STAR 2000™

STAR LABORATORY REFERENCE GUIDE
Anatomic Pathology Module

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Preface

The *Anatomic Pathology Module* is one volume in the STAR Laboratory Reference Guide series. It provides detailed information concerning how to design, build, and use the Anatomic Pathology module.

The *General Information Volume* is prerequisite reading for all other volumes of the *STAR Laboratory Reference Guide*. Successful use of the Anatomic Pathology Module depends upon your knowledge of the concepts covered in the *General Information Volume*.

Documentation Conventions

Documentation for McKesson's STAR 2000™ line of products follows these conventions:

Revisions
Text revisions are indicated by a change bar in the left margin. Paragraphs that contain grammatical changes that do not affect content are not marked.

Canadian Documentation
This volume may include documentation for Canadian users of this product. Complete sections of Canadian text are identified by "CN" and "CN Only."

Key Names
Named keys, such as ENTER, SHIFT, CTRL, and ALT, appear in this document in uppercase (capital) letters. Symbol keys display according to the key name, followed by the symbol on the key in parentheses, such as hyphen (-) and asterisk (*).

Key Chords
Key chords are key entries that require you to hold down one or more keys (typically, CTRL, ALT, or SHIFT) before pressing another key. In this document, key chords display as the names of each key in the chord with a hyphen (-) between each (for example, CTRL-ALT-DEL). You should press the keys in the order indicated.

ENTER
ENTER is a key on a computer keyboard used to complete an entry on a STAR system. (This key may also be referred to NEW LINE or NL in the STAR system.)

Data Entries
Letters or words you enter in response to the system display in **boldface** letters in this document. For example: Enter **Y** for Yes or **N** for No.

Selecting an Entry
This document often instructs you to "select an entry." The method you use to select an entry depends on whether you are using STAR from a terminal or IBM-compatible personal computer. Entry methods include:

- Entering the option number

- Using your arrow keys to highlight the option and pressing ENTER

- Clicking on the option using a mouse or other pointing device (PC only)

For more information about these options, see the *General Information Volume*.

Prompts
System prompts display at the bottom of many STAR screens when the system requests an entry or displays a message. Prompts display in this document italicized and indented from the rest of the text. For example:

Enter patient name--

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Field Characteristics

STAR product documentation provides field explanation codes, in addition to a narrative description for each field on a screen. These codes display the maximum length of your entry in the field, the type of entry you make in the field, and whether the field is required. This information displays in the following format:

- DISPLAY ONLY for a field you cannot edit.

- For X-YY-Z field types, where:

    - X is the maximum number of characters permitted in the field:

        - P for a field length determined by a Parameter

        - T for a field length determined by a Table

        - U for a field having an Undefined length

    - YY is the type of entry technique permitted in the field:

        - A for Letters only

        - N for Numerals only

        - C for Characters (including punctuation)

        - AC for Letters and Punctuation only (no numbers)

        - NC for Numerals and Punctuation only (no letters)

        - AN for Numerals and Letters only (no punctuation)

    - Z is the requirement indicator of the field:

        - R if an entry is required to complete the function

            NOTE: Facilities can designate that certain fields be Required. STAR product documentation does not display R for fields designated as Required by a facility.

        - O if an entry is Optional to complete the function

        - C if an entry is Conditionally required or optional

    - For YY-Z field types, where YY is:

        - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.

        - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.

        - DATE for a field subject to the date entry conventions described in the *General Information Volume*.

        - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

        NOTE: For use of the Z position in this format, refer to the explanations for Z under X-YY-Z.

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Table of Illustrations

NOTE: The report names provided with the illustrations are the default names. If section reports have been defined for a particular report name, this changes the name of the report. For example, the default report name for accession labels is ALALLAL0 (for department A). Using this example, if accession labels are defined to be section specific, the report name would look like, for example, ALHEMLAL0 for the Hematology section (HEM = Hematology section code).

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Introduction

STAR Laboratory's Anatomic Pathology module enables you to process, charge, and result the specialized procedures required for anatomical pathology specimens. ID-specific standard result text, review queue holding areas, and an electronic signature system all serve to speed report turnaround time. Online storage of diagnoses, codes and comments by selective archiving or history cardfile allows you to search data according to predefined criteria.

Chapter 1: Worksheet Instructions

This chapter contains the instructions necessary to complete Anatomic Pathology worksheets. Blank worksheet forms are provided in Appendix B: Worksheet Forms.

