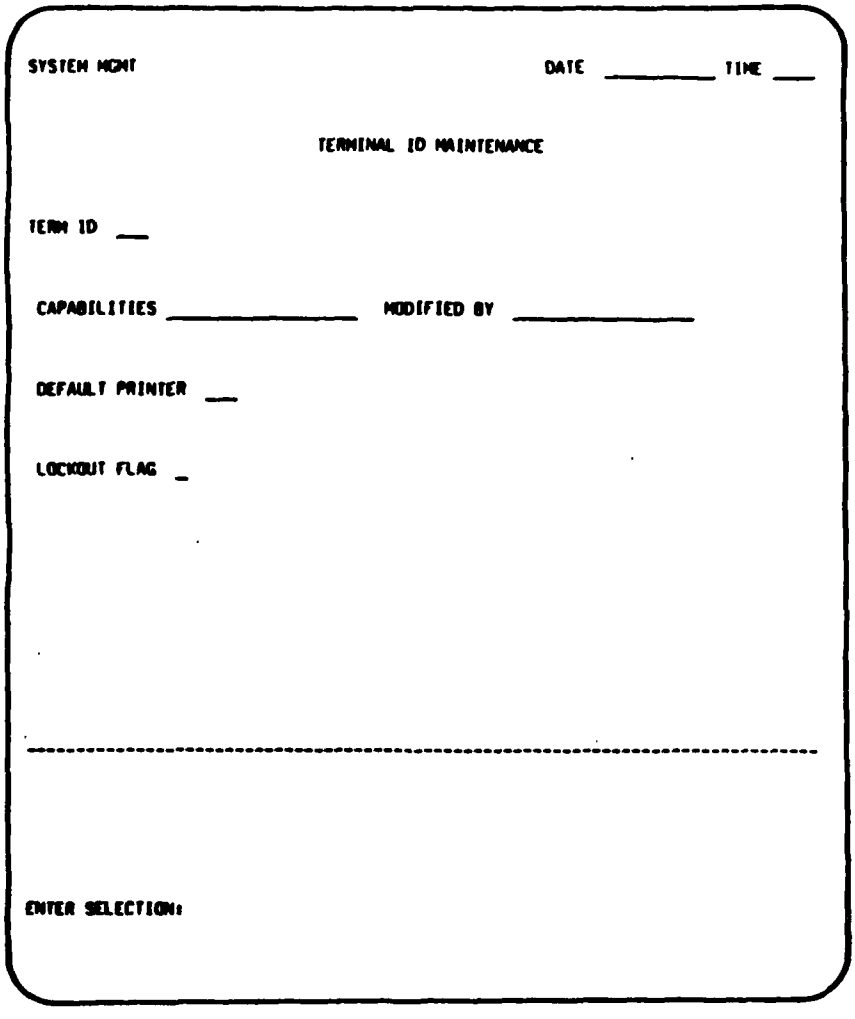
- Use the User ID Maintenance Screen or the List Current Passwords function (option L) to view the regenerated passwords.

7.3 T - TERMINAL CAPABILITIES MAINTENANCE

ACCESS — To access the Terminal ID Maintenance Screen, enter T on the User ID/Terminal Maintenance Menu and press Return.

PURPOSE — Terminal Capabilities Maintenance enables you to view or update functions available to each terminal, to assign the default printer for each terminal, and to lock out or unlock terminals.

DESCRIPTION — The Terminal ID Maintenance Screen displays capabilities, printers, and flags assigned to a terminal.



TERMINAL ID MAINTENANCE SCREEN

7.3.1 TO ASSIGN OR MODIFY SYSTEM CAPABILITIES FOR A TERMINAL

- Enter T on the ID/Terminal Maintenance Menu Screen and press Return.

A blank TERM ID field is displayed.

- Enter the device number of the terminal for which you wish to assign or modify system capabilities, and press Return.

The Terminal ID Maintenance Screen is displayed. If you entered the number of a terminal that is already defined to AQCESS, the screen contains the data for that terminal, and the cursor is at ENTER SELECTION. If you entered the device number of a termial being added to the system, the screen will not contain data, and the cursor will be at the first enterable field.

The chart on the next page describes the data you need to enter in order to assign or modify the system functions that can be performed at this terminal.

CAPABILITIES: Here you enter letters or numbers to designate the functions that can be performed at a terminal. NOTE: capabilities cannot be assigned to printer devices.

There are two ways to designate the system capabilities that can be performed at a terminal. (1) Enter the letters or numbers representing the functions to be assigned (e.g., ADTE1). Or (2) enter, in single quotes, the profile name for a type of user, and the predetermined capabilities authorized for that profile will be assigned to this terminal. You can use Help to list these profiles. For example, the code 'A&D1' stands for "A&D clerk." If you enter this code, the capabilities defined for A&D clerks will be assigned to this terminal. When you press Return, the list of capabilties is displayed in this field.

MODIFIED BY: In this field you can change the capabilities assigned to the terminal by entering +, followed by the letters or numbers of the capabilities to be added, and minus (-), followed by the letters or numbers of the capabilities to be removed. It is not necessary to separate these with spaces or commas. When you press Return, the CAPABILITIES field will reflect the modification you just made.

DEFAULT PRINTER: Enter the device number of the printer that will be used by the CTRL P option to print screens (up to 3 digits).
(Continued on next page)

LOCKOUT FLAG: Enter zero (0) in this field to indicate that the terminal is not locked out of the system. To lock the terminal out, enter 1.

7.3.2 TO LOCK OUT OR UNLOCK A TERMINAL

The Terminal ID Maintenance Screen is displaying data on the terminal you want to lock or unlock, and the cursor is at ENTER SELECTION.

- Enter part of the label for the LOCKOUT FLAG field (e.g., LO), and press Return.

The cursor moves to the LOCKOUT FLAG field.

- Enter 1 to lock the terminal or 0 (zero) to unlock the terminal.

The cursor moves to ENTER SELECTION.

- Press Return to store the change.

7.4 D - DISABLE/RE-ENABLE LOGON

ACCESS — To access this option select D on the User ID/Terminal Maintenance Menu.

PURPOSE — This option enables you to disable all signed-on terminals at the next logical point in the process being performed on that terminal. Additional users will be unable to sign-on.

DESCRIPTION — This option is useful for ensuring that no users are on the system when jobs which could potentially be affected, by their input are running e.g., backups.

NOTE: The System Status report on the Operation's Menu can be run periodically after disable logon until all users have been forced off.

7.4.1 TO DISABLE LOGON

- Enter D on the User ID/Terminal Maintenance Menu and press Return.

The Disable/Re-Enable Logon screen is displayed. The cursor is at Enter Selection.

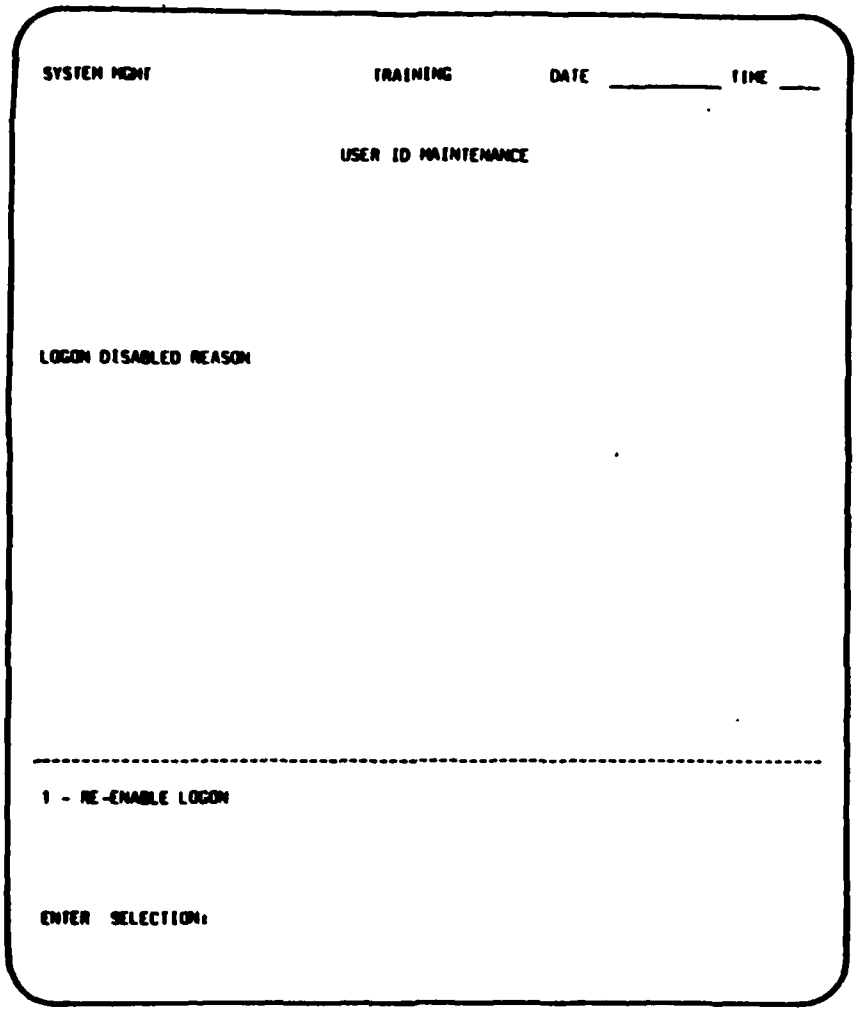
- Enter ALL and press Return.

The cursor moves to LOGON DISABLED REASON.

- Enter the reason why logon is being disabled. Press Return.

Note: This message will display on the screen as each user is forced off the system or as a new user attempts to sign-on.

- Follow the procedures in Section 2 of the HARDWARE MAINTENANCE portion of this manual to obtain and interpret a System Status Report to ensure that all users are off the system prior to performing the system maintenance job for which logon was disabled.



DISABLE/RE-ENABLE LOGON SCREEN

7.4.2 TO RE-ENABLE LOGON

- Enter S; U; D on the User Main Menu and press Return.

Note: The System Manager ID is the only User ID allowed to access the system when Logon is disabled.

The Disable/Re-Enable Logon screen is displayed. The cursor is at Enter Selection.

- Enter 1 and press Return.

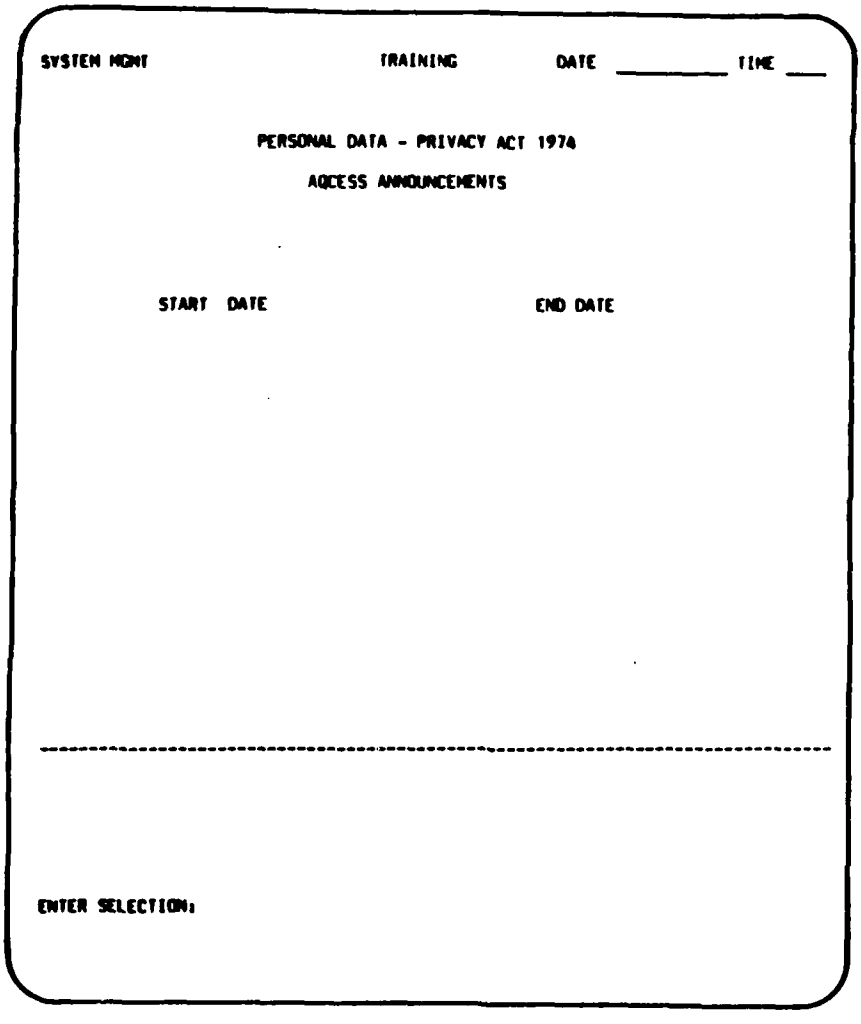
The system is available for access by all users.

8. A - ANNOUNCEMENTS

ACCESS — To access the Announcements screen, enter A on the System Management Menu and press Return.

PURPOSE — To display a message on the User Sign-On screen.

DESCRIPTION — The announcements can be assigned beginning and ending dates. The messages will only appear on the Sign-On during the specified date range. Only one announcement can be displayed at any given time.



SYSTEM MANAGER ANNOUNCEMENTS SCREEN

8.1 TO ENTER AN ANNOUNCEMENT

- o Enter S on the User Entry Menu and press Return.

The System Manager Menu is displayed.

- o Enter A on the System Manager Menu and press Return.

The Announcements screen is displayed. The cursor is at ENTER SELECTION.

- o Enter ALL and press Return.

The cursor moves to START DATE.

- o Enter the first date on which the announcement should display on the Sign-On screen. Press Return.

The cursor moves to END DATE.

- Enter the last date on which the announcement should appear on the Sign-On screen. Press Return.

The cursor moves to the open area below START DATE and END DATE.

- Type the announcement as you want it to appear on the Sign-On screen. The cursor will move to each new live automatically. Press Entry Done when the message is complete.

The cursor moves to ENTER SELECTION.

- Press Return to store the message.

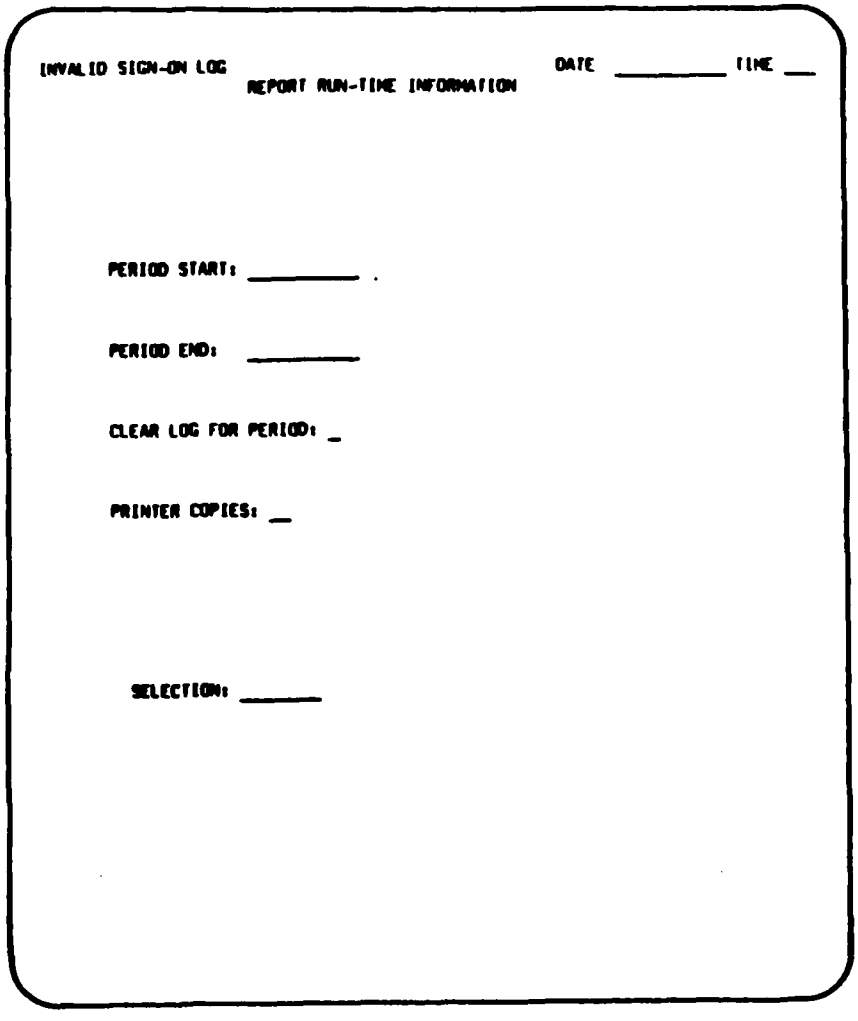
9. SYSTEM MANAGEMENT REPORTS

ACCESS — To access this option, enter S on the System Management Menu and press Return.

PURPOSE — With this option, you can view the Invalid Sign-On Log, a listing of sign-on attempts using incorrect user IDs and passwords and the List of Current Passwords.

DESCRIPTION — The Invalid Sign-On Log shows when the user ID or password errors were made, the terminal used, and the number of attempts.

The List of Current Passwords shows all user IDs with associated passwords, the date last changed and related user information.



RUN-TIME SCREEN FOR THE
INVALID SIGN-ON LOG

9.1 TO PRINT OR VIEW THE INVALID SIGN-ON LOG

- Enter S on the System Management Menu Screen and press Return.

The System Management Reports Menu is displayed. The cursor is at ENTER SELECTION.

- Enter 1 and press Return.

The Report Run-Time Information Screen is displayed, with the cursor at PERIOD START.

- Enter the starting date for the time period for which you want data, and press Return.

The cursor moves to ENTER SELECTION.

The cursor moves to the PERIOD END field.

- Enter the ending date for the reporting period, and press Return.

The cursor moves to CLEAR LOG FOR PERIOD.

NOTE: Normally, invalid sign-on data should be cleared each time you run this report. You will always be able to reprint or re-display the last log should you need another copy.

- In this field you can indicate that you want to remove the invalid sign-on data from the system after the report is printed or displayed. To do this, enter Y. If you do not want to remove this data from the system, leave this field blank.

The cursor moves to the PRINTER COPIES field.

- To print the Log, enter the number of copies you want and press Return. To display the Log on the screen, leave this field blank and press Return.

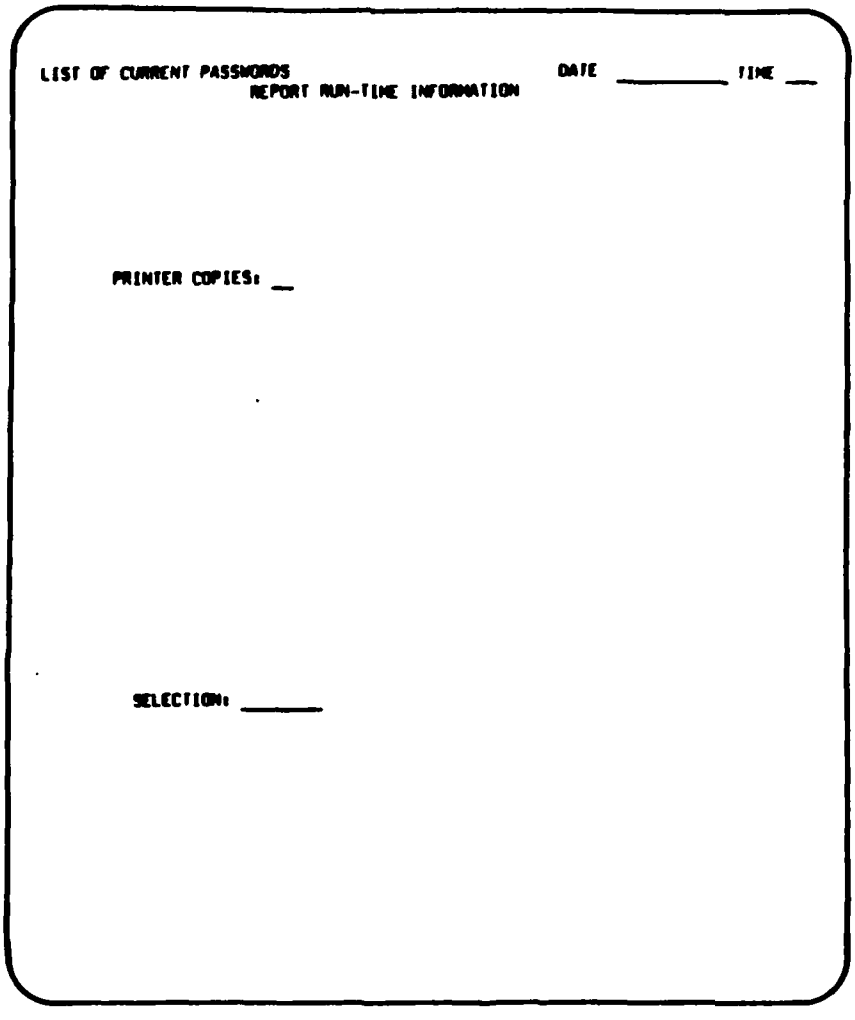
9.2 TO PRINT OR VIEW THE LIST OF CURRENT PASSWORDS

- o Enter on the System Management Menu Screen and press Return.

The System Management Reports Menu is displayed. The cursor is at ENTER SELECTION.

- o Enter 2 and press Return.

The Report Run-Time Information Screen is displayed, with the cursor at PRINTER COPIES.



RUN-TIME INFORMATION SCREEN
FOR THE LIST OF CURRENT PASSWORDS

- To print the list, enter the number of copies you want and press Return. To display the list on the screen, leave this blank and press Return.

The cursor moves to the SELECTION field.

- You can return to the PRINTER COPIES field to change the number of copies by entering part of the field label here (e.g., PR) and pressing Return.

- If you do not wish to change the number of copies, press Return.

If you requested a printed list, the User ID/ Terminal Maintenance Menu is redisplayed, and the list is printed on the printer that is defined in the report table for this report. If you wanted to see the list on the screen, it is displayed next.

- If the list is being displayed on the screen, press Return to see each page of it. Pressing Return on the last page of the list will redisplay the User ID/ Terminal Maintenance Menu Screen.

SYSTEM MANAGEMENT TRAINING AID

1. SYSTEM OPERATIONS OVERVIEW

ACCESS Operating system options can only be accessed via the Letterwriter 100 console. Press Return and the USER ID prompt is displayed. Enter your System Manager User ID and press Return. The PASSWORD prompt is displayed. Enter your System Manager Password and press Return. The OPTION prompt will be displayed. If you enter a question mark (?) in the first field after the prompt, a Main Menu listing all the operation options will be shown.

For many of the options available, subfunctions can be selected. These subfunctions can also be displayed by entering a "?" at the ENTER OPTION prompt. The ENTER OPTION prompt will only be displayed after an option has been selected from the Main Menu.

PURPOSE The options available enable the System Manager to perform System Utility Routines that are part of the operating system. These utilities are used to maintain the system. Because these options enable the user to access the operating system, care should be exercised in making this capability available to other users.

OPTIONS Many of the options have default answers already programmed. The default answer is always displayed between LESS THAN (<) and GREATER THAN

1. SYSTEM OPERATIONS OVERVIEW (CONTINUED)

(>) symbols. If the default answer is correct, you can press Return and the default value will be accepted.

You can cancel out of any option or stop execution by pressing the Return key. You can also use the up arrow (^) symbol to cancel out of an option.

NOTE: Do not use the Break Key, if you have not disabled this key. Call NDC Customer Support for directions on how to do this.

The Main Menu lists the following options:

S - SYSTEM STATUS lists the current status of all active jobs on the computer.

E - ERRORS lists the Error Log of any software errors that have occurred in your system.

ED - EDIT TERMINAL GLOBALS can only be used on instructions from AQCESS Customer Support.

D - DEVICE SETUP is used when adding or moving terminals or printers in your system configuration.

I - INTEGRITY enables you to verify the integrity of data in the system. Integrity should always be executed if an abnormal shutdown occurs.

1. SYSTEM OPERATIONS OVERVIEW (CONTINUED)

SA - SAVE TRAINING DATABASE enables you save (copy) the training database from the system to tape.

L - LOAD TRAINING DATABASE enables you to load the training database from the same tape back on the system. Loading the training database will write over the training database currently on the system.

B - BROADCAST transmits messages from the console to other terminals on the system.

BA - BACKUP SYSTEM enables the MTF to save all of the information on the disk to a backup tape.

C - CLINICAL RECORDS BATCH PROCESSING creates transcript tapes or recreates the previous transcript tape. It also generates a hard-copy listing the records copied to the tape.

T - TALLY DISK BLOCKS lists a summary of disk space usage.

CA - CARETAKER UTILITIES manages the Caretaker job and system Error Logs.

DA - DATE UPDATE sets the current date.

TI - TIME UPDATE sets the current time.

1. SYSTEM OPERATIONS OVERVIEW (CONTINUED)

SH - SHUTDOWN SYSTEM performs an orderly shutdown of the operating system.

U - UPDATE OR VIEW SOFTWARE enables you to update AQCESS software and view status utilities.

R - RESTORE SYSTEM MANAGER enables you to create a password and user ID for the System Manager.

A - ARCHIVE PROCESSING enables you to archive records which meet the Archive Date.

DEE - DEERS Processing enables you to determine and control the up/down status of the DEERS interface and to print the DEERS Error Report.

NOTE: All of the options available can cause system problems if used incorrectly. If you have any questions on the use of any options, please contact the AQCESS Customer Support group. See the front of this Training Aid for the phone number and address.

SYSTEM MANAGEMENT TRAINING AID

```
USER ID
PASSWORD

TYPE A '?' FOR OPTIONS
OPTION:?


S    SYSTEM STATUS
E    ERRORS
ED   EDIT TERMINAL GLOBALS
D    DEVICE SETUP
I    INTEGRITY
SA   SAVE TRAINING DATABASE
L    LOAD TRAINING DATABASE
B    BROADCAST
BA   BACKUP SYSTEM
C    CLINICAL RECORDS BATCH PROCESSING
T    TALLY DISK BLOCKS
CA   CARETAKER UTILITIES
DA   DATE UPDATE
TI   TIME UPDATE
SH   SHUTDOWN SYSTEM
U    UPDATE OR VIEW SOFTWARE
R    RESTORE SYSTEM MANAGER
AR   ARCHIVE
DEE  DEERS PROCESSING
```

2. S - SYSTEM STATUS

ACCESS Enter S at the OPTION prompt and press Return.

PURPOSE The System Status Report may be run to determine the current status of all active jobs on the computer. This can be done to determine the cause of a decline in operating speed, to check the lines in case of terminal failure, and to verify the number of users active prior to performing certain operations (such as Integrity Verificaation) which could substantially impact the speed of the computer's response.

NOTE: This log is for your benefit only. It may remain on console log sheets filed daily at your MTF.

2.1 TO OBTAIN A SYSTEM STATUS

- Enter S (System Status) at the OPTION prompt and press Return.

  The system name, date, and total of active jobs are printed on the console, followed by a listing of currently active jobs.

2.2 INTERPRETING THE SYSTEM STATUS REPORT

Job	State	Devices	UCI	Routine

The **JOB NUMBER** is automatically assigned by the system, depending upon the order of initiation of each process (terminal sign-on, print request). This number will not correspond with the terminal number.

The **STATE** indicates the current status of each job. Your Job Number should be the only one with the Run Queue state.

trmhng - Signed-on, idle or unused terminal.

wait(1q-4q) - Waiting for queued output device, such as a printer. The numbers 1-4 indicate the priority of each job.

dskhng - A job is waiting to read/write to disc.

mthng - A job is waiting to read/write to tape.

dskinhb - Disc drive is off-line.

lockcmd - Device is trying to lock a portion of a global.

hangcmd - Waiting for CPU execution; nightly cycle job waiting for execution.

opencmd - Terminal trying to sign-on.

running - Device on which status report is being run.

DEVICES indicates the device number(s) being used by each job. An * (asterisk) indicates the device is the current one being utilized for this job. The first terminal listed for each job number is the principal device (the device which initiated this job). Parentheses indicate the device is unowned (a background job).

The **UCI** indicates the directory; **Routine** indicates the program the job is running.

3. E - ERRORS

ACCESS Enter E at the OPTION prompt and press Return.

PURPOSE The Error Log details any software errors that occur at your site. The log is designed to provide pertinent information about the data in the system when the error occurs, thereby enabling NDC technical staff to determine the cause of the error and correct it.

The error listing should be run once a week ONLY. Return the weekly error listing at the end of each week to AQCESS Customer Support.

No further action by MTF personnel is required. If NDC requires further information on an error, you will be contacted by Customer Support.

3.1 TO OBTAIN AN ERROR LISTING

- Enter E at the OPTION prompt and press Return.

  The system prompts:

- (MTF Name)
  Which date: (Enter a question mark [?])
  Errors have been logged on: T-13, T-12, T-9, etc.

NOTE: Enter all the days within the range of T-1 through T-7 to list errors for the week ONLY. Ignore any "T" day higher than T-7. If there are no errors listed within the range of T-1 through T-7, press Return to return to the OPTION: prompt.

Enter:
> '^Q' to exist.
> '^' to return to the last question.
> Date as 'DD', 'MM/DD', 'MM/DD/YY', 'T' or 'T-1' (Note: 'T' as in Today.)

(MTF Name)
Which Date:

3.1 TO OBTAIN AN ERROR LISTING (CONTINUED)

- Enter all the days within the T-1 through T-7 range.

  The total number of errors for the date selected will print on the console, followed by a complete summary of each error listed.

- Return the weekly error listing to AQCESS Customer Support at the end of each week.

SYSTEM MANAGEMENT TRAINING AID

4. ED - EDIT TERMINAL GLOBALS

You can only use this option when you are instructed to do so by AQCESS Customer Support.

SYSTEM MANAGEMENT TRAINING AID

5. D - DEVICE SETUP

ACCESS Enter D at the OPTION prompt and press Return.

PURPOSE The Device Setup routine must be initiated when adding or moving terminals or printers or in order to print a listing of all devices. The CPU requires this information in order to know how to communicate to each device and to determine whether the device is a terminal, printer, operator's console, etc.

Your system will arrive with all ports defined as terminals. Therefore, you would not need to select this option if you were simply adding a terminal to your basic system; only printers would require modification.

NOTE: You should contact AQCESS Customer Support whenever you move or add a terminal (see the beginning of this Training Aid for contact information). Customer Support maintains a file for each MIF designating the ports to which each terminal is connected. This information may be used when correcting or investigating a system problem and when preparing the update releases. Therefore, you can be supported most efficiently only if you contact Customer Support when such changes are made.

5.1 TO PRINT A DEVICE LISTING

- Enter D at the OPTION prompt and press Return.

  You will see the prompt, LIST DEVICES?

- Enter Y.

  You will see the prompt, CONFIGURATION? <1>.

- Press Return.

  The prompt OUTPUT DEVICE? will print.

- Enter zero (0) to have the listing printed out on the printer you are on (or enter another device number if you want it to print elsewhere).

  The listing of all devices and the characteristics defining them will be printed. See the Section 5.5 for an explanation of the data contained in this listing.

5.2 TO INITIATE A DEVICE SETUP

- Enter D at the OPTION prompt and press Return.

  You will see the prompt, LIST DEVICES?

- Press Return.

  The system will ask for the name of the configuration you wish to alter, followed by the default configuration.

- Press Return to accept the default.

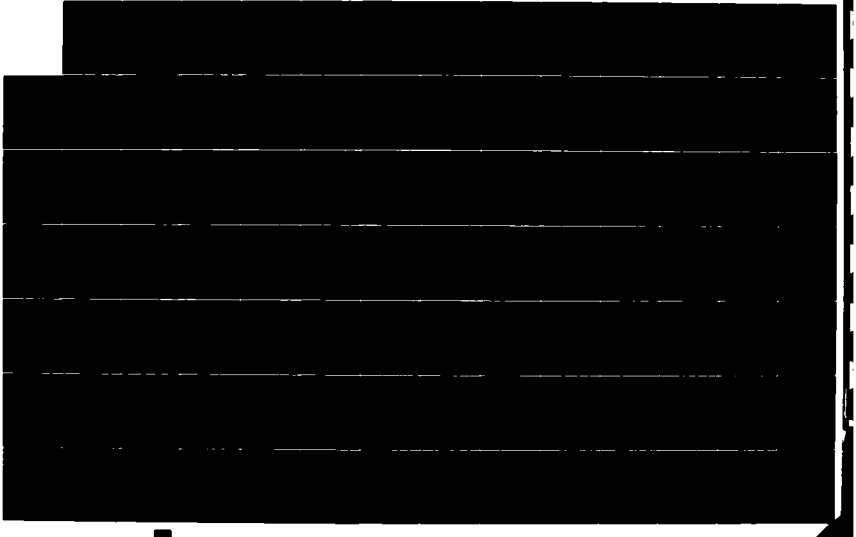
  CONFIGURATION "1" IS RUNNING NOW. IF YOU CONTINUE, BOTH MEMORY AND DISK WILL BE MODIFIED. ARE YOU SURE YOU WANT TO PROCEED? <NO> Y

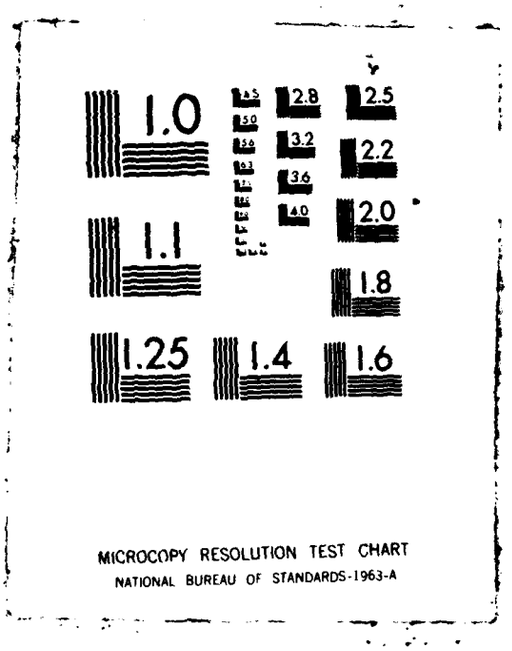
- Enter Y and press Return.

  The instructions ENTER DEVICE NUMBER, OR RANGE OF DEVICE NUMBERS will print, followed by the device characteristics. See Section 5.5 for an explanation of these characteristics.

AD-A178 916 ACCESS (AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM) TRAINING AID. (U) NDC FEDERAL SYSTEMS INC ROCKVILLE MD JAN 87 DOD/SW/MI-87/010a 9/10

UNCLASSIFIED F/G 5/9 NL




1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

5.3 TO ADD A NEW DEVICE

- Enter the device number. If more than one device is being added, you may enter a range of numbers separated by a colon (:).

  The default values will print for each device. On the next line, the device number will print, and the printer will wait at each of the fields.

- If you want to accept the default value, press Return. At each field the printer will wait until you press Return or enter another response.

  The last characteristic, Edit Comment, should be a Y (see explanation of characteristics in Section 5.5). The printer stops at the next line to allow you to enter comments.

- Enter a short description of that device's location and press Return.

- When all the characteristics for the terminal have been established, press Return at the DEVICE NUMBER field.

5.3 TO ADD A NEW DEVICE (CONTINUED)

The system will prompt you for your initials.

- Enter your initials and press Return.

The system will instruct you to enter a comment.

- Enter a short explanation of the additions and include the date.

5.4 TO ALTER AN EXISTING DEVICE

CAUTION: If you attempt to edit a device that is currently active, you may affect the operation and impact the user of that device. Before selecting this option, make certain that the device is free. If uncertain, enter ^ at the prompt "ARE YOU SURE YOU WANT TO PROCEED?" and check the system status before continuing.

- Enter the device number. If more than one device is being altered, you may enter a range of numbers separated by a colon (:).

  The current values assigned to this device will print. The device number will print on the next line, and the printer will stop at each field.

- If you want to accept the current characteristic value, press Return and the printer will go to the next characteristic. To change the value, enter a new value and press Return to move to the next characteristic.

  The last characteristic, Edit Comment, should be a Y (see explanation of characteristic in Section 5.5). The printer will wait on the next line for you to enter comments.

5.4 TO ALTER AN EXISTING DEVICE (CONTINUED)

- Enter a short description of that device's location and press Return.

- When all the characteristics for each terminal have been established, press Return at the DEVICE NUMBER field.

  The system will prompt you for your initials.

- Enter your initials and press Return.

  The system will instruct you to enter a comment.

- Enter a short explanation of the changes made and include the date.

5.5 WHAT EACH CHARACTERISTIC MEANS

DEVICE NUMBER: The device number is the number of the port to which the device will be connected.

PARITY: Parity is required for certain testing by the CPU. You will always enter **N.**

CRT: If you are connecting a terminal, enter **Y;** printers and DEERS device will always be **N.**

AUTO BAUD: Auto Baud will only be used in possible future enhancements. Always enter **N.**

RCVR SPD and XMIT SPD: These two items refer to the speed at which data is transferred between the CPU and the device. If you are connecting a terminal, both will be **9600;** printers will always be **1200;** DEERS device will always be **2400.**

MODEM CNTRL: Modem control will only be considered in possible future enhancements. Always enter **N.**

5.5 WHAT EACH CHARACTERISTIC MEANS (CONTINUED)

ZUSE: ZUSE enables certain communication between devices. For terminals, enter Y; printers and DEERS device must be N or reports generated by AQCESS could be interrupted by operation messages.

OUTPUT ONLY: If you are connecting a printer, answer Y; terminals will always be N to allow two-way communication. DEERS device will also be N.

LOGIN: This refers to the device access capabilities. For terminals, enter Y; printers and DEERS device will always be answered with N.

STALL COUNT: Stall count will not be necessary with this system and could impact operation speed. For all devices, stall count should equal 0.

TAB: Many reports and screen displays require the Tab Feature. All devices will be answered with a Y.

LOWER CASE: If not answered positively, all lower case characters transmitted to any device will be converted to upper case characters. Always enter Y for this characteristic.

5.5 WHAT EACH CHARACTERISTIC MEANS (CONTINUED)

OUTPUT MARGIN: This number refers to the width of the output for hard-copy devices. When adding terminals and DEERS device enter Ø. The Output Margin for all printers should be set at 132 (i.e., printers using 8 1/2 x 11 and 11x14 paper or 3x5 and 5x8 cards).

RTN NUM: This number will identify the device capabilities. For all devices, a standard default between 1 and 9 will automatically be assigned. The system will skip this field.

EDIT COMMENT: This feature allows you to add additional comments about the device, such as location (e.g., A&D, CR, QA), which will print on the System Status Report. For all devices, enter Y and an additional line for comments will be provided.

6. I - INTEGRITY

ACCESS Enter I at the OPTION prompt and press Return to display a list of two choices.

PURPOSE This option enables you to verify the integrity of the data within the system. In the event of an abnormal shutdown, the data may be corrupted with invalid or incomplete data. When this happens, AQCESS may not operate properly or may produce false data based upon corrupted information. Therefore, it is necessary to verify all data, allowing for correction of any incorrect pieces of information.

You will perform this operation on a weekly basis AND in the event of an abnormal shutdown. This includes a power failure or other interruption that prevents you from following the normal system shutdown and power down process.

The copy that is produced weekly may be included with the other weekly reports sent to AQCESS Customer Support. If an Integrity Verification is performed due to an abnormal system shutdown, the copy produced should be forwarded to AQCESS Customer Support immediately. Include a short note describing the circumstances of the abnormal shutdown

6. I - INTEGRITY (CONTINUED)

and the SIR Number provided by the AQCESS Customer Support Representative, your name and number, and other relevant information that could help us resolve any problems caused by the interruption in operation.

Information on how to contact AQCESS Customer Support is included at the beginning of this Training Aid.

OPTIONS 1 - PRINT EXISTING REPORT will reproduce the last integrity report run. This should prove particularly helpful should anything happen to the existing copy.

2 - COMPILE NEW REPORT enables you to verify the current integrity status of all data within the system. Remember, the previous report will be deleted when you select this option.

6.1 TO PRINT THE EXISTING REPORT

- Enter I at the OPTION prompt.

  A selection of two options is printed on the console.

  1. Print existing report
  2. Compile new report

- Enter 1 at the prompt provided.

  Enter one of the above options >
  The system prompts, OUTPUT DEVICE? >

- Enter 0 to print a copy on the console.

  The existing report prints and the two Integrity options are displayed again on the console.

- Choose one of the options or press Return to the OPTION prompt.

6.2 TO COMPILE A NEW REPORT

- Enter I at the OPTION prompt.

  A selection of two options is printed on the console.

- Enter 2 at the prompt provided.

  The system queries, DO YOU WANT THE REPORT TO AUTOMATICALLY PRINT WHEN IT'S DONE? <Y>

- Press Return to accept the default.

  The system prompts, OUTPUT DEVICE? >

- Enter Ø to print a copy on the console or the device number to send it to a designated printer.

  The system queries, CHECK DATA BASE INTEGRITY FOR WHICH VOLUME SET?

- Enter SYS or SØ.

  The system will then prompt STRUCTURE SØ^ :UCI?>

- Enter * (asterisk).

6.2 TO COMPILE A NEW REPORT (CONTINUED)

A list of all UCI numbers and names followed by a designation of all Globals and Routines will print. A message will follow instructing you that Integrity Checker is running in the background. A report will be compiled into ^IC and printed on device #0.

Then the system displays the OPTION prompt. You can continue to perform other functions listed on the Operations Menu. The report will not print unless you hit Return at the OPTION prompt, and the EXIT prompt is displayed. The report is produced within 1-3 hours.

CAUTION: While verification of integrity is a very important process, it can significantly impact the system's performance for other users. Therefore this process is only performed on a regular basis once weekly to minimize the inconvenience to other users. If users will be on the system while Integrity is executing, send a message to the users notifying them that system response will be slow for the next 1 to 3 hours. It is recommended that users do not log on during this operation, because users on the system may cause false errors in the integrity check.

6.2 TO COMPILE A NEW REPORT (CONTINUED)

When the verification process is complete, normally 1 to 3 hours later, a report will print on the console. This may be removed and distributed as outlined under PURPOSE in this Section.

If an error occurs (see example below), the report must be re-run for the Routines/ Globals containing errors for final verification.

EXAMPLE:

TO RE-COMPILE A REPORT

- Enter I at the OPTION prompt.

  A selection of two options is printed on the console.

- Enter 2 at the prompt provided.

  The system queries, DO YOU WANT THE REPORT TO AUTOMATICALLY PRINT WHEN IT'S DONE? <Y>

- Press Return to accept the default.

  The system prompts, OUTPUT DEVICE?>

6.2 TO COMPILE A NEW REPORT (CONTINUED)

- Enter 0 or the device number of a designated printer to print a copy on the console.

  The system queries, CHECK DATA BASE INTEGRITY FOR WHICH VOLUME SET?

- Enter **SYS** or **SO.**

  The system prompts STRUCTURE SO: UCI? >

- Enter the name of the UCI printed above the global that contains error.

  The system prompts GLOBAL? >
  SEARCHING DIRECTORY...

- Enter the name(s) of global(s) which had error(s) in it until error listed globals are completed.

  The system will prompt CHECK ROUTINE DIRECTORY? <Y>

  Press Return to accept the default option if there are routine errors or else enter N and press Return.

6.2 TO COMPILE A NEW REPORT (CONTINUED)

The system will again prompt STRUCTURE SO: UCI? >.

Press Return if there are no more errors listed under any UCI in the report to exit.

- If an error routine or global is selected, the system will prompt INTEGRITY CHECKER RUNNING IN BACKGROUND. A REPORT WILL BE COMPILED INTO ^IC AND PRINTED ON DEVICE #0.

- If error persists call NDC Customer Support for assistance.

7. SA - SAVE TRAINING DATABASE

ACCESS Enter SA at the OPTION prompt and press Return.

PURPOSE During the initial training period, you will be provided with a tape containing a set of "fake" patients. These patients will be loaded into your training database and users will be able to use these patients while training. Users will also have the opportunity to add their own patients to this special database.

Occasionally, you may need to clear out this database and start new. You may also want to keep a copy of the patients already on file for future use. For new personnel learning the system after the initial training, it will be valuable to have the unaltered initial "fake" patient census, which can be loaded from the tape provided during installation.

Save Training Database and Load Training Database will be used to accomplish these tasks.

7.1 TO SAVE THE TRAINING DATABASE

- Load a tape on the drive. If the tape currently holds data, it will be replaced by the training database.

- Enter **SA** at the OPTIONS prompt and press Return.

  The system will prompt you for the tape label name.

- Enter the words "TRAINING DATABASE SAVE" followed by the date (example: TRAINING DATABASE SAVE 07/01/85) and press Return.

  No further action will occur on the console until the Save Operation is complete. When the save is complete, a message informs you that the save is finished, and the console exits.

- Remove the training database tape from the drive and label the outside using the above label.

NOTE: Users should not be accessing the training database during the Save process.

8. L - LOAD TRAINING DATABASE

ACCESS Enter L at the OPTION prompt and press Return.

PURPOSE See PURPOSE, Section 7.

8.1 TO LOAD THE TRAINING DATABASE

- Load the tape containing the appropriate training database on the drive, noting the name on the tape label.

- Enter L at the OPTION prompt and press Return.

  The system will prompt you with the tape label (example: LOAD TYPE TRAINING DATABASE SAVE 10/19/85?).

  Enter "Y" for yes and press Return.

  A list of globals is printed as they load. When the load is complete, the console will exit.

- Press Return to restore the OPTION prompt. Remove the backup tape from the drive.

NOTE: Users should not be accessing the training database when a load is in progress.

9. B - BROADCAST

ACCESS Enter B at the OPTION prompt and press Return.

PURPOSE You may use Broadcast to transmit messages to other terminals on the system. This feature will be used most often to warn users of an impending system shutdown (for backup, software updates, severe weather, etc.)

NOTE: When broadcasting a message to terminals operating a program or series of programs, such as AQCESS, the message may be mistakenly interpreted by the system as an input response. If not caught, this could place unexplainable text in a patient's record. Therefore, use this feature only when needed and restrict it, if possible, to those terminals that truly need to know what you wish to say.

9.1 TO BROADCAST A MESSAGE

- Enter B at the OPTION prompt and press Return.

  The system will prompt you for the text of the message to be broadcast.

- Enter the text, making certain it is accurate by holding the control key down and press R. The system will display the message. If it is correct, press Return.

  The system will request the number of the terminal to which you wish to send this message.

- If you want to send it to all Users, enter **ALL**. The message will be broadcast to all terminals on the system along with a "beep" to notify persons near unattended terminals.

- If you want to send to one or more specific users, enter the Device Number of the first user to receive the message and press Return. The system will continue to ask you for additional users to receive the message. Press Return when all have been sent.

9.1 TO BROADCAST A MESSAGE (CONTINUED)

NOTE: Printers cannot receive messages, since this could damage a report currently being printed. Therefore, you may not specify a printer as a Device Number, and printers will not be affected when selecting ALL.

When all terminals have received the message, the ENTER MESSAGE prompt will display on the console.

- Press Return to return to the OPTION prompt.

10. BA - BACKUP SYSTEM

ACCESS Enter **BA** at the OPTION prompt. Press Return for a choice of four options.

PURPOSE The BACKUP SYSTEM option enables the MTF to save all of the information on the disk to a backup tape. As a System Manager, you will be concerned with the possibility of data loss caused by power failures, system crashes, or by other unpredictable events. If performed on a regular basis, the BACKUP SYSTEM option can minimize data loss.