Chapter 2: Maintenance Functions

This chapter contains screen prints and instructions for using the Maintenance Functions required to build your Anatomic Pathology module.

Chapter 3: Applications

This chapter contains screen prints and instructions for each application of the Anatomic Pathology module. It also contains report examples and explanations.

Appendix A: Report Names

This appendix provides a list of the reports, labels, and forms generated by the STAR Laboratory system.

Certain Anatomic Pathology test results involve a large amount of textual reporting and therefore require word processing for result entry. Two options are available for word processing: Softkey Editor and McKesson's Word Processing Interface. Softkey Editor is provided with base STAR and can be used at any CRT. For further information on Word Processing Interface, refer to the *STAR Navigator User's Guide*. Softkey Editor is documented in the *General Information Volume* of the *STAR Laboratory Reference Guide.* Ask your System Manager for details on the word processing option available to you.

Chapter 1 - Worksheet Instructions

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INTRODUCTION

Complete the following worksheets prior to those for Anatomic Pathology:

NOTE: These worksheets are located in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide.*

- Container Types

- Laboratory Menu - Bay

- Laboratory Menu - Main

- Laboratory Menu - Result

- Laboratory Menu - Section *

- Miscellaneous Charge Items

- Number Pools

- Ordering Priorities

- Result Components **

- Result Table Types

- Result Tables

- Result Unit Codes

- Send Out Laboratories

- Slide Pools

- Special Instructions

- Specimens ***

- Test Worksheets

- Workload

NOTE: The Anatomic Pathology section is built like all other sections of the department. If Miscellaneous Charge/Credit is to be used, include a SIM code range for the Miscellaneous Charge Items. Following is a list of the functions that can be added to the Anatomic Pathology section menu:

- Anatomic Path Order Management

- Anatomic Path Result Reporting

- History Cardfile

- Histotech/Cytotech Processing

- Histotech/Cytotech Processing Report

- Incomplete Work

- Miscellaneous Charge/Credit

- Miscellaneous Charge Report

- Professional Billing Input

- Quality Control/Workload

- Review Queue Reporting

NOTE: ** It is not necessary to create a Number of Blocks component since the number of blocks defined per specimen displays on the results entry screen and on all patient reports (if the flag is set). Otherwise, result components for Anatomic Pathology tests are used the same as they are for all other tests.

NOTE: ***The specimen table should contain any specimen that might be used in Anatomic Pathology.

STANDARD RESULT TEXT

The Standard Result Text worksheet is used to establish pre-formatted text useful as a base document for lengthy textual results. Standard Result Text documents are often created for particular pathologists, specimen types, disease states, or a combination of these. Once created, these documents can be assigned to one or more subgroups for Result Entry or used in Interpretive Reporting.

Within results entry, standard result text documents are available for any test result assigned with Word Processing as a *Special Processing* feature. The standard result text selected can be edited to reflect the specimen at hand.

Complete a separate worksheet for each department.

DEPARTMENT CODE (3-A-R)
Enter the three letter code for the department.

CODE (12-AN-R)
Enter the code for the standard result text. This code should reflect the type or use of the standard result text. For example, if the SRT is specific for a pathologist, use his/her initials as the code.

NOTE: If more than one person is maintaining these files for the laboratory, you may want to prefix the code with a section indicator letter. For example, CCARD for Chemistry.

DESCRIPTION (25-C-R)
Enter the description of this standard result text. This description should reflect the type or use of the SRT.

NOTE: If more than one person is maintaining these files for the laboratory, you may want to prefix the description with the section responsible for maintaining this file. For example, CHEM-Cardiac Profile, Norm. This helps with the selection of the correct standard result text to edit in the processors and in result reporting when you have a component set up for wordprocessing with access to all standard result text documents.

TEXT (U-C-R)
Enter the exact text as it is to appear in a report. The text can be more than 220 characters in length, if necessary. Special characters can be used within the text to represent data element locations which requires editing during result entry. For example, use *XX* where numeric values will be entered for dimensions, weights, and so on. The laboratory staff can replace these data elements with specimen-specific data using the word-processing module. When formatting this text, refer to the line length you defined for your system. For information on line length refer to Chapter 1: Flags/Utilities in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide*.

STANDARD RESULT SUBGROUP

Standard Result Text documents can be grouped by employee ID number, specimen type, diagnosis, or any other category established by the laboratory. This worksheet is used to list the groups and their descriptions.

Complete a separate worksheet for each department.

DEPARTMENT CODE (3-A-R)
Enter the three letter code for the department.

CODE (12-C-R)
Enter the subgroup code under which standard result text documents are to be grouped. If this subgroup is for a laboratory user, enter the user's ID code.

DESCRIPTION (25-C-R)
Enter the description of this subgroup. When an ID is used as the code, enter the employee's name as the description.

NOTE: If you need to know which subgroups are used by which sections for maintenance purposes, you may want to prefix the description with a section indicator. For example, use Serology-ANA to indicate that this subgroup is for Serology and to group the Serology subgroups on the table.

GROUPED STANDARD RESULT TEXT (SPECIAL PROCESSING-R)
This field is used to list Standard Result Text for this group. There is no limit to the number of SRT documents that can be added to a group.

TEST WORKSHEETS

Anatomic Path tests are defined using the same test worksheets as those provided with the base system with the exception of:

Basic Test Information

Special Test Information

Test Results Worksheet

For instructions to complete these worksheets and for the worksheets themselves, refer to Chapter 5: Main Test Information and Chapter 6: Supporting Test Files in the *Maintenance Worksheets Volume I* of the *STAR Laboratory Reference Guide*. Certain fields on these worksheets differ for Anatomic Pathology tests. These are:

Basic Test Information

TEST TYPE (1-N-R)
The test type is always Anatomic Path. This field is already checked on the worksheet.

Special Test Information

ANATOMIC PATH CASE NUMBER POOL (TABLE/CODE-A-O)
In the Anatomic Pathology module, a case number is assigned to each Anatomic Path test within an accession. The case number is derived from a pool of numbers reserved for Anatomic Path test types.

The format of the case number is:

First character of number pool code_Year-NP#

for example: S93-100

SINGLE COLUMN PRIMARY FORMAT (1-A-O)
Always use single column primary format for all Anatomic Pathology tests (check Yes on the worksheet).

T-CODE SPECIMEN SELECTION (1-A-C)
This field is used to select the location of defined specimens for the auto T-coding process. If the department-level flag is set to allow auto T-coding and an indicator character has been added at the department level, you select either login (L), histotech (H), or result entry (R).

If an indicator at the department level was not entered, but auto T-coding is allowed (the department-level flag allows auto T-coding), you select between login (L) or histotech (H).

This field can only be accessed if the test type is Anatomic Pathology and the department level flag is set to allow auto T-coding. If the test is not an Anatomic Path test type, or the department flag is not set to allow auto T-coding, *N/A* displays in the field, and the system does not allow the field to be edited.

If the test meets the necessary criteria, based on the option selected, the following options display in the field:

L - Login   H - Histotech   R - Result Entry

Test Results

In a typical Anatomical Pathology laboratory, results for a single test are entered by different people at different times. Special functions within STAR Laboratory's Anatomic Pathology module enable you to set up test files to fit the unique reporting needs of the pathologist, transcriptionist and technologist and/or the department as a whole.

The purpose of the Test Results worksheet is to specify the result fields for the test and the special functions available for each result. Complete at least one worksheet for each Anatomic Path test. Refer to Chapter 6: Supporting Test Files in the *Maintenance Worksheets Volume I* of the *STAR Laboratory Reference Guide* for instructions to complete this worksheet.

SPECIAL PROCESSING (1-N-R)
For tests defined as Anatomic Path Test Types, the Special Processing options are:

(1) Auto Fill ID	(9) Multiple Table Selections
(2) Auto Fill ID/required complete	(10) Prompt Processing
(3) Comment Processing	(11) SNOMED® Code
(4) Date and/or time	(12) Security Level Specific Menu
(5) Free form text	(13) Table Selection
(6) ID Specific Menu	(14) Template Processing
(7) Menu Selection ID	(15) Word Processing
(8) Menu Selection	

AUTO FILL ID
This feature attaches an employee ID to the result field. If this Special Processing feature is selected, enter Auto Fill ID on the worksheet plus one of the three options listed here:

No Edit - ID of user is automatically filled and cannot be edited

Table Edit - ID can be replaced with an ID selected from a table; enter Table Edit plus the name & code of the result table

Menu Edit - ID can be replaced with an ID selected from a menu; enter Menu Edit plus the name of the menu

For result fields such as Grossed by or Released by, it is particularly helpful to have the system automatically enter the name of the person entering the result or allow ID selection from a menu. In this way, the transcriptionist can enter the result data and identify the pathologist responsible for that test by selecting his or her name from a menu. The test is then placed in the selected queue for final review and electronic signature (if defined on the Review Queue per Test worksheet).