When backups are being performed, all other terminal activity is suspended by the system. The only operable terminal is the console. This is where you will be performing the back-up. To keep user inconvenience to a minimum, backups should be scheduled at the same time every day, preferably during the evening. Immediately prior to performing backups, run a system status to determine which users are online. You can use the BROADCAST option to notify users to sign off before backups begin.

NOTE: It is strongly recommended that back-ups be performed on a daily basis. As this option will affect other users, daily backups should be performed when user activity is at a minimum.

10. BA - BACKUP SYSTEM (CONTINUED)

OPTIONS

1 - CREATE, DELETE, OR EDIT A BACKUP-COMMAND-FILE should be executed only when instructed by AQCESS Customer Support.

2 - PERFORM REGULAR BACKUP (ATTENDED BACKUP) enables you to back up the system and creates a backup tape.

3 - PERFORM SCHEDULED BACKUP (UNATTENDED BACKUP). This option should not be executed.

4 - MAINTAIN SCHEDULED BACKUP FILES. This option should not be executed.

10.1 TO CREATE, DELETE, OR EDIT A BACKUP-COMMAND-FILE

This option should be executed only when instructed by AQCESS Customer Support.

10.2 TO PERFORM REGULAR BACKUP (ATTENDED BACKUP)

- Mount the backup tape. If your system has more than one disk drive, mount the first backup tape. If your unit is the TK25 cassette, the tape will be rewound for correct tension. This operation takes approximately 5 minutes. It is complete when the online light stops blinking. Press the online button to bring the tape online. This procedure must be repeated for each tape in a multiple-drive configuration.

- Enter **BA** at the OPTION prompt.

  The system will respond with:

  1. CREATE, DELETE, OR EDIT A BACKUP-COMMAND-FILE
  2. PERFORM REGULAR BACKUP (ATTENDED BACKUP)
  3. PERFORM SCHEDULED BACKUP (UNATTENDED BACKUP)
  4. MAINTAIN SCHEDULED BACKUP FILES

- ENTER **2.**

10.2 TO PERFORM REGULAR BACKUP (ATTENDED BACKUP) (CONTINUED)

The system will respond with

NOTE: PLEASE DO NOT DISMOUNT ANY RESIDENT DISKS UNLESS EXPLICITLY ASKED TO DO SO.

ENTER NAME OF THE BACKUP COMMAND FILE YOU WISH TO EXECUTE >

- If you do not know the name of the backup command file, enter a question mark (?) in this field. The system will display the name of the current backup command file.

The system will respond by listing all jobs that are still logged in (giving the job number, principal device, and routine), and then will display the prompt:

DO YOU WISH TO PROCEED WITH THE BACKUP [Y OR N]? <Y>

- If you do not wish to continue with the backup, answer N to this prompt.
- If you wish to proceed with the backup, press Return to accept the default.

10.2 TO PERFORM REGULAR BACKUP (ATTENDED BACKUP) (CONTINUED)

- If you proceed with the backup, the system will not be available to any users from this point until the next backup is complete.

The system will respond with:

```
(PROCEEDING WITH 63 BUFFERS)

BEGIN BACKUP #1  DISK DUO  LABEL =
"MASTER 0"

PLEASE MOUNT THE TAPE THAT WILL HOLD
THE BACKED UP INFORMATION, ON MAGTAPE
UNIT #0  * WRITE ENABLED *  (RING IN)
THEN TYPE <CR>
```

CAUTION: Make sure the tape is completely rewound and online before you press Return. If you press Return before the tape is ready, the system will force you to exit and you must begin the backup process again.

```
17:45:08  BEGIN BACKUP #1
17:52:55  BACKUP #1 COMPLETE
```

10.2 TO PERFORM REGULAR BACKUP (ATTENDED BACKUP) (CONTINUED)

- Remove the backup tape. Turn the "safe" indicator or remove the write ring, whichever is appropriate. Label the tape and store it.

  If the backup is being performed on the PDP-11/23 PLUS, the system will respond with:

  BEGIN BACKUP #2 DISK DU1 LABEL = "MASTER 1"

  PLEASE MOUNT THE TAPE THAT WILL HOLD THE BACKED UP INFORMATION, ON MAGTAPE UNIT #0 * WRITE-ENABLED * (RING IN)

- (For the PDP-11/23 PLUS), mount the second backup tape.

  CAUTION: Make sure the tape is completely rewound and online before you press Return.

- Press Return to begin Backup #2

  17:57:23 Begin Backup #2
  18:04:46 Backup #2 Complete

10.3 TO PERFORM A SCHEDULED BACKUP (UNATTENDED BACKUP) AND MAINTAIN SCHEDULED BACKUP FILES

- Remove the backup tape. Turn the "safe" indicator or remove the write ring, whichever is appropriate. Label the tape and store it.

  These procedures, options 3 and 4, should only be executed when instructed to do so by AQCESS Customer Support.

11. C - CLINICAL RECORDS BATCH PROCESSING

ACCESS Enter C at the OPTION prompt. A choice of two functions will be displayed for Navy and Air Force and four functions for Army.

PURPOSE The CLINICAL RECORDS BATCH PROCESSING option enables Air Force and Navy users to create or recreate the Transcript Tape. This function enables Army users to create X&Y Card Tapes and ABC Card Tapes, to recreate ABC Card Tapes, and to place records of dispositioned patients under the control of Clinical Records.

OPTIONS Through Clinical Records Batch Processing you can perform the following functions, depending on your military department.

AIR FORCE AND NAVY OPTIONS

1 - TRANSCRIPT TAPE enables you to create the Coded Transcript Tape. The Transcript Tape must be created as directed by your Military Department. For Air Force only, the tape will include records that were approved and patients discharged before the end of the previous month (based on the current system date). For Navy only, the tape will include records of all patients from the previous month (the

11. C - CLINICAL RECORDS BATCH PROCESSING (CONTINUED)

month the tape was created). A hard-copy list of all records copied to this tape is also created.

This list, called the Records Transmittal Roster, gives the following data for each record contained on the tape: register member, FMP, SSN, patient name, date of birth, admission and disposition dates, and card ID.

2 - RECREATE TRANSCRIPT CARD TAPE recreates the Transcript Card Tape any time during the month in which the tape was originally created. New records which meet the criteria for higher command will be selected. A hardcopy list of all records copied to the tape is also created (see option 1, above).

ARMY OPTIONS

1 - X&Y CARD TAPE creates the X&Y Card Tape of the previous month's dispositioned patients. Option 4 must always be run before the X&Y Card Tape is created. The X&Y must be created within the first 5 days of each month. A Records Transmittal Roster is also created.

11. C - CLINICAL RECORDS BATCH PROCESSING (CONTINUED)

2 - ABC CARD TAPE creates the Coded Transcript Tape and a Records Transmittal Roster in two periods within the month. (First period - 1st day of the month through 15th day of the month, Second period - 16th day of the month through the end of the month).

The ABC Card Tape must be created as directed by your Military Department.

3 - RECREATE ABC CARD TAPE recreates the ABC card tape. New records which meet the criteria for higher command will be selected. A Records Transmittal Roster is also created.

4 - PULL DISPOSITIONED PATIENTS FROM LAST MONTH INTO CR. This option puts under the control of Clinical Records the records of all patients who have been dispositioned in the previous month but whose CR processing has not yet been initiated. This option causes the patient's CR record to be built so that an X card can be produced in option 1. If this option is not run, the number of dispositions reported on the Y card will not match the number of X card records generated. This option also prints a list of records with Army edit errors.

11.1 TO CREATE THE TRANSCRIPT TAPE (AIR FORCE AND NAVY)

- Insert or mount the tape. The tape rewinds for correct tension while the on-line light blinks (this takes about 5 minutes). Press the online button to bring the tape online or press LOAD REWIND and ON-LINE, whichever is appropriate.

- Enter 1 at the TAPE OPTION prompt and press Return.

  The system will begin to select records internally. The Records Transmittal Roster will print on the console. When the Roster has finished printing, the system will display:

  TOTAL CARDS IN TRANSMITTAL XXX
  TOTAL PATIENTS IN TRANSMITTAL XXX

  The cursor will hang while the records are being copied to tape. Do not remove the tape until the system prompts:

  FINISHED!
  EXIT

WARNING: If the tape aborted by error, please do not create for the second time. Contact Customer Support for further assistance.

11.1 TO CREATE THE TRANSCRIPT TAPE (AIR FORCE AND NAVY) (CONTINUED)

- Remove the tape from the tape drive. Set the "Safe" indicator or remove the write ring, whichever is appropriate. Immediately label the tape with the FULL NAME of the site, date the tape was created, and total cards transmitted on the tape. It is essential this be done to ensure the data on the tape is not destroyed.

11.2 TO RECREATE THE TRANSCRIPT CARD TAPE (AIR FORCE AND NAVY)

- Insert or mount the tape. The tape rewinds for correct tension while the online light is blinks (this takes about 5 minutes). Press the online button to bring the tape online or press LOAD REWIND and ON-LINE, whichever is appropriate.

- Enter C at the OPTION prompt and press Return. The system will respond with the TAPE OPTION prompt.

- Enter 2 at the TAPE OPTION prompt and press Return. The system will display:

  REDUMP CTT FOR APR >

  (Enter month for which to recreate tape - Navy only.)

  The system will begin to select records internally. The Records Transmittal Roster will print on the console. When the Roster has finished printing, the system will display:

  TOTAL CARDS IN TRANSMITTAL XXX
  TOTAL PATIENTS IN TRANSMITTAL XXX

11.2 TO RECREATE THE TRANSCRIPT CARD TAPE (AIR FORCE AND NAVY) (CONTINUED)

The cursor will hang while the records are being copied to tape. Do not remove the tape until the system prompts:

FINISHED!
EXIT

- Remove the tape from the tape drive. Set the "Safe" indicator or remove the write ring, whichever is appropriate. Immediately label the tape with the FULL NAME of the site, date the tape was created, and total cards transmitted on the tape. It is essential this be done to ensure the data on the tape is not destroyed or mixed up.

11.3 TO CREATE THE X&Y CARD TAPE (ARMY)

- Insert or mount the tape. The tape rewinds for correct tension while the online light blinks (this takes about 5 minutes). Press the online button to bring the tape online or press LOAD REWIND and ON-LINE, whichever is appropriate.

- Enter C at the OPTION prompt and press Return. The system will respond with the TAPE OPTION prompt.

- Enter 1 at the TAPE OPTION prompt and press Return.

  AUTODIN? Y (Enter Y = Yes)

  The system will respond with:

  MONTH OF REPORT

- Enter the first three letters of the name of the month for which you want the report.

  The system will respond with:

  TOTAL CLINIC VISITS

11.3 TO CREATE THE X&Y CARD TAPE (ARMY) (CONTINUED)

- Enter the total number of clinic visits.

  The system will begin to select records internally. The Records Transmittal Roster will print on the console. When the Roster has finished printing, the system will display:

  TOTAL CARDS IN TRANSMITTAL XXX
  TOTAL PATIENTS IN TRANSMITTAL XXX

  The cursor will hang while the records are being copied to tape. Do not remove the tape until the system prompts:

  FINISHED!
  EXIT

- Remove the tape from the tape drive. Set the "Safe" indicator or remove the write ring, whichever is appropriate. Immediately label the tape with the FULL NAME of the site, date the tape was created, and total cards transmitted on the tape. It is essential this be done to ensure the data on the tape is not destroyed or mixed up.

11.4 TO CREATE THE ABC CARD TAPE (ARMY)

- Insert or mount the tape. The tape rewinds for correct tension while the online light blinks (this takes about 5 minutes). Press the online button to bring the tape online or press LOAD REWIND and ON-LINE, whichever is appropriate.

- Enter C at the OPTION prompt and press Return. The system will respond with the TAPE OPTION prompt.

- Enter 2 at the TAPE OPTION prompt and press Return.

  AUTODIN? Y (Enter Y = Yes)

  The system will respond with:

  ABC-MO-PERIOD-YR.

- Enter the month, period, and year for the ABC tape you wish to recreate as follows:

  - MONTH - a 2-digit number representing the month for which the records are being selected (e.g., 01, 02, etc.),

11.4 TO CREATE THE ABC CARD TAPE (ARMY) (CONTINUED)

- PERIOD - the period in the month for which the records are being selected (should be 1 or 2),

- YEAR - the last number for the current year (e.g., for 1986, enter 6).

EXAMPLE:

- To create the ABC Card Tape for the first period of January, 1986, you should enter: 0116. This should be done between Jan 1, 1986 and Jan 5, 1986.

- To create the ABC Card Tape for the second period of January 1986, you should enter: 0126. This should be done between Jan 16, 1986 and Jan 20, 1986.

The system will begin to select records internally. The Records Transmittal Roster will print on the console. When the Roster has finished printing, the system will display:

TOTAL CARDS IN TRANSMITTAL XXX
TOTAL PATIENTS IN TRANSMITTAL XXX

The cursor will hang while the records are being copied to tape. Do not remove the tape until the system prompts:

11.4 TO CREATE THE ABC CARD TAPE (ARMY) (CONTINUED)

```
FINISHED!
EXIT
```

- Remove the tape from the tape drive. Set the "Safe" indicator or remove the write ring, whichever is appropriate. Immediately label the tape with the FULL NAME of the site, date the tape was created, and total cards transmitted on the tape. It is essential this be done to ensure the data on the tape is not destroyed or mixed up.

11.5 TO RECREATE THE ABC CARD TAPE (ARMY)

- Insert or mount the tape. The tape rewinds for correct tension while the online light blinks (this takes about 5 minutes). Press the online button to bring the tape online or press LOAD REWIND and ON-LINE, whichever is appropriate.

- Enter C at the OPTION prompt and press Return. The system will respond with the TAPE OPTION prompt.

- Enter 3 at the TAPE OPTION prompt and press Return.
  > AUTODIN? Y (Enter Y = Yes)

  The system will respond with:

  ABC-MO-PERIOD-YR.

- Enter the month, period, and year for the ABC tape you wish to recreate, as described in Section 11.4.

  The system will begin to select records internally. The Records Transmittal Roster will print on the console. When the Roster has finished printing, the system will display:

11.5 TO RECREATE THE ABC CARD TAPE (ARMY) (CONTINUED)

TOTAL CARDS IN TRANSMITTAL XXX
TOTAL PATIENTS IN TRANSMITTAL XXX

The cursor will hang while the records are being copied to tape. Do not remove the tape until the system prompts:

FINISHED!
EXIT

- Remove the tape from the tape drive. Set the "Safe" indicator or remove the write ring, whichever is appropriate. Immediately label the tape with the FULL NAME of the site, date the tape was created, and total cards transmitted on the tape. It is essential this be done to ensure the data on the tape is not destroyed, or mixed up.

11.6 TO PULL DISPOSITIONED PATIENTS FROM LAST MONTH INTO CR (ARMY)

- Enter 4 at the TAPE OPTION prompt and press Return.

  The system will list any CR errors for the records selected. These records are then put under the control of Clinical Records.

  No tapes are created with this option. When the list of records is complete, the system will print EXIT.

SYSTEM MANAGEMENT TRAINING AID

12. T - TALLY DISK BLOCKS

ACCESS Enter T at the OPTION prompt.

PURPOSE The TALLY DISK BLOCKS option provides a summary of disk usage showing allocated and free blocks. A report is generated from this option which breaks down the disk space usage per block. The Disk Block Tally report will also display a total of how much space is available.

12.1 TO EXECUTE TALLY DISK BLOCKS OPTION

- Enter T at the OPTION prompt.

  The system will respond with:

  WOULD YOU LIKE A FAST TALLY [Y OR N]
  <Y>

- Press Return for this question. This will cause the system to accept the default answer, which is yes.

  If this question is answered "NO", the system will generate a SLOW DISK BLOCK TALLY. A SLOW TALLY can change data structure and should only be executed when requested by AQCESS Customer Support.

  The system will respond with:

  TALLY ALL DISKS CURRENTLY MOUNTED [Y OR N]

- Enter Y and press Return for this option.

  The system will perform the DISK BLOCK TALLY and print the resulting report on the console.

12.1 TO EXECUTE TALLY DISK BLOCKS OPTION (CONTINUED)

NOTE: A FAST DISK BLOCK TALLY should be executed every week at the same time. The hard-copy of this report should be sent to AQCESS Customer Support.

12.2 THE TALLY DISK BLOCKS REPORT

DESCRIPTION The TALLY DISK BLOCK report is divided into three columns.

MAP NUMBER shows the actual disk space location by MAP number.

BLKS AVAIL shows the amount of space available in blocks per map.

USE shows how each map is being used, for example, if the disk space is being used by the database, or if the disk space is FREE.

13. CA - CARETAKER UTILITIES

ACCESS Enter **CA** at the OPTION prompt. Seven options will be displayed.

PURPOSE The CARETAKER is a background job that is transparent to the user and performs basic housekeeping functions for the system. The caretaker utilities manage the system caretaker job and the system error log for both hardware and software errors.

The three functions of the CARETAKER are:

- Monitoring the status of the printers and the system disk. If an error occurs when writing to the system disk, a message is printed on the designated error printer, usually the console terminal. A write-locked system disk is also reported this way.
- Recording other types of disk errors, as well as magnetic tape drive errors.
- Optionally, logging software errors.

NOTE: The CARETAKER should be executing at all times. If the caretaker job stops executing, the system will display: CARETAKER STOPPED.

13. CA - CARETAKER UTILITIES (CONTINUED)

OPTIONS 1 - START SYSTEM CARETAKER starts the caretaker job.

2 - STOP SYSTEM CARETAKER stops the caretaker job.

Options 3 through 7 should be used only at the request of AQCESS Customer Support.

3 - PRINT HARDWARE ERROR LOG prints a list of hardware errors.

4 - ERASE HARDWARE ERROR LOG purges obsolete hardware error information.

5 - CHANGE ERROR PRINTER changes the printer where the errors are printed.

6 - PRINT DISK ERROR SUMMARY lists disk errors.

7 - SOFTWARE ERROR LOG shows software errors; it performs the same function as Main Menu option E (see Section 3).

13.1 USING THE CARETAKER UTILITIES

OPTION 1 Start System Caretaker

- Enter 1 after entering CA at the OPTION prompt.

  The system will respond with:

  CARETAKER IS NOW RUNNING AS JOB NUMBER X.

NOTE: You should use this option to restart the caretaker if you initiate a shutdown procedure but, due to system status, decide not to complete the shutdown.

OPTION 2 Stop System Caretaker

(This option should not be used. If the caretaker is stopped, the system status will no longer be monitored, the system operator will not be notified of any special conditions, and errors will no longer be recorded.)

OPTIONS 3-7 Should be executed only on the request of AQCESS Customer Support.

SYSTEM MANAGEMENT TRAINING AID

14. DA - DATE UPDATE

ACCESS Enter DA at the OPTION prompt and press Return.

PURPOSE The DATE UPDATE function enables you to set the current date.

This option would be used if the date had been entered incorrectly when the system was started up.

TO PERFORM DATE UPDATE:

- Enter DA at the OPTION prompt.

  The system will respond with:

  PLEASE ENTER TODAY'S DATE
  <DD-MMM-YY>

- Enter the current date in the format shown and press Return.

  The system will respond with:

  IS TODAY (DAY)? <Y>

- Press Return if the day displayed by the system is the correct day.

  NOTE: It is extremely important that the correct date is entered.

15. TI - TIME UPDATE

ACCESS Enter TI at the OPTION prompt and press Return.

PURPOSE The TIME UPDATE function enables you to set the current time.

This would be used if the time had been entered incorrectly when the system was started up.

TO PERFORM TIME UPDATE

- Enter TI at the OPTION prompt.

  The system will respond with:

  PLEASE ENTER TIME [HH:MM:SS] >

- Enter the current time in the format shown and press Return.

  The system will respond with:

  IS THIS (HH:MM AM,PM) IN THE
  MORNING
  AFTERNOON
  EVENING

- Press Return if the time displayed is correct.

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16. U - UPDATE OR VIEW SOFTWARE

ACCESS Enter U at the OPTION prompt and press Return. The present date and time and an UPDATE OPTION prompt will be displayed. To view update options, type ? and press Return.

PURPOSE The UPDATE OR VIEW SOFTWARE option enables you to update AQCESS and view status programs. Specifically, you can:

- modify existing routines,
- modify existing globals,
- execute the release routine,
- display contents of a global,
- check the storage efficiency of a global,
- view a patient's data in global format.

OPTIONS The UPDATE Options Menu displays the capabilities which are available under the UPDATE OR VIEW SOFTWARE option.

- R - ROUTINE LOAD enables you to update a routine from a mag tape or cassette.
- G - GLOBAL enables you to update a global from mag tape or cassette.
- RE - RELEASE UPDATE ROUTINE enables you to execute a special release routine that was loaded through option R above.

16. U - UPDATE OR VIEW SOFTWARE (CONTINUED)

D - DISPLAY GLOBAL lists the contents and logical structure of a global.

E - EFFICIENCY OF GLOBALS displays how efficiently a global is being stored.

V - VIEW PATIENTS enables you to print data on individual patients, when requested to do so by AQCESS Customer Support.

NOTE:
1. The UPDATE OR VIEW SOFTWARE option is to be selected ONLY when instructed to do so by AQCESS Customer Support.
2. The ROUTINE LOAD, GLOBAL LOAD, AND RELEASE UPDATE ROUTINE are for new releases. Specific instructions will accompany new releases and system loads when they are delivered.

16.1 R - ROUTINE LOAD

The ROUTINE LOAD option enables you to load a routine from a mag tape or cassette.

NOTE: This option will only be used on the request of AQCESS Customer Support. Specific instructions will be provided.

16.2 G - GLOBAL LOAD

The GLOBAL LOAD option enables you to load a new global from a mag tape or cassette.

NOTE: This option will only be used on the request of AQCESS Customer Support. Specific instructions will be provided.

16.3 RE - RELEASE UPDATE ROUTINE

The RELEASE UPDATE ROUTINE option enables you to execute a special release program that accompanies each software release.

NOTE: This option will only be used on the request of AQCESS Customer Support. Specific instructions will be provided.

16.4 D - DISPLAY GLOBAL

The DISPLAY GLOBAL option will enable AQCESS Customer Support to view current global listings to ensure a current/error-free version of the global.

The data displayed will be a list of the contents and logical structure of a global.

- Enter D (DISPLAY GLOBAL) at the UPDATE OPTION prompt and press Return.

  The system will prompt, TRAINING, LIVE, OR MANAGER.

- Enter T for TRAINING, L for LIVE, or M for MANAGER, and press Return.

  The system will display the prompt GLOBAL ^ .

- Enter the name of the global you wish to list and press Return.

  A content listing of the selected global will be displayed. When the listing is complete, the prompt GLOBAL ^ will again be displayed.

- Enter the name of another global or press Return to exit this option.

16.4 D - DISPLAY GLOBAL (CONTINUED)

If you select another global, the process will repeat (i.e., global contents will be listed and then you will be prompted for another global). If you press Return, you will exit the Display Global option.

INTERPRETING THE DISPLAY GLOBAL LISTING

The DISPLAY GLOBAL will contain a list of the contents and logical structure of a global.

AQCESS Customer Support will interpret the global listing. It is not necessary for the System Manager to understand the listing. In most cases a hard copy of this listing will be forwarded to AQCESS Customer Support for review.

16.5 E - EFFICIENCY OF GLOBALS

The EFFICIENCY OF GLOBALS option displays how efficiently a global is being stored.

The data displayed will indicate the percentage of each block that is being filled with data for a given global, i.e., the efficiency of the operating system in using disk block space.

USING THE EFFICIENCY OF GLOBALS OPTION

- Enter E (EFFICIENCY OF GLOBALS) at the UPDATE OPTION prompt and press Return.

  The system will prompt, TRAINING, LIVE, OR MANAGER.

- Enter T for TRAINING, L for LIVE, or M for MANAGER, and press Return.

  You will see the prompt, GLOBAL ^ .

- Enter the name of the global whose efficiency you wish to check and press Return.

  Again, the prompt, GLOBAL ^ , will be displayed. If you wish to display the efficiency of another global, enter the global name and press Return. If you do not wish to display another global, press Return.

16.6 V - VIEW PATIENTS

Using this option, you can print an internal dump of the data on an individual patient. This is to be done on request of AQCESS Customer Support, which is where you send the resulting data.

USING THE VIEW PATIENTS OPTION

- Enter V (VIEW PATIENTS) at the UPDATE OPTION prompt and press Return.

  The system will display the prompt TRAINING, LIVE, OR MANAGER.

- Enter T for TRAINING, L for LIVE, or M for MANAGER, and press Return.

  The system will prompt you to identify the patient you want data on, either by entering an FMP and SSN, or by entering the patient's register number.

  When you have entered a valid FMP and SSN or a register number, the patient data will print.

SYSTEM MANAGEMENT TRAINING AID

17. SH - SHUTDOWN SYSTEM

ACCESS Enter **SH** at the OPTION prompt. A choice of three functions will be displayed.

PURPOSE The SYSTEM SHUTDOWN option brings the system to the point where the processor can be halted. Among other things, the SYSTEM SHUTDOWN option checks for any active jobs. This option should ALWAYS be used to shut down a system.

A SYSTEM SHUTDOWN need not be performed on a daily basis.

Terminal users should log off before performing a system shutdown. You can use the DELAYED SHUTDOWN function or BROADCAST option to alert users of the impending shutdown, so that they have time to complete what they are doing.

CAUTION: Halting the system without performing the SYSTEM SHUTDOWN can leave the database in an inconsistent condition.

17. SH - SYSTEM SHUTDOWN (CONTINUED)

OPTIONS 1 - DISPLAY LOGGED-IN JOBS shows all jobs currently executing on the system.

2 - PERFORM TIMED SHUTDOWN enables you to specify how much time should elapse prior to SHUTDOWN. This allows the System Manager to notify users of the impending shutdown.

3 - TERMINATE ALL JOBS, PERFORM IMMEDIATE SHUTDOWN shuts down immediately.

NOTE: After you enter **SH** at the OPTION prompt, the system will display the message, CARETAKER STOPPED. If the SYSTEM SHUTDOWN is not completed, use the Caretaker option to restart the Caretaker job (see Section 13.1).

17.1 TO DISPLAY LOGGED-IN JOBS

- Enter **SH** at the OPTION prompt and press Return.

  The system will respond with:
  CARETAKER STOPPED.

- Enter **1** at the OPTION prompt and press Return.

  The system will display any jobs currently executing.

- Continue the shutdown procedure by completing the steps given in Section 17.2, TIMED SHUTDOWN, or 17.3, IMMEDIATE SHUTDOWN.

17.2 TO PERFORM A TIMED SHUTDOWN

- Enter **SH** at the OPTION prompt and press Return.

  The system will respond with: CARETAKER STOPPED.

- Enter **2** at the OPTION prompt and press Return.

  The system will respond with: HOW MANY MINUTES TILL SHUTDOWN?

- Enter the time in *minutes before* the system shuts down.

  The system will respond with: BROADCAST 'SYSTEM GOING DOWN' MESSAGES TO WHICH JOBS? <ALL>

- Press Return to send broadcast messages to all terminals still logged on.

  The system will respond with: DO YOU WISH TO RE-ENABLE LOG-INS UNTIL SHUTDOWN TIME [Y OR N]? <N>

- Press Return.

17.2 TO PERFORM A TIMED SHUTDOWN (CONTINUED)

The system will display a timed countdown. The system will respond by listing any jobs that are still logged in (giving job number, prinicipal device, and routine). It will then display:

```
DO YOU WISH TO KILL THESE JOBS AND
SHUTDOWN NOW (10 SECONDS TO ANSWER)
[Y OR N]? <Y>
```

- Press Return to accept the default.

The system will continue processing shutdown and display:

```
READY TO HALT
EXIT
```

17.3 TO TERMINATE ALL JOBS, PERFORM IMMEDIATE SHUTDOWN

- Enter SH at the OPTION prompt and press Return.

  The system will respond with:
  CARETAKER STOPPED.

- Enter 3 at the OPTION prompt and press Return.

  The system will process SHUTDOWN and display:

  READY TO HALT
  EXIT

NOTE: After receiving READY TO HALT and EXIT prompt, you can halt the processor. See SHUTDOWN PROCEDURES for the type of system in your MIF (Sections 22 through 24).

18. R - RESTORE SYSTEM MANAGER

ACCESS — Enter R at the UPDATE OPTION prompt and press Return.

PURPOSE — When AQCESS arrives at your installation, there will be no user IDs or passwords available to users--not even you, the System Manager, will be able to sign on to AQCESS. The Restore System Manager option will enable you to establish the System Manager's user ID and password so that you can gain access to the system.

Additionally, you will use this option if you should ever accidentally lock out your user ID, preventing yourself from signing on. Also, this option can be used by someone designated by the Hospital Commander to perform a System Management task when the System Manager is away from the facility.

IMPORTANT — This option is a specially designed function that operates somewhat differently than the other options. To perform Restore System Manager, you must have the System Manager Save Tape. Because System Management in AQCESS is a very sensitive privilege, this tape

18. R - RESTORE SYSTEM MANAGER (CONTINUED)

should be secured at all times in the Commander's office. If you exercise reasonable care while using your user ID, you should never need to use this option after installing AQCESS.

Once the new System Manager ID and password have been established, the routine used to create this ID will be erased from the system. Therefore, you will be unable to select Update Option R without having the tape.

18.1 TO PERFORM RESTORE SYSTEM MANAGER

- With the System Manager Save Tape mounted on the drive, rewound and online, select U (Update) at the OPTION prompt and press Return.

  The UPDATE OPTION prompt is displayed.

- Enter R (Routine Load) and press Return.

  The system prompts, TRAINING, LIVE OR MANAGER.

- Enter L for LIVE and press Return.

  The system will respond with ROUTINE RESTORE, and you'll be asked for the Input Device.

- Enter 47 and press Return.

  The system prompts, MAGTAPE MODE? <D>.

- Press Return to accept the default value.

  The system prompts, BLOCK SIZE? <1024>.

- Press Return to accept the default value.

18.1 TO PERFORM RESTORE SYSTEM MANAGER (CONTINUED)

The computer will then give you the date the routine was placed on tape, as well as and the header, which should be SYSTEM MANAGER SAVE TAPE. The system will then display the prompt RESTORE ALL (A) OR SELECTED (S) <A>.

- Press Return to load all routines.

After printing the routine name, SMRC, the INPUT DEVICE prompt will display again.

- Press Return to exit this option. Return to the OPTION prompt and select R (RESTORE SYSTEM MANAGER).

The system will prompt you for TERMINAL NUMBER.

- Enter the terminal number you will be using to perform AQCESS System Manager tasks and press Return.

The system will ask you for the user ID and password you wish to use.

NOTE: The new USER ID can only be 3 characters long and the new password must be at least 3 characters long.

18.1 TO PERFORM RESTORE SYSTEM MANAGER (CONTINUED)

- Enter the System Manager user ID. Enter a password. To maintain security, either destroy this log sheet or, as soon as this procedure is complete, sign on to AQCESS and change the password through System Management.

  After pressing Return, you will see the EXIT prompt. You will not be able to select this Restore Option again, unless you perform this entire operation again.

  You must use AQCESS System Management to establish additional user IDs before anyone else may sign on to AQCESS. You may want to review your privileges and add any not provided to you.

SYSTEM MANAGEMENT TRAINING AID

19. AR - ARCHIVE PROCESSING

ACCESS — Enter AR at OPTION prompt on the Operations Main Menu and press Return.

PURPOSE — Archiving, which releases inactive records from the data base, is performed monthly by the system manager/operator. The system archives records onto tape and deletes these records from the data base. Registration data will never be removed from the data base.

DESCRIPTION — When the archiving function is performed, the system will select records in the data base which meet the criteria listed below, and archive only those records.

a. Inpatient Records must meet these four criteria:

   1. The Clinical Records must have a status of "T" (Transmitted to tape for higher commands) or "D" (Deleted from being transmitted to tape for higher commands).

   2. If the record has gone through Cashier Processing, then Cashier records must have a status of "Z" (Zero balance) or "T" (Transferred) or "I" (Initial MSA Install).

19. AR - ARCHIVE PROCESSING (CONTINUED)

3. If the record has gone through Inpatient Occurrence Screening Checklist (Quality Assurance), then Inpatient Occurrence Screening records must have a return date from review for every action code of "Y" (entered into the provider profile) for all existing audit subfile records.

4. The latest date among the Clinical Records last modified date (item 1 above), Cashier Status Date (item 2 above), and the latest return date from review of the Inpatient Occurrence Screening Checklist (item 3 above) must be older than the Archive Date. The Archive Date is based on today's date and CR ARCHIVE MONTHS specified in the MTF Profile.

b. QA Incident, Problems and Provider Profile Records with the following criteria will be archived.

1. Incidents -
The latest dates among Date of Incident, Date Action 1, Date Action 2, and Date Action 3 must be older than

19. AR - ARCHIVE PROCESSING (CONTINUED)

the Archive Date. The Archive Date is based on today's date and QA INCIDENT/PROBLEM MONTHS specified in the MTF Profile.

2. Problems -
The Resolve Flag must have a value of "Y" and the last Status Date must be older than the Archive date. The Archive Date is based on today's date and QA INCIDENT/PROBLEM MONTHS specified in the MTF Profile.

3. Provider's Profile -
The Provider must have a Delete Date which is older than the Archive Date. The Archive Date is based on today's date and QA PROVIDER PROFILE MONTHS specified in the MTF Profile.

IMPORTANT The system will not perform archiving functions unless a value is set for the Archive Months fields in the MTF Profile, both for the Archive Months field on the CR Parameters Screen and the QA Archive Months fields on the QA Parameters Screen. The value set for the Archive Months determines how 'old' a completed record must

19. AR - ARCHIVE PROCESSING (CONTINUED)

be for it to qualify for archiving. For example, if the value set for the Archive Months is 3, records 3 months old and older will be archived when the archiving function is performed, provided all remaining criteria are met.

OPTIONS I - INPATIENT archives all inpatient records that meet the archiving criteria.

Q - QA ACCIDENT/PROBLEMS AND PROVIDE PROFILE archives all incidents, problems, and provider profiles that meet the archiving criteria.

After selecting I or Q, the following options are available:

OPTIONS C - CREATE ARCHIVE TAPE will evaluate which records are to be archived and those meeting the criteria will be transferred to a tape.

L - LIST ARCHIVE TAPE will provide a list of all records which have been archived to the designated tape.

R - RESTORE ARCHIVE TAPE will enable the MTF to load any archived data back into the database.

19.1 TO CREATE ARCHIVE TAPE

- With a blank tape in the tape drive, select I (INPATIENT) or Q (QA INCIDENT/PROBLEMS AND PROVIDER PROFILE) at ARCHIVE OPTION prompt and press Return.

ARCHIVING PROCEDURE: prompt is displayed.

- Enter C (CREATE ARCHIVE TAPE) and press Return.

The system will respond, DO YOU HAVE A BLANK TAPE IN THE TAPE DRIVE?

- Enter "Y"(Yes) or "N"(No).

If you enter "Y", the system will respond, CONFIRM BY RESPONDING "YES" TO CONTINUE ARCHIVING:

- Enter "Y" or "N."

If you enter "Y", the system will respond by printing a "." for each record archived. When the archiving process is complete the message ARCHIVE TAPE FROM (MTF NAME) CREATED ON (TODAY'S DATE) AT (TIME) will print. The system will then display the ARCHIVING ROSTER.

19.1 TO CREATE ARCHIVE TAPE (CONTINUED)

NOTE: The system will not perform archiving functions unless a value is set for the ARCHIVE MONTHS in the MTF Profile.

19.2 TO LIST ARCHIVED RECORDS

- With the Archive tape in the tape drive, enter I(INPATIENT) or QA (INCIDENT/PROBLEMS AND PROVIDER PROFILE) at ARCHIVE OPTION prompt and press Return.

The ARCHIVING PROCEDURE options will be displayed.

- Enter L (LIST ARCHIVE TAPE) and press Return.

The system will respond with the question, DO YOU HAVE THE ARCHIVED TAPE IN THE TAPE DRIVE?

- Enter "Y" or "N" and press Return.

If you enter "Y" the system will respond with a list of all records which have been archived onto the designated tape.

19.3 TO RESTORE RECORDS

19.3.1 TO RESTORE INPATIENT RECORDS

- With Archive tape in the tape drive, select I (INPATIENT) at the ARCHIVE OPTION prompt and press Return.

The system will respond with the ARCHIVE PROCEDURE prompt.

- Select R (RESTORE ARCHIVE TAPE) and press Return.

The system will respond with the question, DO YOU HAVE THE ARCHIVED TAPE IN THE TAPE DRIVE?

- Enter "Y" or "N" and press Return.

The system will respond with the question, ARCHIVE TAPE FROM (MTF NAME) CREATED ON (ARCHIVE CREATION DATE) OKAY?

- Enter "Y" or "N", and press Return.

If "Y" is entered, system will respond with the question, DO YOU WANT TO RESTORE THE ENTIRE TAPE?

19.3.1 TO RESTORE INPATIENT RECORDS (CONTINUED)

- Enter "Y" if you wish to restore the entire tape, or "N" if you want to restore only individual INPATIENT records.

If you enter "Y" the entire tape will be restored. If you enter "N" the system will respond with REGISTER NO.

- Enter the REGISTER NUMBER of the inpatient record you wish to restore, and press Return.

The system will respond with LOADED REGISTER NO(the number you entered), then request the next desired REGISTER NO.

- Enter the REGISTER NUMBER of the next inpatient record you wish to restore, if any, and press Return. Repeat this procedure until you have entered the REGISTER NUMBER of each record you wish to restore. Press Return at the REGISTER NUMBER prompt to exit the Restore function.

19.3.2 TO RESTORE QA INCIDENT/PROBLEMS AND PROVIDER PROFILE RECORDS

- With Archive Tape in the tape drive, select Q (QA INCIDENT/PROBLEMS AND PROVIDER PROFILE) at the ARCHIVE OPTION prompt and press Return.

The system will respond with the ARCHIVE PROCEDURE prompt.

- Select R (RESTORE ARCHIVE TAPE) and press Return.

The system will respond with the question, DO YOU HAVE THE ARCHIVED TAPE IN THE TAPE DRIVE?

- Enter "Y" or "N" and press Return.

The system will respond with the question, ARCHIVE TAPE FROM (MTF NAME) CREATED ON (ARCHIVE CREATION DATE) OKAY?

- Enter "Y" or "N", and press Return.

If "Y" is entered, system will respond with the question, DO YOU WANT TO RESTORE THE ENTIRE TAPE?

19.3.2 TO RESTORE QA INCIDENT PROBLEMS AND PROVIDER PROFILE RECORDS

- Enter "Y" if you wish to restore the entire tape, or "N" if you want to restore only individual QA INCIDENT/PROBLEM AND PROVIDER PROFILE records, and press Return.

If you enter "Y" the entire tape will restored. If you enter "N" the system will respond with the ENTER TYPE prompt.

- Enter I (INCIDENT) if you wish to restore individual INCIDENT records.

The system will respond with the INCIDENT NO prompt.

- Enter the INCIDENT NO of the INCIDENT you wish to restore.

The system will respond with the INCIDENT NO prompt.

- Enter the INCIDENT NO of the next INCIDENT you wish to restore. When you have restored all the INCIDENTS you wish to, press Return at the INCIDENT NO prompt.

The system will respond with the ENTER TYPE prompt.

19.3.2 TO RESTORE QA INCIDENT/PROBLEMS AND PROVIDER PROFILE RECORDS

Enter P (PROBLEM) if you wish to restore individual PROBLEM records.

The system will respond with the PROBLEM NO prompt.

- Enter the PROBLEM NO of the the PROBLEM you wish to restore.

The system will respond with the PROBLEM NO prompt.

- Enter the PROBLEM NO of the next PROBLEM you wish to restore. When you have restored all the PROBLEMS you wish to, press Return at the PROBLEM NO prompt.

The system will respond with the ENTER TYPE prompt.

- Enter V (PROVIDER) if you wish to restore PROVIDER records.

The system will respond with the PROVIDER ID prompt.

- Enter the PROVIDER ID of the PROVIDER records you wish to restore.

19.3.2 TO RESTORE QA INCIDENT/PROBLEMS AND PROVIDER PROFILE RECORDS

The system will respond with the confirmation message LOADED PROVIDER (PROVIDER ID).

The system will then respond with the PROVIDER ID prompt.

- Enter the PROVIDER ID of the next PROVIDER record you wish to restore. When you have restored all the PROVIDER records you wish to, press Return at the PROVIDER ID prompt.

The system will respond with the ENTER TYPE prompt.

- Press Return at the ENTER TYPE prompt if you have no more QA INCIDENT/PROBLEMS AND PROVIDER records to restore.

20. SO - LOAD RELEASE SOFTWARE

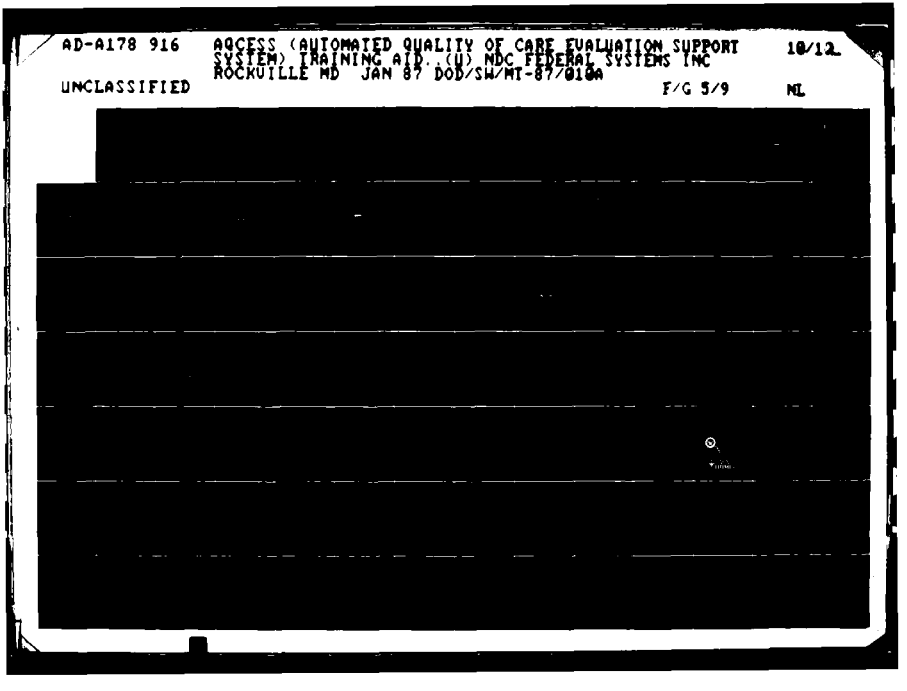
ACCESS: Enter SO at the OPTION prompt.

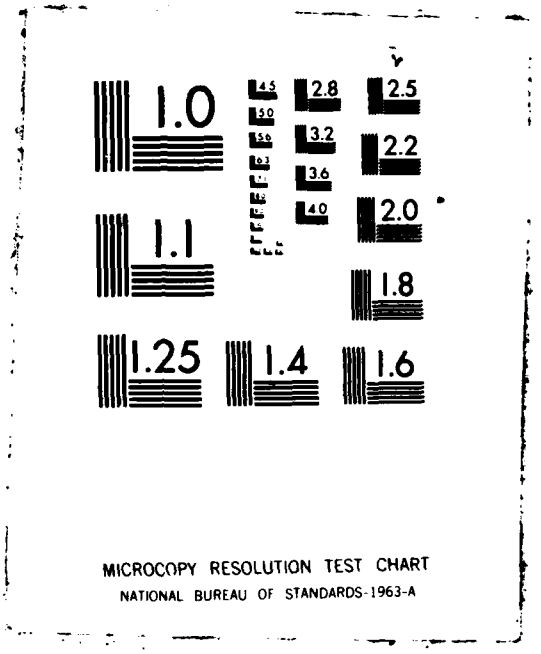
PURPOSE: This option automates the upgrade of AQUEST software by loading newly released software in a one-step process.

SYSTEM MANAGEMENT TRAINING AID

AD-A178 916 AQCESS (AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM) TRAINING AID..(U) NDC FEDERAL SYSTEMS INC ROCKVILLE MD JAN 87 DOD/SW/MT-87/010A 10/12

UNCLASSIFIED F/G 5/9 NL




1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
4.5
5.0
5.6
MICROCOPY RESOLUTION TEST CHART
NATIONAL BUREAU OF STANDARDS-1963-A

21. DAILY/WEEKLY/MONTHLY CHECKLIST

Certain reports have been noted in these instructions which must be sent to AQCESS Customer Support on a regular basis. Additionally, certain functions must be performed on a regular basis. This Section contains a reference list, which can assist you in verifying these reports and functions and in observing the schedule.

21.1 DAILY FUNCTIONS/REPORTS

CHECK CONSOLE LOG: At the end of each day, the console log should be removed from the console and examined for:

<CRASH>
<DKRES>
<DBOYF>
<DKJER>
<DSCON>
<NOBUF>
<DKHER>
<DKSER>

These are errors that may cause harm to your system if not investigated. Should you find any of these errors on your console log, notify AQCESS Customer Support immediately (see the front of this Training Aid).

Additionally, you should verify that the correct date and time were entered when booting the system. If the date and time are wrong, correct them; you may wish to notify any departments that could have been impacted by the incorrect information.

COMPILE ERROR LIST: See Section 3.

BACKUP SYSTEM: See Section 10.

21.2 WEEKLY FUNCTIONS/REPORTS

VERIFY INTEGRITY: See Section 6.

TALLY DISK BLOCKS: See Section 12.

SEND REPORTS TO AQCESS CUSTOMER SUPPORT: The Integrity Report, Error Lists, and Disk Block Tally should be sent to AQCESS Customer Support (see front of this Training Aid for the address).

SYSTEM MANAGEMENT TRAINING AID

22. HARDWARE OVERVIEW

This section describes the hardware configurations on which AQCESS operates, the terminals, printer, and power system used, and contains illustrations of each.

22.1 SYSTEM CONFIGURATION

AQCESS runs on the PDP-11 series of computers manufactured by the Digital Equipment Corporation (DEC). Specifically, AQCESS operates on the following types of PDP-11's:

- PDP-11/23 (System 1). This is the smallest of the PDP-11 computers used by AQCESS. The total hardware configuration for the PDP-11/23 consists of:

  - PDP-11/23 Processor (with RD52 Disk Drive) (Figure 1)
  - TK 25 Cassette Tape Drive (Figure 2)
  - Letterwriter 100 Console (Figures 3a and 3b)

22.1 SYSTEM CONFIGURATION (CONTINUED)

- PDP-11/23 PLUS (System 2). This is the middle-sized computer used by AQCESS. The hardware configuration for the PDP-11/23 PLUS consists of:

  - PDP-11/23 PLUS Processor (with RD51 Disk Drive, RD52 Disk Drive) (Figure 4)
  - TK 25 Cassette Tape Drive (Figure 2)
  - Letterwriter 100 Console (Figures 3a and 3b)

- PDP-11/84 (System 3). This is the largest computer used by AQCESS. The hardware configuration for the PDP-11/84 consists of:

  - PDP-11/84 Processor (Figure 5)
  - RA80 Disk Drive (Figure 6)
  - TU80 Mag Tape Drive (Figure 7)
  - Letterwriter 100 Console (Figures 3a and 3b).

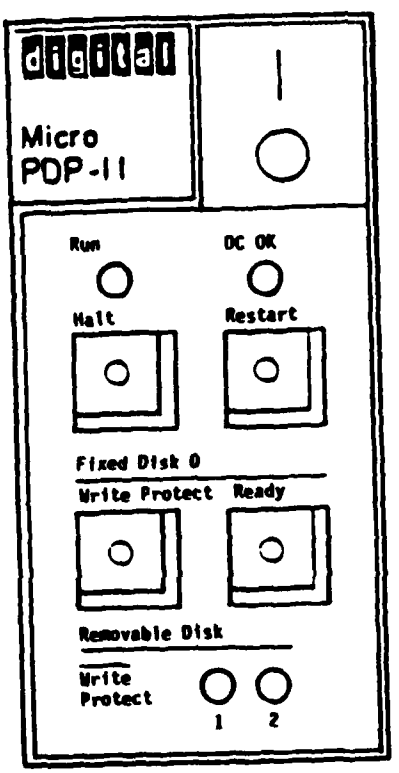


Figure 1. PDP-11/23 Processor

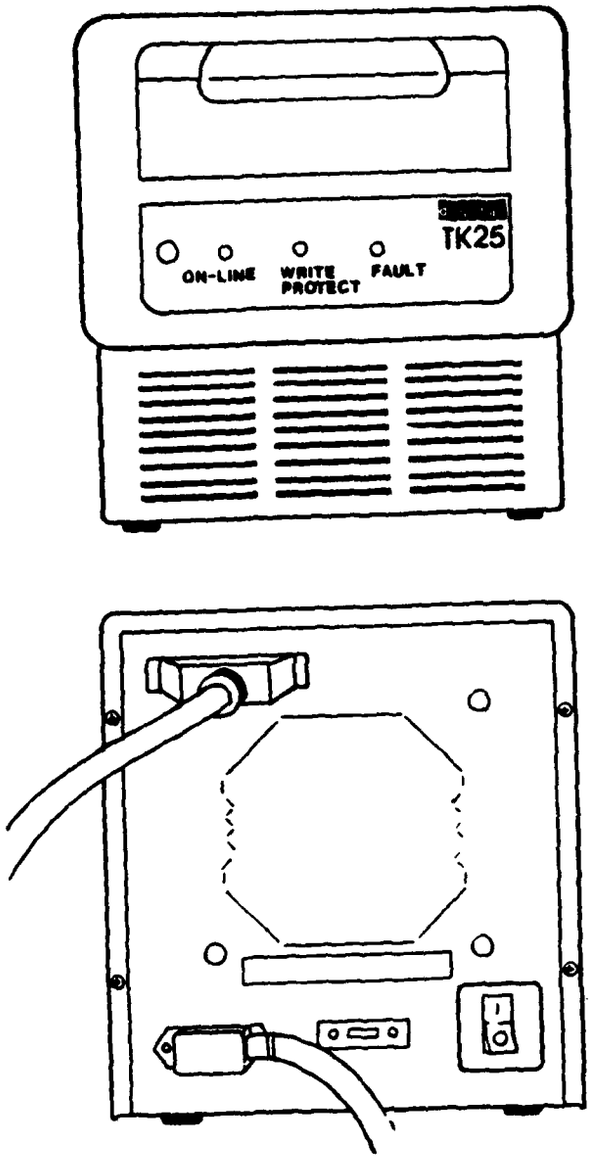


Figure 2. TK25 Tape Drive

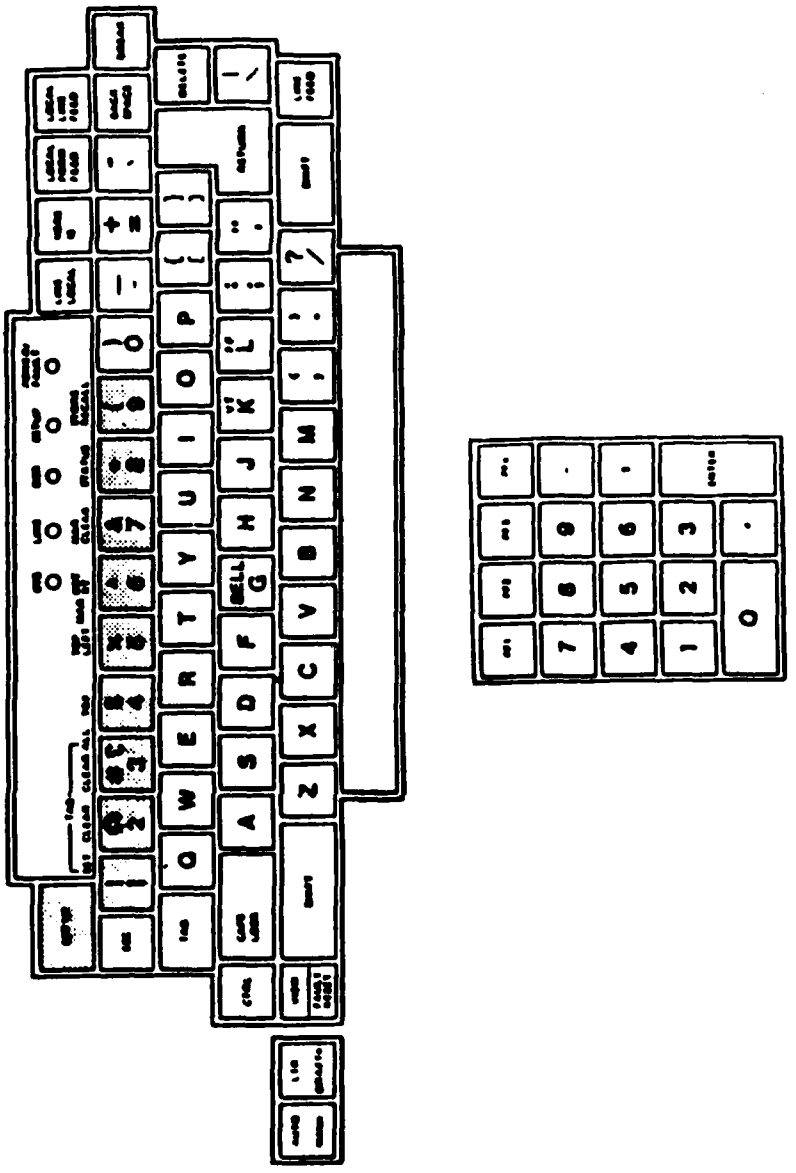
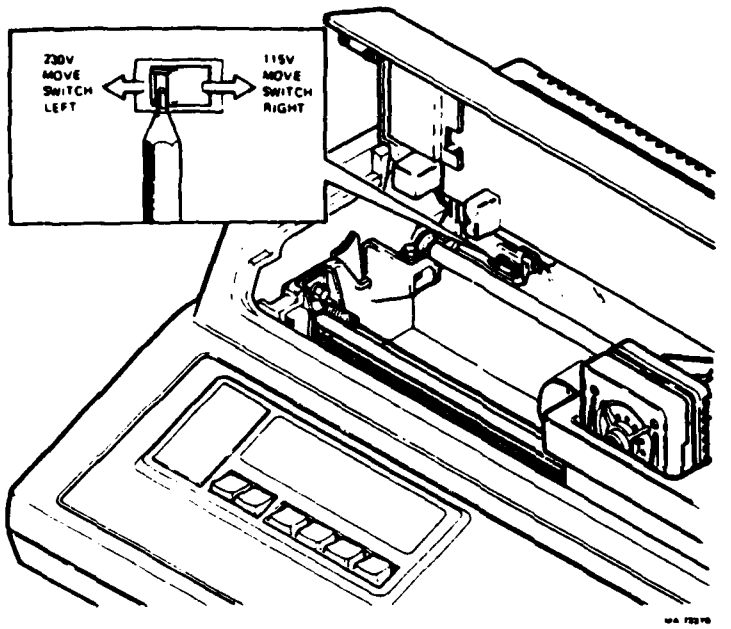
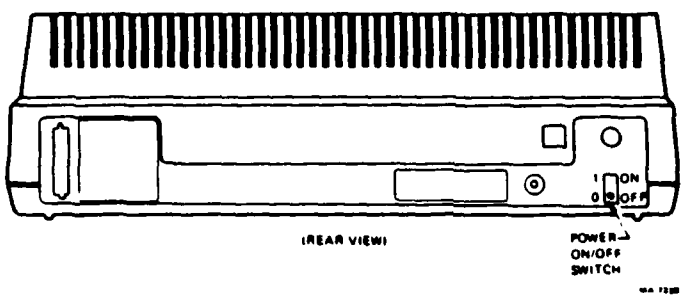


Figure 3a. Letterwriter 100 Console (Keyboard)



VOLTAGE SELECTOR SWITCH



POWER ON/OFF SWITCH

Figure 3b. Letterwriter 100 Console

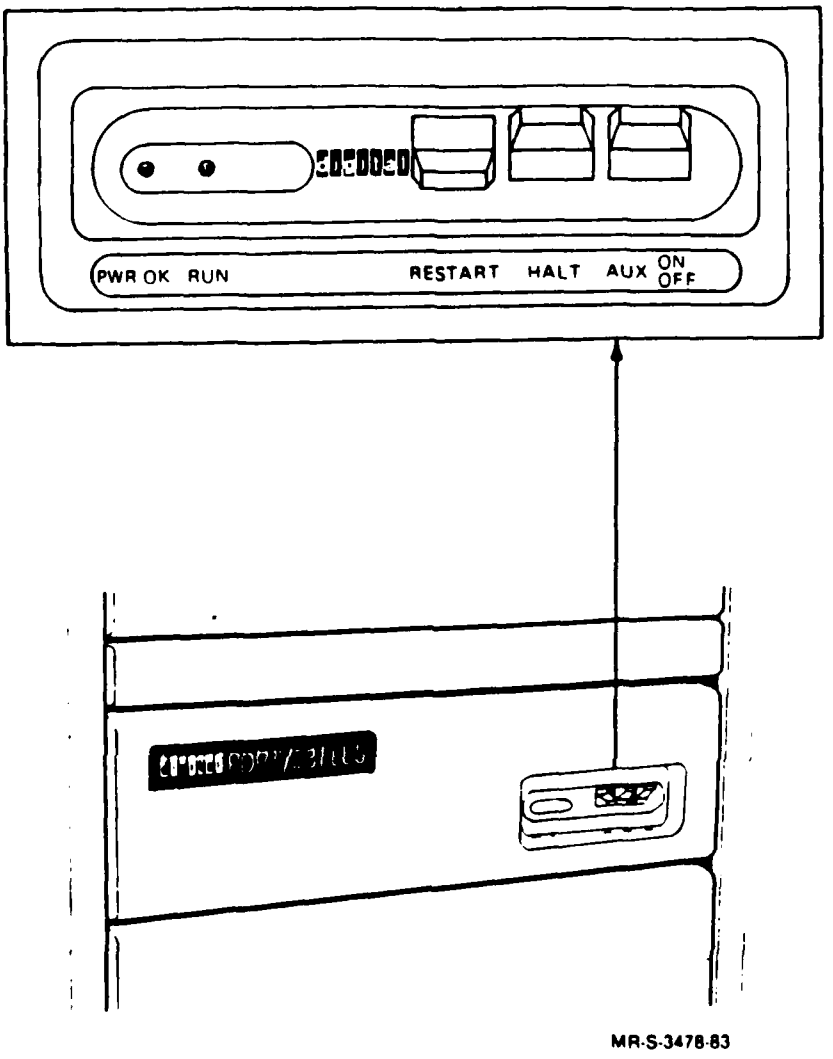


Figure 4. PDP-11/23 PLUS Processor

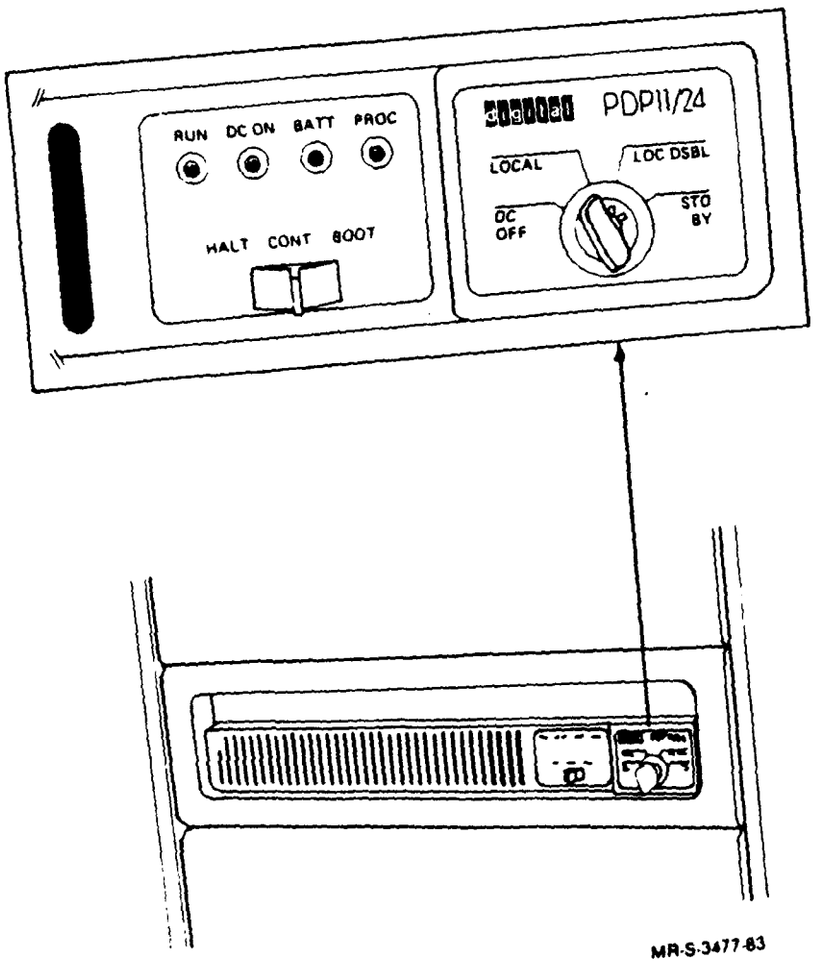


Figure 5. PDP-11/84 Processor

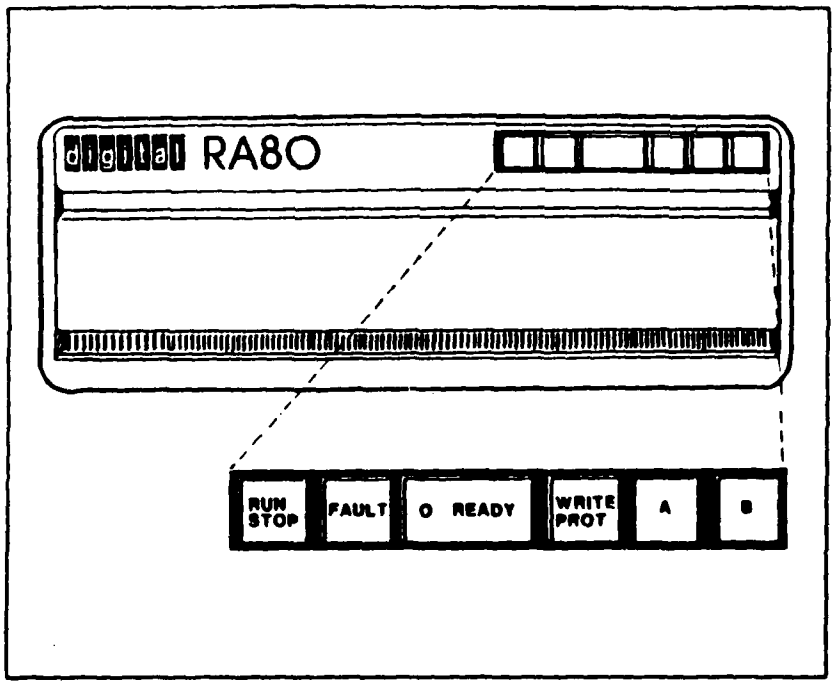


Figure 6. RA80 Disk Drive

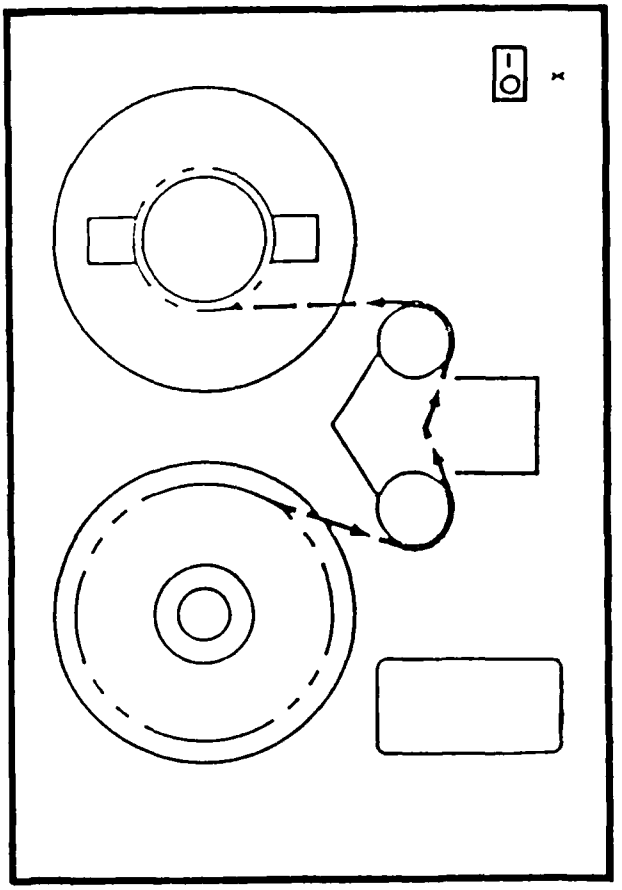


Figure 7. TU80 Mag Tape Drive

22.2 ACCESS TERMINALS

Terminals used to communicate with the PDP-11 computer fall into two general categories:

- Hard-copy Terminals, which print on continuous forms of paper. This type of terminal will provide a permanent record of the terminal session. Hard-copy terminals will be used as the consoles for all systems. The Letterwriter 100 hard-copy terminal will be used with all of the PDP-11 systems (see Figures 3a and 3b).

- Video Display Terminals, which print on a television-like screen called a Cathode Ray Tube (CRT). Generally you cannot get a permanent record of your terminal session from a video display terminal. However, you will find that a video display terminal offers a faster and more effective work environment than a hard-copy device. The VT220 will be the display terminal used by all MTF's (Figures 8a, 8b, and 8c).

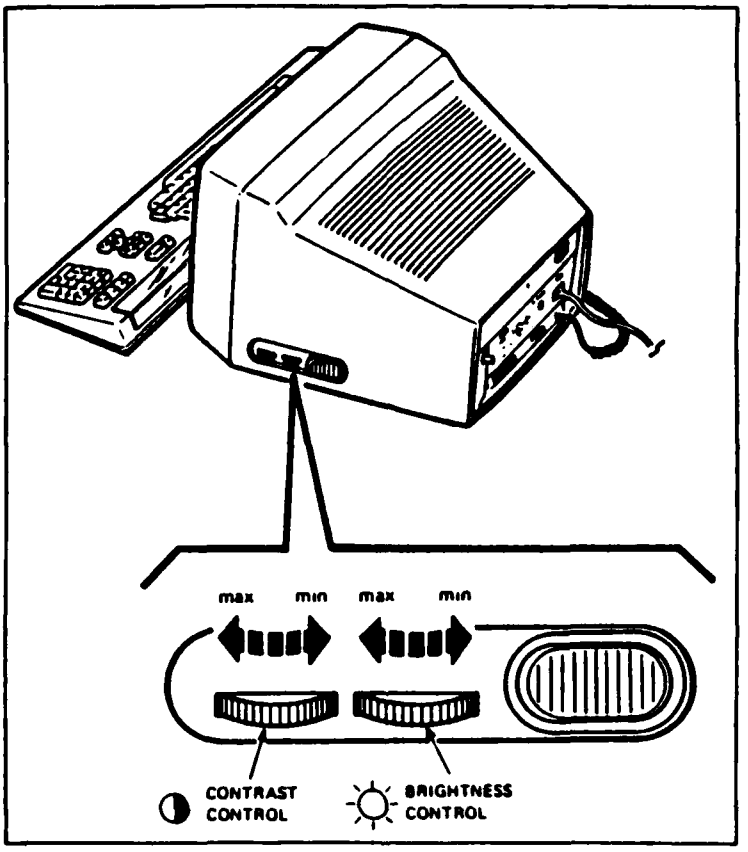


Figure 8a. VT220 Controls

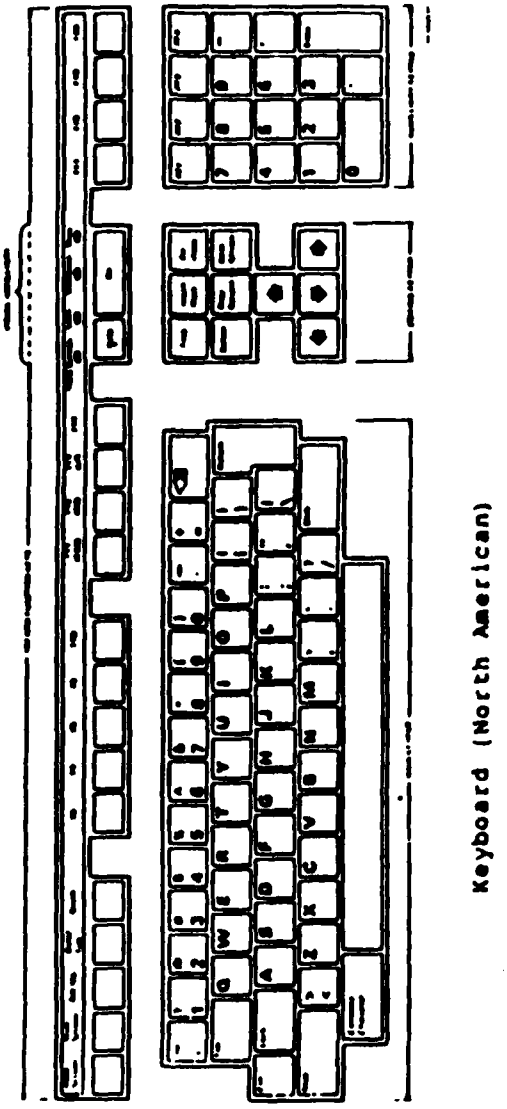


Figure 8b. VT220 Keyboard

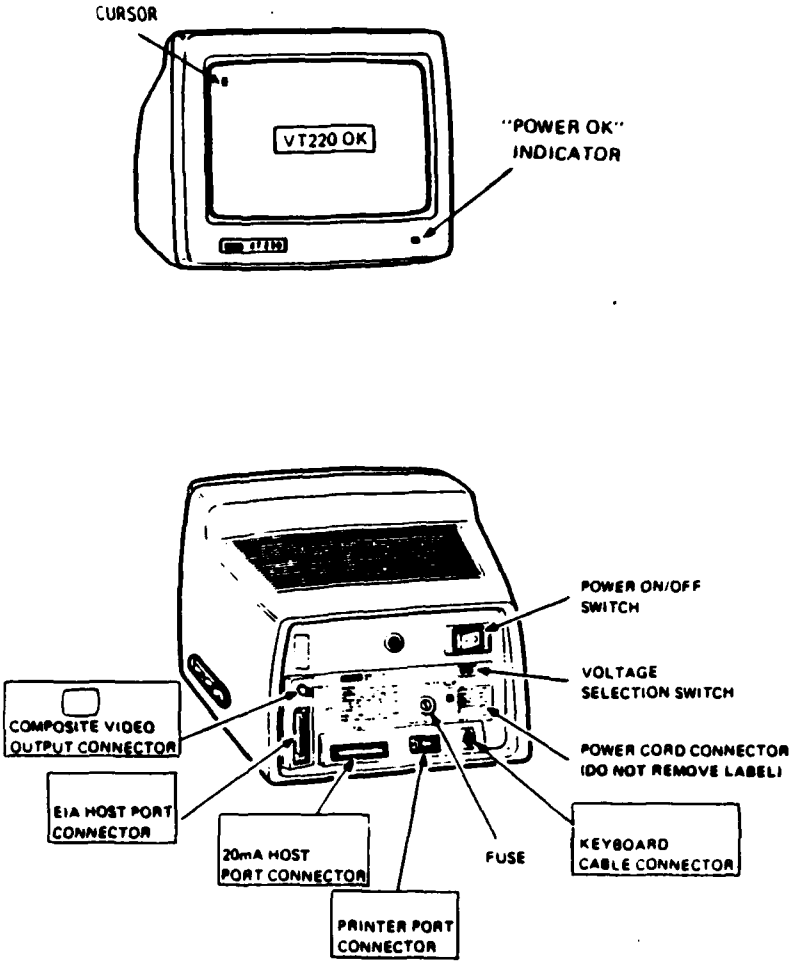


Figure 8c. VT220 CRT

22.3 PRINTER

The Letterwriter 100 printer (Figure 9) will be used to print your reports and related AQCESS products such as A&D Cover Sheets, A&D Index Cards, and Clinical Records Cover Sheets.

The type of printer stand available at your site will determine how your paper and forms are loaded. The optimal set-up consists of a printer stand with an opening in the bottom (Figure 10a). Another set-up is a stand without a opening (Figure 10b).

If you have a printer stand with an opening (Figure 10a), load the paper up through the opening in the stand and then through the bottom of the printer. Continue to feed the paper until it reaches the tractors.

If you have a printer stand without an opening (Figure 10b), place your paper or forms in front of the printer. Tilt the printer up and load paper through the bottom until it reaches the tractors.

The tractors need to be adjusted to the paper size. Position the left tractor to the extreme left side. Lift the tractor covers and place the holes of the paper into the tractor pins. Close the left cover and proceed to position the right side of the paper so that the holes of the paper line up with the pins in the right tractor.

22.3 PRINTER (CONTINUED)

Set the paper to top of form (TOF) by pressing the button labeled "Online Off". Turn the platen to scroll the paper so that the print head is just below the perforation. Press the "set TOF" button and then the "Online Off" button. Your paper or forms are now ready for printing.

Whenever different sizes of paper are loaded (e.g., changing from index cards to admission forms), the printer must be turned off and then on again and the top of form alignment must be reset.

NOTE: Loading of paper for the console follows the same procedures.

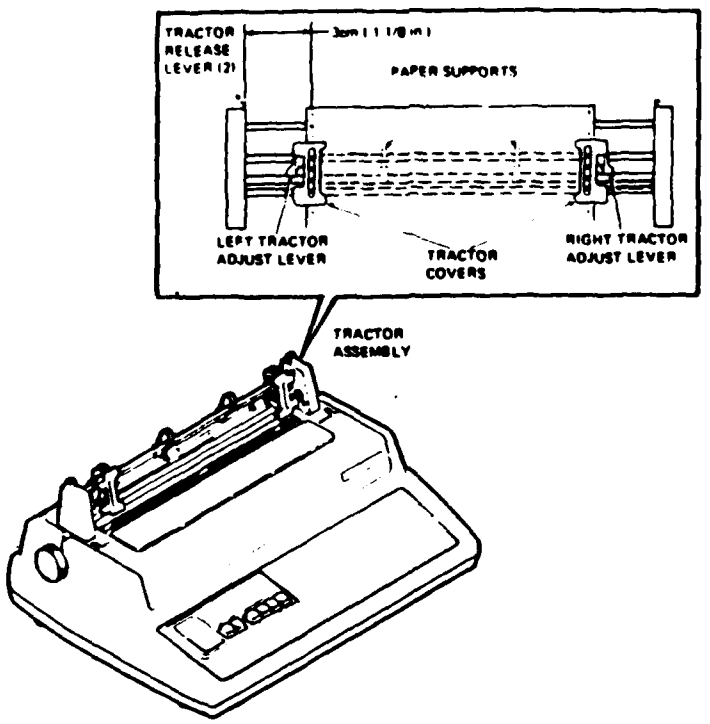


Figure 9. Letterwriter 100 Printer

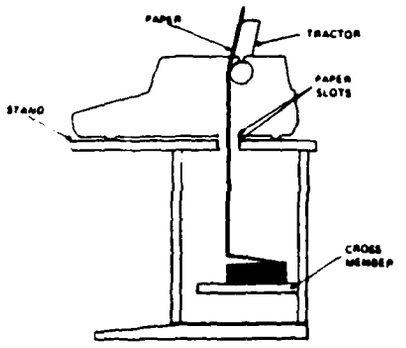


Figure 10a. Printer Stand with Opening

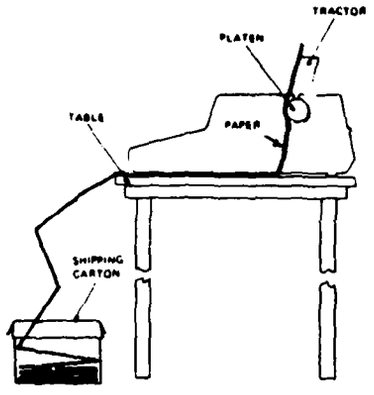


Figure 10b. Printer Stand without Opening

22.4 THE POWER SYSTEM

DESCRIPTION AQCESS uses the Topaz Powermaker Uninterruptible Power System, which connects to an AC power line between the utility power source and the critical load. As long as the AC input voltage is 85% of nominal, AC power flows through the UPS to the load. A battery charger used the AC power to keep the batteries fully charged.

If the utility power fails or drops more than 15% below nominal, the AC input line is disconnected from the UPS output receptacle. The inverter then draws DC power from the batteries to generate an AC voltage that is applied to the UPS output receptacle. When the utility power returns to within 9% of nominal, the AC input line is reconnected to the UPS output receptacle, the inverter switches off, and the battery charger recharges the batteries.

If the TOPAZ batteries are completely drained, the batteries are not completely recharged for 24 hours.

OPERATION Set the On/Off switch to ON. The indicator lamp lights whenever there is power at the output receptacle. The inverter initially delivers power to the output recep-

22.4 THE POWER SYSTEM (CONTINUED)

tacle, so the fan will start up. If the line voltage is normal, transfer to the AC line will occur in approximately three seconds, and the inverter and fan will turn off.

The audible alarm will sound whenever the inverter is running; it will also continue to sound after an overload shutdown or a low battery shutdown. The audible alarm consists of a short "beep" tone repeated at approximately 8 second intervals.

If transfer to the AC line does not occur within a few seconds after turning the unit on (audible alarm sounds and the fan continues to run), an adjustment of the transfer level may be required. Call DEC Field Service.

NOTE: The ON/OFF switch should be OFF whenever the UPS is not connected to the power line. If the switch is left on, the batteries will slowly drain.

If there is a power shutdown each evening at your facility, be sure to switch OFF the UPS. Otherwise, the inverter will start up and run until the batteries are discharged. If the unit is left in this state for more than 10 days, transfer to the line may not occur. Call DEC Field Service.

23. PROCEDURES FOR THE PDP-11/23

In these instructions, numbers in brackets refer to the hardware diagram named in the section.

23.1 TO POWER UP THE PDP-11/23

Figures 11a and 11b show the system configuration for the PDP-11/23.

- Push the switch on the front of the TOPAZ to the ON (up) position. When the TOPAZ is ON, the level light will be red.

- Push the switch in the back of the Letterwriter 100 (console) [1] to the ON (up) position.

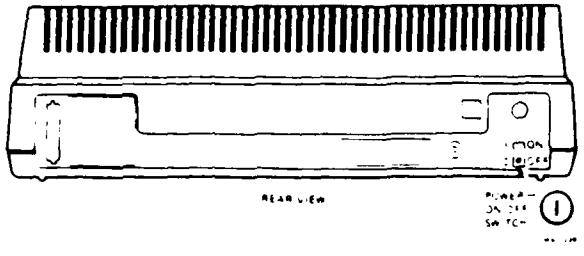
- Push the red switch on the back of the tape drive (TK25) [9] to the ON (up) position.

- Push the Power On Switch [2] to the ON (up) position. The Power On Switch will be red. The green "RUN" light [3] and green "DC OK" light [4] should be on.

23.1 TO POWER UP THE PDP-11/23 (CONTINUED)

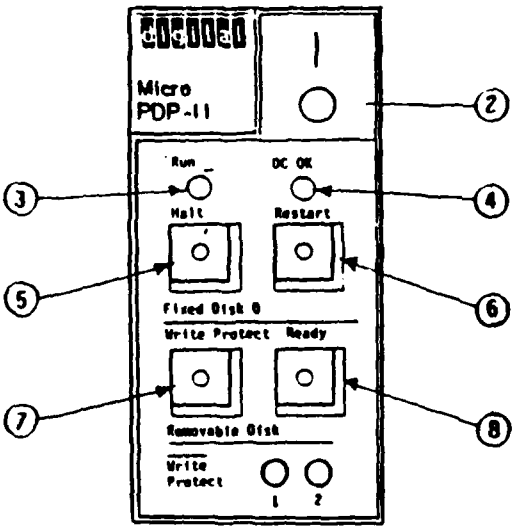
The PDP-11/23 is now powered up.

Verify: Write Protect [7] is off.
Disk Ready [8] light is on.
Run light on.
DC OK light on.

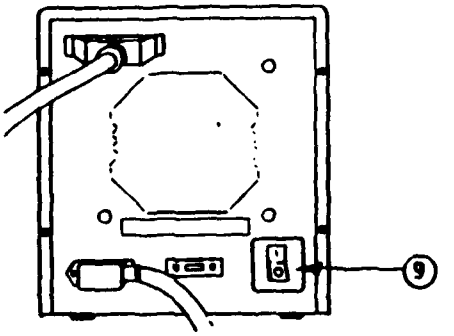


Letterwriter 100 Power On/Off Switch

Figure 11a. PDP-11/23 System Configuration



PDP-11/23 CPU



TK25 Power ON/OFF Switch

Figure 11b. PDP-11/23 System Configuration

23.2 TO START UP THE PDP-11/23

See Figures 11a and 11b.

- The HALT button [5] should be OUT.

- Push the restart button [6] IN.

  The system will now begin to boot from the disk.

- Press Return for ALL prompts except DATE and TIME. The DATE should be entered in the format: DD-MMM-YY (DD=day, MMM=month, YY=year).

  The TIME should be entered in the format: HH:MM:SS (HH=hours, MM=minutes, SS=seconds).

  When the system is completely up, the following message will be displayed:

  DSM-11 VERSION 3.0A IS NOW UP AND RUNNING! EXIT

- Press Return for the system operations OPTION prompt.

23.3 TO SHUT DOWN THE PDP-11/23

See Figures 11a and 11b.

- At the OPTIONS prompt on the console enter **SH** (SHUTDOWN SYSTEM). Refer to the Operations Manual for more information on this option.

  When the system is completely shutdown, the following message will be displayed:

  ```
  READY TO HALT
  EXIT
  ```

23.4 TO POWER DOWN THE PDP-11/23

See Figures 11a and 11b.

- Push the HALT button [5] IN.
- Turn the POWER ON switch [2] to the OFF (down) position.
- Push the red switch on the back of the tape drive (TK25) [9] to the OFF (down) position.
- Push the switch in the back of the Letterwriter 100 (console) [1] to the OFF (down) position.
- Push the switch on the front of the TOPAZ to the OFF (down) position.

  Verify: All lights should be off.

23.5 TO USE THE TK25 CASSETTE TAPE DRIVE

Figure 12 shows a diagram of the TK25 Tape Drive.

- Insert the cassette tape into the TK25.

  The online light will be flashing, indicating that the tape is rewinding and checking tape tension. This process is performed regardless of the position of the tape and takes approximately 5 minutes.

- When the rewind completes, press the online button.

  The online light will be a solid green. If the write-protect feature on the cassette has been set, the yellow write-protect light will be on. The tape is now ready for use.

- To eject the tape, press the eject bar on the front of the tape drive.

  The read-write heads will disengage.

- Remove the tape and place it in the cover.

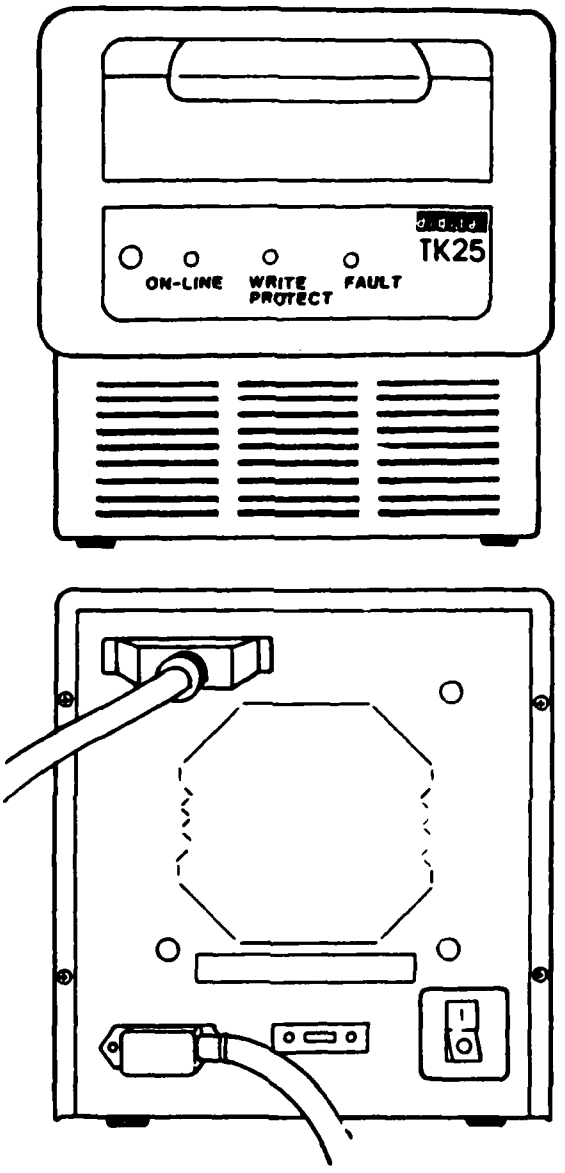


Figure 12. TK25 Tape Drive

SYSTEM MANAGEMENT TRAINING AID

24. PROCEDURES FOR THE PDP-11/23 PLUS

In these instructions, numbers in brackets refer to the hardware diagram named in the section.

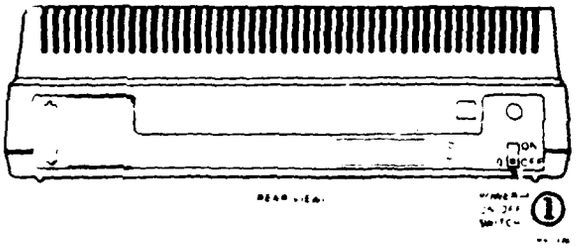
24.1 TO POWER UP THE PDP-11/23 PLUS

Figures 13a and 13b show the system configuration for the PDP-11/23 PLUS.

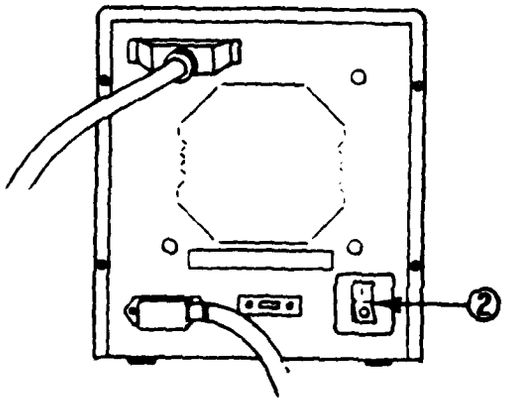
- Push the switch on the front of the TOPAZ to the ON position. When the TOPAZ is on, the lever will be red.
- Push the switch in back of the Letterwriter 100 (console)[1] to the ON (up) position.
- Push the red switch in back of the tape drive (TK25)[2] to the ON (up) position.
- Flip the AUX switch [3] to the ON (up) position. The red PWR OK light [4] on the front panel will come on.

  The PDP-11/23 PLUS is now powered up.

  Verify: Red PWR OK Light ON.
  Both Disk Online Lights [8] ON (green).
  Both Write-Protect Lights [9] OFF. (If on, would be orange.)

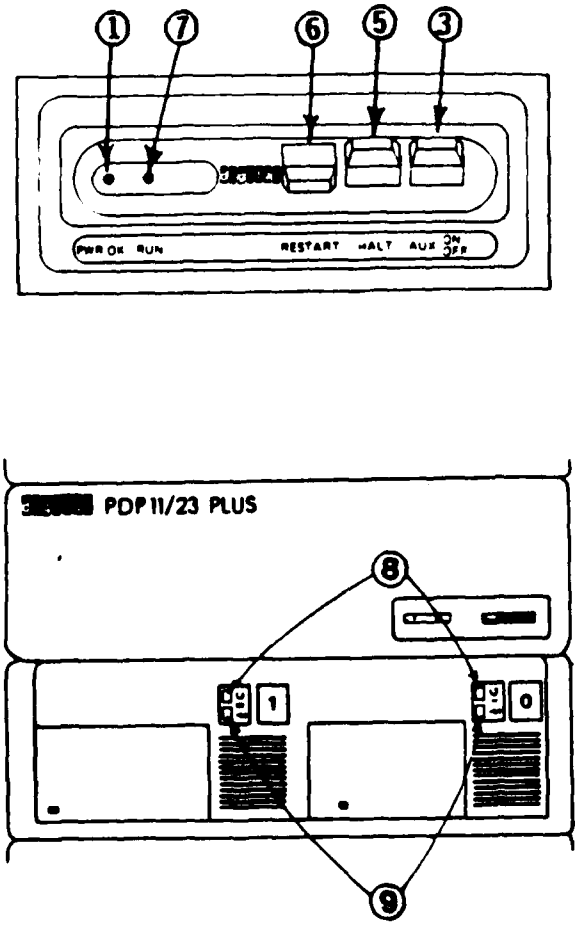


Letterwriter 100 Power ON/OFF Switch



TK25 Power ON/OFF Switch

Figure 13a. PDP-11/23 PLUS System Configuration



PDP-11/23 PLUS CPU

Figure 13b. PDP-11/23 PLUS System Configuration

24.2 TO START UP THE PDP-11/23 PLUS

See Figures 13a and 13b.

- Lift the HALT switch [5] to the UP position.
- Lift the RESTART switch [6] to the UP position. The RESTART switch will spring back to the center position and the red run indicator light [7] will come on.

The system will now begin to boot from the disk.

- Press Return for ALL prompts except DATE and TIME. The DATE should be entered in the format: DD-MMM-YY (DD=day, MMM= month, YY=year).

The TIME should be entered in the format: HH:MM:SS (HH=hour, MM=minutes, SS=seconds).

When the system is completely up, the following message will be displayed:

DSM-11 VERSION 3.0A IS NOW UP AND RUNNING! EXIT

- Press Return for the System Operations OPTION prompt.

24.3 TO SHUT DOWN THE PDP-11/23 PLUS

See Figures 13a and 13b.

- At the OPTIONS prompt on the console, enter **SH** (SHUTDOWN SYSTEM). Refer to the Operations Manual for more information on this option.

When the system is completely shutdown, the following message will be displayed:

```
READY TO HALT
EXIT
```

24.4 TO POWER DOWN THE PDP-11/23 PLUS

See Figures 13a and 13b.

- Push the HALT switch [5] to the down position.
- Flip the AUX switch [3] to the OFF (down) position.
- Push the red switch in the back of the tape drive (TK25)[2] to the OFF position.
- Push the switch in the back of the Letterwriter 100 [1] to the OFF (down) position.
- Push the switch on the front of the TOPAZ to the OFF position.

Verify: All lights should be off.

24.5 TO USE THE TK25 CASSETTE TAPE DRIVE

Figure 14 shows a diagram of the TK25 Tape Drive.

- Insert the cassette tape into the TK25.

  The online light will be flashing, indicating that the tape is rewinding and checking tape tension. This process is performed regardless of the position of the tape and takes approximately 5 minutes.

- When the rewind completes, press the online button.

  The online light will be a solid green. If the write-protect feature on the cassette has been set, the yellow write-protect light will be on. The tape is now ready for use.

- To eject the tape, press the eject bar on the front of the tape drive.

  The read-write heads will disengage.

- Remove the tape and place it in the cover.

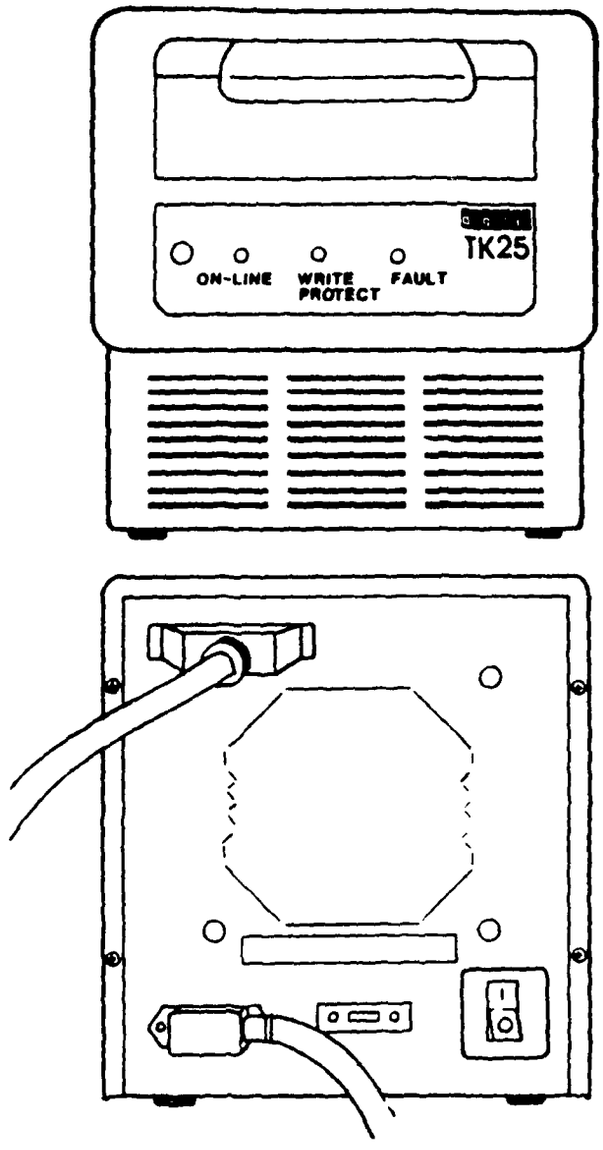


Figure 14. TK25 Tape Drive

25. PROCEDURES FOR THE PDP-11/84

In these instructions, numbers in brackets refer to the hardware diagram named in the section.

25.1 TO POWER UP THE PDP-11/84

Figures 15a and 15b show the system configuration for the PDP-11/84.

The UPS should be running at all times. During periodic maintenance the system must be shut down and unplugged from the electrical outlet. Make sure the "Audible Alarm Volume Control" in the cabinet is set to "LOUD". If required to activate the UPS, do the following steps:

- Turn the top right hand corner key switch to a horizontal (ON) position activating UPS operation. Move the Battery Circuit Breaker and Line Circuit Breaker Load Circuit Breaker(s) inside the cabinet to ON position. If a breaker does not remain closed, DO NOT TRY TO RECLOSE IT. Do not proceed further. Inform NOC Customer Support and place a service call to DEC.

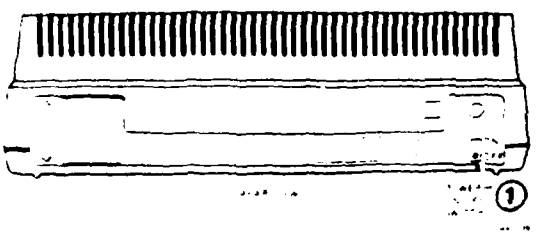
- During the startup sequence of the unit several alarm lights, as well as the audible alarm, will activate. Ignore these at this time but silence the

25.1 TO POWER UP THE PDP-11/84 (CONTINUED)

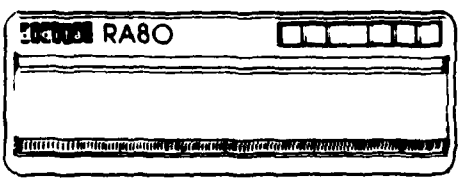
audible alarm by pushing the Alarm Silence push button on the right side of the display panel. When the charge sequence routine is discontinued all alarms will go off and "SYSTEM NORMAL" should come on. EXCEPTION: "LOW BATTERY" indicator will remain on until battery has recovered to 132 VDC.

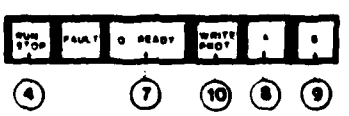
NOTE: During operation of the UPS, there are dangerous voltages present within the cabinetry. Do not operate the UPS with the cabinet door open.

- Press the switch at the back of the Letterwriter 100 (console) [1] to the ON (up) position.
- Verify that the circuit breaker at the back of the disk drive (RA80) is ON. (If the circuit breaker is on, the fan for the disk drive should be running.)
- Open the lid of the tape drive and push the red switch [2] to the ON (down) position.
- Push the LOGIC ON button [3] on the front of the tape drive (TU80).
- Push in the RUN/STOP[4] button on the front of the CPU. The RUN/STOP light should be yellow.



Letterwriter 100 Console Power On/Off Switch





RA80 DISK DRIVE

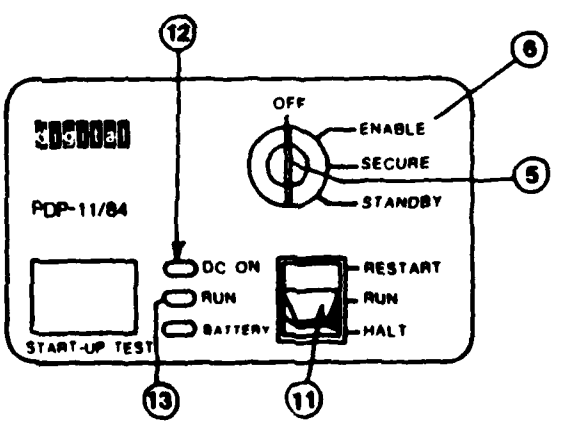
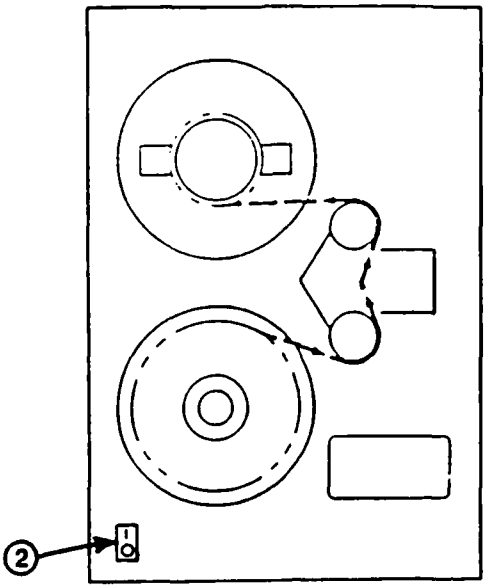


FIGURE 15a. FRONT PANEL CONTROLS AND INDICATORS

Refer to table(s) 1, 2, and 3 for description of Front Panel Controls and Indicators.



TU80 Mag Tape Drive

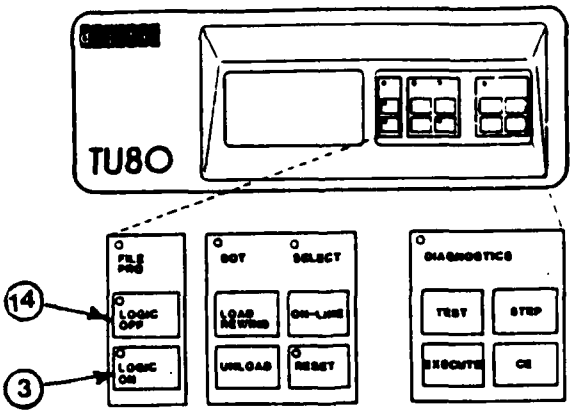


FIGURE 15b. PDP-11/84 SYSTEM CONFIGURATION

25.1 TO POWER UP THE PDP-11/84 (CONTINUED)

- Turn the red CPU KEY [5] to the ENABLE position [6]. The DC ON light [12] and RUN light [13] will be green.

  The PDP-11/84 is now powered up.

  Verify: Yellow Run/Stop Light is on.
  White Ready Light [7] is on.
  "A" Button [8] is in.
  "B" Button [9] is out.
  Yellow Write-Protect button [10] is off (out).
  Halt Switch [11] in the center position (Run).

25.2 TO START UP THE PDP-11/84

See Figures 15a and 15b.

- Push the HALT switch [11] to HALT.
- Return HALT switch [11] to CENTER (Run) position, then over to Restart.

  The system will now begin to boot from the disk. The run light will glow green.

- Press Return for ALL prompts except DATE and TIME. The DATE should be entered in the format: DD-MM-YY (DD=day, MMM= month, YY=year).

25.2 TO START UP THE PDP-11/84 (CONTINUED)

The TIME should be entered in the format: HH:MM:SS (HH=hour, MM=minutes, SS=seconds).

When the system is completely up, the following message will be displayed:

DSM-11 VERSION 3.0A IS NOW UP AND RUNNING! EXIT

- Press Return for the system operations OPTION prompt.

NOTE: When the system is completely up, turn the red CPU key to SECURE, then remove the key. Store the key in a safe, easily accessible place.

25.3 TO SHUT DOWN THE PDP-11/84

See Figures 15a and 15b.

- At the OPTIONS prompt on the console, enter **SH** (SHUTDOWN SYSTEM). Refer to information on this option.

When the system is completely shutdown, the following message will be displayed.

```
READY TO HALT
EXIT
```

25.4 TO POWER DOWN THE PDP-11/84

See Figures 15a and 15b

- Turn the red CPU key to ENABLE.
- Press the HALT switch [11] to HALT.
- Push the RUN/STOP button. The light should go OFF and the button will be OUT.
- Turn the red CPU key [5] to OFF.
- Push the LOGIC OFF [14] button on the front of the tape drive (TU80).
- Open the lid of the tape drive and turn the red switch [2] to the OFF (down) position.
- Press the switch at the back of the Letterwriter 100 [1] to the OFF (down) position.
- Flip the circuit breaker at the back of the disk drive (RA80) OFF.

The UPS should be running at all times. During periodic maintenance the system must be shut down and unplugged from the electrical outlet. If required to deactivate the UPS, do the following steps or leave the system running.

- Turn the top right hand corner key switch to a vertical (OFF) position, deactivating UPS operation.

- Turn off the Line Circuit Breaker and the Battery Circuit Breaker inside the cabinet to (OFF) position.

To remove power from your critical load equipment:

- Move the corresponding Load Circuit Breaker(s) to their (OFF) positions.
- Unplug the input power cord before performing maintenance on this equipment.

25.5 TO USE THE TU80 MAG TAPE DRIVE

Figure 16 shows a diagram of the TU80 Tape Drive.

TO MOUNT MAGNETIC TAPES

- Press LOGIC ON so that the light is ON.
- Open dust cover on top of drive.
- The center button on the Locking Hub [1] should be in the pressed-in position; the ring surrounding it should be in the UP position.
- Place tape on the Locking Hub [1] and thread it through the write/read heads as shown in the diagram, wrapping it around the center of the Take-Up Reel [2] until the loose end is tucked inside the remaining tape. Press IN the ring surrounding the Locking Hub [1].

25.5 TO USE THE TU80 MAG TAPE DRIVE (CONTINUED)

- Turn the Take-Up Reel four complete revolutions.
- Close the dust cover on the top of the drive.
- Press LOAD REWIND so that the light is ON.
- The tape will begin spinning.
- When the BOT LIGHT comes on, press ON LINE.

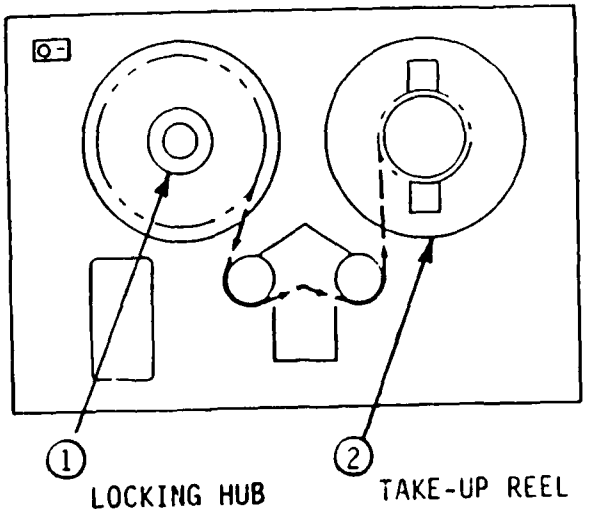


FIGURE 16. TU80 TAPE DRIVE

TO REMOVE MAGNETIC TAPES

- Press RESET.
- Press UNLOAD. The tape will automatically rewind.
- Open the dust cover on top of the drive.
- The center button on the Locking Hub [1] should be pressed in; the ring surrounding the Locking Hub [1] should be in the UP position.

MODE	STATUS	FUNCTION
RUN	ON	The processor is fetching and executing instructions. This is a normal condition.
	OFF	The processor is halted or waiting for an interrupt. The Run indicator blinks for each console keystroke.
DC ON	ON	DC power is available to the logic and all voltages are present but not within specified level.
	OFF	DC voltages are not available to the logic or voltages are present but within tolerances.
BATTERY	ON	Battery is present and charged to 80% or greater capacity.
Slow Blink (10 #2)		Battery is at less than 80% capacity and is charging.
Fast Blink (10 #2)		The ac power has failed; the battery is discharging, but the memory content remains valid.

The two-digit Start-up Test mode display provides the start-up diagnostic error codes.

TABLE 1. FRONT PANEL INDICATORS

MODE	FUNCTION
OFF	Power supplies are turned off, DC power to the logic and blower/fan assembly is off. However, AC power into the power supplies is present.
ENABLE	The ON position. Power supply voltages are present to the logic and blower/fan assembly.
SECURE	Same as the ENABLE position except the console terminal Halt-On-Break feature and the HALT/RUN/RESTART switch are disabled.
STANDBY	Power is supplied to the memory and blower/fan assembly but other voltages are turned off.

The keylock switch is a four-position rotary switch used to select one of the four power states.

TABLE 2. KEYLOCK POSITION DESCRIPTIONS.

MODE	FUNCTION
HALT	The CPU program is stopped and the incremented content of the program counter is displayed on the console terminal.
RUN	Entering RUN from RESTART enables CPU operation to run. Entering Run from HALT causes the processor to remain in the system awaiting a command from the console terminal.
RESTART	This momentary switch position initiates processor execution of bootstrap program instructions.

The HALT/RUN/RESTART switch functions are enabled only when the keylock switch is in the ENABLED position.

TABLE 3. HALT/RUN/RESTART SWITCH

SYSTEM MANAGEMENT TRAINING AID

APPENDIX A

GLOSSARY

GLOSSARY

Software Terms

A&D -	Admission and Disposition. The AQCESS subsystem that processes patient Administration information.
Ad Hoc -	Ad Hoc Report Generator. The AQCESS subsystem that allows users to create MTF-specific AQCESS reports.
A&S -	Appointing and Scheduling. The module of the Outpatient Encounter subsystem of AQCESS that processes outpatient booking information.
AQCESS -	Automated Quality of Care Evaluation Support System.
Character -	Any letter, number, symbol, or space in a field.
CR -	Clinical Records. The AQCESS subsystem that processes clinical records information.
Codes -	Characters that serve as abbreviations for words. For example, "S" designates a marital status of single.

Software Terms (continued)

Computer -	A device capable of accepting data (input), applying prescribed processes (program) to the data, and supplying the results of these processes as meaningful information (output).
Computer Hardware -	A computer's mechanical, magnetic, electronics, and electrical equipment.
Computer Terminal -	The keyboard, display screen, or printer on which data is input or output.
CRT -	Cathode Ray Tube. The screen or display unit on a computer terminal that resembles a television screen.
Cursor -	The blinking rectangle on the CRT screen that marks the current position on the screen where data or a menu selection can be entered.
Data -	A collection of facts or figures.
Database -	A collection of data.
Data entry screen -	A screen on which data is input.
DEERS -	Defence Enrollment Eligibility Reporting System. A system that Patient Administration systems

Software Terms (continued)

	can interface with to get information about an individual's eligibility for care.
Default -	A selection made automatically by the system when no explicit choice is specified by the user.
DoD -	Department of Defense.
Down -	The condition in which the computer is not operational.
Edit -	Computer activities that check input for validity and consistency.
Enter -	The process by which information is transmitted to the computer through a terminal.
Field -	An area of the screen in which you can enter, or which displays, a particular type of information (e.g., the NAME field.)
Input -	The transfer of data into the computer. Also, the data to be processed.
Keyboard -	The collection of keys attached to the CRT. It is used to communicate data to the computer.

Software Terms (continued)

Label -	The word or words on a screen that identifies the type of data that is entered or displayed in a field.
Menu Screen -	A screen on which you can select from a list of processing options.
MTF -	Medical treatment facility; a military hospital.
MSA -	Medical Services Accounting. The AQCESS subsystem that automates the accounting process.
Numeric -	Pertaining to a character set that contains numbers only.
Online -	A piece of hardware is considered "online" when it can be used to send information to or receive information from the computer.
Output -	Information produced by a computer in a readable form such as a printed report or a display screen.
Password -	A confidential code that allows a user to access the computer system. Passwords are a security feature that allows only authorized people access to the system.

Software Terms (continued)

Printer -	The equipment used to print messages, forms, labels, and reports.
QA -	Quality Assurance. The AQCESS subsystem that processes quality assurance information.
Required Field -	A field on a screen where data must be entered.
Screen -	The display surface of a terminal or the information on the terminal.
Sign-on -	The identification process that a user performs to begin work with a computer system. In AQCESS, sign-on consists of entering a user ID and a password. These are assigned by the System Manager.
Software -	A set of computer programs, procedures, rules, and documentation recorded in the computer's memory which operate and direct the use of the computer hardware.
Submenu -	A menu displayed on the bottom of a data entry screen, listing the processing options that can be performed from that screen.
Up -	The condition in which the computer is operational.

Software Terms (continued)

Update - To change data after it has been stored in the system.

User - A person who uses the computer system on a day-to-day basis.

Hardware Terms

Abnormal Shutdown -	A termination of computer operations in any manner other than that described under Normal Shutdown.
Background Job -	A job that operates independently of other processes and does not prohibit other jobs from being active (e.g., Caretaker, print requests).
Block -	A method of grouping large amounts of data for quick reference. A block is usually either free, or available for use by the computer, or it is allocated, which means that the computer has promised it to other data for use and it cannot be used.
Boot -	To activate the system, allowing all processes to be used.
Configuration -	The specific hardware layout of your system (i.e., how many terminals, where they are located, etc.).
Corrupted -	Invalid, contaminated, incomplete, or "bad" data that will not allow AQCESS to operate properly.

Hardware Terms (continued)

CPU - Central Processing Unit. Part of the computer that controls all operations and functions. This term is sometimes used in this Training Aid to refer to the hardware part that has the halt/restart button.

Device - Any hardware piece that can be used for input and/or output (e.g., printer, terminal).

Device Number - The number that the CPU uses to identify a device. This number is based on the port number. You can determine a terminal's device number from the AQCESS Sign-On Screen.

Disk - The medium used by the computer to store data. Your system contains a system disk, which is a large, rigid disk that cannot be removed. It contains all information used by the CPU while operating AQCESS (i.e., patient records, MIF profile, etc.). Some systems also have small, removable diskettes, often called floppy disks, but you will not use those.

Global - A file where data is stored.

Hardware Terms (continued)

Job -	A system activity or process. The computer automatically assigns a number to each job in order to keep track of it.
Integrity -	The completeness of data in storage. If normal shutdown procedures are not followed, some pieces of information may not be stored properly, and integrity could become questionable.
Logical Structure -	How the data is organized in each global (not the specific data that is in the global).
Map -	A reference area that tells the CPU how to get to other maps and data, much like a road map tells you where to find places you want to go.
Normal Shutdown -	Taking down the computer using the "SH" option on the operator's console menu, according to the instructions provided in this Training Aid.
Peripherals -	Devices or hardware pieces attached to the CPU (e.g., printer, terminal, tape drive).
Port -	An outlet on the back of the machine where a line leading to a terminal or printer can be connected or plugged in.

Hardware Terms (continued)

Power Down - To turn off electricity to all hardware.

Power Up - To turn on electricity to all hardware.

Printhead - A moving piece on the printer used to print letters and numbers on paper by pressing these characters, at very high speed, against an ink ribbon.

Routine - A program, or set of instructions, that tells the computer what to do.

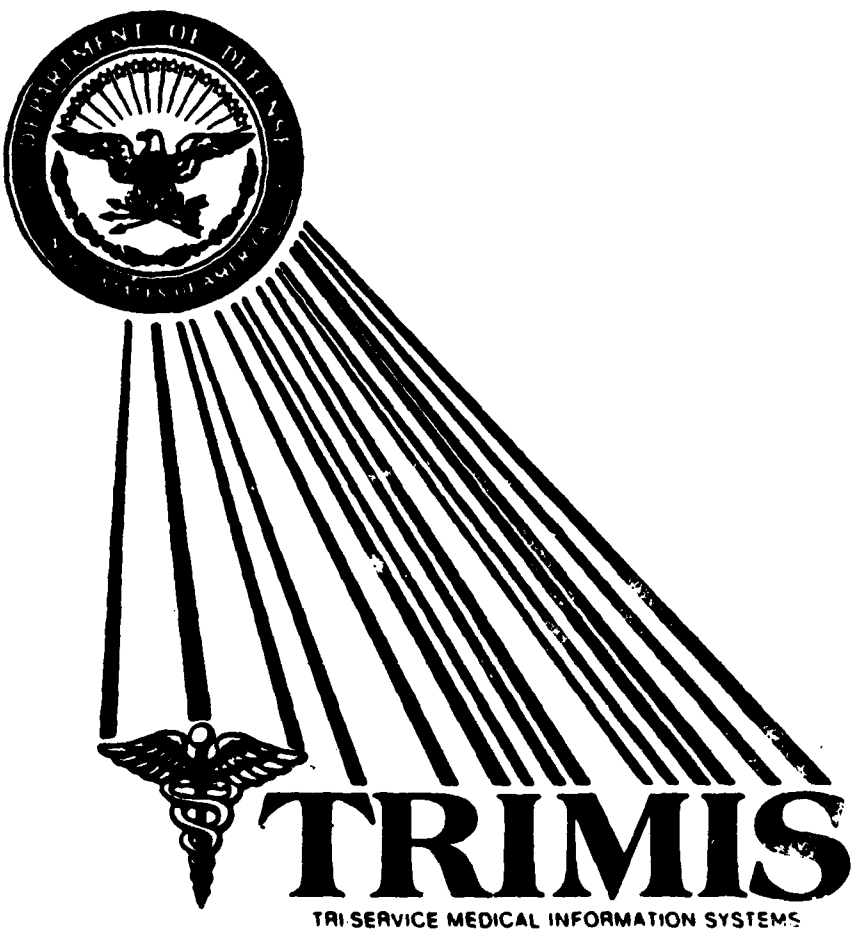
Shutdown - To terminate all active processes on the computer and disable any future processes until the System Manager reactivates, or boots, the system from the console.

Software Update - A tape that contains improvements, corrections, or other updates to the AQCESS software used at your MTF. This tape is released on a regular basis by NDC.

Store - To save information in the computer so that it can be recalled later when needed. The usual process for saving data in AQCESS is to press Return when the cursor is at ENTER SELECTION at the bottom of the screen.

AQCESS

APPOINTING & SCHEDULING TRAINING AID



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APPOINTING AND SCHEDULING TRAINING AID

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AQCESS SITE SUPPORT PROCEDURES

AQCESS Customer Support Group recommends that the following procedures be used at each installation when questions or problems arise regarding the AQCESS system.

The AQCESS toll-free telephone customer support number is 800-368-3325, or local Maryland access 301-258-9200. This access number should be used by the facility point of contact from 7:00 a.m. until 11:00 p.m. EST, Mondays through Thursdays and from 7:00 a.m. until 8:00 p.m. Fridays.

When contacting AQCESS Customer Service, the facility point of contact should identify himself or herself to the operator by name, give the facility name, say that the call is regarding the AQCESS system, and give a telephone number that the customer service representative can use to return the call if necessary. The operator will route the telephone call to an AQCESS customer service representative who will log the call and assist in resolving the problem.

All written correspondence should be mailed to the following address:

AQCESS Customer Support
1300 Piccard Drive, Suite 101
Rockville, Maryland 20850

APPOINTING AND SCHEDULING TRAINING AID

INTRODUCTION TO APPOINTING AND SCHEDULING

This Training Aid is intended to provide you with the basic information necessary to perform Appointing and Scheduling functions at your facility. Section 1 introduces you to AQCESS in general, describing many of the features common to the system as a whole. It also provides an overview of the functions you can perform through Appointing and Scheduling.

The Appointing and Scheduling Module enables you to perform clinic record-keeping functions quickly and easily. Using this module, you can register patients, book appointments in the Health Care Provider's (HCP) schedule, and generate reports.

The Appointing and Scheduling Module is menu driven. The functions you perform are listed on the menus within the system, and are designated by a letter or number. You enter this letter or number at ENTER SELECTION on the menu screen to access the function you wish to perform. If the system manager has not assigned a function to your terminal, an 'Invalid Entry' message will be displayed at the bottom of the screen.

For each function shown on the screen, there are areas where you enter data. These are called fields. The field names appear in capital letters throughout this training aid.

This section is divided into subsections describing separate system functions. Each section contains a description of the function, screens used to perform the function, and the step-by-step procedures that are necessary to complete each function.

Sections 2 through 6 explain the input process; Section 7 explains the available reports and how to request them.

In the step-by-step procedures, actions you take are indicated by plain type; functions performed by the system appear in **bold** type. Boxed USER HINTS appear when extra information is helpful. NOTES emphasize important elements of the procedure, and appear at the end of each section.

Each screen is also provided with a data chart, which defines what is to be entered in each field on the screen. If additional help is needed to complete a field, position the cursor at that field and press the [Help] key. Instructions, or a table of possible entries, will be displayed on the screen.

INTRODUCTION TO AQCESS

AQCESS, the Automated Quality of Care Evaluation Support System, is a computerized system intended to support quality of care and patient administration processing. This system has six basic objectives:

1. To improve the quality and timeliness of the evaluation of health care;
2. To support Patient Administration functions,
3. To support Clinical Records processing,
4. To support the Medical Services Accounting Office,
5. To support Outpatient Appointing and Scheduling Functions, and
6. To provide Ad Hoc Reporting capability.

AQCESS will make it easier for MTF personnel to keep and process accurate data, and will make that data available to system users who need it. Specifically, AQCESS can help MTF personnel with the following tasks:

1. Register, admit, and disposition patients;
2. Keep track of patients' wards, clinical services, and physician assignments;
3. Track patients who are absent from the MTF;

4. Complete the medical record and prepare monthly reports for submission to higher command;

5. Maintain figures on resource use, such as bed days;

6. Produce forms and reports for individual patients and for the MTF as a whole;

7. Monitor quality of care indicators, and identify occurrences that could adversely affect the quality of health care;

8. Identify, document, and track quality of care problems;

9. Maintain provider profile and clinical indicator data;

10. Calculate patient charges based on A&D data;

11. Support automated accounting with on-line payment posting and one-time charges posting;

12. Support recording of Dining Hall monies and reporting of Group Meal Sales;

13. Automatically distribute payments to accounting funds, and create cash collection vouchers;

14. Provide automated reporting to manage the accounting function;

15. Provide outpatient clinics with a method of appointing individual patients to a specific HCP and clinic; and

16. Create and maintain unique AQCESS reports.

AQCESS accomplishes its objectives through seven subsystems:

1. Admission and Disposition (A&D),

2. Clinical Records (CR),

3. Quality Assurance (QA),

4. System Management (SM),

5. Medical Services Accounting (MSA),

6. Ad Hoc Report Generator (Ad Hoc), and

7. Appointing and Scheduling Module of the Outpatient Encounter Subsystem (A&S).

These subsystems are made up of functions or processes, as shown on the next page.

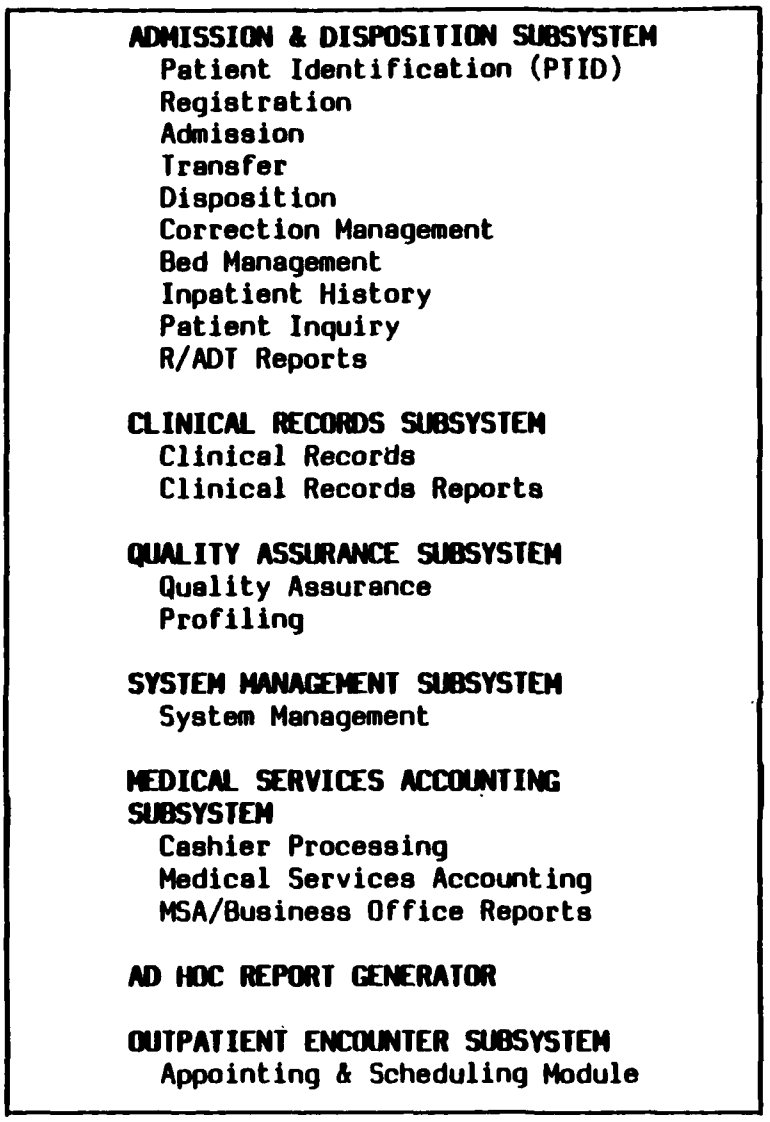


FIGURE 1.1 AQCESS SUBSYSTEMS AND FUNCTIONS

Training Yourself to Use AQCESS

The following sections give you an overview of the various features of using AQCESS. For more detailed information, you can consult the A&D, Clinical Records, Quality Assurance, Medical Services Accounting, and Ad Hoc Report Generator Training Aids, and the AQCESS online Tutorial. The Tutorial consists of lessons on how to use the system. It also allows you to use the system in the training mode to see how AQCESS operates, without interfering with "real" MTF data.

USING AQCESS

What makes AQCESS run is the data you enter into it. You enter and update data on the system by means of a DEC terminal, which consists of a keyboard that looks like a sophisticated typewriter keyboard, and a Cathode Ray Tube Screen (CRT) that resembles a television screen.

The Keyboard

You use the keyboard to type in data that will go into the system. In addition to the letter and number keys, this keyboard has other keys that you use to communicate with the computer <u>about</u> the data you type in. The chart on the following pages summarizes how these key functions are used. For more information, see the AQCESS Tutorial, Lesson 2.

Name & Symbol	Used With	When You Press this Key:
Return		Cursor moves from field to field. Used at the end of a screen, Return transmits the data entered to the system for storage.
Shift	Many Keys	The top character of a two-character key is entered, as on a standard typewriter.
Help		The screen displays information about the data field you are in, such as length, type, and format of the data you can enter. Also displays codes that can be entered in that field.
Explain Error		The screen displays a detailed explanation of the error message that is being displayed.
Back-up		Cursor moves back one field at a time. Cursor must be at the first character of the field when you press Back-up. This key will not work if you are at the first field on the screen.
Entry Done		Cursor skips the remaining fields on the screen and moves to the bottom of the screen.

SPECIAL FUNCTION KEYS (page 1)

Name & Symbol	Used With	When You Press this Key:
ALL		Cursor moves from bottom of screen to the first accessible field on the screen; you can then access any updateable field on the screen and enter data.
Delete DEL		Cursor backs up one space and deletes whatever letter occupied that space. Used to delete typographical errors that were just entered.
Clear Data		All the data entered in a field is erased. Cursor must be at first character in a field when this key is pressed.
Cancel		The system abandons what you have entered on the screen and none of the data is stored on the system. You return to the previous processing function or screen.
CTRL	P	The screen being displayed is printed at the printer associated with your terminal.

SPECIAL FUNCTION KEYS (page 2)

The Screen

A screen is a display that appears on your CRT in a certain format. An area of the screen where data can be entered is called a field. The cursor is a blinking rectangle that shows you where the first character of data will be typed.

There are two types of screens: menu screens and data entry screens. Menu screens list functions you can perform and allow you to choose a function by entering the letter or number representing it in a selection field.

Data entry screens are arrangements of fields in which you can enter data. The lower portion of most data entry screens contains a submenu, listing functions you can perform at this screen.

A screen segment is a group of related data fields that can replace part of a data entry screen. The area in which alternate screen segments can be displayed is called a screen window.

Some fields on screens are required, meaning that you must enter data in them. If data is not entered in a required field, an error message will be displayed. On the other hand, some fields cannot be used because they do not apply to your military department; you will not be able to access these fields.

Examples of AQCESS screens appear throughout this Training Aid, illustrating the Appointing and Scheduling functions.

Entering Data

Usually, the first time you access a screen, the cursor will be positioned at the first field where you can enter data. You must begin your entry at the first character in the field.

You can update, or change data on a screen by typing over it. There are two ways to move the cursor to a field you wish to update: (1) you can type the label of that field or part of the label at ENTER SELECTION, and press Return. When you have finished entering the update, the cursor will return to ENTER SELECTION; or (2) you can type ALL to go to each field on the screen. The cursor will return to ENTER SELECTION after the last field on the screen.

When you have finished an initial data entry or an update, the cursor will be at ENTER SELECTION. To store the data you have just entered, press Return. No data is actually stored on the system until you do this.

Errors and Edits

AQCESS checks data as you enter it. This checking process is called editing. There are two types of edits: validity and consistency editing.

Validity Edits

Validity edits are performed as you enter data in each field. They check to see whether the data you enter fits the parameters set up for the individual field. For example, if you enter a date of March 35th or a Social Security Number such as 123-AB-4566, validity edits will detect this as an error.

For some fields there is a list of the codes that can be entered (this list is called a system table). Validity edits determine whether the code you entered exists on the table or not.

When you enter invalid data, a beep sounds and an error message, such as INVALID ENTRY, appears at the bottom of the screen, along with a description of the kind of data or a list of codes that can be entered. The cursor goes to the beginning of the incorrect field, and you must enter valid data before you can go on. (You can press Return, and that field will redisplay what it contained before, either previous data or a blank.)

Consistency Edits

Consistency edits are performed after you have completed data entry on an entire screen. Consistency edits check whether relationships between data entered in different fields are correct. Data entered in one field may be incompatible with data entered in another field on the screen; for example, if you had indicated in one field that a patient is active duty and in another field that the patient is 12 years old. Consistency edits would detect this as an error.

When a consistency error is found, an error message is displayed and the cursor moves to the first field in the inconsistent relationship. If you press Return, the cursor will go to the next field involved in the error. You can change any of the fields involved. When the error is corrected, the cursor returns to ENTER SELECTION.

Warnings

A consistency error usually must be corrected before you can go on. However, occasionally you are given a warning of a condition that may or may not be inconsistent. Warning error messages are followed by the question, OVERRIDE? To override the message and indicate that this data is actually correct, enter Y.

AQCESS

AQCESS can not only edit and store data, making it available to those who need it, but can also manipulate data. AQCESS can select and format data, and can print the data in the form of reports for use in your MTF and for submission to higher command. This will eliminate the hours of work involved in manually preparing reports. And since production is faster, reports can be more timely and more useful to MTF staff.

System Security

Because AQCESS processes highly sensitive data on patient care, a number of provisions have been designed to protect the security of the system. Among these features are the following:

1. Each user is assigned a private user ID and password, which are used to gain access to the system. Associated with each user ID and password are the system capabilities this user is authorized to perform. Also associated with each user ID and password are the clinic capabilities this user is authorized to book into, view only, or neither book nor view.

2. Screens time out, or are erased from the CRT, if no data is entered or no function key is pressed within a specified

length of time. This prevents unattended terminals from being accessed by unauthorized personnel.

3. The capabilities that can be performed at each terminal are also designated.

4. Some reports are defined as "secure" reports and may only be printed on the primary printer for the report.

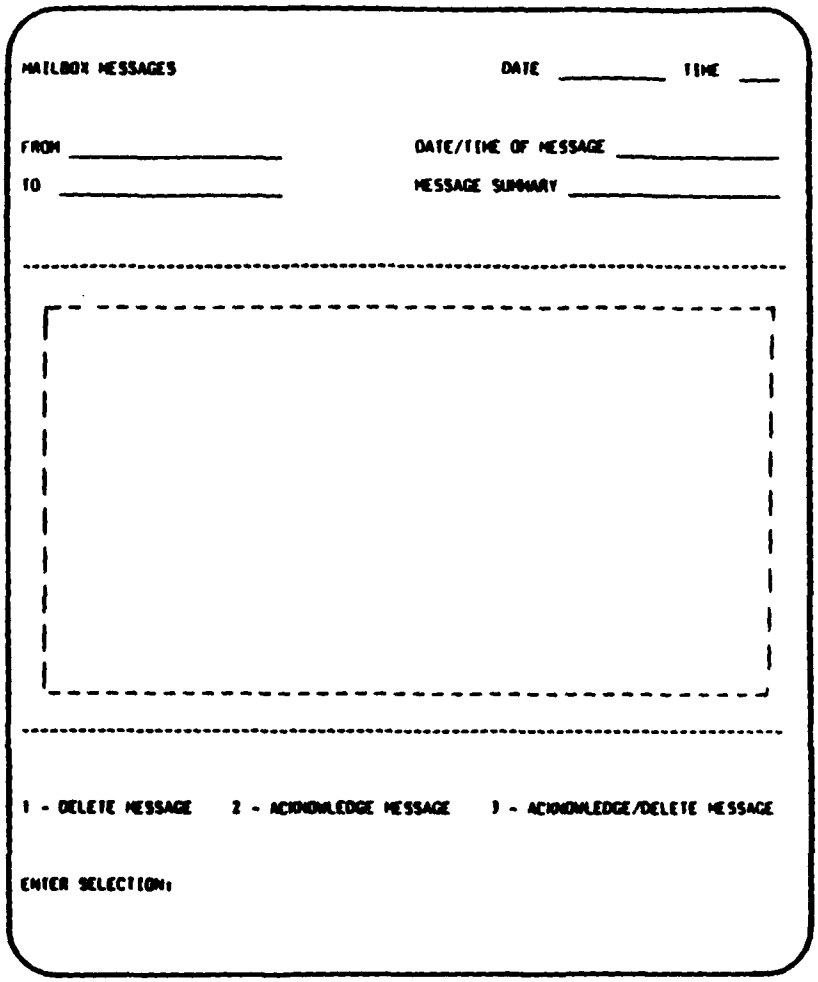


FIGURE 1.2 MAILBOX MESSAGE SCREEN

THE MAILBOX FUNCTION

ACCESS The Mailbox function is accessed by entering MX on the User Entry Menu.

PURPOSE The Mailbox function enables you to send 'mail' to other users. Messages can be viewed on the screen or printed on paper, acknowledged (returned to sender with or without notation), and deleted.

DESCRIPTION The Mailbox function is comprised of two screens: the Mailbox Message Screen and the Mailbox Candidate Message Screen. The Mailbox Message Screen is used to send, acknowledge, or delete a message. The Mailbox Candidate Message Screen is used to select a particular message from a group of messages for viewing.

OPTIONS On the Mailbox Message Screen:

1 - DELETE MESSAGE enables you to delete a message from your mailbox.

2 - ACKNOWLEDGE MESSAGE enables you to communicate to a sender that you have receive his or her message.

3 - ACKNOWLEDGE/DELETE MESSAGE enables you to acknowledge a message and to delete it from your mailbox.

On the Mailbox Candidate Message Screen:

S - SEND A MESSAGE enables you to send a new message. This option is used to access a blank Mailbox Message Screen.

1.1 To Send a Message

1. Enter 'MX' on the User Entry Menu Screen. Press [Return].

   The Mailbox Menu Screen is displayed. The FROM field defaults to your User ID. The DATE/TIME OF MESSAGE field defaults to the current date and time. The cursor is at the TO field.

2. Enter the User ID of the individual who should receive your message. Press [Return].

   The cursor moves to MESSAGE SUMMARY.

3. Enter a short description of the message. Press [Return].

   The cursor moves to the first character position of the message box.

4. Enter the message. Press [Entry Done] when the message is complete.

   The cursor moves to ENTER SELECTION.

5. Press [Return] to send the message to the receiver.

   The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

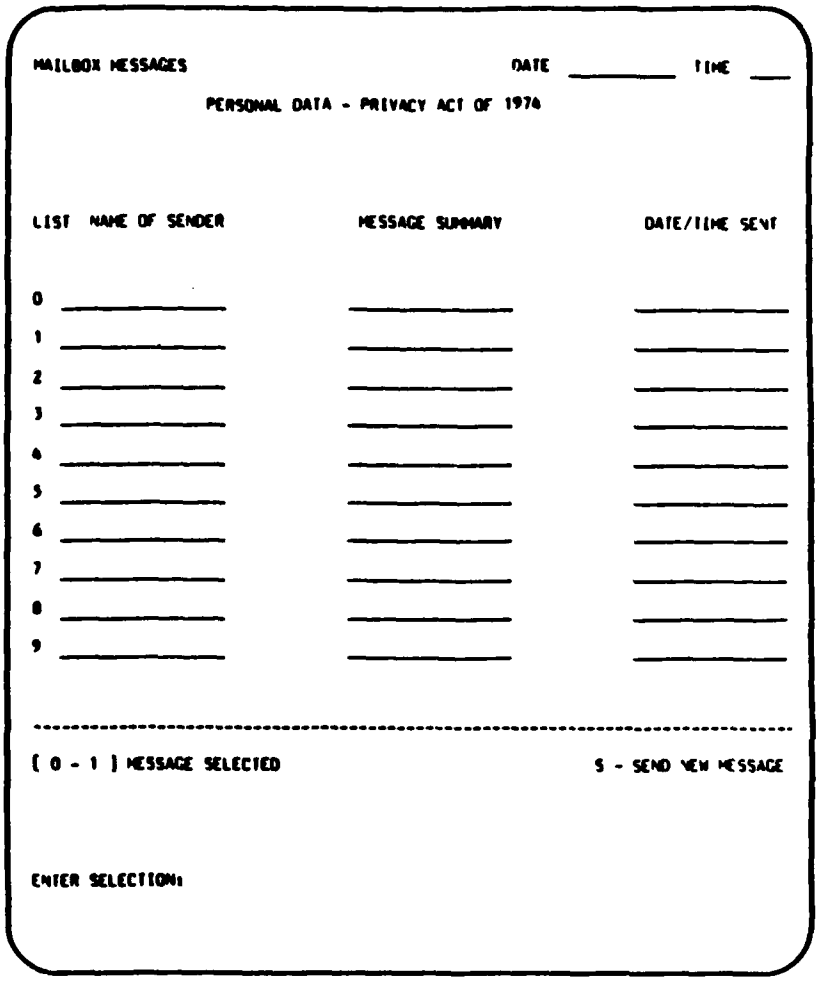


FIGURE 1.3 MAILBOX CANDIDATE MESSAGE SCREEN

1.2 To View a Message

If you have a message in your mailbox, the system will display the following at the bottom of the User Entry Menu Screen: MAILBOX MESSAGES WAITING - ENTER MX FOR MAILBOX FUNCTION.

1. Enter 'MX' at ENTER SELECTION. Press [Return].

   The Mailbox Candidate Messages Screen is displayed. The cursor is at ENTER SELECTION.

2. Enter the number identifying the message you wish to view. Press [Return].

   The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

NOTE: Only 10 messages can be listed on the Mailbox Candidate Messages Screen at one time. If you have accumulated 10 messages, the system will not allow you to send mail. You must delete stored messages to reinstate the capability. Messages that you wish to save can be printed using the CTRL P function at ENTER SELECTION.

1.3 To Delete a Message

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

1. Enter '1' at ENTER SELECTION. Press [Return].

   The message is deleted. The User Entry Menu is displayed.

1.4 To Acknowledge a Message:

If you wish to send an acknowledgment message back to the sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

1. Enter ALL. Press [Return].

   The cursor moves to the TO field.

2. Press [Return] until you move the cursor into the message box. Enter the message. Press [Entry Done] when the message is complete.

   The cursor moves to ENTER SELECTION.

3. Enter '2' at ENTER SELECTION. Press [Return].

NOTE: If you wish to acknowledge the message and also delete it from your mailbox, enter '3' at ENTER SELECTION.

The system will send the acknowledgment message to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

If you wish to acknowledge receipt of a message, but you do not want to send a new message back to the original sender:

The selected Mailbox Message Screen is displayed. The cursor is at ENTER SELECTION.

1. Enter '2' at ENTER SELECTION. Press [Return].

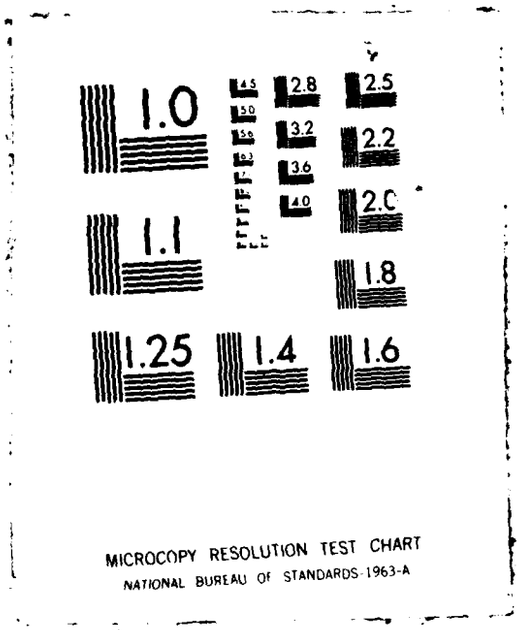
NOTE: If you wish to acknowledge the message and also delete it from your mailbox, enter '3' at ENTER SELECTION.

The system will send an acknowledgment to the sender. The User Entry Menu Screen is displayed. The cursor is at ENTER SELECTION.

AD-A178 916 ACCESS (AUTOMATED QUALITY OF CARE EVALUATION SUPPORT SYSTEM) TRAINING AID. (U) MDC FEDERAL SYSTEMS INC ROCKVILLE MD JAN 87 DOD/SW/MT-87/010A 11/12

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APPOINTING AND SCHEDULING TRAINING AID

2. IDENTIFYING AND REGISTERING PATIENTS

IDENTIFYING PATIENTS

The Patient Identification (PTID) Screen is the first screen displayed in several Appointing and Scheduling functions. It allows you to locate an existing patient record, or to begin the process of registering a new patient.

On the PTID Screen, enter data items that identify the patient: Name, Social Security Number, Family Member Prefix, Date of Birth, and Sex. The system will perform a search for that patient's registration information based on the data you have entered, even if this data is incomplete. Entering the patient's Social Security Number or a part of the name is sufficient to initiate the search.

If the patient is registered in the system his or her name will appear on the Outpatient Candidate List Screen. If the patient is not registered (i.e., he or she is a new patient), completing the PTID Screen is the first step required. The system will display a message that the patient described on the PTID Screen is not registered. You will then indicate that he or she is a new patient, and begin registration on the Outpatient Registration Screen.

The PTID Screen is also used by the system to locate patient records when performing the following functions: Book Appointments, Cancel Appointments, Scan Appointments, and Register Walk-Ins.

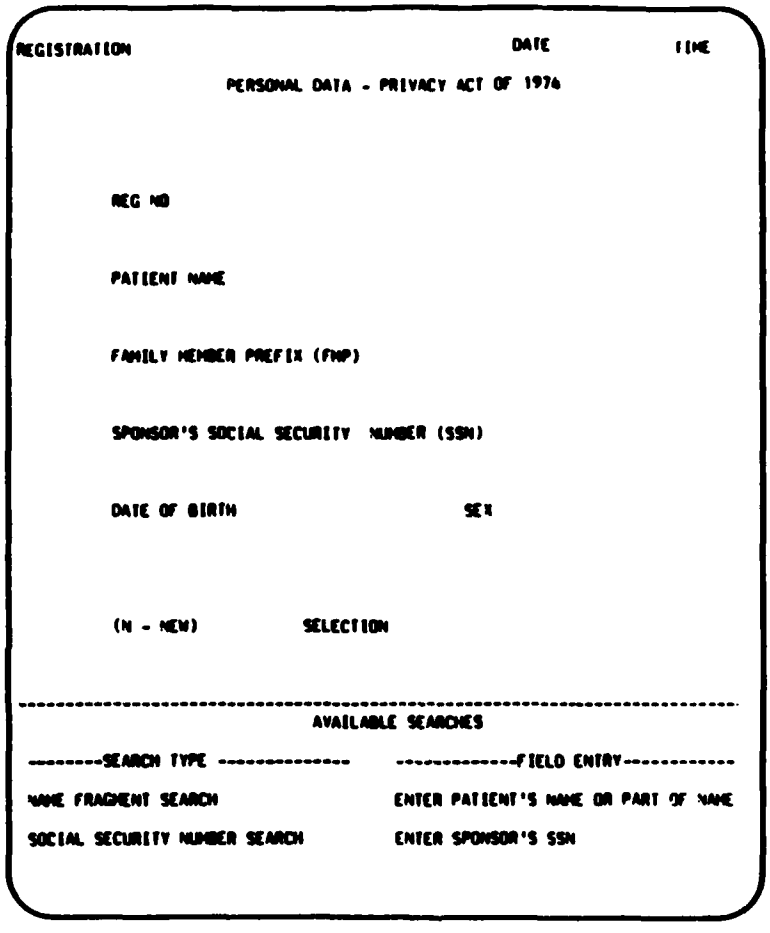


FIGURE 2.1 PTID SCREEN

DATA CHART - PATIENT IDENTIFICATION SCREEN

PATIENT NAME.	Name of the patient, in the following format: last name followed by a comma, followed immediately by first name. First name can be followed by a space and a middle initial or middle name, and/or a space and a title. Punctuation: only hyphens or apostrophes in last names; only hyphens in first and middle names. Required field only when registering a new patient.
FMP.	Patient's Family Member Prefix. An FMP of 20 means that the patient is a sponsor. If the patient is not a sponsor, the FMP indicates the relationship of the patient to the sponsor. Required field only when registering a new patient.
SSN.	Social Security Number of sponsor. Required field only when registering a new patient.

2.1 To Record Patient Identification Information

1. When the PTID Screen is displayed, enter the patient's last name, comma, first name, space, and middle initial. Press [Return].

   The cursor moves to FAMILY MEMBER PREFIX (FMP).

2. Enter the FMP code for the new patient.

   The cursor moves to SPONSOR'S SOCIAL SECURITY NUMBER (SSN).

3. Enter the sponsor's SSN. Spaces or hyphens are not required but may be entered. Press [Return].

   The SSN is redisplayed with hyphens. The cursor moves to DATE OF BIRTH.

4. Enter the patient's date of birth in a numeric format. Press [Return].

   The date of birth is redisplayed DD MMM YY. The cursor moves to SEX.

5. Enter the code representing the patient's sex.

   The cursor moves to SELECTION.

6. Enter 'N' to create the new patient record. Press [Return].

   The system checks whether any similar records already exist. Two situations are possible.

A. A similar record may exist for this patient.

If a person with the same last name, same first four letters of the first name, same SSN, and a different FMP has been registered, a Candidate List Screen will appear listing this person.

You can check the Candidate List data to see if this is really the same patient for whom you just entered PTID data.

If the data appear to be the same, you can access the existing record through the Candidate List Screen.

If the patient on the Candidate List is not the same as the one you wish to register, press [Return] to view the PTID Screen.

B. No similar records exist.

The Outpatient Registration Screen is displayed. If the patient is a dependent of a registered sponsor, the sponsor's information is displayed by the system. The cursor is at PATIENT: ADDRESS. Complete the screen following the procedures in 2.5, To Register a New Patient.

2.2 To Locate a Record By FMP/SSN

1. When the PTID Screen is displayed, press [Return] to move the cursor to FMP.

   The cursor moves to FMP.

2. Enter the patient's FMP.

   The cursor automatically moves to SSN.

3. Enter the sponsor's SSN. Press [Return].

   The cursor moves to DATE OF BIRTH.

4. Press the [Entry Done] key to move the cursor to SELECTION. Do not type 'N'.

5. Press [Return] to initiate the search for this patient's previous record.

   The system locates the patient's record by the sponsor's SSN and then by the FMP. The Outpatient Registration Screen is displayed.

2.3 To Locate a Patient Record By SSN

1. When the PTID Screen is displayed, press [Return] to move the cursor to SSN.

   The cursor moves to SSN.

2. Enter the Sponsor's SSN. Press [Return].

   The cursor moves to DATE OF BIRTH.

3. Press [Entry Done] to move the cursor to SELECTION.

4. Press [Return] at SELECTION to search.

   The Candidate List Screen is displayed. The system locates all records with the specified SSN (i.e., all family members). The cursor is at ENTER SELECTION.

5. Enter the number to the left of the name of the family member whose registration record you wish to process. Press [Return].

2.4 To Locate a Patient Record by Name

1. When the PTID Screen is displayed, enter the patient's name or partial name at PATIENT NAME. Press [Return].

   The cursor moves to FMP.

2. Press [Entry Done] to move the cursor to SELECTION.

   The cursor moves to SELECTION.

3. Press [Return] to search.

   The Outpatient Candidate List Screen is displayed. All patients having names that match the spelling you entered will be displayed. The cursor is at ENTER SELECTION.

USER HINT: If the Candidate List Screen occupies more than one page, the system will display **CONTINUED* at the bottom of the list. Enter 'N' to display the next page.

4. Enter the number to the left of the name of the patient whose registration record you wish to process. Press [Return].

NOTES:

1. You can locate a patient's record directly by sponsor SSN and the patient's FMP.

2. You can search for a record by entering the patient's partial name or SSN.

3. More specific information listed on the PTID Screen will result in fewer names being shown on the Candidate List Screen.

4. You cannot update registration information using the PTID Screen. To correct PTID information, use the Outpatient Registration Screen.

5. Patient identification information entered on the PTID Screen is not stored until registration is complete. Therefore, if you cancel out of the Outpatient Registration Screen before completing the information and storing it, no patient record will exist for that patient.

6. The PTID Screen is used to create patient registration records or locate those that already exist. The Outpatient Registration Screen follows the PTID Screen.

OUTPATIENT REGISTRATION

The Outpatient Registration function allows you to store and edit patient registration information. The Outpatient Registration Screen is a record of patient information, including demographics, military affiliation, and sponsor's address.

This Screen can be accessed by selecting 'E' (Outpatient Registration) or 'B' (Book Appointments) from the Appointing and Scheduling Main Menu. Selection 'E' allows you to register a patient or edit a registration without performing other system functions. Selection 'B' allows you to perform these functions before booking an appointment for that patient.

Whether you choose 'E' or 'B', access the Outpatient Registration Screen by completing the PTID Screen.

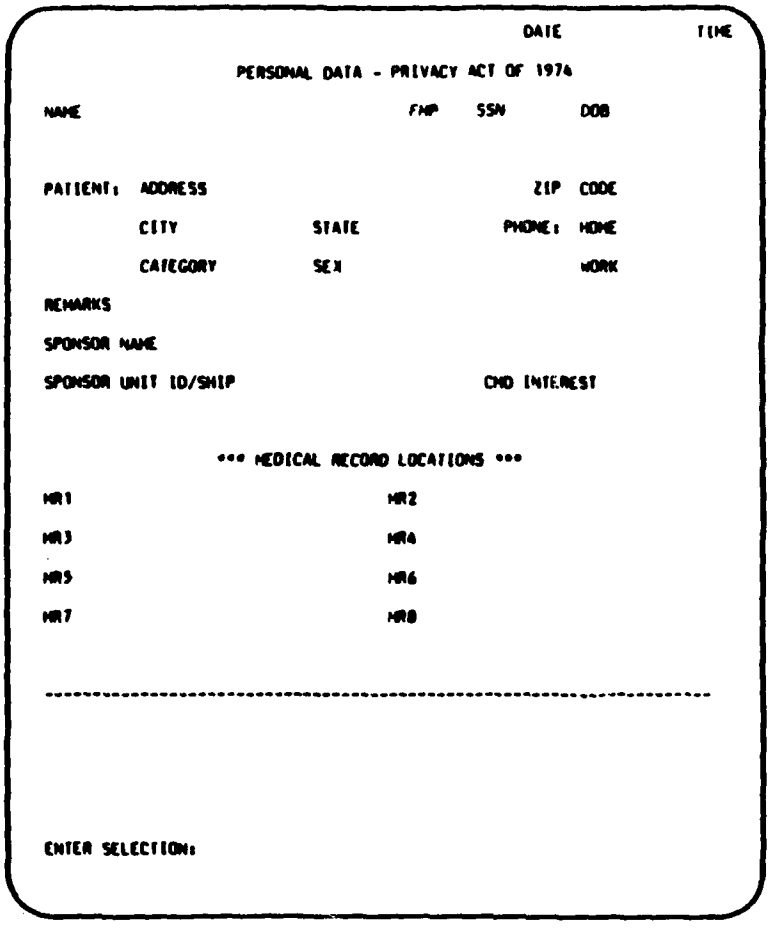


FIGURE 2.2 OUTPATIENT REGISTRATION SCREEN

DATA CHART - OUTPATIENT REGISTRATION SCREEN

PATIENT ADDRESS.	Street name and number, and apartment number, of patient's home address. 28 characters.
ZIP CODE.	The patient's zip code. If user enters a zip code that is on the MTF's zip code table, the CITY and STATE fields will default to the city and state associated with that zip code on the table. 9 spaces available.
CITY.	The city in which the patient lives. 20 characters.
STATE.	2-letter abbreviation for the state in which the patient lives.
HOME PHONE.	Patient's home telephone number: area code first, followed by 7-digit number, with 5-digit extension, if any. 7-19 characters.
WORK PHONE.	Patient's business or day telephone number: area code, followed by 7-digit number with 5-digit extension, if any. Can include Autovon number for military patients. 7-19 characters. (One number - home or work phone - is required.)

PATIENT CATEGORY.	Code indicating the service affiliation and the classification that authorizes care. 3 characters. Required field.
SEX.	Patient's sex. 1 character.
REMARKS.	User can enter up to 70 characters of free-text remarks about the registration in this field.

SPONSOR DATA SEGMENT

SPONSOR NAME.	Name of the patient's military sponsor. If the patient is a sponsor (i.e., the FMP is 20), this field will default to the patient's name. 27 spaces available. Required field.
UNIT/SHIP ID.	The unit's ID. 5-9 digits.
CMD INTEREST.	Code indicating a special category or type of patient. Up to three 3-character codes can be entered.
MEDICAL RECORDS.	Up to 8 Medical Record Locations are displayed here. Enter a 3-character location beside each type. One location required.

2.5 To Register a New Patient

1. Access the Outpatient Registration by selecting 'E' or 'B' from the Appointing and Scheduling Main Menu (B - Booking Appointments - allows you to book an appointment for the patient after registering the patient).

   The PTID Screen is displayed, with the cursor at NAME.

2. Complete the PTID Screen. See Section 2.1, To Record Patient Identification Information.

   The Outpatient Registration Screen is displayed, with the cursor at ADDRESS.

3. Enter the patient's street address and press [Return].

   The cursor moves to ZIP CODE.

4. Enter the patient's ZIP code and press [Return].

NOTE: When you enter a zip code that is in the system table, the name of the city and state are filled in automatically.

   The cursor moves to CITY.

5. Press [Return] to accept the city name that was defaulted by the ZIP code, or enter the name of the city in which the patient resides. Press [Return].

The cursor moves to STATE.

6. Press [Return] to accept the State name that was defaulted by the ZIP code, or enter the postal abbreviation for the State in which the patient resides. Press [Return].

The cursor moves to PHONE: HOME.

7. Enter the patient's home telephone number, including the area code, and press [Return]. If you do not specify the area code, the system will enter the area code of your MTF. Parentheses and hyphens are not needed; the system will insert them after you press [Return].

The system reformats the phone number and the cursor moves one space to the right.

8. Enter any applicable extension number for the home phone number. Press [Return].

NOTE: Either the home phone or the work phone must be entered.

The cursor moves to CATEGORY.

9. Enter the patient category of the patient.

The cursor moves to SEX.

10. This information is defaulted from the PTID screen, but can be changed if necessary. Enter any change.

The cursor moves to WORK.

11. Enter the patient's work phone number, including the area code. Press [Return]. Parentheses and hyphens are not needed; the system will insert them after you press [Return].

    The system reformats the phone number and the cursor moves one space to the right.

12. Enter any applicable extension number for the work phone number. Press [Return].

    The cursor moves to REMARKS.

13. Enter any remarks associated with this patient. Up to 70 characters are allowed. Press [Return].

    The cursor moves to SPONSOR NAME.

14. Enter the name of the patient's sponsor. Press [Return].

NOTE: If the patient is the sponsor, this field will default to the name of the patient. If another family member has been registered previously, this field will default from that record.

The cursor moves to SPONSOR UNIT ID/SHIP.

15. Enter the sponsor's unit ID or ship ID. Press [Return].

The cursor moves to CMD INTEREST.

16. Enter the code representing any special command interest for this patient. The cursor moves automatically to allow you to enter two additional command codes.

    The cursor moves to the first medical record type.

17. Enter the location of the first medical record type. Press [Return] to move the cursor to each additional record type.

NOTE: At least one record location must be entered for a new patient.

18. Press [Return] or [Entry Done] to move the cursor to ENTER SELECTION.

    The cursor is at ENTER SELECTION.

19. Press [Return] to store the data.

    If two or more data items are inconsistent, a consistency error message is displayed. The cursor moves to the first of the inconsistent fields.

20. Press [Explain Error] for details about the error.

21. Correct the item if this field is wrong.

    Press [Return] to move the cursor to the next inconsistent field(s). Correct the data as necessary.

NOTE: The cursor continues to move to each field involved in the consistency error until one of the data items is changed. The system then checks the consistency of the new data.

When all the errors are corrected, the cursor moves to ENTER SELECTION. The data is complete and consistent.

22. Press [Return] to store the registration data. The new record is created.

2.6 To Edit Patient Registration

1. Access the Outpatient Registration Screen by selecting 'E' or 'B' from the Appointing and Scheduling Main Menu.

   The PTID Screen is displayed, with the cursor at NAME.

2. Complete the PTID screen. See Section 2.1, To Record Patient Identification Information.

   The Outpatient Registration Screen is displayed with the cursor at ENTER SELECTION.

3. Enter ALL or the name of the field to be edited and press [Return].

> USER HINT: It is not necessary to enter the entire field name, only enough of the field name to uniquely distinguish it from other fields on the screen.

4. If you entered ALL, advance the cursor from field to field by pressing [Return]. Move the cursor backward by pressing [Back Up]. To change the information in any field, type over the data displayed.

   If you entered a specific field name, type the desired information for that field and press [Return]. Store the revised registration information by pressing [Return] with the cursor at ENTER SELECTION.

NOTES:

1. A record is not stored until you have completed all the required fields and have pressed [Return] with the cursor at ENTER SELECTION.

2. When you register any patient who has had a family member previously registered, the sponsor's demographic information is displayed on the Outpatient Registration Screen.

3. The data on the PTID Screen can be updated on the Outpatient Registration Screen. Enter the partial field label for the field to be updated, and type over the existing information. Press [Return].

APPOINTING AND SCHEDULING TRAINING AID

3. APPOINTING FUNCTIONS

INTRODUCTION

The Appointing Functions available to you are: booking appointments, cancelling appointments, and scanning pending appointments.

The appointment booking function allows you to search for available appointments based on the HCP, clinic, day of the week, and time criteria entered.

The appointment cancellation function allows you to cancel a booked appointment.

You may scan a patient's appointments to determine the dates and times of pending appointments.

BOOKING APPOINTMENTS

A patient must have an appointment to see a Health Care Provider (HCP). Booking an appointment requires finding a date and time suitable for both the HCP and the patient and involves several steps. However, before any appointment can be booked, the patient must be registered.

After you select 'B' on the Appointing and Scheduling Main Menu, the Patient Identification (PTID) Screen will be displayed. The PTID Screen -- common to many AQCESS processes -- is used to identify the patient in order to retrieve information already stored in the system, or to prompt you to register a new patient.

After the patient is identified, the Outpatient Registration Screen is displayed. If the patient is registered, use the screen to make any necessary changes to the information. If the patient is new, complete the entire screen as specified in Section 2.5.

After the patient has been identified, and registered if necessary, the system will display the Book Appointment Screen. When the appropriate fields are completed, the system displays a list of available appointment times. The appointment clerk selects the time best suited for the patient. When a record of the appointment is displayed, the Book Appointment process is complete.

```
APPT & SCHED                                    DATE _________  TIME __
                          BOOK APPOINTMENT

PATIENT                        CAT      HOME PHONE
   FMP      SSN                                    WORK PHONE
CLINIC      HCP          APPT TYPE       APPT REASON
FROM DATE              THRU DATE          FROM TIME       THRU TIME
DAY OF WEEK MTWTHFSSN                     REFERRED FROM
                          ••• PENDING APPTS •••
#  CLINIC       HCP       TYPE       DATE            TIME
0
1
2
3
4
5
6
-------------------------------------------------------------------------
     7 - NEXT PAGE          8 - PREVIOUS PAGE        9 - VIEW AVAILABLE
    10 - CANCEL APPT

ENTER SELECTION:
```

FIGURE 3.1 BOOK APPOINTMENT SCREEN

DATA CHART - BOOK APPOINTMENT SCREEN

PATIENT.	Name of patient. 1-27 characters.
FMP.	Family Member Prefix. Display only. 2 characters.
SSN.	Social Security Number. Display only. 11 characters.
CAT.	Patient Category. Display only. 3 characters.
WORK PHONE.	Display only. 11 characters.
HOME PHONE.	Display only. 11 characters.
ZIP.	Display only. 10 characters.
UNIT.	Display only. 4 characters.
CLINIC.	3-character code representing the name of the clinic. Required field.
HCP.	Name of patient's health care provider. 6 characters available. Enter 'C*Clinic Code?' to see all HCPs in a clinic. Enter 'S*Clinical Service Code?' to see all HCPs in a given specialty.
APPT TYPE.	3-character appointment type.
APPT REASON.	Reason for the appointment. 20 characters.

FROM DATE. Earliest date when patient desires to schedule appointment. Default is current date. 11 characters. Required field.

THRU DATE. Latest date when patient would like appointment. Default is 30 days from current date. 11 characters. Required field.

FROM TIME. Earliest time of day when patient wants to schedule appointment. 4 digits.

THRU TIME. Latest time of day when patient wants to schedule appointment. 4 digits.

DAY OF WEEK. Enter all days of week on which appointment would be acceptable. Valid entries include: M, T, W, TH, F, S, and SN. Up to 9 characters. Default is all 9 characters.

REFERRED FROM. This field is entered if a referral is required for this HCP/Appt Type combination. A referral can be from either a clinic (entered as 'C*Name of Clinic') or from an HCP ('H*Name of HCP').

3.1 To Book an Appointment

1. Select 'B' from the Appointing and Scheduling Main Menu.

   The PTID screen is displayed.

2. Identify the patient as described in Section 2.1, To Record Patient Identification Information.

   The Book Appointment Screen is displayed with the cursor at CLINIC. The patient's pending appointments are displayed in the center of the screen.

3. Enter the code representing the clinic where the patient would like an appointment. This field must be entered for you to book an appointment. Press [Return].

   The cursor moves to HCP.

4. Enter the HCP with whom the patient would like an appointment. Press [Return].

   OR

   Leave HCP blank to view appointments available with all HCPs in that clinic. Press [Return].

   The cursor moves to APPT TYPE.

5. Enter the code representing the type of appointment desired. Press [Return].

   The cursor moves to APPT REASON.

6. Enter the reason for the appointment, as specified by the patient. Press [Return].

   The cursor moves to FROM DATE. T is displayed to represent today's date.

7. If the earliest date the patient is able to visit the clinic is different from today's date, type it in place of T. Press [Return].

   OR

   If today is the first date the patient is available, press [Return].

   The cursor moves to THRU DATE. A date 30 days from today's date is displayed.

8. If the latest date the patient can visit the clinic is different from the date displayed, type it in place of the defaulted date. Press [Return].

   OR

   If the date displayed is approximately the last date the patient is available, press [Return].

   The cursor moves to FROM TIME.

9. Enter the earliest time of day the patient is available. Press [Return].

   The cursor moves to THRU TIME.

10. Enter the latest convenient time of day. Press [Return].

    The cursor moves to DAY OF WEEK. MTWTHFSSN is displayed.

11. Press [Return] if the patient is available any day of the week, or enter the most convenient day(s) of the week. Press [Return].

    The cursor moves to REFERRED FROM.

12. Enter the code representing the HCP or Clinic that referred the patient, if any. Press [Return].

    Two system responses are possible.

A. The system displays a list of available appointments that correspond to the appointment requirements you entered. Each appointment is numbered.

    Also displayed are the following options:

    7 - NEXT PAGE (View more appointments)
    8 - PREVIOUS PAGE (Return to earlier appointments)
    9 - VIEW PENDING (View pending appointments)

    The cursor moves to ENTER SELECTION.

1. Enter the number of the option you wish to perform. If you wish to book an appointment, enter the number of the appointment best suited to the patient's requirements. Press [Return].

NOTE: Select '9', VIEW PENDING, to view any appointments currently booked for the patient. When the pending Appointments are displayed, selecting '9', VIEW AVAILABLE, will redisplay the appointments available for booking.

The system displays the appointment you have selected, clinic and HCP comments if any, and the question 'BOOK?'

2. Enter 'Y' to book the appointment. Press [Return]. If you enter 'N', the available appointments are redisplayed.

B. The system displays the message NO APPOINTMENTS FOUND FOR THESE CRITERIA. SEARCH FOR OVERBOOK?

1. Enter 'Y' to view available overbook appointments. (If you enter 'N', the cursor returns to CLINIC so that you may make changes in the appointment criteria.)

The available overbooks are displayed.

2. Enter the number of the appointment you wish to overbook. Press [Return].

The system displays the appointment you have selected, clinic and HCP comments, if any, and the question 'OVERBOOK?'

3. Enter 'Y' to overbook the appointment.

   If there are no overbooks that fulfill the patient's requirements, the system will display the message **NO OVERBOOKS FOUND FOR THESE CRITERIA.** To find an appointment for the patient, you must change some of the data on the Book Appointment Screen. At ENTER SELECTION, enter the field name where you will make a change and press [Return]. Enter ALL to make changes in more than one field.

After you have booked or overbooked the appointment for the patient, you may perform multiple bookings - booking more than one appointment for the same patient. There are two options.

A. If the date(s) for an additional appointment is within the dates/times on the screen:

1. Enter '9' at ENTER SELECTION and press [Return].

   The system displays a list of available appointments.

2. Select an appointment from those displayed and enter the number at ENTER SELECTION. Press [Return].

   The system displays the appointment you have chosen, clinic and HCP comments if any, and the query 'BOOK?'

3. Enter 'Y' to book the appointment.

   The system displays patient's pending appointments.

NOTE: If you enter 'N', the system will continue to display available appointments.

B. If the date(s) for an additional booking is not within the same FROM DATE and THRU DATE:

1. Enter 'FROM DATE;THRU DATE' at ENTER SELECTION, and press [Return].

   The cursor moves to FROM DATE, and then THRU DATE.

2. Enter the new FROM DATE and THRU DATE. Press [Return].

   The cursor moves to ENTER SELECTION.

3. Press [Return] for available appointments.

   Available appointments are displayed.

4. Select the number corresponding to the appointment desired by the patient. Press [Return].

   The system will display BOOK?

5. Enter 'Y' to book the new appointment.

NOTE: To book additional appointments for the same patient, but with a different clinic, HCP, or appointment type, enter that field name at ENTER SELECTION, when the patient's pending appointments are displayed. Press [Return]. With the cursor at the selected field, follow the instructions above.

The system will display all of the patient's pending appointments.

After booking appointments for that patient, press [Return] with the cursor at ENTER SELECTION. Enter a new patient name on the PTID Screen to book appointments for a different patient, or press [Cancel] to exit the function.

3.2 To Cancel an Appointment From The Booking Function.

From the Booking Screen, you may cancel a pending appointment any time the option 10, CANCEL APPOINTMENT, and a list of pending appointments are displayed.

1. With the cursor at ENTER SELECTION, enter '10'. Press [Return].

   The message # OF APPOINTMENT TO CANCEL is displayed.

2. Enter the number corresponding to the appointment to be cancelled.

The cursor moves to CANCEL REASON.

3. Enter the code for the reason for the cancellation. If you do not enter a code, the appointment will not be cancelled.

   The cursor moves to ENTER SELECTION. Pending appointments are displayed.

CANCELLING APPOINTMENTS

The Cancel Appointment function allows you to view and/or cancel appointments booked for patients. After cancelling a booked appointment, you may book a new appointment for the patient.

The PTID Screen is the first screen displayed after you select Cancel Appointment from the Appointing and Scheduling Main Menu. The PTID Screen works with the Outpatient Candidate List Screen to help you locate a patient's records. Using these screens, you will locate the records of the patient whose appointment(s) you wish to cancel.

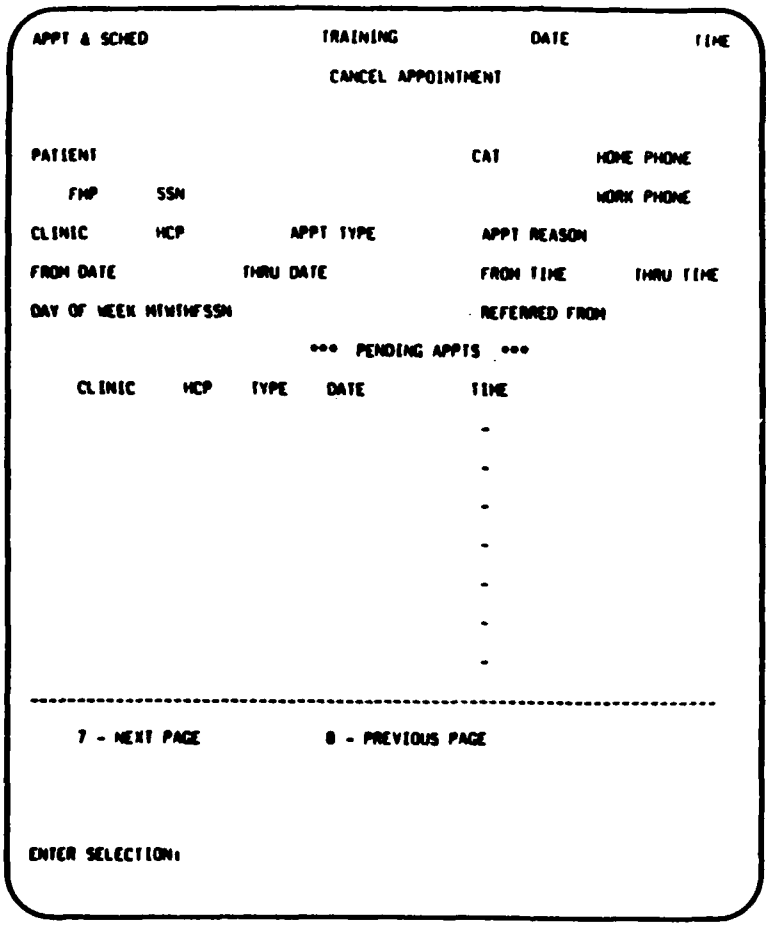


FIGURE 3.2 CANCEL APPOINTMENT SCREEN

DATA CHART - CANCEL APPOINTMENT SCREEN

PATIENT.	Patient name as identified through PTID screen.
FMP.	Family Member Prefix. Display only.
SSN.	Social Security Number. Display only.
CAT.	Patient Category. Display only.
WORK PHONE.	Display only.
HOME PHONE.	Display only.
ZIP.	Display only.
UNIT.	Display only.
CANCEL REASON.	The code representing the reason the appointment was cancelled. 3 characters. Required field.
CLINIC.	Clinic in which appointment has been scheduled. 3 characters.
APPOINTMENT TYPE.	Type of appointment for which patient is scheduled. 3 characters.
HCP.	Health Care Provider with whom appointment was scheduled. 6 characters.

FROM DATE. Earliest date when patient could have requested an appointment. Default is current date. 11 characters. Required field.

THRU DATE. Latest date when patient could have requested an appointment. Default is 30 days from current date. 11 characters. Required field.

FROM TIME. Earliest time of day when patient could have requested the appointment. 4 digits.

THRU TIME. Latest time of day when patient could have requested the appointment. 4 digits.

DAY OF WEEK. Enter all days of week on which appointment could be scheduled. Valid entries include: M, T, W, Th, F, S, and SN. Up to 9 characters. Default is all 7 days.

3.3 To Cancel Patient Appointment

1. Enter 'C' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The PTID Screen is displayed.

2. Identify the patient as described in Section 2.1, To Record Patient Identification Information.

   The Cancel Patient Appointment Screen and the patient's pending appointments are displayed. The cursor is at ENTER SELECTION.

3. Enter the number of the appointment you want to cancel. Press [Return].

   The appointment to be cancelled and the field CANCEL REASON are displayed. The cursor moves to CANCEL REASON.

4. Enter the code for the reason the appointment was cancelled.

   The patient's remaining appointments are displayed. The cursor moves to ENTER SELECTION.

5. To cancel more appointments, enter the number of each appointment and press [Return]. Follow the procedures above.

   To cancel a different patient's appointment, press [Return] with the cursor at ENTER SELECTION. The PTID Screen will appear.

APPOINTING AND SCHEDULING TRAINING AID

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SCANNING APPOINTMENTS

The Scan Appointment Screen provides the user with information about a patient's pending appointments. The Scan Appointment Screen provides a list of all the patient's appointments booked for any clinic. After Scan Appointment is selected from the Main Menu, the Scan Appointment Screen is accessed by using the PTID Screen and the Outpatient Candidate List Screen.

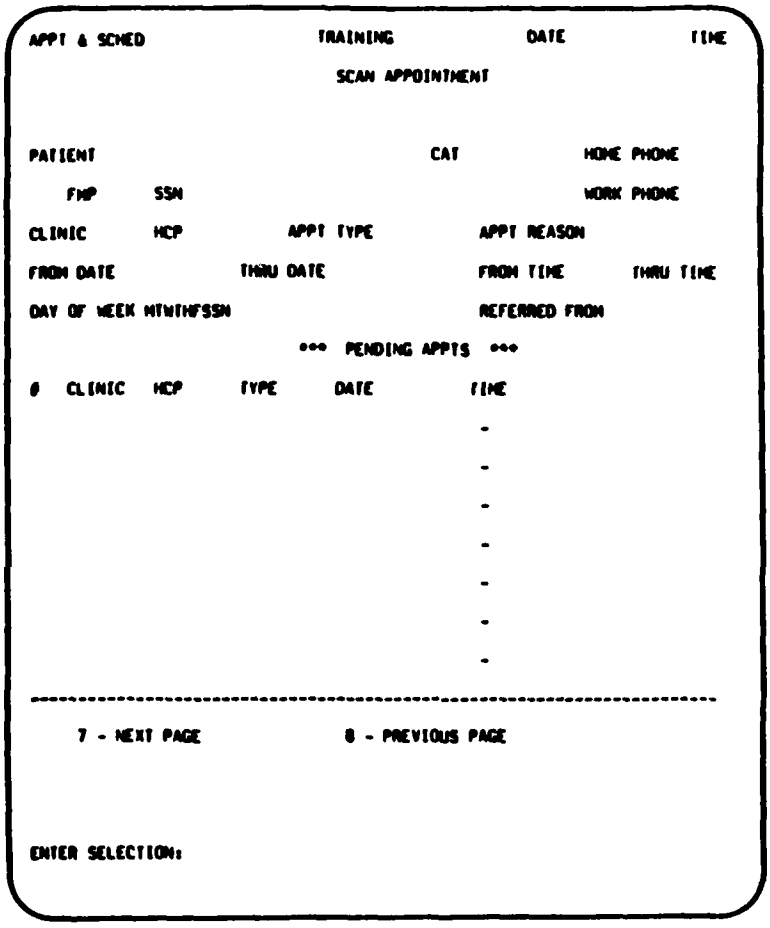


FIGURE 3.3 SCAN APPOINTMENT SCREEN

DATA CHART - SCAN APPOINTMENT SCREEN

PATIENT.	Patient name as identified through PTID screen. Required field.
CLINIC.	Clinic in which appointment has been scheduled. 3 characters.
HCP.	Health Care Provider with whom appointment was scheduled. 6 characters.
APPOINTMENT TYPE.	Type of appointment for which patient is scheduled. 3 characters.
FROM DATE.	Earliest date when patient could have requested an appointment. Default is current date. 11 characters.
THRU DATE.	Latest date when patient could have requested an appointment. Default is 30 days from current date. 11 characters.
FROM TIME.	Earliest time of day when patient could have requested the appointment. 4 digits.
THRU TIME.	Latest time of day when patient could have requested the appointment. 4 digits.
DAY OF WEEK.	Enter all days of week on which appointment could be scheduled. Valid entries include: M, T, W, TH, F, S, and SN. Up to 9 characters. Default is all 7 days.

3.4 To Scan Appointments

1. Enter 'P' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Patient Identification (PTID) Screen is displayed.

2. Identify the patient as described in Section 2.1, To Record Patient Identification Information.

   The Scan Appointment Screen is displayed. A list of the patient's pending appointments is displayed at the bottom of the page. The cursor is at ENTER SELECTION.

3. To view the pending appointments for a different patient, press [Return].

   The PTID Screen is displayed.

4. Follow the procedures above.

4. CREATING SCHEDULES

INTRODUCTION

The purpose of the scheduling function is to create schedules for each HCP. The schedules you create will be used to book appointments for patients. This section of the Appointing and Scheduling Training Aid addresses the fundamental elements of creating schedules: the Edit Profile, Create/Edit Template, Copy Template, and Create/Edit Schedule functions.

The first step in creating a schedule is the Edit Profile function. An HCP profile is a description of the types of appointments the HCP handles, the number of patients the HCP regularly sees, and the HCP's requirements concerning patient records. It is important to remember that an HCP must be profiled -- the HCP Profile edited -- for every type of appointment he or she handles.

The next step is to create templates for each HCP. It is helpful to think of a template as a group of days on a calendar -- Monday, Tuesday, Wednesday, etc. -- with no dates attached. Using the Create Template Screen, you will fill each day in this group of days with appointment slots, according to the types of appointments the HCP handles. In this way you 'create' the HCP's week (templates can be created for periods of from 1 to 7 days). Give the templates names so they can be stored in the system and retrieved for reuse. Templates can be copied from one HCP's profile to another HCP's profile.

The Create/Edit Schedule Screen allows you to perform two functions. First, the Create Schedule Screen is used to assign a date to a template. This creates a schedule. You can create a schedule longer than the template by using the template more than once. The schedule you create using this function will then be ready to receive appointments.

Next, the Create/Edit Schedule Screen enables you to edit already existing schedules. You can change the appointment type of a scheduled appointment, cancel and/or delete schedules, combine templates, and add partial templates to already existing schedules.

Other scheduling functions, which refine already existing schedules, are described in Section 5, Modifying Schedules, of this Appointing and Scheduling Training Aid.

PROFILING AN HCP

The Edit HCP Profile Screen is accessed by selecting 'P' from the Schedule Menu. Creating an HCP Profile is the first step in creating an HCP Schedule.

An HCP Profile contains information about the types of appointments the HCP handles, details about these appointment types, and information about patients' medical records. Because this information differs with each appointment type, a separate set of data must be entered into the HCP's profile for each appointment type. In this way you 'build' the HCP's Profile to include all relevant information about each appointment type.

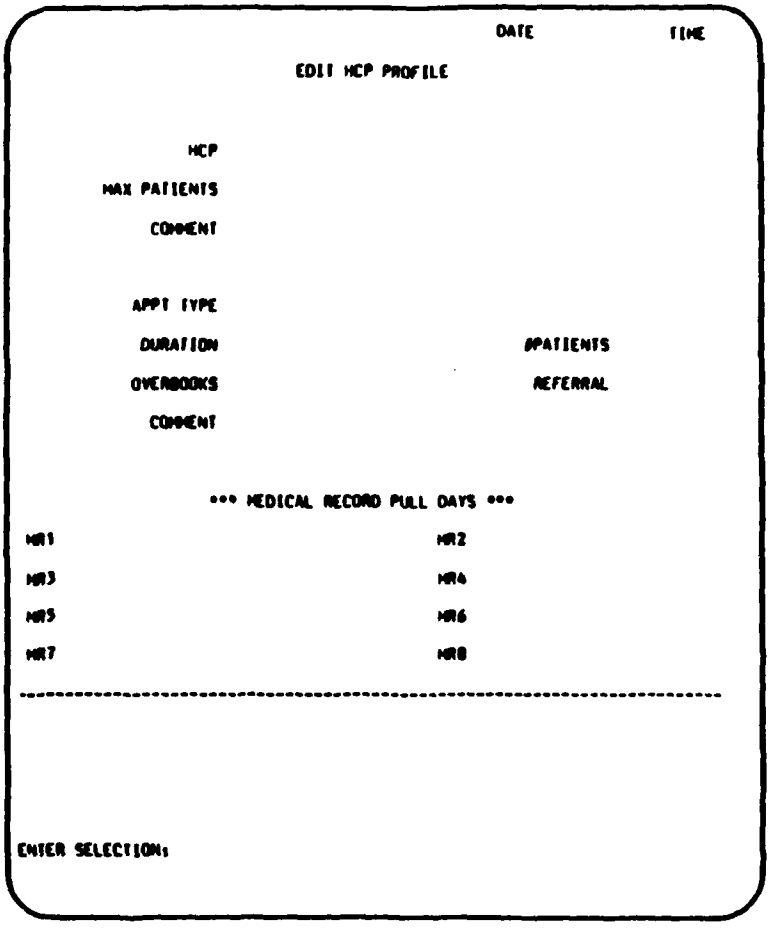


FIGURE 4.1 EDIT HCP PROFILE SCREEN

DATA CHART - EDIT HCP PROFILE SCREEN

APPT. TYPE. Appointment Type. 3 characters. Required field.

DURATION. The number of minutes, in 5-minute intervals only, that is required for this appointment type. 3 digits. Required field.

PATIENTS. The maximum number of patients an HCP is willing to see at one time for this appointment type. Used in instances when group appointments are normally booked for this appointment type. Options: 2-99. Default: 1. 2 digits. Required field.

OVERBOOKS. This field indicates the number of overbooks allowed if more than one patient can be appointed to each time slot in instances when group appointments are not the norm for this appointment type. Options: 2-99. 2 digits.

REFERRAL. This field indicates whether a referral is required for this appointment type. Options 'Y' or 'N'. 1 character.

COMMENT. A comment to be displayed with this appointment type. 30 characters. Optional field.

MEDICAL RECORDS.	The types of records displayed will vary from one MTF to another. The data entered for this field label indicates how many days before the appointment this type of medical record should be pulled for review by the HCP. Options: 0-9, or null (1 digit). Null means this record is not to be pulled at all. '0' (zero) means the record is to be given to the HCP on the day of the appointment. '1' means the record is to be given to the HCP one day before the appointment.

4.1 To Edit an HCP Profile

1. Access the Edit HCP Profile Screen by entering 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'P' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Edit HCP Profile Screen is displayed.

3. Enter the HCP whose profile you wish to edit. Press [Return].

   The cursor moves to MAX PATIENTS.

4. Enter the maximum number of patients the HCP will see in a day. Press [Return].

EXAMPLE: To calculate the MAX PATIENTS field, total the maximum number of patients the HCP may see on a full day, taking into account all appointment types -- including group appointments -- their duration, and the HCP's lunch break. For example, if a Physical appointment has a 30-minute duration, an HCP can probably handle fourteen of these appointments in an 8-hour work day, with 60 minutes for lunch. The HCP will see 14 patients on this day. If Physical is the HCP's shortest appointment type, the HCP's MAX PATIENTS will be 14 (this calculation assumes that an HCP will have days booked with Physical appointments only).

The cursor moves to COMMENT.

5. Enter a comment to be displayed with that HCP Profile. Press [Return].

The cursor moves to APPT TYPE.

6. Enter the appointment type you wish to include in the HCP Profile. Press [Return].

The cursor moves to DURATION.

7. Enter the duration, in minutes, of that appointment type. Press [Return].

NOTE: The duration must be a multiple of 5 minutes.

The cursor moves to #PATIENTS.

8. Enter the number of patients the HCP will see for that appointment type. Press [Return].

The cursor moves to OVERBOOKS.

9. Enter the maximum number of overbooks the HCP can see during the appointment type. Press [Return].

The cursor moves to COMMENT.

10. Enter the comment to be displayed with the appointment type. Press [Return].

The cursor moves to the first medical record type.

11. Enter the number of days before the appointment that the HCP would like to see this type of record. Repeat this process for each type of patient record.

    The cursor moves to ENTER SELECTION.

12. To add another appointment type to the HCP's profile, enter ALL and press [Return]. With the cursor at APPOINTMENT TYPE, follow the procedure above.

    To discontinue profiling, press [Return] at ENTER SELECTION. The profiled information will be stored. The Schedule Menu will be displayed.

NOTES:

1. Change information in the HCP profile by positioning the cursor at the field(s) you wish to change, then typing over the data displayed.

2. An HCP should be profiled for only the types of appointments he or she conducts. Profiles for appointment types the HCP does not conduct wastes system memory, and may result in the HCP being scheduled for the wrong types of appointments. Delete invalid appointment types by displaying the appointment type to be deleted and then pressing [Clear Data] in the APPT TYPE field. Press [Entry Done] with the cursor at DURATION. The following query will appear: **ARE YOU SURE YOU WANT TO DELETE THIS APPT TYPE?** Press 'Y' to delete the appointment type. Press [Return] to store the deletion.

3. Pressing [Help] at APPT TYPE will display a list of all appointment types. Those for which the HCP is already profiled are designated by an * (asterisk).

CREATING AND EDITING TEMPLATES

Access the Create/Edit Template Screen by selecting 'T' from the Schedule Menu. A template is a potential schedule, a group of days up to 7 days long. It is not associated with a date. The days in a template must be filled with appointment slots, in whatever order the HCP wishes to handle appointments during the day.

Before beginning to construct a template, it is important to consider a number of factors:

1. How many days should the template include?

2. Will the HCP begin seeing patients at the same time every day?

3. Will the HCP break for lunch at the same time and for the same amount of time every day?

4. What is the duration of the appointment types you are inserting?

5. Is the HCP profiled for every different appointment type that he or she has?

In most cases it will be useful to create a template that represents the HCP's regular work week. This template can be used again and again in the schedule creation process, whenever the HCP's routine remains the same. Different templates can be created to incorporate unusual

work weeks, such as those that include the HCP's vacation days or days off. Reference the templates with easy word associations. For example, the HCP's template representing the regular work week may be called REGULAR.

After identifying the HCP and the template you are creating, you are ready to 'build' a day of the template. First specify the DAY of the template, the APPOINTMENT START TIME, then the APPOINTMENT TYPE. '1' will appear at REPEAT to indicate that one appointment of the type specified will take place at the appointment time indicated. If you wish to insert several of these appointment types consecutively, enter the appropriate number at REPEAT. The system will calculate the duration of the appointments you have entered and will display the template as it is being built. The end time of these appointments will serve as the APPOINTMENT START TIME of the next group of appointments you will insert.

To edit an already existing template, identify the template and enter the template day and appointment time to be changed. The system will display the entire day's template as it is currently stored. Select the appointment time to be changed. The appointment type currently stored for that time will default to the APPT TYPE field. Change the appointment type by entering new data over it. Also type over the REPEAT field with any changes.

To add a day(s) to the template, specify the HCP and TEMPLATE to be changed, and follow the procedures for creating a new template.

To delete an appointment time and type from a template, press [Clear Data] at the APPOINTMENT TYPE field when the appointment type to be deleted is displayed.

To delete an entire template, select option 3 from the options displayed at the bottom of the Create/Edit Template Screen.

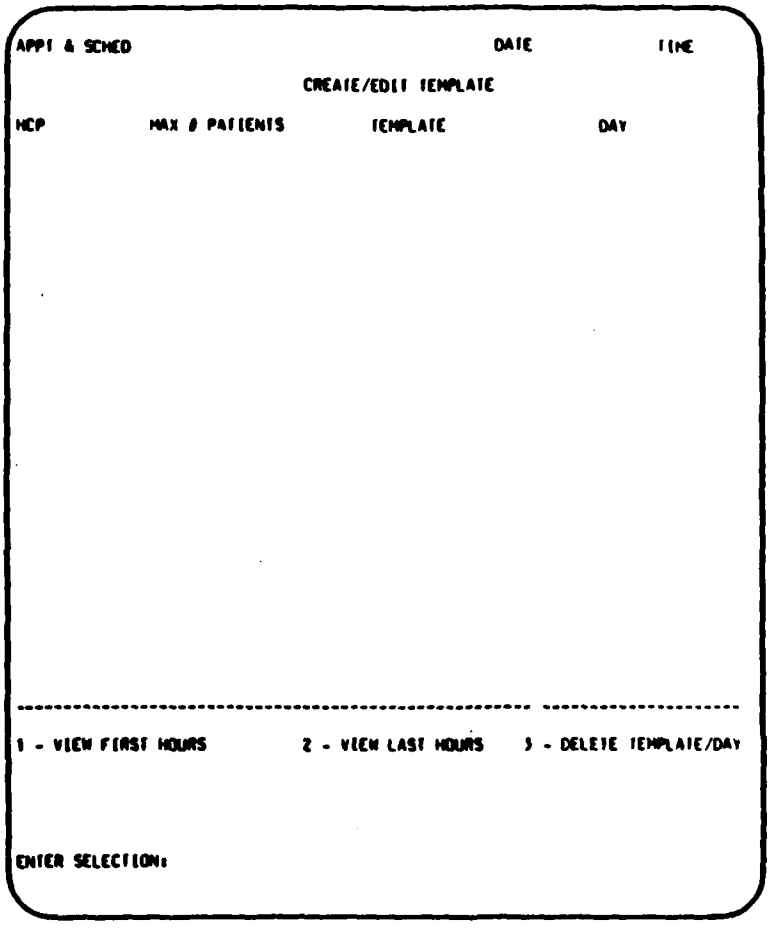


FIGURE 4.2 CREATE/EDIT TEMPLATE SCREEN

DATA CHART - CREATE/EDIT TEMPLATE SCREEN

HCP.	Health Care Provider. 6 characters. Required field.
MAX # PATIENTS.	The maximum number of patients the HCP can see in one day. Display only.
TEMPLATE.	Name of the template. 4-15 characters. Required field.
DAY.	A number representing the ordinal placement of this day in the template, i.e., first day = 1, etc. 1 digit. Options: 1-7. Required field.
START TIME.	The starting time for an appointment. 4 digits. Required field.
APPT TYPE.	The appointment type to be slotted into this time period. 3 characters. Required field.
REPEATS.	The number of consecutive times an appointment type is to be repeated starting from the Start Time. Default is 1. 2 digits. Options: 1-20.

4.2 To Create A Template

1. Enter 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'T' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Create/Edit Template Screen is displayed, with the cursor at HCP.

3. Enter the HCP for which you are creating a template. Press [Return].

   MAX # PATIENTS is filled automatically. The cursor moves to TEMPLATE.

4. Enter the name of the template you are creating. Press [Return].

   If the template name is not already in the system, the confirmation question ARE YOU ADDING A NEW TEMPLATE? will appear.

5. Enter 'Y'.

   The cursor moves to DAY. '1' is displayed automatically.

6. Press [Return].

NOTE: Days must be created sequentially.

The fields APPOINTMENT START TIME, APPOINTMENT TYPE, and REPEAT are displayed. A grid showing hourly time increments is displayed.

The cursor moves to APPOINTMENT START TIME.

7. Enter the time of day when the HCP will see his or her first patient.

   The cursor moves to APPOINTMENT TYPE.

8. Enter the type of appointment the HCP will handle at the time specified.

   The cursor moves to REPEAT. '1' is displayed.

9. Enter the number of consecutive appointments of that type that the HCP will conduct beginning at the time indicated. Default is 1. Press [Return].

   The system displays your entry on the grid. The cursor moves to APPOINTMENT START TIME. The next available appointment time is displayed.

10. Enter the start time for the next group of appointments. The default is the next available time, as displayed. Press [Return].

    The cursor moves to APPOINTMENT TYPE.

11. Enter the appointment type to begin at that time.

The cursor moves to REPEAT. '1' is displayed.

12. Enter the number of repeats for the appointment type indicated, if it differs from 1. Press [Return].

    The system displays your entry on the grid. The cursor moves to APPOINTMENT TIME. The next available appointment time is displayed.

13. Repeat the procedure above until the day you are constructing is complete. To create the next day, press [Clear Data] and [Entry Done] at APPOINTMENT START TIME.

    The system displays the message, ARE YOU READY TO FILE THIS DAY OF THE TEMPLATE?

14. Enter 'Y'.

    The cursor moves to ENTER SELECTION.

15. Press [Return] to store the template.

4.3 To Edit a Template

1. Enter 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'T' at ENTER SELECTION on the Schedule Menu. Press [Return].

The Create/Edit Template screen is displayed with the cursor at HCP.

3. Enter the name of the HCP whose template you wish to edit. Press [Return].

   MAX # PATIENTS is completed automatically. The cursor moves to TEMPLATE.

4. Enter the name of the template you wish to edit. Press [Return].

   The cursor moves to DAY.

5. Enter the day of the template you wish to edit.

   A grid of the template day is displayed. If there is any appointment type already slotted for this time, it is displayed.

   The cursor moves to APPOINTMENT START TIME.

6. Enter the time of the appointment to be changed.

   The cursor moves to APPOINTMENT TYPE.

7. To substitute an appointment type for the one shown, type the new appointment type over the old.

   To delete the appointment type shown, press [Clear Data] and [Return].

   The cursor moves to REPEAT. '1' is displayed at the REPEAT field.

NOTE: Entering a number greater than 1 indicates to the system that you want to replace more than one appointment slot with the different appointment type. This may interfere with appointment slots already entered. If so, the system will respond with the message **THIS APPOINTMENT WILL RUN OVER THE NEXT APPOINTMENT. OVERRIDE?** Answer 'Y' to implement the change. The cursor will return to APPOINTMENT START TIME.

If the time you have selected shortens or replaces an existing appointment, the system will display the message, **PREVIOUS APPOINTMENT OVERRUNS THIS APPOINTMENT TIME. OVERRIDE?** Answer 'Y' to implement this change. The cursor will return to APPOINTMENT START TIME.

The cursor moves to APPOINTMENT START TIME.

8. Perform additional edits according to the procedure described above. To exit the function, press [Entry Done] with the cursor at APPT START TIME.

   The system displays the message, ARE YOU READY TO FILE THIS DAY OF THE TEMPLATE?

9. Enter 'Y'.

   The cursor moves to ENTER SELECTION.

10. Press [Return] to store the changes.

4.4 To Delete a Template

A. To Delete an Entire Template

1. Enter 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'T' at the ENTER SELECTION on the Schedule Menu. Press [Return].

   The Create/Edit Template Screen is dislayed. The cursor is at HCP.

3. Identify the HCP. Press [Return].

   The cursor moves to template.

4. Identify the template. Press [Return].

   The cursor moves to DAY.

5. Press [Return].

   The cursor moves to ENTER SELECTION.

6. Enter '3'. Press [Return].

   The system displays the message DELETE THE ENTIRE TEMPLATE?

7. Enter 'Y'. (If you enter 'N', the cursor will return to ENTER SELECTION.)

   The cursor moves to HCP.

B. To Delete Template Day(s)

USER HINT: The delete template day function is designed to allow you to shorten an existing template by one day. When deleting a template day, keep in mind that

- The day you choose to cancel must have been stored;
- You cannot cancel a 'middle' day (a day between two stored days); and
- Deleting one day of a one-day template deletes the template.

To find out how many days are contained in a template, identify the HCP and template and press [Help] with the cursor at DAY.

1. Identify the HCP and template. Press [Return].

   The cursor moves to DAY.

2. Enter the day of the template you want to cancel. Press [Return].

   The template day is displayed. The cursor moves to APPOINTMENT START TIME.

3. Press [Entry Done].

   The cursor moves to ENTER SELECTION.

4. Enter '3'. Press [Return].

   The system displays the query DELETE ONE DAY OF THE TEMPLATE?

5. Enter 'Y'.

   The cursor returns to HCP.

COPYING TEMPLATES

The Copy Template Screen, accessed by selecting 'C' on the Schedule Menu, is used to copy a day from an HCP's template or to copy the entire template. Copying in this way is easier and faster than creating template days identical to template days already stored in the system.

There are two ways to use the Copy Template Screen. They are designated 'A' and 'B' in the procedures, which begin on 4-28. First, if several days in one HCP's template are identical -- the appointments and their order are the same -- simply make copies of the original day. You can perform this function by entering the same data in the TO HCP and TO TEMPLATE as you entered in the FROM HCP and FROM TEMPLATE, respectively. You will change the TO DAY to each successive day of the template.

Next, if one HCP has the same daily routine as another, and a template has been created for the first HCP, use the Copy Template Screen to duplicate this template, or portions of it, for the second HCP. To copy an entire template, leave the FROM DAY and the TO DAY fields empty.

It is important to remember that the 'receiving' HCP must be profiled for the appointment types included in the template days that are copied to his template. The receiving template does not have to be created before it can be copied into.

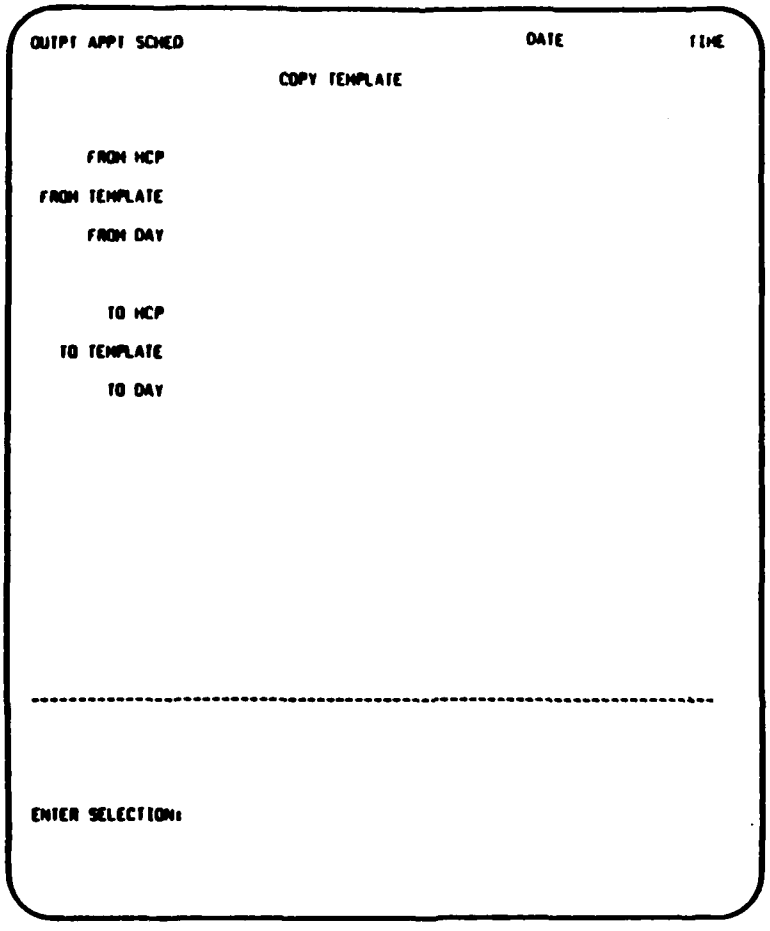


FIGURE 4.3 COPY TEMPLATE SCREEN

DATA CHART - COPY TEMPLATE SCREEN

FROM HCP.	Name of health care provider whose template is being copied. 6 characters. Required field.
FROM TEMPLATE.	Name of template from which day is being copied. 4-15 characters. Required field.
FROM DAY.	The number of the day within the template that is to be copied. Null copies all days.
TO HCP.	Name of health care provider whose template is receiving this modification. 6 characters. Required field.
TO TEMPLATE.	Name of template into which this modification is being copied. 4-15 characters. Required field.
TO DAY.	The number to be assigned to this day in the recipient template.

4.5 To Copy a Template

A. To Copy One Template Day to The Same Template.

1. Enter 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'C' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Copy Template Screen is displayed. The cursor is at FROM HCP.

3. Enter the name of the HCP whose template day you wish to copy. Press [Return].

   The cursor moves to FROM TEMPLATE.

4. Enter the name of the template from which you wish to copy a day.

   The cursor moves to FROM DAY.

5. Enter the day of the template you wish to copy. Press [Return].

   The cursor moves to TO HCP.

6. Enter the same HCP entered in FROM HCP. Press [Return].

   The cursor moves to TO TEMPLATE.

7. Enter the same name entered in FROM TEMPLATE. Press [Return].

   The cursor moves to TO DAY.

8. Enter the number of the day of the template (1-7) you wish to copy the FROM DAY onto.

   The cursor moves to ENTER SELECTION.

9. Press [Return].

   The process is complete. The Schedule Menu is displayed.

10. Repeat the procedure described above for each additional copy you wish to make of the original day. Change the TO DAY field to each successive day for which the original day is to be copied.

B. To Copy Days From a Template or To Copy an Entire Template To That of Another HCP.

1. Follow steps 1 and 2 in Procedure A on the preceding page.

2. With the Copy Template Screen displayed and the cursor at HCP, enter the HCP whose template days you wish to copy. Press [Return].

   The cursor moves to FROM TEMPLATE.

3. Enter the name of the template from which you wish to copy. Press [Return].

   The cursor moves to FROM DAY.

4. Enter the day of the template to be copied. If you wish to copy the entire template, leave this field blank. Press [Return].

   The cursor moves to TO HCP.

5. Enter the name of the HCP whose template is receiving the day(s) of the original template. Press [Return].

   The cursor moves to TO TEMPLATE.

6. Enter the name of the template receiving the day(s) of the original template. Press [Return].

   The cursor moves to TO DAY.

7. Enter the day of the template receiving the day. If you wish to copy the whole template onto the receiving template, leave TO DAY blank. Press [Return].

   The cursor moves to ENTER SELECTION.

8. Press [Return].

   The Schedule Menu is displayed.

9. To copy another day from the template, begin the procedure again.

CREATE/EDIT SCHEDULES

The Create/Edit Schedule Screen is accessed by selecting 'S' on the Schedule Menu. Creating a schedule consists of two steps. First, you must indicate the day of the week on which the template is to begin. Second, you need to determine how many weeks are to be scheduled identically. A 5-day template beginning on Monday will create a schedule through Friday. However, you can create that same schedule for several weeks by entering a number greater than one at the NUMBER OF WEEKS field.

The Create/Edit Schedule Screen is also used to perform three schedule editing functions. You may change an appointment type already scheduled, delete an appointment type from the schedule, or combine two half-day templates to create a schedule day.

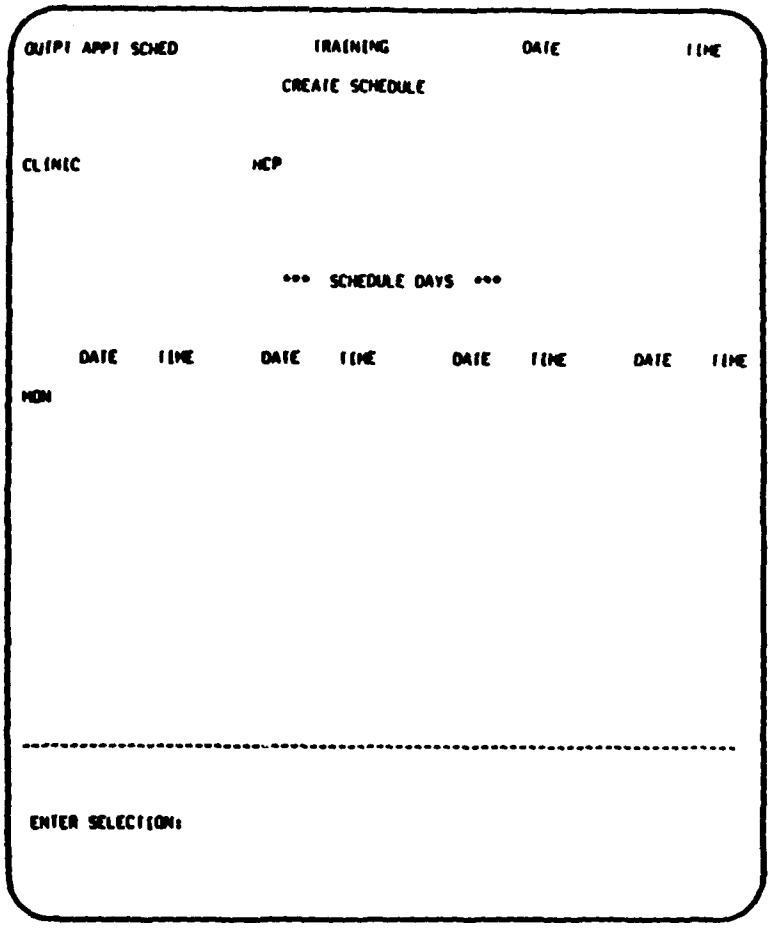


FIGURE 4.4 CREATE SCHEDULE SCREEN

DATA CHART - CREATE/EDIT SCHEDULE SCREEN

CLINIC.	Name of clinic for which schedule is being created. 3 characters. Required field.
HCP.	Health Care Provider assigned to this clinic on the day for which the schedule is being created. 6 characters. Required field.
TEMPLATE.	Name of template to be applied to create the schedule. 4-15 characters. Required field.
DAY OF WEEK.	Day for which user is creating schedule. There must not be anything currently scheduled for this Clinic/HCP/Date combination. 1 or 2 characters. Required field.
NUMBER OF WEEKS.	The number of times the template is to be repeated for the schedule's time period. 1 digit. Options: 1-5. Required field.

4.6 To Create a Schedule

1. Enter 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'S' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Create Schedule Screen is displayed, with the cursor at CLINIC.

3. Enter the clinic of the HCP for whom you are creating a schedule.

   The cursor moves to HCP.

4. Enter the HCP for whom you are creating a schedule. Press [Return].

   The system displays the message, BUILDING DISPLAY OF PROVIDER'S SCHEDULE. The cursor moves to ENTER SELECTION. A grid showing the HCP's schedule days is displayed and at the bottom of the screen are the following options:

   1 - NEXT PAGE
   2 - PREVIOUS PAGE
   3 - EDIT SCHEDULE
   4 - ADD SCHEDULE

NOTE: Dashes on the grid at TIME field indicate that this date has not been scheduled yet.

5. Determine the day on which you want to begin the new schedule. Use options 1 and 2 to display prior or following dates, respectively. Enter '4' and press [Return].

   The cursor moves to TEMPLATE NAME.

6. Enter the name of the template you are using to create the HCP's schedule. Press [Return].

   The cursor moves to DAY OF WEEK.

7. Enter the code for the day(s) of the week on which the schedule will be created. Press [Return].

   The cursor moves to NUMBER OF WEEKS.

8. Enter the number of times you want the template used in the schedule. Press [Return].

   The system displays the message DO YOU WISH TO START THIS SCHEDULE ON DD/MM/YY? The date displayed is the next day available for scheduling, as you specified at DAY OF WEEK.

EXAMPLE: If your DAY OF WEEK is M (Monday), and your template is 4 days long, a NUMBER OF WEEKS of 1 will create a schedule through Thursday. A NUMBER OF WEEKS of 2 will create a schedule through Thursday for the current week, and from Monday through Thursday for the following week. A NUMBER OF WEEKS of 3 will create Monday through Thursday schedules for the current week and the next two consecutive weeks. Friday through Sunday will remain unscheduled for those weeks, unless you schedule them separately.

If an HCP has two different kinds of days during a week, the easiest way to create the schedule may be to use one-day templates. For example, assume that Monday, Wednesday, and Friday will be the same, as will Tuesday and Thursday. Enter the name of a one-day template at TEMPLATE NAME, enter MWF (Monday, Wednesday, Friday) at DAY OF WEEK; enter the number of weeks to be scheduled at NUMBER OF WEEKS. Using a different template, create schedules for Tuesday and Thursday by entering TTH (Tuesday, Thursday) at DAY OF WEEK.

9. Enter 'Y' to add the schedule. If you enter 'N', the system will respond with the same message, but with a date one week later than the date previously displayed. Enter 'Y' or 'N'. Press [Return].

   The system will display a grid showing the HCP's schedule for the next month. The cursor moves to ENTER SELECTION.

10. Press [Return].

    The system displays the message DO YOU WISH TO FILE THESE SCHEDULE CHANGES?

11. Enter 'Y' to store the changes. If you enter 'N', the system allows you to make more changes, and store all changes later.

4.7 To Edit a Schedule

A. To Change an Appointment Type:

1. Follow steps 1-4 of the procedure from Section 4.6 To Create a Schedule.

   The cursor moves to ENTER SELECTION. A grid showing the HCP's schedule days is displayed.

2. Enter '3' at ENTER SELECTION. Press [Return].

   The cursor moves to DATE.

3. Enter the date of the schedule to which you would like to make changes.

   The cursor moves to APPOINTMENT TIME. The system displays the appointments created for the day you selected.

4. Enter the time of the appointment you would like to change.

   The cursor moves to APPOINTMENT TYPE. The appointment type currently stored for this time slot is displayed.

5. Enter the new appointment type or type over the appointment type displayed to change the appointment type. To delete the appointment type, press [Clear Data].

   The cursor moves to TEMPLATE.

NOTE: This field is used only to add whole templates to a schedule.

6. Press [Return].

   The cursor moves to APPOINTMENT TIME.

7. Continue to perform editing functions, or press [ENTRY DONE].

   The cursor moves to ENTER SELECTION.

8. Press [Return].

   The system displays the message DO YOU WISH TO FILE THESE SCHEDULE CHANGES?

9. Enter 'Y' to file the changes or 'N' to continue to perform scheduling functions.

B. To Add a Template Day:

1. Follow steps 1-4 on the procedure from Section 4.6 To Create a Schedule.

   The cursor moves to ENTER SELECTION. A grid showing the HCP's schedule days is displayed.

2. Enter '3' at ENTER SELECTION. Press [Return].

   The cursor moves to DATE.

3. Enter the date at which you want to add a template day. Press [Return].

NOTE: This procedure can only be used with one-day templates.

The cursor moves to APPOINTMENT TIME.

4. Press [Return].

The cursor moves to APPOINTMENT TYPE.

5. Press [Return].

The cursor moves to TEMPLATE.

6. Enter the name of the template to be added to that day. Press [Return].

The system displays the template day. The cursor moves to APPOINTMENT TIME.

7. Press [Entry Done].

The cursor moves to ENTER SELECTION.

8. Press [Return].

The system displays the message DO YOU WISH TO FILE THESE SCHEDULE CHANGES?

9. Enter 'Y' to file the changes or 'N' to continue to perform scheduling functions.

APPOINTING AND SCHEDULING TRAINING AID

5. MODIFYING SCHEDULES

INTRODUCTION

The functions accessed from the Modify Schedules Menu are used to make changes to existing schedules. Once created, schedules are difficult to modify, so take care to provide accurate and appropriate schedules that will not require substantial changes later.

The Cancel Schedule Screen allows you to cancel portions of an HCP's schedule. You may cancel entire days of a schedule or a portion of one or more days. Performing the Cancel Schedule function makes it impossible to book appointments to the cancelled portion of the schedule.

The Cancel Schedule screen also allows you to delete schedules from the system. This is useful when you wish to not only void an existing schedule, but also create a new one in its place. While cancelling a schedule prevents booking appointments on that schedule, it also keeps a new schedule from being created for that time period. Before you can create a new schedule for a period in which another existed, the old schedule must be cancelled and deleted.

The Freeze Schedule Screen should be used when there is some doubt as to whether the HCP will be able to see some portion of the appointments already scheduled. This function prevents unbooked appointments from being booked for entire days or portions of days. Unlike the Cancel Schedule function, the Freeze Schedule function is not permanent.

The 'frozen' portions of the schedule are not deleted from the system. When HCP availability or nonavailability is finalized, the frozen portion of the schedule can be unfrozen for booking or deleted from the system.

The Unfreeze Schedule Screen is used only to 'unfreeze' for booking those appointment slots frozen in the Freeze Schedule procedure. The portions of the schedule that were 'frozen' can be 'unfrozen' by the Unfreeze Schedules Screen, making them again available for booking.

Use the Change Scheduled HCP Screen to substitute one HCP with another for one day's schedule in a clinic.

CANCELLING SCHEDULES

The Cancel Schedule Screen is accessed by selecting option 'C' from the Modify Schedule Menu. Use the Cancel Schedule Screen to remove any portion of an HCP's schedule from the system.

To cancel a day or days from the schedule, complete the FROM DATE, THRU DATE, and REASON fields, and leave the FROM TIME and THRU TIME fields empty. To eliminate the appointments for a part of a day, or for the same part of several days, complete all the fields.

Cancelling a schedule prevents patients from being booked into appointments on that schedule and also prevents another schedule from being created during that time period for the same HCP. To create a new schedule you must first delete the old. The Cancel Schedule Screen displays a message allowing you to delete a schedule after you have cancelled it.

If patients were booked to a schedule you are cancelling, an appointment roster will be printed listing those patients so that they may be notified. If no patients were booked for the schedule, you will be given the opportunity to delete it.

The Cancel Schedule Screen performs a function different from the Freeze Schedule Screen; the former eliminates the schedule, the latter makes the schedule temporarily unavailable for booking.

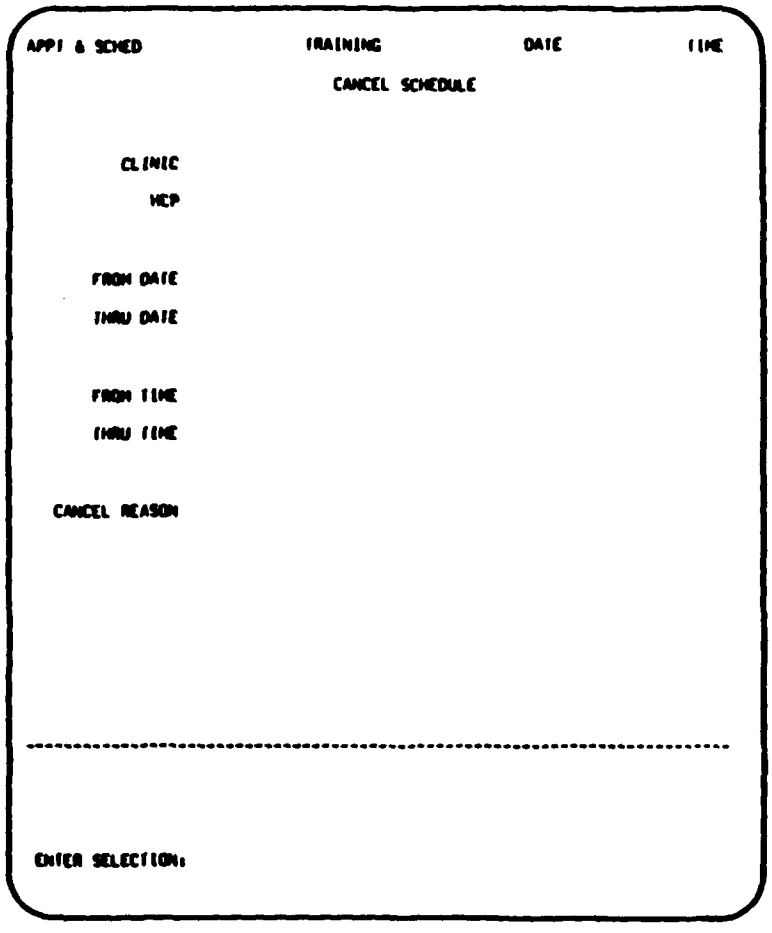


FIGURE 5.1 CANCEL SCHEDULE SCREEN

DATA CHART - CANCEL SCHEDULE SCREEN

CLINIC.	Name of clinic in which the schedule is to be cancelled. 3 characters. Required field.
HCP.	Name of health care provider. 6 characters. Required field.
FROM DATE.	The first date in a series of schedule days to be cancelled. 11 characters. Default is current date. Required field.
THRU DATE.	The last date in a series of schedule days to be cancelled. 11 characters. Default is current date. Required field.
FROM TIME.	The earliest time slot to be cancelled. 4 digits.
THRU TIME.	The latest time slot to be cancelled. 4 digits.
CANCEL REASON.	The code representing the reason for the cancellation. 3 characters. Required field.

5.1 To Cancel a Schedule

1. Access the Cancel Schedule Screen by entering 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'M' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Modify Schedules Menu is displayed.

3. Enter 'C' at ENTER SELECTION on the Modify Schedules Menu. Press [Return].

   The Cancel Schedule Screen is displayed, with the cursor at CLINIC.

4. Enter the CLINIC for which the schedule you wish to cancel is active.

   The cursor moves to HCP.

5. Enter the HCP whose schedule you wish to cancel. Press [Return].

   The cursor moves to FROM DATE.

6. Enter the first day of the period you wish to cancel. Press [Return].

   The cursor moves to THRU DATE.

7. Enter the final day of the period you wish to cancel. Press [Return].

The cursor moves to FROM TIME.

NOTE: To cancel the entire schedule for the period you have indicated in the FROM DATE and THRU DATE fields, leave FROM TIME and THRU TIME empty.

8. To cancel parts of the day(s) indicated, enter the first *appointment* time in the period you wish to cancel. Press [Return].

   The cursor moves to THRU TIME.

9. Enter the last appointment time of the period you wish to cancel in the day(s) you have indicated above. Press [Return].

   The cursor moves to CANCEL REASON.

10. Enter the reason why you are cancelling the schedule.

Two options are possible:

A. **The system displays the message PATIENTS BOOKED - WILL PRINT APPOINTMENT ROSTER - CONTINUE WITH CANCEL?**

   Enter 'Y' to cancel the schedule, 'N' to discontinue the procedure.

NOTE: CANCELLING A SCHEDULE results in the booked appointments being recorded as cancellations during check-in. These cancellations are reflected on the report of the HCP Statistics Report. You will be unable to create a new schedule for the same HCP/Date(s)/Clinic.

If you cancel a schedule containing booked appointments, the system will print a list of the patients affected so that they may be notified.

8. The system displays the message NO PATIENTS BOOKED - DELETE SCHEDULE?

Enter 'Y' to delete the schedule, 'N' to cancel the schedule only.

NOTE: DELETING A SCHEDULE results in the schedule being erased from the system. No record of the schedule will exist.

The cursor moves to ENTER SELECTION.

11. To conclude the Cancel Schedule procedure, press [Return].

The Schedule Menu is displayed.

12. To cancel schedules for a different HCP, or to cancel different schedule dates and times for the same HCP, you must access the Cancel Schedule Screen again.

FREEZING SCHEDULES

The Freeze Schedule Screen is accessed by selecting option 'F' from the Modify Schedule Menu.

Freezing a part of a schedule does not remove that part of the schedule from the system's memory, but does prevent that part of the schedule from being booked with additional appointments. This function may be used when an HCP is not sure that he or she will be available to conduct all of the appointments for which he or she is scheduled.

Entire days or parts of day(s) can be frozen, based on the fields completed.

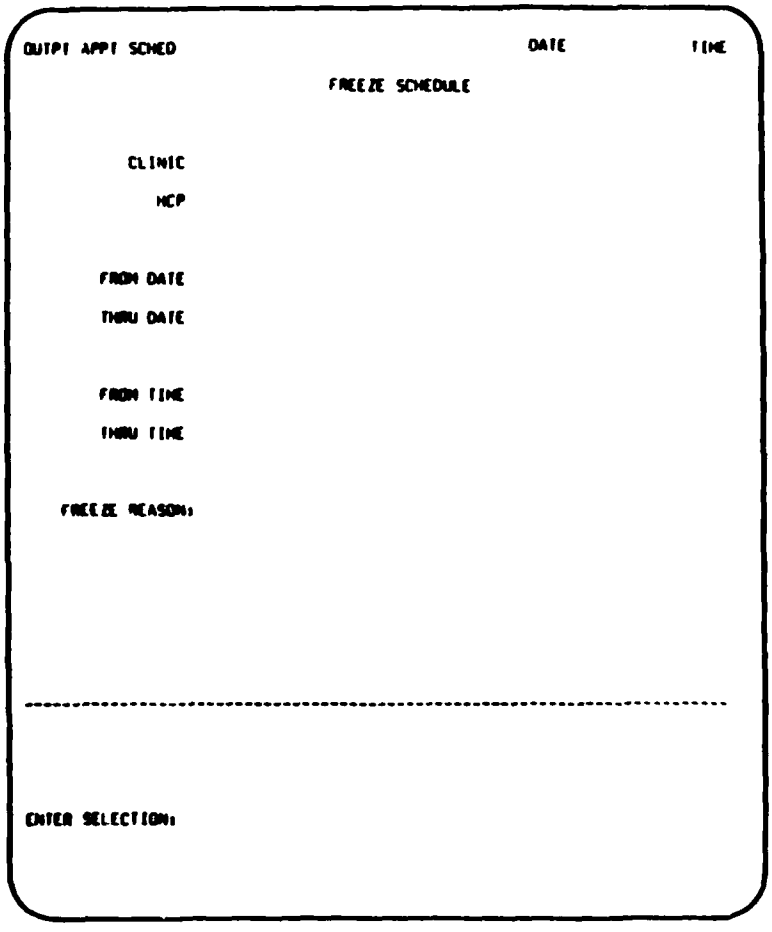


FIGURE 5.2 FREEZE SCHEDULE SCREEN

DATA CHART - FREEZE SCHEDULE SCREEN

CLINIC.	Name of clinic in which the schedule to be frozen is active. 3 characters. Required field.
HCP.	Name of health care provider. 6 characters. Required field.
FROM DATE.	The first date in a series of days to be frozen. 11 characters. Required field.
THRU DATE.	The last date in a series of days to be frozen. 11 characters. Required field.
FROM TIME.	The earliest time slot to be frozen. 4 digits.
THRU TIME.	The latest time slot to be frozen. 4 digits.
FREEZE REASON.	The code representing the reason for freezing the schedule. 3 characters. Required field.

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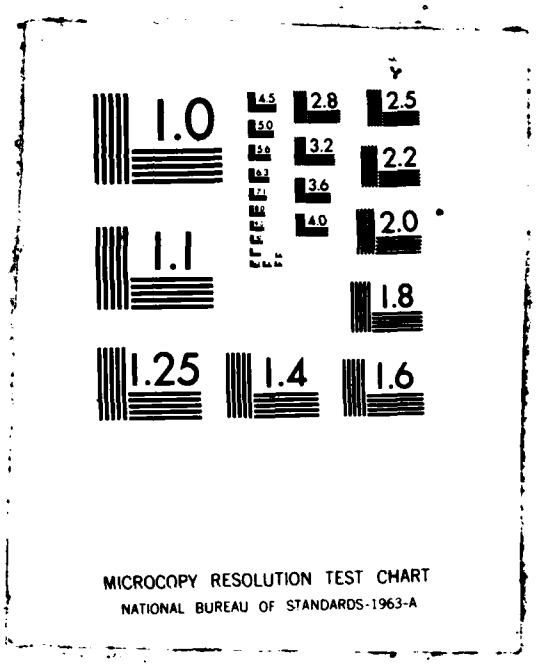
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END

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1.0
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5.0
5.6
6.3
MICROCOPY RESOLUTION TEST CHART
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5.2 To Freeze a Schedule

1. Access the Freeze Schedule Screen by entering 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'M' at ENTER SELECTION. Press [Return].

   The Modify Schedule Menu is displayed.

3. Enter 'F' at ENTER SELECTION on the Modify Schedule Menu. Press [Return].

   The Freeze Schedule Screen is displayed, with the cursor at CLINIC.

4. Enter the name of the clinic in which the schedule you wish to freeze is active.

   The cursor moves to HCP.

5. Enter the HCP whose schedule you wish to freeze. Press [Return].

   The cursor moves to FROM DATE.

6. Enter the first day of the period of the schedule you wish to freeze. Press [Return].

   The cursor moves to THRU DATE.

7. Enter the last day of the period of the schedule you wish to freeze. Press [Return].

   The cursor moves to FROM TIME.

8. To freeze the entire day(s) of the period you have indicated, leave FROM TIME and THRU TIME blank.

   To freeze parts of the day(s) of the period you have indicated, enter the first appointment time of the period you wish to freeze. Press [Return].

   The cursor moves to THRU TIME.

9. Enter the last appointment time of the period you wish to freeze. Press [Return].

   The cursor moves to FREEZE REASON.

10. Enter the code representing the reason you are freezing the schedule.

    The cursor moves to ENTER SELECTION.

11. Press [Return].

    The Modify Schedules Menu is displayed.

NOTE: To freeze one appointment, enter the starting time of the appointment in FROM TIME and THRU TIME. If you enter the next appointment's Start Time in THRU TIME, it will freeze through that appointment as well.

APPOINTING AND SCHEDULING TRAINING AID

UNFREEZING SCHEDULES

The Unfreeze Schedule Screen is accessed by selecting 'U' on the Modify Schedule Menu. It is used to make available for booking those appointments that were frozen in the Freeze Schedule procedure.

Like the Freeze Schedule Screen, the Unfreeze Schedule Screen affects entire days or portions of one or more days.

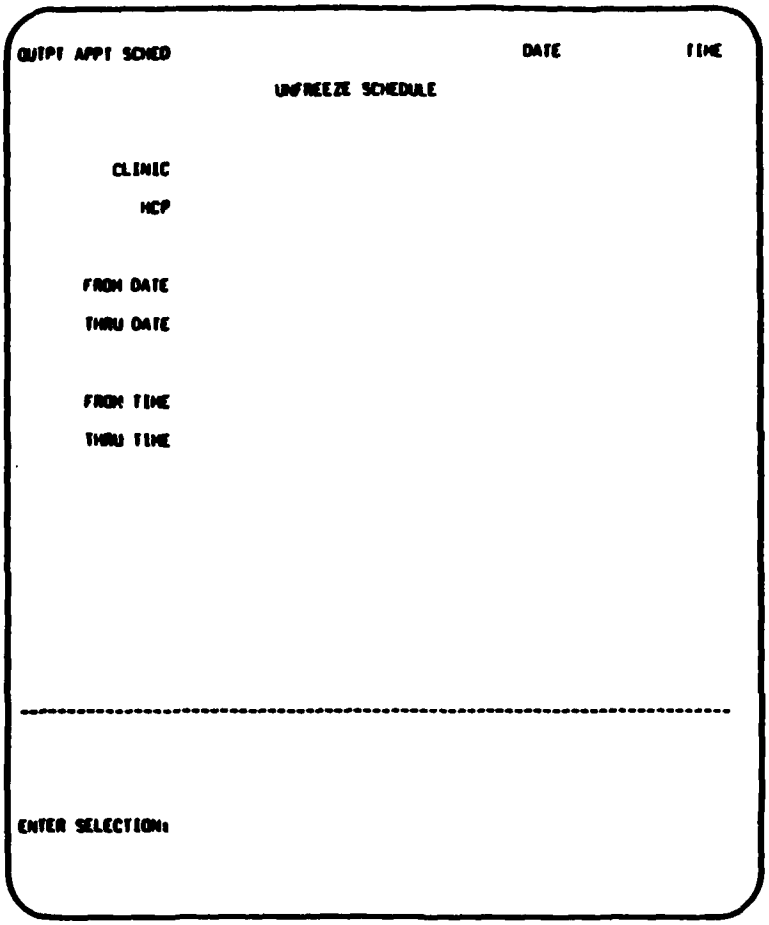


FIGURE 5.3 UNFREEZE SCHEDULE SCREEN

DATA CHART - UNFREEZE SCHEDULE SCREEN

CLINIC.	Name of clinic to be unfrozen. 3 characters. Required field.
HCP.	Name of health care provider. 6 characters. Required field.
FROM DATE.	The first in a series of days to be unfrozen. 11 characters. Required field.
THRU DATE.	The last in a series of days to be unfrozen. 11 characters. Required field.
FROM TIME.	The earliest time slot to be unfrozen. 4 digits.
THRU TIME.	The latest time slot to be unfrozen. 4 digits.

5.3 To Unfreeze a Schedule

1. Access the Unfreeze Schedule Screen by entering 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'M' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Modify Schedule Menu is displayed.

3. Enter 'U' at ENTER SELECTION on the Modify Schedule Menu. Press [Return].

   The Unfreeze Schedule Screen is displayed with the cursor at CLINIC.

4. Enter the name of the clinic for which the schedule you wish to unfreeze was created.

   The cursor moves to HCP.

5. Enter the name of the HCP whose schedule you wish to unfreeze. Press [Return].

   The cursor moves to FROM DATE.

6. Enter the first day in the period you wish to unfreeze. Press [Return].

   The cursor moves to THRU DATE.

7. Enter the last day of the period you wish to unfreeze. Press [Return].

   The cursor moves to FROM TIME.

NOTE: To unfreeze an entire day(s) of a schedule, leave FROM TIME and THRU TIME empty.

8. To unfreeze portions of day(s), enter the starting time of the first appointment in the period you wish to unfreeze. Press [Return].

   The cursor moves to THRU TIME.

9. Enter the starting time of the last appointment in the period you wish to unfreeze. Press [Return].

   The cursor moves to ENTER SELECTION.

10. Press [Return].

    The Modify Schedules Menu is displayed.

APPOINTING AND SCHEDULING TRAINING AID

CHANGING THE SCHEDULED HCP

The Change Scheduled HCP Screen is accessed by selecting option 'H' from the Modify Schedules Menu. The screen is used to substitute one HCP with another for one day's schedule in a clinic.

It is important to remember that the substitute HCP must be profiled for all of the appointment types that the normal HCP was scheduled to conduct on that day. Until the substitute HCP is profiled, it will be impossible to make the substitution.

Also note that the schedule for the 'new' HCP may not have been designed with the same clinic habits in mind. He or she may conduct the same types of appointments as the regular HCP, but spend different amounts of time on each. For the substitution day, he or she is expected to conduct the clinic appointments in the scheduled order and at the scheduled appointment start times.

If the new HCP already has a schedule with booked appointments, the system will ask you to confirm that the two schedules should be merged.

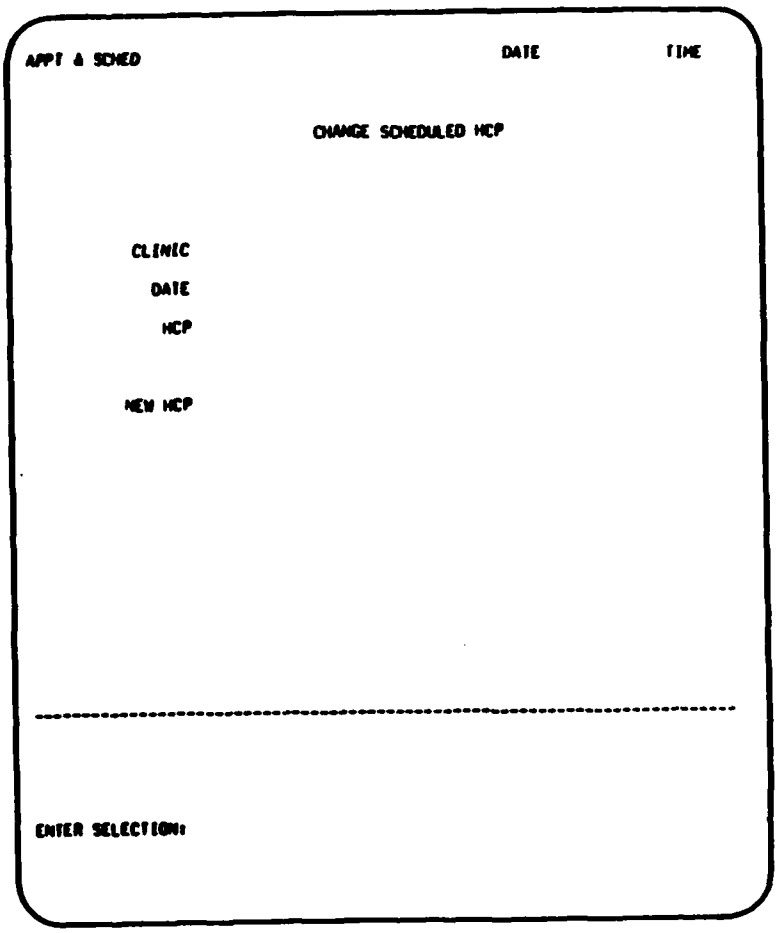


FIGURE 5.4 CHANGE SCHEDULED HCP SCREEN

DATA CHART - CHANGE SCHEDULED HCP SCREEN

CLINIC.	Clinic name. 3 characters. Required field.
DATE.	Date on which new HCP is to be substituted. 11 characters. Required Health Care Provider.
HCP.	6 characters. Required field.
NEW HCP.	6 characters. Required field.

5.4 To Change the Scheduled HCP

1. Access the Change Scheduled HCP Screen by entering 'S' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Schedule Menu is displayed.

2. Enter 'M' at ENTER SELECTION on the Schedule Menu. Press [Return].

   The Modify Schedules Menu is displayed.

3. Enter 'H' at ENTER SELECTION on the Modify Schedules Menu. Press [Return].

   The Change Scheduled HCP Screen is displayed, with the cursor at CLINIC.

4. Enter the CLINIC in which the HCP change is to occur.

   The cursor moves to *DATE*.

5. Enter the date on which the HCP change will take place. Press [Return].

   The cursor moves to HCP.

6. Enter the HCP currently scheduled for the clinic/date specified.

   The cursor moves to NEW HCP.

7. Enter the HCP who is to be substituted for the scheduled HCP.

   The cursor moves to ENTER SELECTION.

Three system responses are possible:

A. The NEW HCP is already scheduled for that day.

   The system will display the statement and query HCP IS ALREADY SCHEDULED FOR THAT DAY. MERGE SCHEDULES? Enter 'Y' to complete the change.

B. The system will display the statement HCP PROFILE NOT ENTERED FOR THIS APPOINTMENT TYPE.

   Either select a new HCP who is profiled for all of the appointment types present in the schedule, or re-profile the NEW HCP, and attempt the Change Scheduled HCP process again.

C. The system accepts the replacement, and the cursor moves to ENTER SELECTION.

   Press [Return].

   The Modify Schedule Menu is displayed.

6. PERFORMING PATIENT CHECK-INS

INTRODUCTION

The Check-In function allows you to make a record of booked appointment statuses at the end of each day. Use the Check-In Individual Patients Screen to make a record of those patients who did not keep a booked appointment, or who have kept the appointment but were ssen by an HCP different from the one they were booked to see.

To record patients who missed an appointment, enter 'NS' (No Show) at the APPOINTMENT STATUS field on the Check-In Patients Screen. The HCP SEEN field is used for patients who were seen by an HCP different from the one they were booked to see. Complete the Check-In Patients Screen at the end of each day after processing Walk-In patients.

Use the Register Walk-Ins Screen to record appointments for walk-in patients, who did not book an appointment in advance. This screen works in conjunction with the PTID Screen and the Outpatient Registration Screen to ensure that a complete record is created for every patient seen in the clinic. To give walk-in patients a Kept status, complete the Register Walk-Ins procedure before beginning the Batch Check-In function. Use the Batch Check-In Screen to record all remaining patients as K (Kept).

CHECKING-IN SCHEDULED PATIENTS

Access the Check-In Patients Screen by selecting option 'K' from the Check-In Menu.

The Check-In Patients Screen is used at the end of a day to record the status of every appointment conducted at the clinic. To do this, first make a written record of those patients who missed their appointments. Complete the clinic information at the top of the screen.

If only one patient was booked at a particular appointment time, the name will display and the cursor will move to STATUS. Change the status to 'NS' for "No Show" patients.

If more than one patient was booked for that appointment time (i.e., overbooked or group appointments), a list of patients to select from will be displayed.

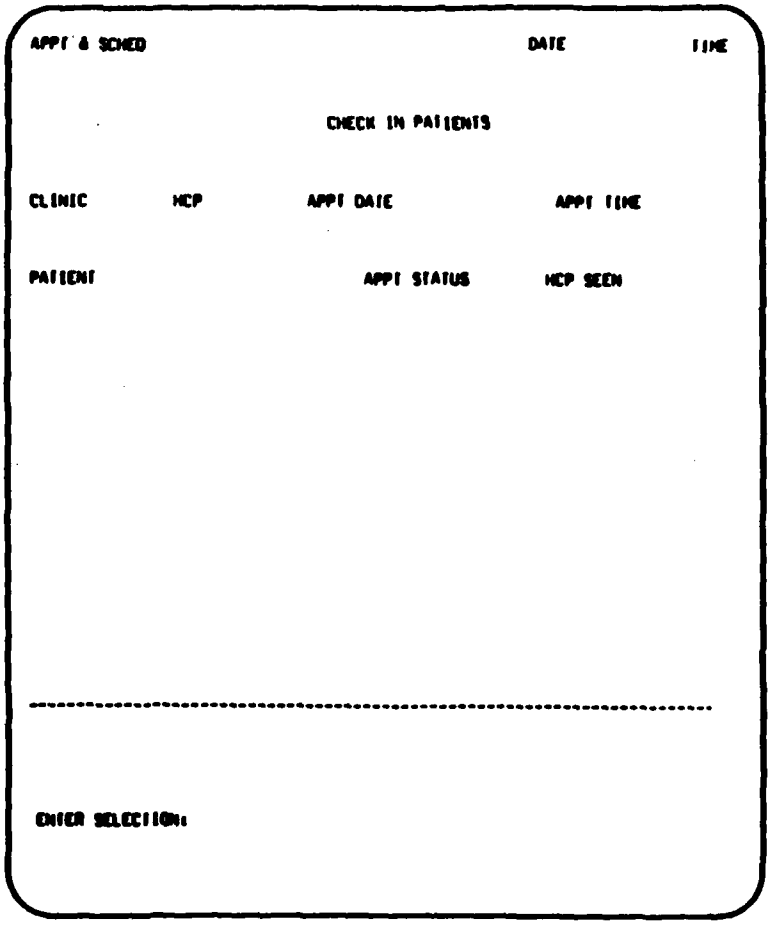


FIGURE 6.1 THE CHECK-IN PATIENTS SCREEN

DATA CHART - CHECK-IN PATIENTS SCREEN

CLINIC.	Clinic for which check-in is to be processed. 3 characters. Required field.
HCP.	HCP the patient was scheduled to see. 6 characters. Required field.
APPOINTMENT DATE.	Date for which check-in is to be processed. 11 characters. Required field.
APPOINTMENT	Time the patient was scheduled to be seen by an HCP. 4 characters.
PATIENT.	Patient's name. Display only.
APPOINTMENT STATUS.	Designation of whether the patient kept his or her appointment. Required field. Only "NS" or "K" are accepted.
HCP SEEN.	HCP the patient actually saw. Defaults to the HCP above unless changed. Required field.

6.1 To Check-In Patients

1. Access the Check-In Patients Screen by entering 'K' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Check-In Menu is displayed.

2. Enter 'K' at ENTER SELECTION on the Check-In Patients Menu. Press [Return].

   The Check-In Patients Screen is displayed with the cursor at CLINIC.

3. Enter the clinic for which you are processing patients.

   The cursor moves to HCP.

4. Enter the HCP whose patients you are processing.

   The cursor moves to APPOINTMENT DATE.

5. Enter the date for which you are processing patients. This should be today's date. Press [Return].

   The cursor moves to APPOINTMENT TIME.

6. Press [Help] for a list of the day's appointments and their statuses. Enter the APPOINTMENT TIME of the patient you are processing.

The name of the patient booked for that time will be displayed, as well as the appointment status and HCP. The cursor is at APPOINTMENT STATUS.

7. Enter the appointment status if it differs from the one displayed. Press [Return].

   The cursor moves to HCP SEEN.

8. Enter the HCP seen if the data differs from that displayed.

   The cursor moves to ENTER SELECTION.

9. To perform more check-ins, enter ALL. Press [Return].

   To record the check-in and return to the Check-In Menu, press [Return].

   The Check-In Menu is displayed.

10. To perform additional check-ins, follow the procedure above, changing field data to reflect the appointment(s) you wish to check-in.

APPOINTING AND SCHEDULING TRAINING AID

REGISTERING WALK-IN PATIENTS

The Register Walk-Ins Screen is accessed by selecting option 'W' from the Check-In Menu.

This screen is used at the end of each day to record the patients who have visited the clinic without booked appointments. These patients were not booked when they arrived because of time constraints at the clinic, or because no terminal was available there.

It is important to conduct the Register Walk-Ins function before performing the Batch Check-In Appointment function.

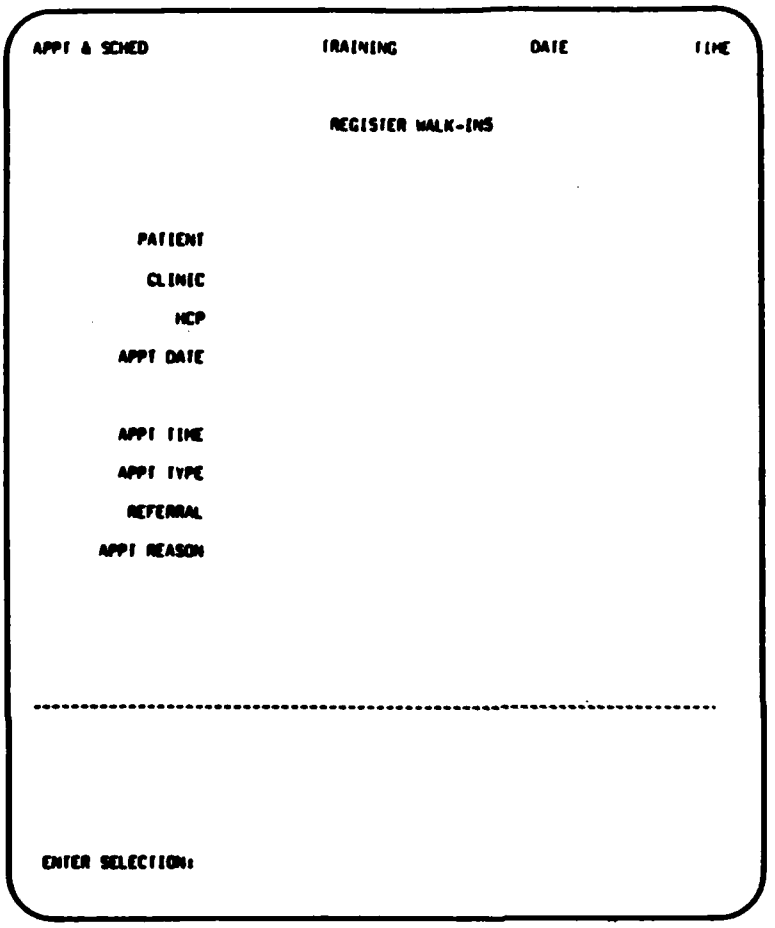


FIGURE 6.2 REGISTER WALK-INS SCREEN

DATA CHART - REGISTER WALK-INS SCREEN

PATIENT.	Displays patient name.
CLINIC.	Clinic for which walk-in is to be processed. 3 characters. Required field.
APPOINTMENT DATE.	Date for which walk-in is to be processed. 11 characters. Required field.
HCP.	HCP name. 6 characters. Required field.
APPOINTMENT TIME.	The time patient was seen by an HCP. 4 characters.
PATIENT.	Patient's name.
APPOINTMENT TYPE.	Type of Appointment for which the patient was seen. 3 characters. Required field.
REFERRAL.	The name of the HCP or Clinic who referred the patient, if any. Enter when the appointment type requires a referral. A referral can be either from a clinic (entered as 'C*Name of Clinic') or from a HCP ('H*Name of HCP').
APPOINTMENT REASON.	The reason for the appointment. 20 characters.

6.2 To Register Walk-Ins

1. Access the Register Walk-Ins Screen by entering 'K' on the Appointing and Scheduling Main Menu. Press [Return].

   The Check-In Menu is displayed.

2. Enter 'W' at ENTER SELECTION on the Check-In Menu. Press [Return].

   The PTID Screen is displayed with the cursor at NAME.

3. Identify the patient (See Section 2.1, To Record Patient Identification Information).

   The Outpatient Registration Screen is displayed.

4. Edit patient registration, if necessary. If you are registering a new patient, complete the entire screen (see section 2.5, Registering a New Patient). Press [Return] at ENTER SELECTION.

   The Register Walk-Ins Screen is displayed with the cursor at CLINIC.

5. Enter the clinic in which you wish to register walk-in patients.

   The cursor moves to HCP.

6. Enter the HCP whose patients you are registering. Press [Return].

   The cursor moves to APPOINTMENT DATE.

7. Enter the date for which you are registering walk-in patients. This should be today's date. Press [Return].

   The cursor moves to APPOINTMENT TIME.

8. Enter the time the patient was seen by the HCP.

   The cursor moves to APPOINTMENT TYPE.

9. Enter the type of appointment conducted.

   The cursor moves to REFERRAL.

10. Enter the name of the referring HCP or clinic, if any. Press [Return].

    The cursor moves to APPOINTMENT REASON.

11. Enter the reason for the appointment. Press [Return].

    The cursor moves to ENTER SELECTION.

12. Press [Return].

    The PTID Screen is displayed.

13. To record additional walk-ins, identify the patient and follow the procedure above. To exit the function, press [Entry Done] and [Return].

APPOINTING AND SCHEDULING TRAINING AID

BATCH CHECK-IN

Batch check-in allows you to check in all the patients booked at a clinic in one procedure. After you record those patients who missed an appointment, or whose appointment was cancelled, or who were walk-ins, the system can record all other appointments as "K" (Kept), using the Batch Check-In Screen.

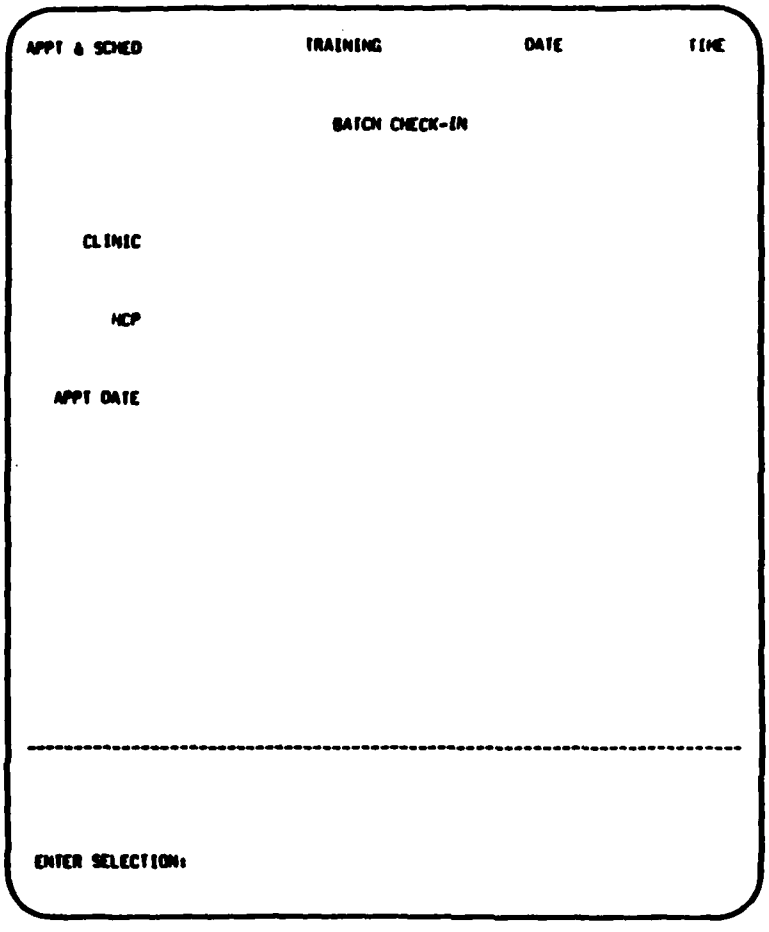


FIGURE 6.3 BATCH CHECK-IN SCREEN

DATA CHART - BATCH CHECK-IN SCREEN

CLINIC.	Clinic for which check-in is to be processed. 3 characters. Required field.
HCP.	HCP name. 6 characters. Required field.
APPOINTMENT DATE.	Date for which check-in is to be processed. 11 characters. Required field.

6.3 To Perform Batch Check-Ins

1. Access the Batch Check-In Screen by entering 'K' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Check-In Menu is displayed.

2. Enter 'B' at ENTER SELECTION on the Check-In Menu. Press [Return].

   The Batch Check-In Screen is displayed with the cursor at CLINIC.

3. Enter the code for the clinic for which you are performing check-in.

   The cursor moves to HCP.

4. Enter the HCP whose patients you are checking in. Press [Return].

   The cursor moves to APPOINTMENT DATE.

5. Enter the date for which you are performing check-in. Press [Return].

   The cursor moves to ENTER SELECTION.

6. Press [Return] to record the Batch check-in.

   The Check-In Menu Screen is displayed.

7. APPOINTING AND SCHEDULING REPORTS

INTRODUCTION

The Appointing and Scheduling reports provide a wide range of data concerning patient registration information and appointments, HCP schedules, and the system activity performed by clinic personnel. In addition, the reports function enables you to create charge out/routing cards to assist in your MTF's record retrieval procedure.

When requesting reports, keep in mind these basic principles:

1. **All report request screens are accessed through the Appointing and Scheduling Report Menu.**

   This menu is accessed by selecting 'R' on the Appointing and Scheduling Main Menu.

2. **All reports are not necessarily available to all clinic personnel.**

   On the Appointing and Scheduling Reports Main Menu, submenus are displayed that allow access to different groups of reports. Each group contains reports of a specific category. The system manager of your MTF will determine which of these submenus, and therefore which of the reports are available to each AQCESS terminal in your MTF.

3. **The more specific the screen input, the smaller the report.**

   This means that if you want a short report about an individual or clinic, you must describe the specific individual or clinic within the fields provided. Also, you must specify the time period for which you are requesting information. For example, if you want the appointment roster for a certain MTF clinic for a particular week, you must specify both the clinic and the date range. If you only want reports for appointments of a specific status, i.e., B (Booked) or C (Cancelled), enter that type at the APPOINTMENT STATUS field.

4. **The less specific the screen input, the larger the report.**

   This means that if you leave fields blank, the report you get for that request will be larger than if you had filled in all the fields. For example, if you leave the APPOINTMENT STATUS field blank, appointments of every status will be printed.

5. **Leaving the PRINTER COPIES field blank allows you to view the report requested on your terminal screen. No copies are printed.**

6. **When entering information on any screen you must fill in the required fields.**

   If you try to leave a required field blank, the cursor will not move beyond that field, and the message REQUIRED FIELD will be displayed at the bottom of the screen. If you

do not understand what information to enter into the field, consult the description of the report, or press [Help] with the cursor at the field in question.

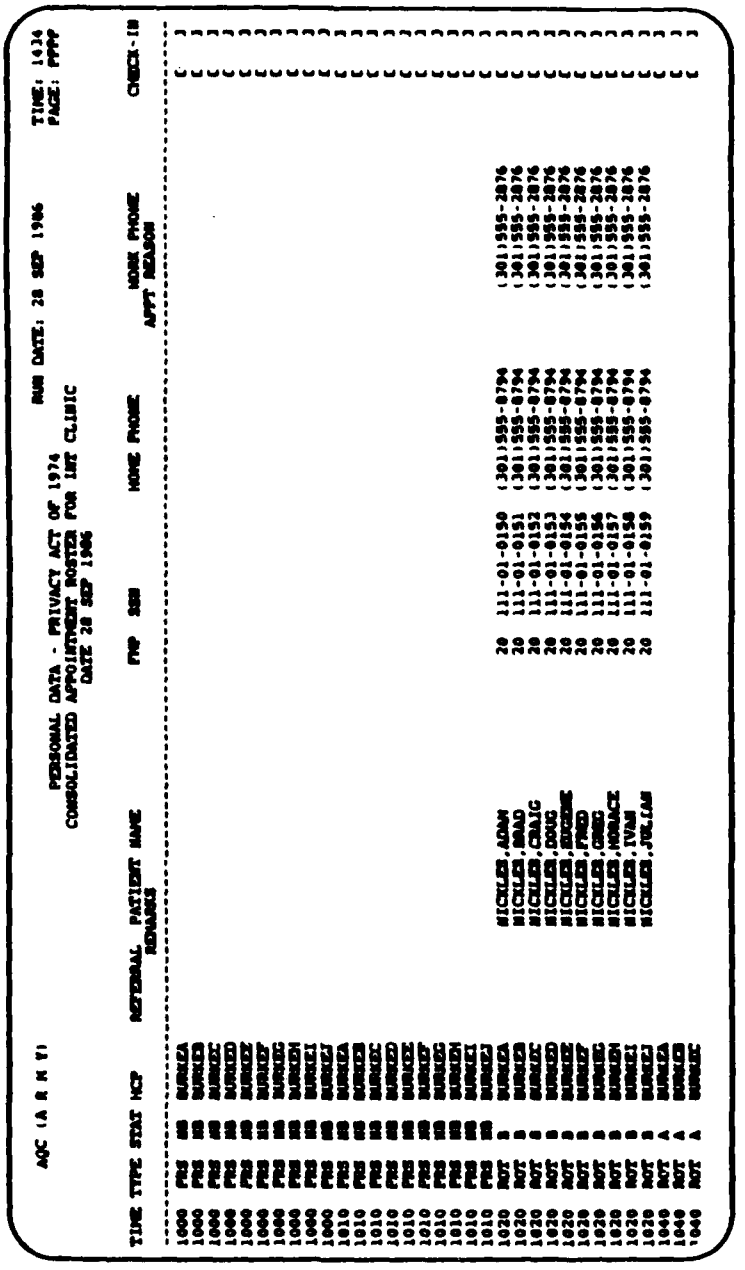
7. **Two reports, the Registration Report and the Medical Summary Report, require the system to perform a massive database compilation.**

   There will be a time delay between requesting the report and the initiation of the printing. During this time you will be able to perform additional system functions on your terminal; however, until the report is printed, no other reports will be available from the printer assigned to your terminal.

APPOINTMENT ROSTER REPORT

The Appointment Roster Report shows a clinic and an HCP's appointment schedule for the date range specified. Included in the report is information about the patients booked into the clinic and the appointments for which they are booked.

The Appointment Roster Report Request Screen will provide individual reports based upon the information entered on the screen. The contents of a report will vary, depending on the fields completed. For example, if you want to view the appointment roster for all the HCPs in a given clinic, specify the clinic in the CLINIC field but leave the HCP field blank when requesting the reports.



PERSONAL DATA - PRIVACY ACT OF 1974
CONSOLIDATED APPOINTMENT ROSTER FOR INT CLINIC
DATE 28 SEP 1986

RUN DATE: 28 SEP 1986 TIME: 1434
PAGE: ####

AOC (A R M Y)

TIME	TYPE	STAT	HCP	REFERRAL/ PATIENT NAME REMARKS	PAT	SSN	HOME PHONE	WORK PHONE APPT REASON	CHECK-IN
1000	PAT	#	BURKEA	#ICKLER,ADAM	20	111-01-0150	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEB	#ICKLER,BRAD	20	111-01-0151	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEC	#ICKLER,CRAIG	20	111-01-0152	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKED	#ICKLER,DOUG	20	111-01-0153	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEE	#ICKLER,EUGENE	20	111-01-0154	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEF	#ICKLER,FRED	20	111-01-0155	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEG	#ICKLER,GREG	20	111-01-0156	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEH	#ICKLER,HORACE	20	111-01-0157	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEI	#ICKLER,IVAN	20	111-01-0158	(301)555-0794	(301)555-2876	
1000	PAT	#	BURKEJ	#ICKLER,JULIAN	20	111-01-0159	(301)555-0794	(301)555-2876	
1010	PAT	#	BURKEA						
1010	PAT	#	BURKEB						
1010	PAT	#	BURKEC						
1010	PAT	#	BURKED						
1010	PAT	#	BURKEE						
1010	PAT	#	BURKEF						
1010	PAT	#	BURKEG						
1010	PAT	#	BURKEH						
1010	PAT	#	BURKEI						
1010	PAT	#	BURKEJ						
1020	NOT	#	BURKEA						
1020	NOT	#	BURKEB						
1020	NOT	#	BURKEC						
1020	NOT	#	BURKED						
1020	NOT	#	BURKEE						
1020	NOT	#	BURKEF						
1020	NOT	#	BURKEG						
1020	NOT	#	BURKEH						
1020	NOT	#	BURKEI						
1020	NOT	#	BURKEJ						
1040	NOT	4	BURKEA						
1040	NOT	4	BURKEB						
1040	NOT	4	BURKEC						

FIGURE 7.1 APPOINTMENT ROSTER SAMPLE

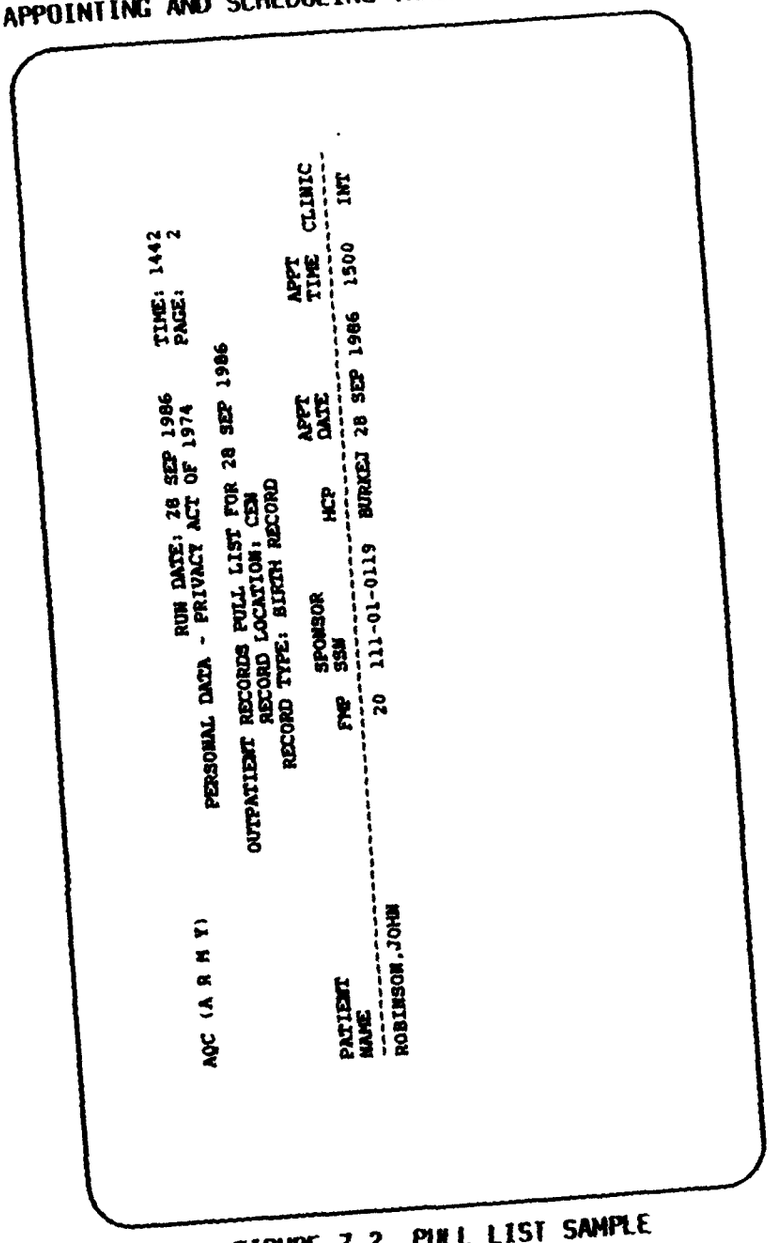
PATIENT RECORD PULL LIST

The Patient Record Pull List is used to request records from the Records Room for patients booked into upcoming appointments. These records will be retrieved from their location and delivered to the HCP handling the appointment.

Each clinic's records will be printed on a separate page. For a list of patients with upcoming appointments ordered by patient name or terminal digit sequence, see the Consolidated Patient Record Pull List (Report #16).

Enter 'Y' at TERMINAL DIGIT SEQUENCE SORT to print the reports in the order of the patient's terminal digit. Enter 'N' to print the reports in alphabetical order by the patients' names.

If patient appointments are booked after the Patient Record Pull List for those dates has been processed, enter the date the Pull List was last processed at APPOINTED SINCE DATE. The report printed will consist of a list of the patients booked for an appointment since the Pull List was last processed, allowing you to pull those patients' records.



```
                                                    RUN DATE: 28 SEP 1986    TIME: 1442
                                                                             PAGE:    2
AQC (A R M Y)          PERSONAL DATA - PRIVACT ACT OF 1974

                    OUTPATIENT RECORDS PULL LIST FOR 28 SEP 1986
                                  RECORD LOCATION: CEN
                                RECORD TYPE: BIRTH RECORD

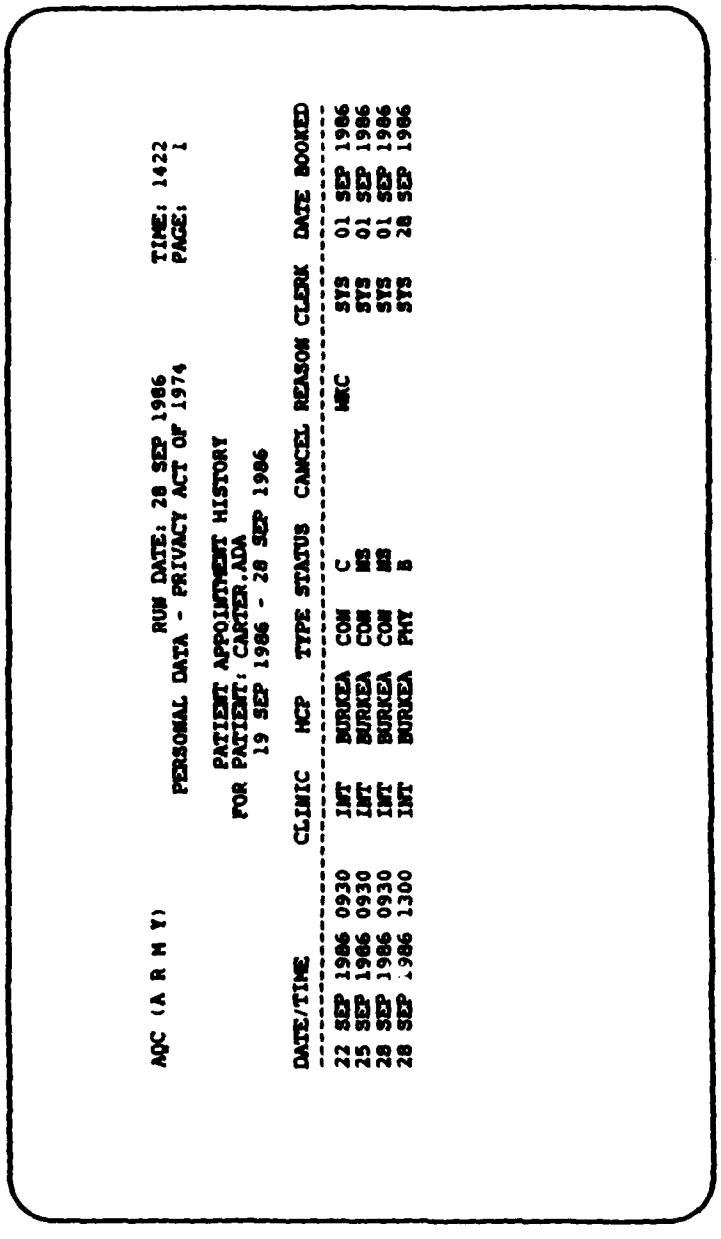
                                                                  APPT          APPT  CLINIC
PATIENT                                  SPONSOR       HCP        DATE          TIME
NAME                                     FMP SSN
--------------------------------------------------------------------------------------------
ROBINSON,JOHN                              20 111-01-0119 BURKEI 28 SEP 1986  1500  INT
```

FIGURE 7.2 PULL LIST SAMPLE

PATIENT APPOINTMENT HISTORY REPORT

This report lists the appointments scheduled for the patient indicated for the date range specified, and provides a variety of information about the appointments booked. It includes the appointment date, time, and type, the HCP who handled the appointment, the appointment status and cancel reason, if any, the clerk who booked the appointment, and when it was booked.

The Patient Appointment History Report Request Screen works with the PTID Screen and the Outpatient Candidate List Screen. If you enter a complete name at PATIENT on the Report Request Screen, and that patient is registered in the MTF, the PTID Screen will not be displayed. If you enter a partial name at PATIENT, the PTID Screen is displayed. Identify the patient as outlined in Section 2 and the Patient Appointing History Report Request Screen will be displayed again, with the patient's full name entered at PATIENT.



AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1422
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1

PATIENT APPOINTMENT HISTORY
FOR PATIENT: CARTER,ADA
19 SEP 1986 - 28 SEP 1986

DATE/TIME	CLINIC	HCP	TYPE	STATUS	CANCEL REASON	CLERK	DATE BOOKED
22 SEP 1986 0930	INT	BURKEA	COM	C	NRC	STS	01 SEP 1986
25 SEP 1986 0930	INT	BURKEA	COM	NS		STS	01 SEP 1986
28 SEP 1986 0930	INT	BURKEA	COM	NS		STS	01 SEP 1986
28 SEP 1986 1300	INT	BURKEA	PHY	R		STS	28 SEP 1986

FIGURE 7.3 PATIENT APPOINTMENT HISTORY REPORT SAMPLE

SCHEDULING INCONSISTENCY LIST

This report lists system inconsistencies determined by system consistency edits. Any scheduling criteria that do not meet the system consistency standards will appear on this report.

There are four types of inconsistencies:

1. No schedule has been created for a clinic's HCP.

2. The number of days that an HCP's schedule is opened into the future is less than the number required by the system.

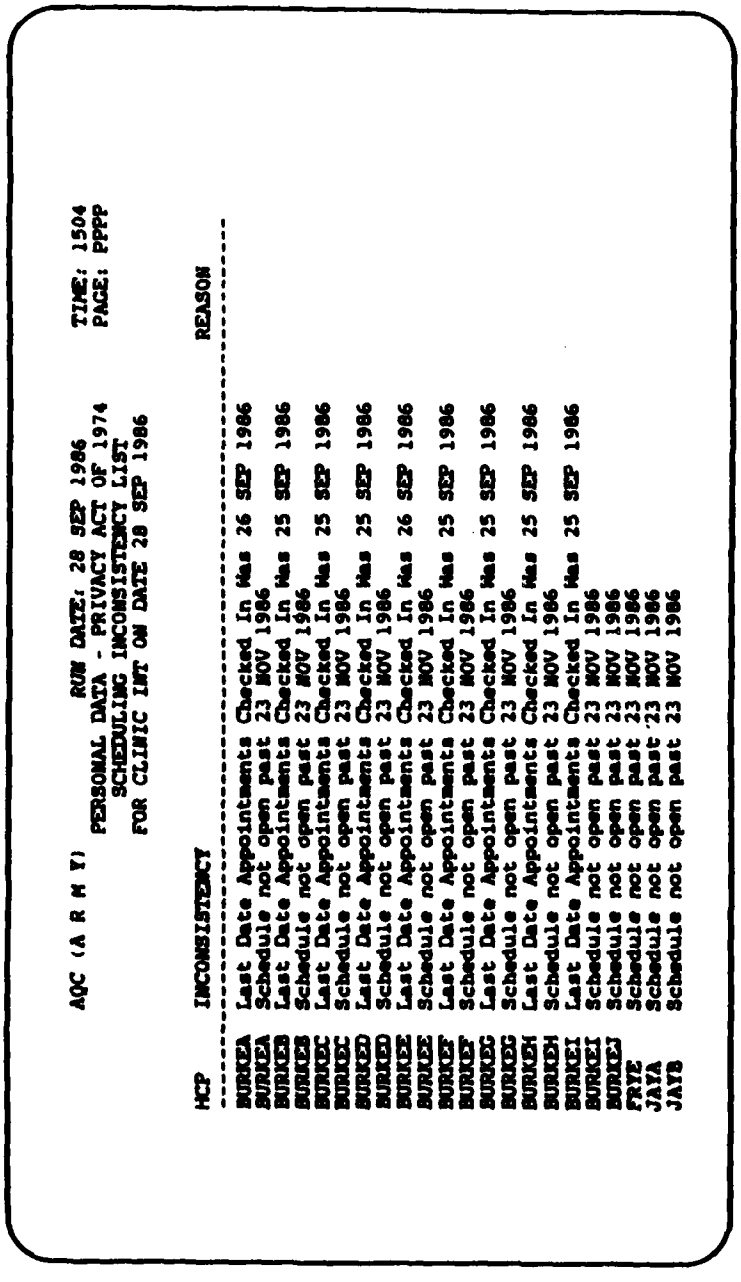
3. A schedule has remained frozen for longer than allowed by the system.

4. More than 2 days have passed since Patient Check-In was performed.

To view a list of all scheduling inconsistencies in all clinics of your MTF, leave CLINIC blank; otherwise, specify the clinic desired.

To view a list of scheduling inconsistencies for all HCPs, leave HCP blank; otherwise, specify the HCP desired.

To view all scheduling inconsistencies for all HCPs at all clinics, leave both CLINIC and HCP blank.



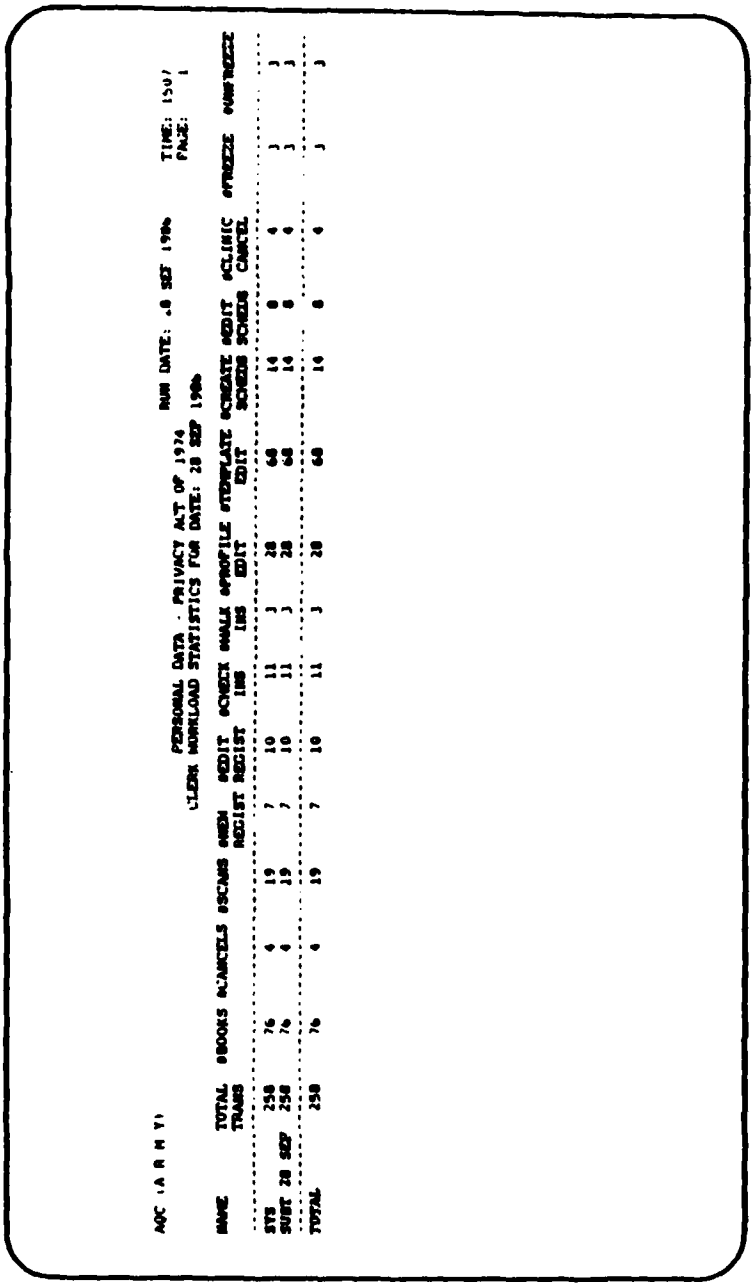
AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1504
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: PPPP
SCHEDULING INCONSISTENCY LIST
FOR CLINIC LMT ON DATE 28 SEP 1986

HCP	INCONSISTENCY	REASON
BURKEA	Last Date Appointments	Checked In Was 26 SEP 1986
BURKEA	Schedule not open past	23 NOV 1986
BURKEB	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEB	Schedule not open past	23 NOV 1986
BURKEC	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEC	Schedule not open past	23 NOV 1986
BURKED	Last Date Appointments	Checked In Was 25 SEP 1986
BURKED	Schedule not open past	23 NOV 1986
BURKEE	Last Date Appointments	Checked In Was 26 SEP 1986
BURKEE	Schedule not open past	23 NOV 1986
BURKEF	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEF	Schedule not open past	23 NOV 1986
BURKEG	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEG	Schedule not open past	23 NOV 1986
BURKEH	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEH	Schedule not open past	23 NOV 1986
BURKEI	Last Date Appointments	Checked In Was 25 SEP 1986
BURKEI	Schedule not open past	23 NOV 1986
BURKEJ	Schedule not open past	23 NOV 1986
FRYE	Schedule not open past	23 NOV 1986
JAYA	Schedule not open past	23 NOV 1986
JAYB	Schedule not open past	23 NOV 1986

FIGURE 7.4 SCHEDULING INCONSISTENCY LIST SAMPLE

CLERK WORKLOAD STATISTICS REPORT

This report provides a record of system use for all clerks in all clinics in the MTF for the date range indicated. Both FROM DATE and THRU DATE fields are required fields.



AOC (A R M Y)

PERSONAL DATA - PRIVACY ACT OF 1974
CLERK WORKLOAD STATISTICS FOR DATE: 28 SEP 1986

RUN DATE: 29 SEP 1986 TIME: 1307
PAGE: 1

NAME	TOTAL TRANS	#BOOKS	#CANCELS	#SCANS	#NEW REGIST	#EDIT REGIST	#OVER 18S	#WALK INS	#PROFILE EDIT	#TEMPLATE EDIT	#CREATE SCHEDS	#EDIT SCHEDS	#CLINIC CANCEL	#FREEZE	#WAITLIST
STB	250	76	4	19	7	10	11	3	28	68	14	8	4	3	3
SUBT 28 SEP	250	76	4	19	7	10	11	3	28	68	14	8	4	3	3
TOTAL	250	76	4	19	7	10	11	3	28	68	14	8	4	3	3

FIGURE 7.5 CLERK WORKLOAD STATISTICS SAMPLE

CLERK HOURLY STATISTICS REPORT

This report provides a record of system use for one or all clerks in any MTF. The Clerk Hourly Statistics Report shows a record of the clerks' system use and indicates the hour during which the functions were performed, for the date range specified.

To view the hourly statistics for all clerks in the MTF, leave FOR CLERK blank. To view the hourly statistics for an individual clerk, enter his/her User ID at FOR CLERK.

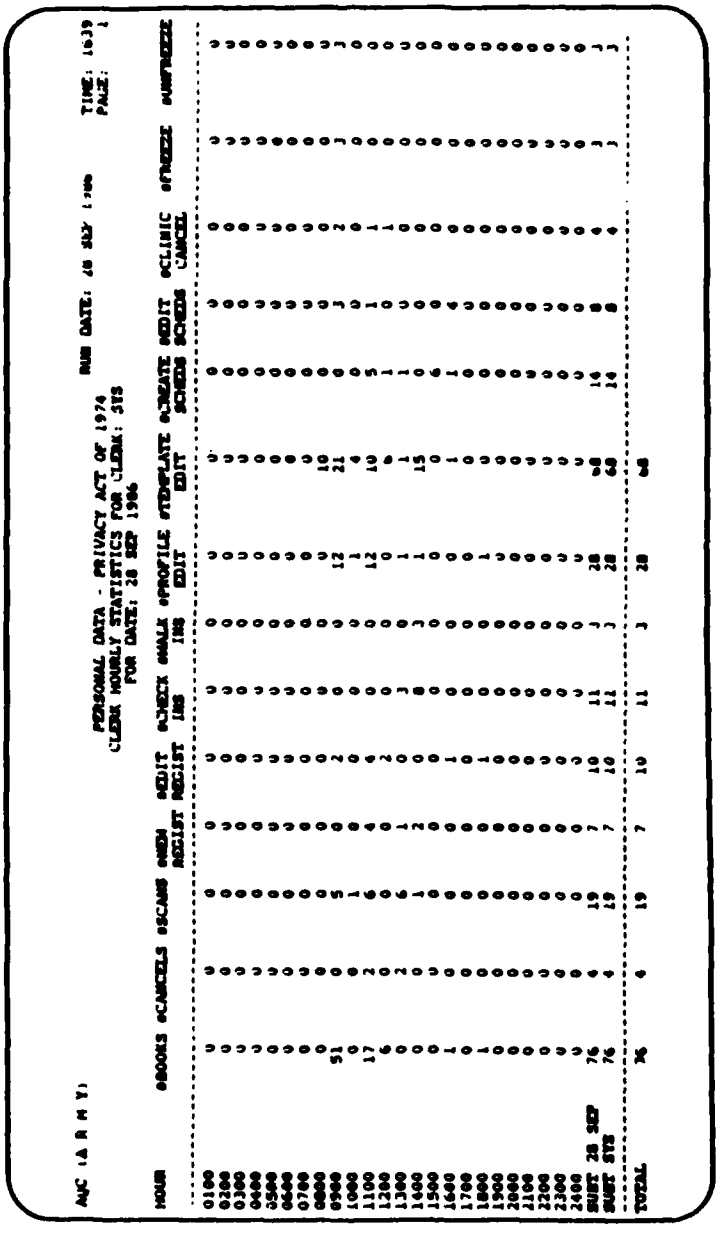
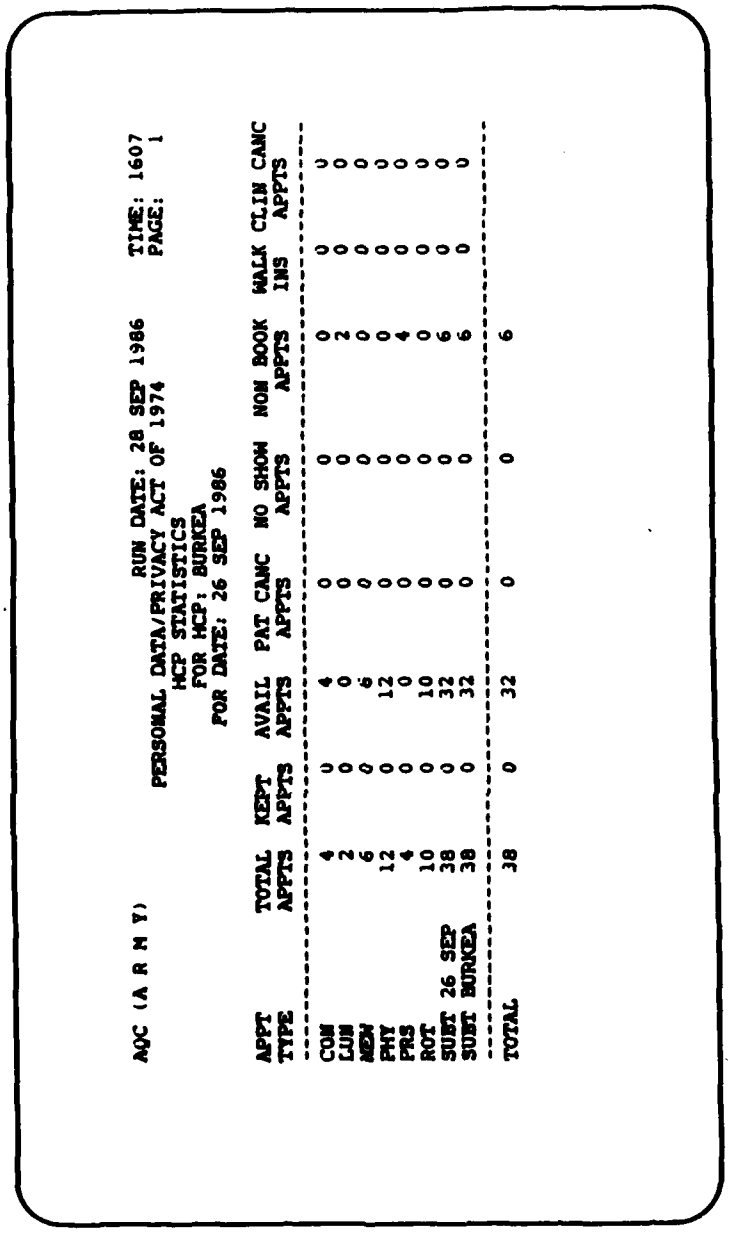


FIGURE 7.6 CLERK HOURLY STATISTICS REPORT SAMPLE

HCP STATISTICS REPORT

This report shows the record of appointment activity for a particular HCP for the date range indicated.

To view the statistics for all the HCPs in your MTF, leave HCP blank. To view the statistics for a specific HCP, enter the appropriate name at HCP.



AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1607
PERSONAL DATA/PRIVACY ACT OF 1974 PAGE: 1
HCP STATISTICS
FOR HCP: BURKEA
FOR DATE: 26 SEP 1986

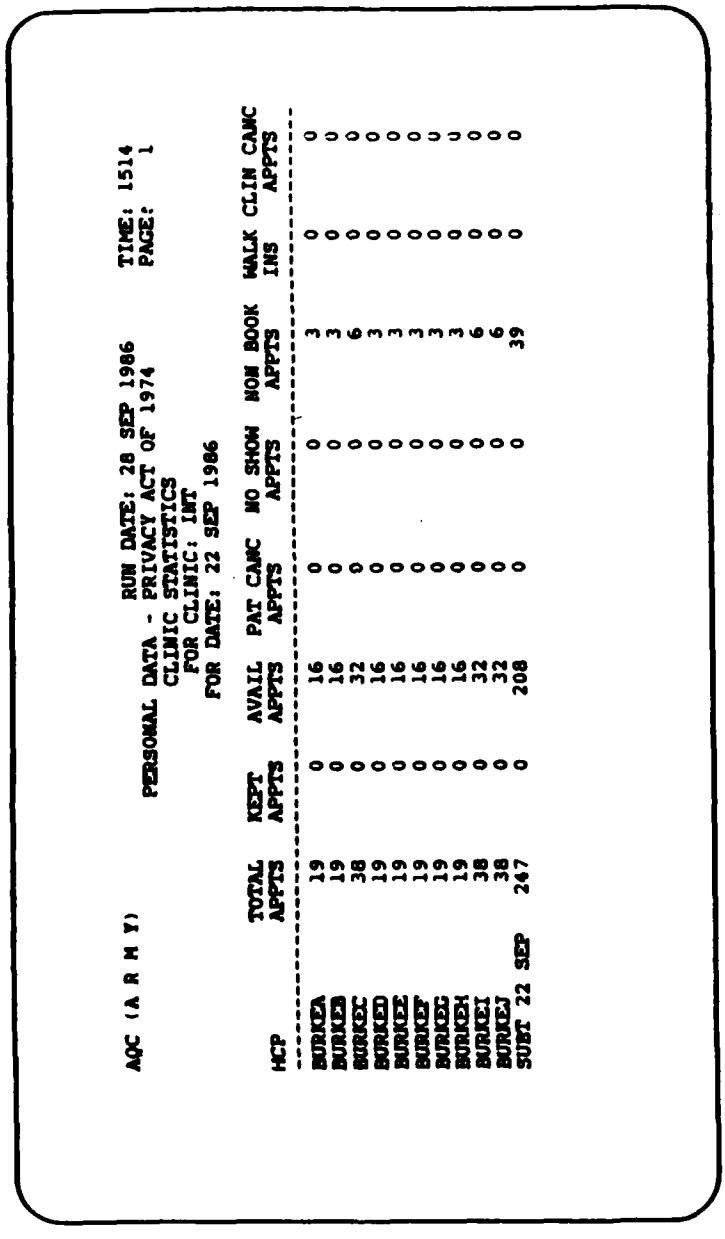
APPT TYPE	TOTAL APPTS	KEPT APPTS	AVAIL APPTS	PAT CANC APPTS	NO SHOW APPTS	NON BOOK APPTS	WALK INS	CLIN CANC APPTS
COM	4	0	4	0	0	0	0	0
LAB	2	0	0	0	0	2	0	0
MEN	6	0	6	0	0	0	0	0
PHY	12	0	12	0	0	4	0	0
PRS	4	0	0	0	0	0	0	0
ROT	10	0	10	0	0	6	0	0
SUBT 26 SEP	38	0	32	0	0	6	0	0
SUBT BURKEA	38	0	32	0	0	6	0	0
TOTAL	38	0	32	0	0	6	0	0

FIGURE 7.7 HCP STATISTICS REPORT SAMPLE

CLINIC STATISTICS REPORT

This report displays a record of the activity of a clinic for the date range specified. This report is sorted by HCP and shows the total numbers of appointments held at the clinics as well as the percentage of the overall total represented by each appointment type.

To view the statistics of every clinic, leave CLINIC blank. To view the statistics for an individual clinic, enter its name at CLINIC.



AQC (A R M Y)

PERSONAL DATA - PRIVACY ACT OF 1974
CLINIC STATISTICS
FOR CLINIC: INT
FOR DATE: 22 SEP 1986

RUN DATE: 28 SEP 1986 TIME: 1514
PAGE: 1

HCP	TOTAL APPTS	KEPT APPTS	AVAIL APPTS	PAT CANC APPTS	NO SHOW APPTS	NON BOOK APPTS	WALK INS	CLIN CANC APPTS
BURKEA	19	0	16	0	0	3	0	0
BURKEB	19	0	16	0	0	3	0	0
BURKEC	38	0	32	0	0	6	0	0
BURKED	19	0	16	0	0	3	0	0
BURKEE	19	0	16	0	0	3	0	0
BURKEF	19	0	16	0	0	3	0	0
BURKEG	19	0	16	0	0	3	0	0
BURKEH	19	0	16	0	0	3	0	0
BURKEI	38	0	32	0	0	6	0	0
BURKEJ	38	0	32	0	0	6	0	0
SUBT 22 SEP	247	0	208	0	0	39	0	0

FIGURE 7.8 CLINIC STATISTICS REPORT SAMPLE

CHARGE OUT/ROUTING CARDS

This request screen creates routing cards for patient records. The Charge Out/Routing Cards can be used in the fileroom to indicate the location of a removed file. They can also be attached to records to indicate where the patient record should go.

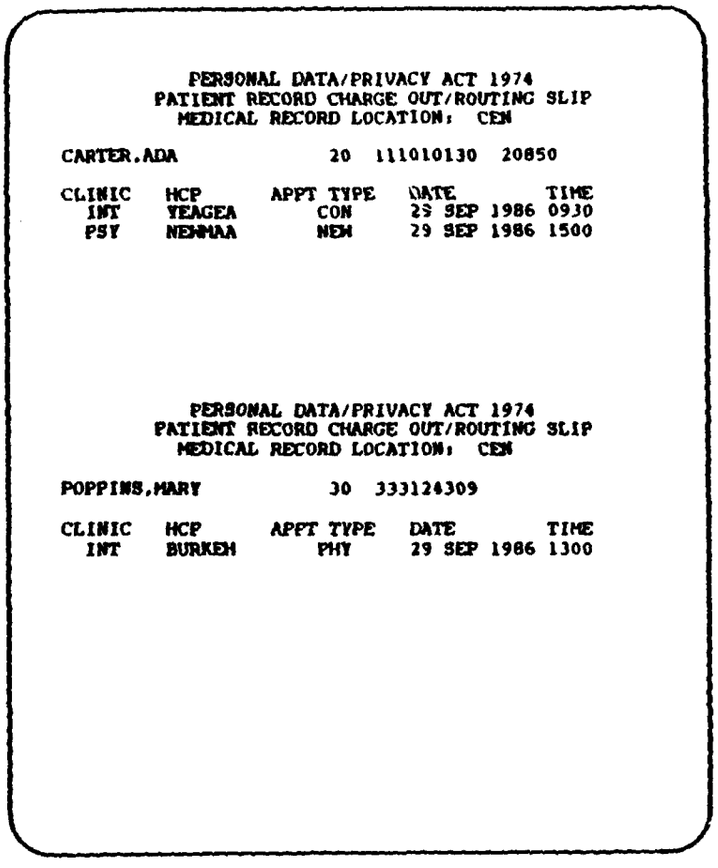
At RECORD LOCATION, enter the specific location of the patient records. If you leave the field blank, a card will be printed for each record room at the MTF.

At RECORD TYPE, enter the specific type of record to be pulled. Leaving the field blank results in the printing of every record type.

Answer 'Y' or 'N' at TERMINAL DIGIT SEQUENCE SORT. If you answer 'Y', the report will list the cards in order of the patients' terminal digit sequence. If you answer 'N', the cards will appear in alphabetical order according to the patients' names.

If patient appointments are booked <u>after</u> the Patient Record Pull List for those dates has been processed, enter the date that the list was last processed at APPOINTED SINCE DATE to receive routing cards for those patients' records.

Answer 'N' at '3 x 5' CARD to receive '8.5 x 11' cards.



PERSONAL DATA/PRIVACY ACT 1974
PATIENT RECORD CHARGE OUT/ROUTING SLIP
MEDICAL RECORD LOCATION: CEN

CARTER,ADA 20 111010130 20850

CLINIC	HCP	APPT TYPE	DATE	TIME
INT	YEAGEA	CON	29 SEP 1986	0930
PSY	NEHMAA	NEW	29 SEP 1986	1500

PERSONAL DATA/PRIVACY ACT 1974
PATIENT RECORD CHARGE OUT/ROUTING SLIP
MEDICAL RECORD LOCATION: CEN

POPPINS,MARY 30 333124309

CLINIC	HCP	APPT TYPE	DATE	TIME
INT	BURKEH	PHY	29 SEP 1986	1300

FIGURE 7.9 CHARGE OUT/ROUTING CARDS SAMPLE

ACTIVE DUTY APPOINTMENT REPORT

This report provides general information about the appointments booked to active duty military personnel and includes information such as SSN, FMP, patient category, and flight status.

To view the appointments of a specific military unit, enter that unit at MILITARY UNIT. To view the appointments of all active duty personnel regardless of unit, leave MILITARY UNIT blank.

To view only the appointments of personnel with a specific COMMAND INTEREST entered into their records, enter that command interest code at COMMAND INTEREST. Leave COMMAND INTEREST blank if you wish to view patient appointments regardless of command interest.

Enter 'Y' at FLIGHT STATUS ONLY to view only the appointment records of patients with a flight status. Enter 'N' if you do not want to limit the records to those patients with a flight status.

Enter 'Y' at NO SHOWS ONLY to view the appointment records of patients with an appointment status of NS (No Show). Enter 'N' to view patient appointments of any status.

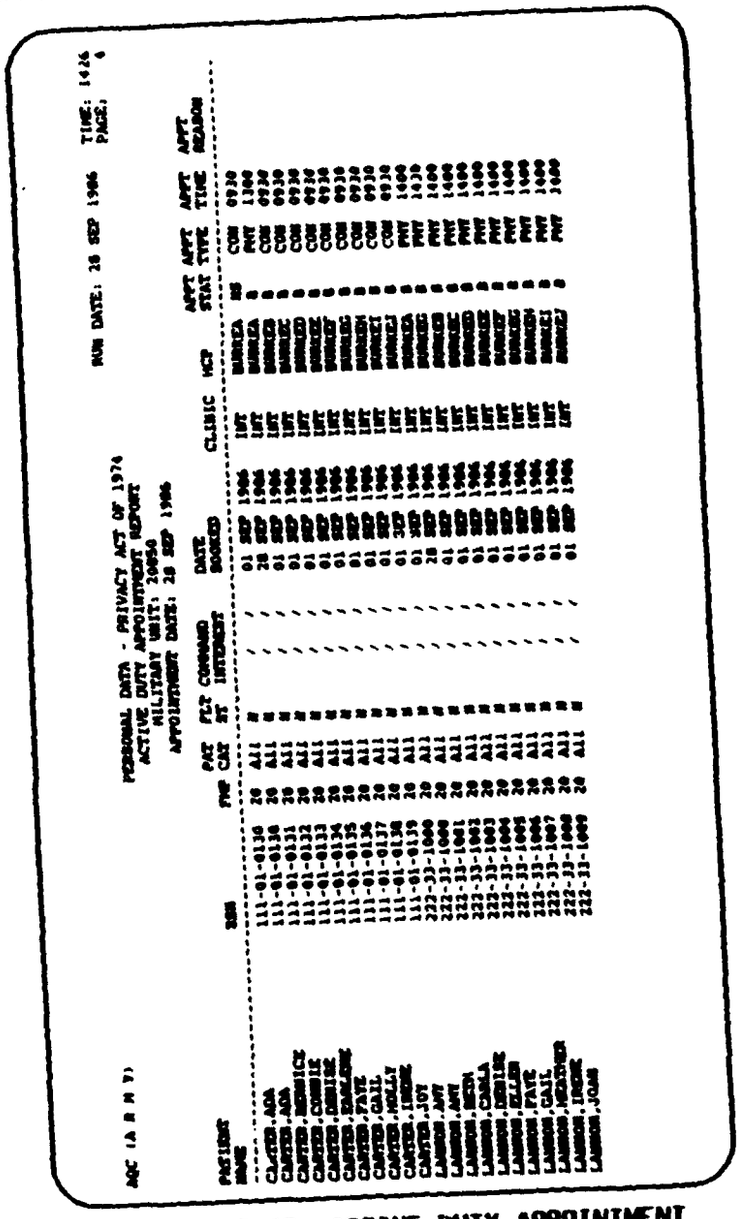


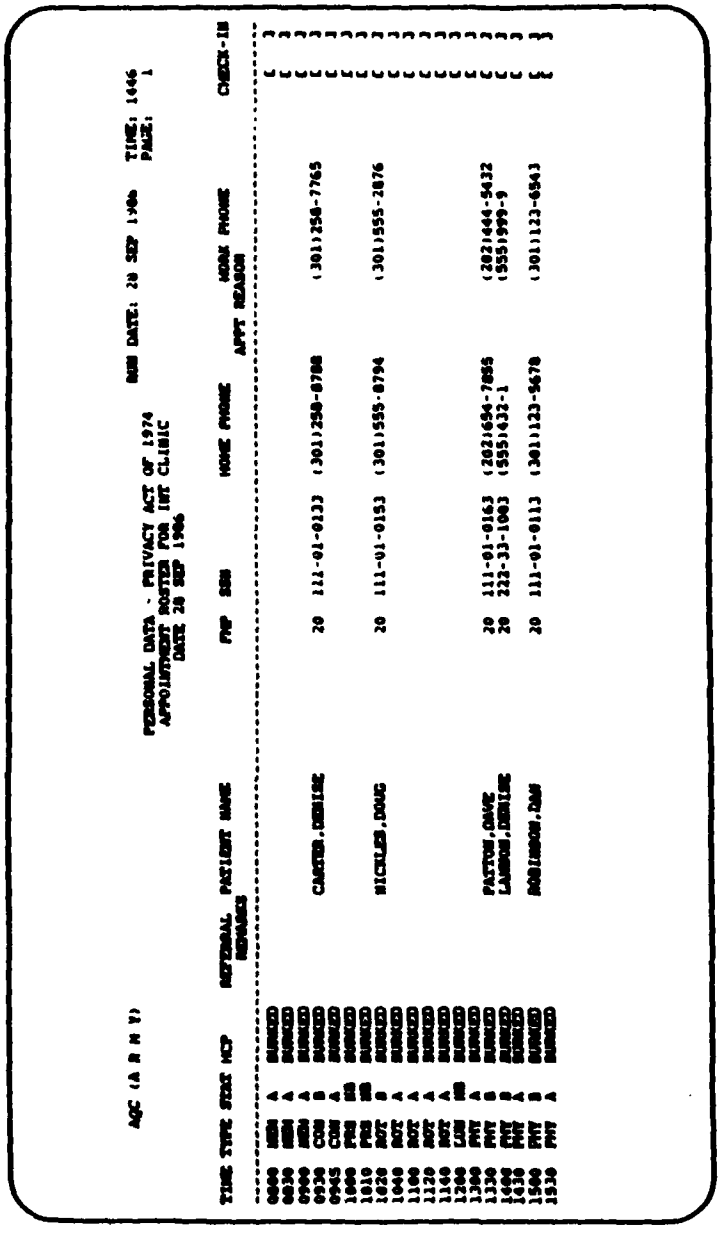
FIGURE 7.10 ACTIVE DUTY APPOINTMENT REPORT SAMPLE

CONSOLIDATED APPOINTMENT ROSTER REPORT

This report lists scheduled patients by appointment time for the date range and clinic indicated on the request screen. In addition, the report provides general information, including the patient's FMP, sponsor's SSN, home and work phone numbers, appointment reason and the appointment time, type, status, and any special remarks.

Leave CLINIC blank if you wish to view all the patients booked for appointments in all the clinics in the MTF. To view patients booked into a specific clinic, enter its name at CLINIC.

To view only those patients whose appointments have a specific status, enter that status at APPT STATUS. Leave the field blank to view all patients regardless of appointment status.



PERSONAL DATA - PRIVACY ACT OF 1974
APPOINTMENT ROSTER FOR INT CLINIC
DATE 20 SEP 1986

RUN DATE: 20 SEP 1986 TIME: 1446
PAGE: 1

AGE (A R M Y)

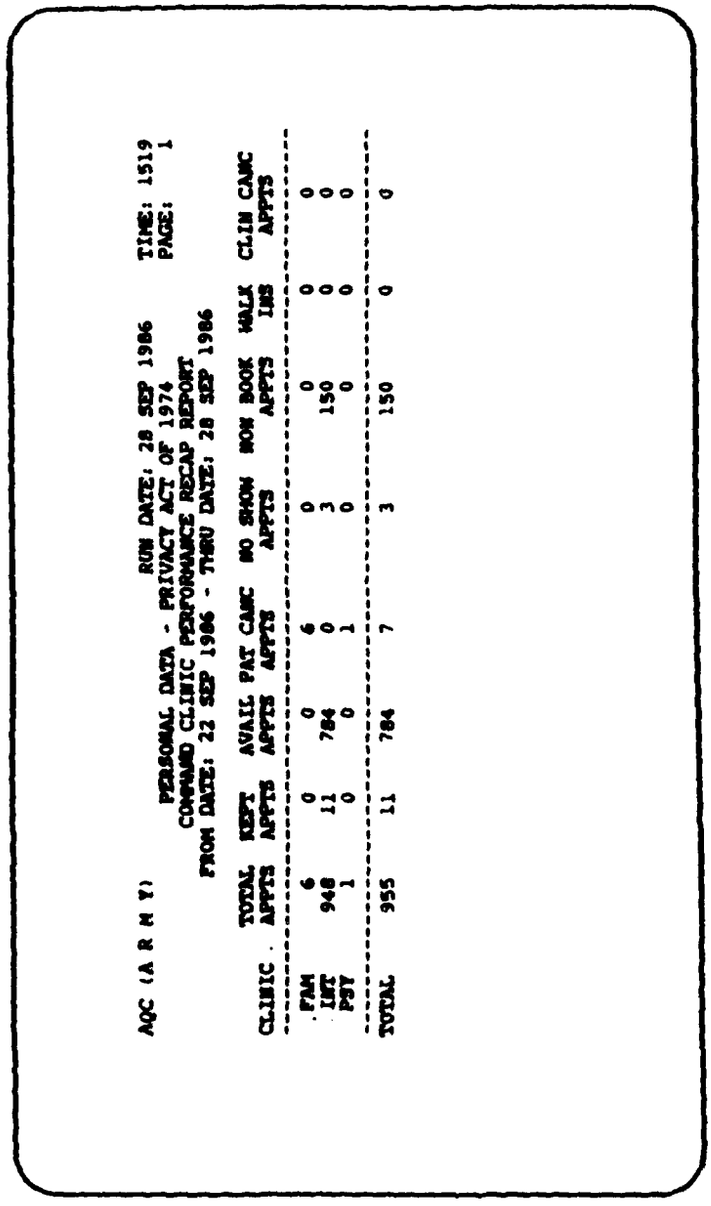
TIME	TYPE	STAT	HCP	REFERRAL REMARKS	PATIENT NAME	FMP	SSN	HOME PHONE	APPT REASON	WORK PHONE	CHECK-IN
0900	NEW	A	SURGCO								
0930	NEW	A	SURGCO								
0945	CON	A	SURGCO		CARTER,DENISE	20	111-01-0133	(301)258-8788		(301)258-7765	
1000	CON	A	SURGCO								
1015	PRE	A	SURGCO								
1030	ACT	A	SURGCO		NICKLES,DOUG	20	111-01-0153	(301)555-8794		(301)555-2876	
1045	ACT	A	SURGCO								
1100	ACT	A	SURGCO								
1120	ACT	A	SURGCO								
1200	LAB	A	SURGCO								
1330	PHY	A	SURGCO		PATTON,DAVE	20	111-01-0163	(202)696-7895		(202)444-5432	
1400	PHY	A	SURGCO		LARSON,DENISE	20	222-33-1003	(555)432-1		(555)999-9	
1430	PHY	A	SURGCO								
1500	PHY	A	SURGCO		ROBINSON,DAN	20	111-01-0113	(301)123-9678		(301)123-6543	
1530	PHY	A	SURGCO								

FIGURE 7.11 CONSOLIDATED APPOINTMENT ROSTER SAMPLE

COMMAND CLINIC PERFORMANCE RECAP REPORT

This report provides statistics about appointments for the clinics in the MTF for the date range indicated. The report also shows the total number of appointments conducted by a clinic.

Leave CLINIC blank if you wish to view the appointment record of every clinic in the MTF. To view the record of a specific clinic, enter its name at CLINIC.



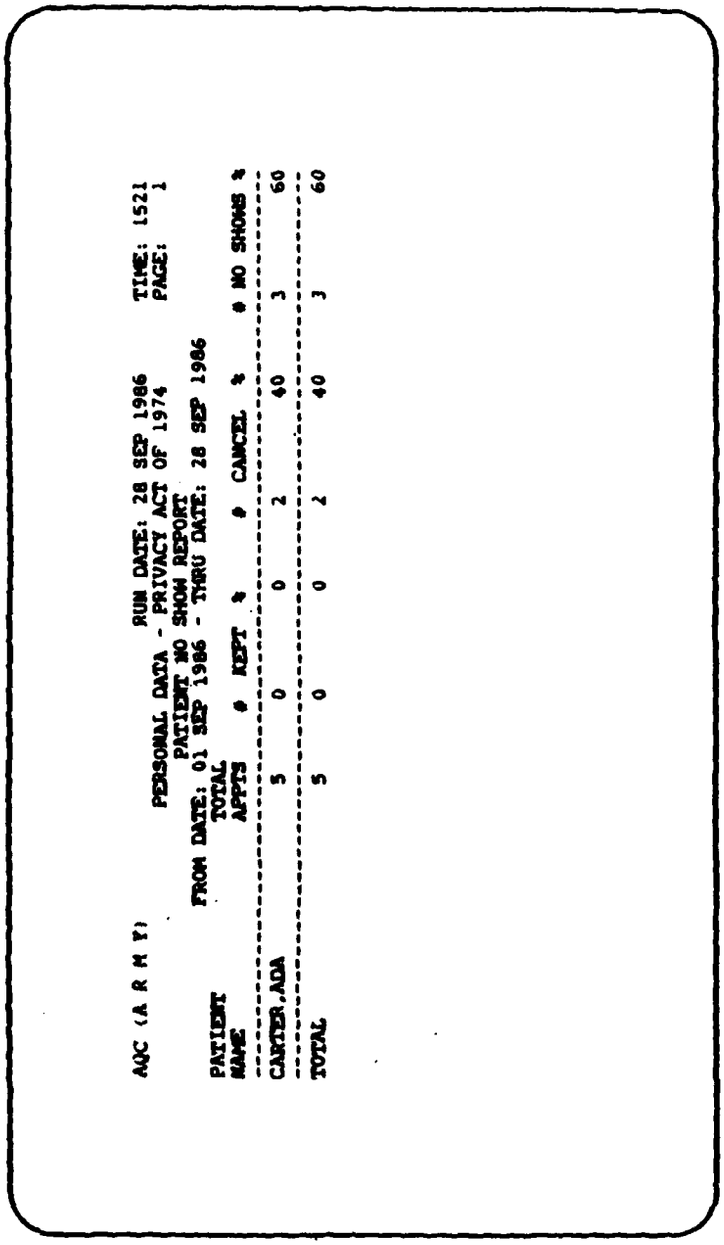
AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1519
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1
COMMAND CLINIC PERFORMANCE RECAP REPORT
FROM DATE: 22 SEP 1986 - THRU DATE: 28 SEP 1986

CLINIC	TOTAL APPTS	KEPT APPTS	AVAIL APPTS	PAT CANC APPTS	NO SHOW APPTS	NOW BOOK APPTS	WALK INS	CLIN CANC APPTS
FAM	6	0	0	6	0	0	0	0
INT	948	11	784	0	3	150	0	0
PSY	1	0	0	1	0	0	0	0
TOTAL	955	11	784	7	3	150	0	0

FIGURE 7.12 COMMAND CLINIC PERFORMANCE RECAP REPORT SAMPLE

PATIENT NO SHOW REPORT

This report shows information concerning a patient's appointment attendance history. The information consists of the total number of appointments scheduled for the patient, and the number and percentage of those appointments that were kept, cancelled, and no shows.



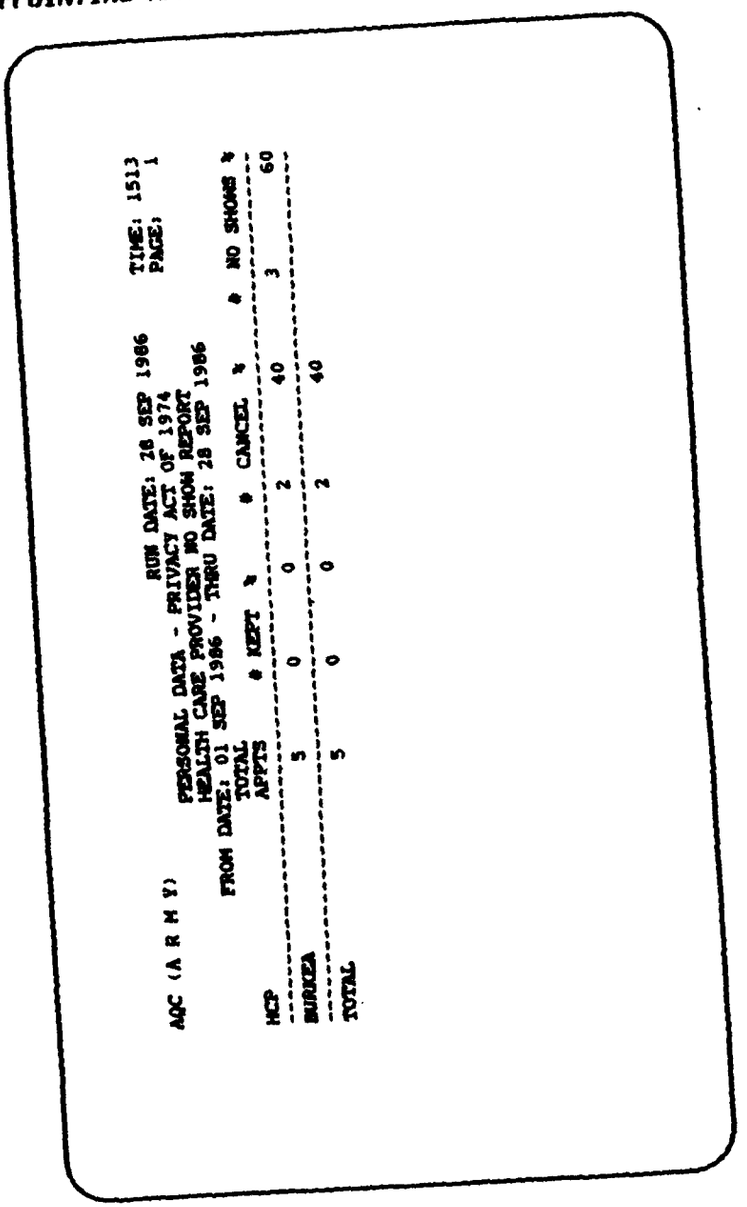
AOC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1521
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1
PATIENT NO SHOW REPORT
FROM DATE: 01 SEP 1986 - THRU DATE: 28 SEP 1986

PATIENT NAME	TOTAL APPTS	# KEPT	%	# CANCEL	%	# NO SHOWS	%
CARTER,ADA	5	0	0	2	40	3	60
TOTAL	5	0	0	2	40	3	60

FIGURE 7.13 PATIENT NO SHOW REPORT SAMPLE

HCP NO SHOW REPORT

This report shows information regarding patient appointment attendance for HCPs during the period of time indicated. The report shows the total number of appointments scheduled for an HCP, along with the number and percentages of these appointments that were kept, cancelled, and no shows.



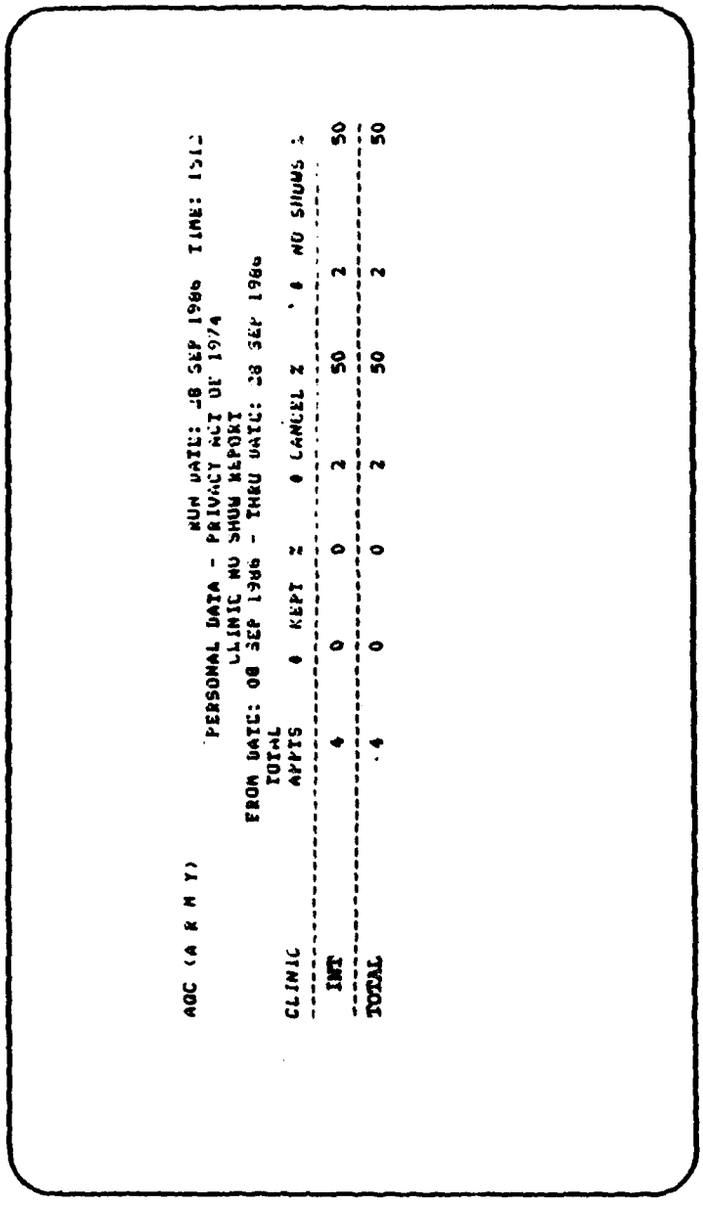
AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1513
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1
HEALTH CARE PROVIDER NO SHOW REPORT
FROM DATE: 01 SEP 1986 - THRU DATE: 28 SEP 1986

HCP	TOTAL APPTS	# KEPT	%	# CANCEL	%	# NO SHOWS	%
BURKEA	5	0	0	2	40	3	60
TOTAL	5	0	0	2	40		

FIGURE 7.14 HCP NO SHOW REPORT SAMPLE

CLINIC NO SHOW REPORT

This report shows information regarding patient attendance for all clinics during the period of time indicated. The report shows the total number of appointments scheduled at the clinic, and the numbers and percentages of the appointments that were kept, cancelled, and no shows.



AOC (A K M Y) NOW DATE: 28 SEP 1986 TIME: 1515

PERSONAL DATA - PRIVACY ACT OF 1974

CLINIC NO SHOW REPORT

FROM DATE: 08 SEP 1986 - THRU DATE: 28 SEP 1986

CLINIC	TOTAL APPTS	# KEPT	%	# CANCEL	%	# NO SHOWS	%
INT	4	0	0	2	50	2	50
TOTAL	4	0	0	2	50	2	50

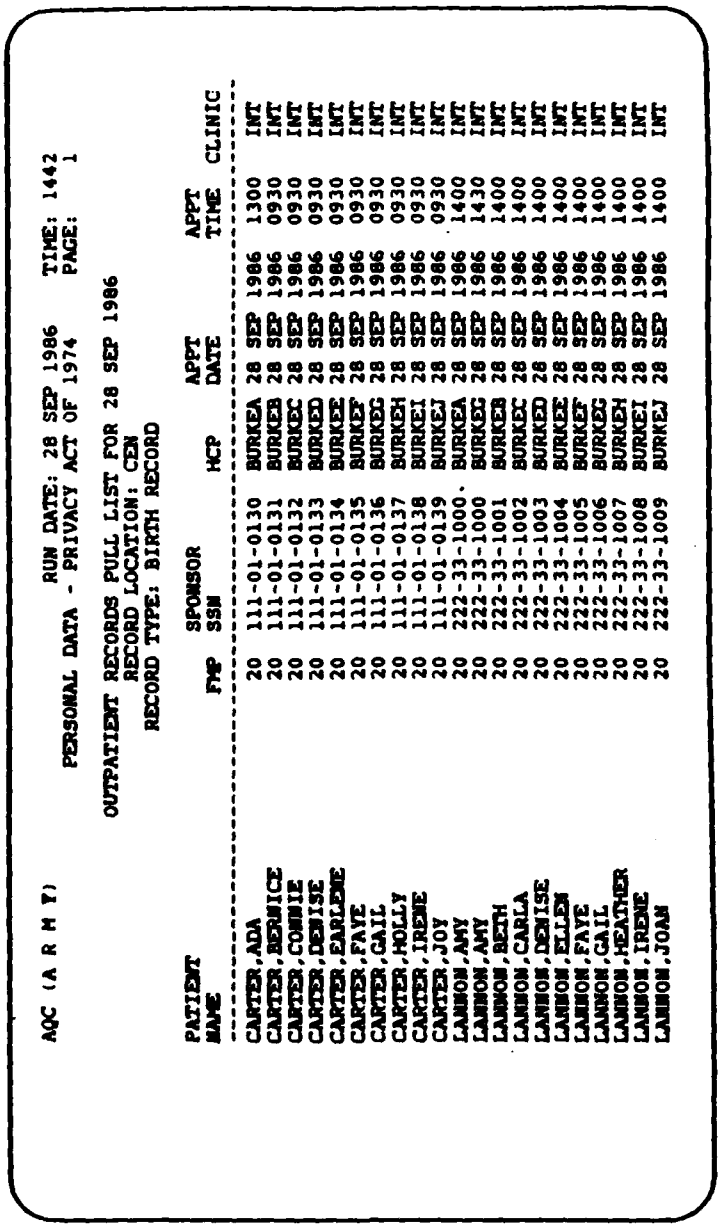
FIGURE 7.15 CLINIC NO SHOW REPORT SAMPLE

CONSOLIDATED PATIENT RECORD PULL LIST

This report lists the patients booked for appointments at all clinics. The Consolidated Patient Record Pull List is used to request records from the records room for patients booked into upcoming appointments.

Enter 'Y' at TERMINAL DIGIT SEQUENCE SORT to print the reports in the order of the patient's terminal digit. Enter 'N' to print the reports in alphabetical order by the patients' names. Unlike the Pull Record List (Report 7.2), this report lists all patients booked for the date range specified; it does not order the list by clinic.

If patient appointments are booked after the Patient Record Pull List for those dates has been processed, enter the date the Pull List was last processed at APPOINTED SINCE DATE. The report printed will consist of a list of the patients booked for an appointment since the Pull List was last processed, allowing you to pull those patients' records.



AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1442
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1

OUTPATIENT RECORDS PULL LIST FOR 28 SEP 1986
RECORD LOCATION: CEN
RECORD TYPE: BIRTH RECORD

PATIENT NAME	FMP	SPONSOR SSN	HCP	APPT DATE	APPT TIME	CLINIC
CARTER,ADA	20	111-01-0130	BURKEA	28 SEP 1986	1300	INT
CARTER,BERNICE	20	111-01-0131	BURKEB	28 SEP 1986	0930	INT
CARTER,CONNIE	20	111-01-0132	BURKEC	28 SEP 1986	0930	INT
CARTER,DENISE	20	111-01-0133	BURKED	28 SEP 1986	0930	INT
CARTER,EARLENE	20	111-01-0134	BURKEE	28 SEP 1986	0930	INT
CARTER,FAYE	20	111-01-0135	BURKEF	28 SEP 1986	0930	INT
CARTER,GAIL	20	111-01-0136	BURKEG	28 SEP 1986	0930	INT
CARTER,HOLLY	20	111-01-0137	BURKEH	28 SEP 1986	0930	INT
CARTER,IRENE	20	111-01-0138	BURKEI	28 SEP 1986	0930	INT
CARTER,JOY	20	111-01-0139	BURKEJ	28 SEP 1986	0930	INT
LAMMON,AMY	20	222-33-1000	BURKEA	28 SEP 1986	1400	INT
LAMMON,AMY	20	222-33-1000	BURKEG	28 SEP 1986	1430	INT
LAMMON,BETH	20	222-33-1001	BURKEB	28 SEP 1986	1400	INT
LAMMON,CARLA	20	222-33-1002	BURKEC	28 SEP 1986	1400	INT
LAMMON,DENISE	20	222-33-1003	BURKED	28 SEP 1986	1400	INT
LAMMON,ELLEN	20	222-33-1004	BURKEE	28 SEP 1986	1400	INT
LAMMON,FAYE	20	222-33-1005	BURKEF	28 SEP 1986	1400	INT
LAMMON,GAIL	20	222-33-1006	BURKEG	28 SEP 1986	1400	INT
LAMMON,HEATHER	20	222-33-1007	BURKEH	28 SEP 1986	1400	INT
LAMMON,IRENE	20	222-33-1008	BURKEI	28 SEP 1986	1400	INT
LAMMON,JOAN	20	222-33-1009	BURKEJ	28 SEP 1986	1400	INT

FIGURE 7.16 CONSOLIDATED PULL LIST REPORT SAMPLE

HCP TEMPLATE REPORT

This report shows all the templates created for the HCP specified. The HCP Template Report includes appointment times, appointment types, and appointment durations for each day of every template stored for the HCP indicated.

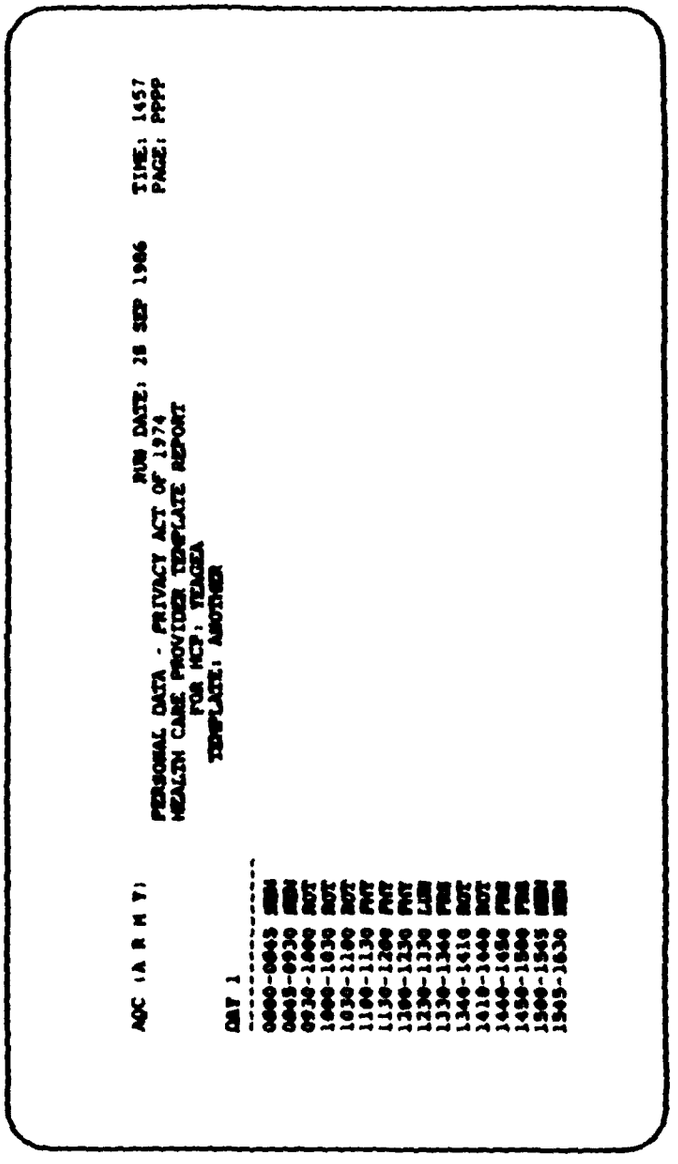
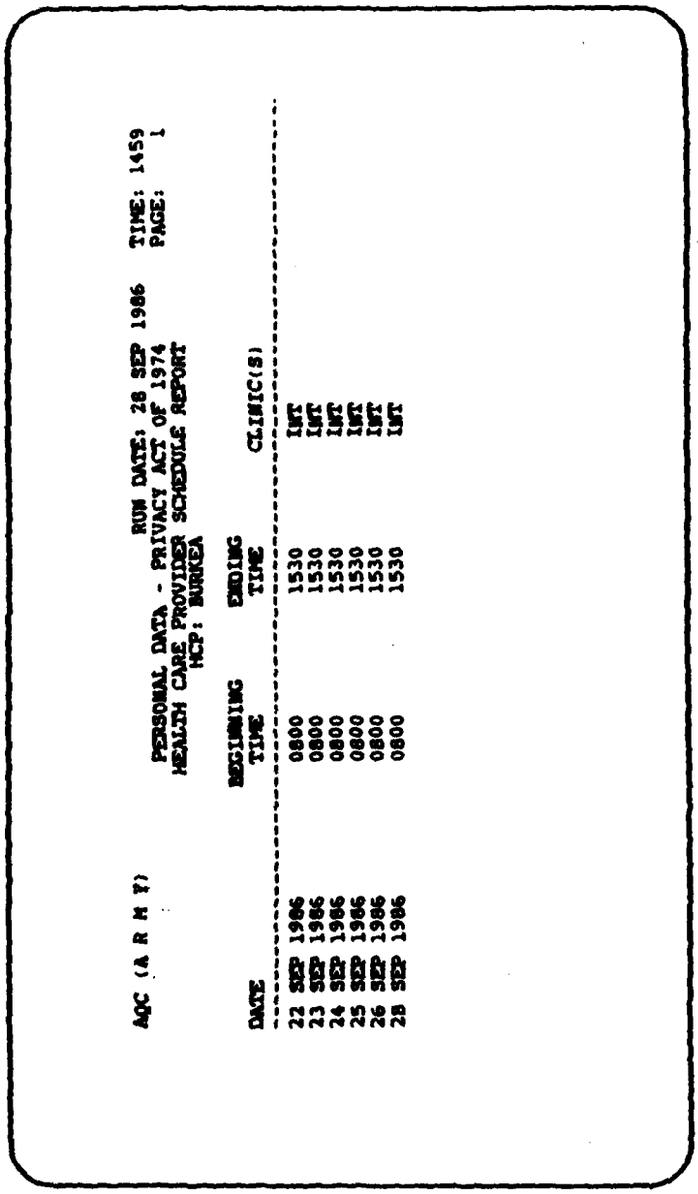


FIGURE 7.17 HCP TEMPLATE REPORT SAMPLE

HCP SCHEDULE REPORT

This report shows the schedules of individual HCPs for the date range specified on the report screen. The HCP Schedule Report includes the date of the schedule, the beginning and ending time of the scheduled day, and the clinics at which the HCP has scheduled appointments.



AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1459
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1
HEALTH CARE PROVIDER SCHEDULE REPORT
HCP: BURKEA

DATE	BEGINNING TIME	ENDING TIME	CLINIC(S)
22 SEP 1986	0800	1530	INT
23 SEP 1986	0800	1530	INT
24 SEP 1986	0800	1530	INT
25 SEP 1986	0800	1530	INT
26 SEP 1986	0800	1530	INT
28 SEP 1986	0800	1530	INT

FIGURE 7.18 HCP SCHEDULE REPORT SAMPLE

HCP PROFILE REPORT

This report shows the HCP Profile for the HCP indicated. The HCP Profile consists of the appointment types profiled for the HCP and the information about those appointment types entered on the Edit HCP Profile Screen. For each appointment type, this information includes the HCP's maximum number of patients, the comment to appear with every appointment, duration of the appointment, number of patients seen, number of overbooks, the comment to appear with that appointment type, referral code, and the patient records required.

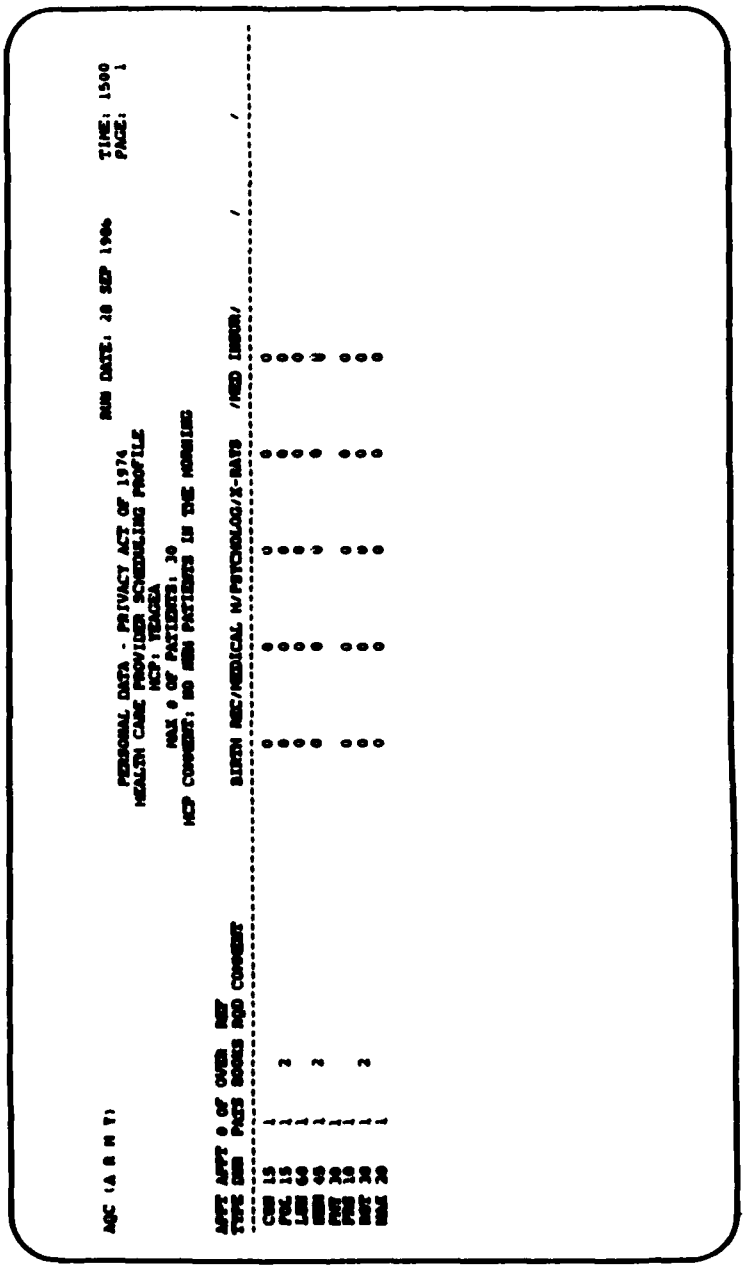


FIGURE 7.19 HCP SCHEDULING PROFILE SAMPLE

NON-ACTIVE DUTY APPOINTMENT REPORT

This report shows the appointments booked for non-active duty military personnel for the date range specified.

If you wish to view reports for non-active duty personnel who have a specific command interest entered in their records, enter that particular code at COMMAND INTEREST on the request screen. (For a list of command interest codes, press [Help] with the cursor at this field.)

If you wish to view reports for all non-active duty personnel regardless of command interest, leave COMMAND INTEREST blank.

If you wish to view the reports of those non-active duty personnel whose appointment status was No Show only, enter 'Y' (Yes) at NO SHOW ONLY.

Enter 'N' if you want to view all appointments. The NO SHOW ONLY field is a required field. You must enter 'Y' or 'N'.

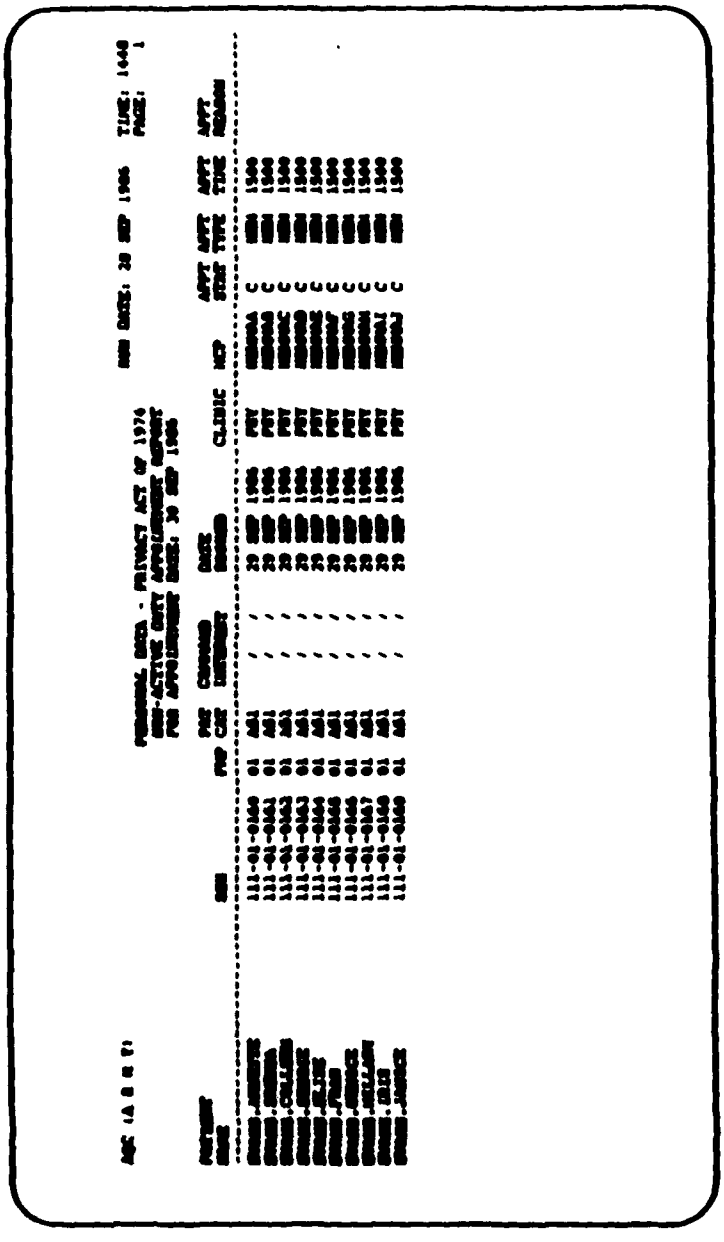


FIGURE 7.20 NON-ACTIVE DUTY APPOINTMENT REPORT SAMPLE

REGISTRATION REPORT

This report details the total number of MTF registered patients by patient category and by sex.

This report requires a massive database compilation to determine the number of patients in each patient category and total them by sex; therefore, the report will run only during the off-peak hours specified by your System Manager.

There will be a time delay between requesting the report and the initiation of the printing.

AQC (A R M Y) RUN DATE: 20 SEP 1986 TIME: 1454
PERSONAL DATA/PRIVACY ACT OF 1974 PAGE: 1
REGISTRATION REPORT

PATIENT CATEGORY	MALE	FEMALE	UNKNOWN	TOTAL
A11	94	33	0	127
A21	0	5	0	5
A31	5	0	0	5
A32	5	0	0	5
A34	1	0	0	1
A51	15	33	0	48
A62	1	1	0	2
F11	1	2	0	3
H11	6	0	0	6
S22	1	0	0	1
S45	5	0	0	5
X44	0	1	0	1
X61	0	1	0	1
X71	20	5	0	25
X73	0	1	0	1
TOTAL	154	82	0	236

FIGURE 7.21 REGISTRATION REPORT SAMPLE

MEDICAL SUMMARY REPORT

This report details the total number of Inpatient and Outpatient visits, by patient category, for all registered patients of your MTF.

This report requires a massive database compilation to determine the number of visits in each patient category and total them by clinic; therefore, the report will run only during the off-peak hours specified by your System Manager.

There will be a time delay between requesting the report and the initiation of the printing.

AQC (A R M Y) RUN DATE: 28 SEP 1986 TIME: 1522
PERSONAL DATA - PRIVACY ACT OF 1974 PAGE: 1
MEDICAL SUMMARY REPORT
FROM DATE: 08 SEP 1986 THRU DATE: 28 SEP 1986
CLINIC: INT

PATIENT CATEGORY	INPATIENT VISITS	OUTPATIENT VISITS	TOTAL
A11	0	83	83
A62	0	1	1
F11	0	1	1
SUBTOTAL INT	0	85	85
TOTAL	0	85	85

FIGURE 7.22 MEDICAL SUMMARY SAMPLE

7.1 To Request a Report

1. To access the Appointing and Scheduling Reports Main Menu, enter 'R' at ENTER SELECTION on the Appointing and Scheduling Main Menu. Press [Return].

   The Appointing and Scheduling Reports Main Menu will appear, with the cursor at ENTER SELECTION.

2. Enter the number of the submenu you wish to view. Press [Return].

   The submenu you have selected is displayed. At the left of each report name is a number.

3. At ENTER SELECTION, enter the number of the report you are requesting and press [Return]. The following description demonstrates the procedure used for completing the Appointment Roster Request Screen.

   The Appointment Roster Request Screen is displayed, with the cursor at CLINIC.

4. Enter the clinic for which you are requesting reports. If you wish Appointment Roster Reports for every clinic in the MTF, leave CLINIC blank. Press [Return].

   The cursor moves to HCP.

5. Enter the HCP whose appointments you wish to view. If you wish to view the appointments booked for all HCPs in the clinic or MTF, leave the field blank. Press [Return].

   The cursor moves to APPOINTMENT DATE.

6. Enter the date for which you wish to view appointment records. Press [Return].

   The cursor moves to APPOINTMENT STATUS.

7. If you wish to view records of appointments with one specific status only, enter it at APPOINTMENT STATUS. To view records of every appointment status, leave the field blank. Press [Return].

   The cursor moves to PRINTER COPIES.

8. Enter the number of copies you want. To view the report on the screen only, leave the field blank. Press [Return].

   The cursor moves to ENTER SELECTION.

9. Press [Return].

   The Appointing and Scheduling Report Menu is displayed and the report begins to print.

   OR

   The report will be displayed on the screen if no printer copies were requested.

10. To return to the Appointing and Scheduling Main Menu, press [Return].

    The Appointing and Scheduling Reports Main Menu is displayed.

11. Press [Return].

    The Appointing and Scheduling Main Menu is displayed.


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