AUTO FILL ID/REQUIRED COMPLETION
This feature automatically attaches the user's ID to the result field and makes the result field required for the test to be completed. This field can be edited and used to prevent release of the report. Select this feature by entering Auto Fill ID/required completion on the worksheet.

COMMENT PROCESSING
When you assign comment processing to a component and an accessioning comment is present, the system displays the comment in Result Reporting so you can select the comment to fill in the component.

DATE AND/OR TIME
This feature assigns the result field as a date &/or time result. Enter Date and/or time plus the number corresponding to the date/time format to appear on reports. Use the following list:

1 = 2 Jan 87 0900

2 = 02 Jan 87 0900

3 = Jan 2, 1987 0900

4 = Jan 02, 1987 0900

5 = 1/2/87 0900

6 = 01/02/87 0900

7 = 01/02/87

8 = 2 Jan 87

9 = Jan 2, 1987

FREE FORM TEXT

This feature allows free-form entry of numeric or textual results. It is the most common option selected and the default for the Special Processing field. Enter Free Form Text to use this option.

ID SPECIFIC MENU

This feature allows results to be set up such that special menus (based on a particular ID code, an ID-specific result, or the user's security) display for results entry.

A) Special Menu Based on an ID:

Results (such as Grossed by or Read by) assigned as ID fields (that is, the first two Special Processing options) can be linked with a second result field, such as Gross Description or Interpretation. This second result field can then have a menu appear based on the ID contained in the first field.

For example, consider the Bone Marrow test. The results are:

•   Slides Read by

•   Interpretation

The cytotech who reads the slides enters his ID number (10444) in Field # 1. If the ID Specific Menu option is assigned to result 2, Interpretation, upon accessing result 2 in results entry, a menu displays based on ID 10444. If another technician had entered field # 1 or, if the ID code is selected from a list of IDs, a result menu based on that person's ID would have appeared.

B) Special Menu Based on an ID-Specific Result

In the previous example, had result # 1 been assigned with Auto Fill ID as the special processing feature, the ID of the user would automatically be captured within results entry. Once again, result 2 is based on that ID. See Auto Fill ID under Special Processing for a more detailed discussion of other options available.

C) Special Menu Based on Security of the user

A third way this test can be set up is to have a security level attached to result 1--for example, level 40 (cytotechnologist). Any user (with a security level of 40) who enters a result field will have a menu appear based on that security level. By setting up the test this way, the same menu appears for all cytotechs.

This result-result linking must be indicated on the worksheet using the Based On: column. First, indicate the result that uses a specific menu as a #4 (Free Text) Special Processing option. Then, on the same line, enter the component number of the ID field under the Based On: column. Finally, enter the ID code(s) and/or security level(s) and their associated menu(s) under the ID

Number... column. Menu name(s) should be obtained from the Laboratory Menu - Result worksheet. Each ID and security level must be previously defined in the Employee Data Files.

To use this option, enter ID Specific Menu plus:

- **I** for user ID

- **R** for result-determined ID; also enter the component number of the result which contains the ID (place the component number in the Based On column)

List each employee name and ID code for which a specific menu will be defined and follow this with the actual menu name (refer to the Laboratory Menu - Result worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* for this information). In addition to ID-specific menus, also specify the default menu to display for employees not listed above.

MENU SELECTION ID
This feature requires the result always be used for reporting an ID. It must have a menu composed of IDs attached to it. Select this option by entering Menu Selection ID plus the name of the ID menu (from the Laboratory Menu - Result worksheets I & II).

MENU SELECTION
This feature allows result entry by selecting an option or combination of options from a menu. Enter Menu Selection plus the name of the menu (obtained from the Laboratory Menu - Result worksheet).

MULTIPLE TABLE SELECTIONS
This feature allows result entry by selecting option(s) from a table. Two mechanisms exist for table entries:

1. The table automatically displays upon entry of the result field.

2. You have the option of entering the code for the desired result, a partial name followed by a hyphen (**-**) for alpha-lookup (to display part of the table), or a hyphen (**-**) to display the entire table.

Enter Multiple Table Selections plus the name of the result table (obtained from the Result Table worksheet). Indicate the table entry method by entering **1** or **2**.

NOTE: While short tables are well-suited for auto-display (option 1), it is recommended that, for long tables, the user be given the option of entering the result code or of partial table display (option 2).

PROMPT PROCESSING
When you assign prompt processing to a component and a prompt response comment is present, the system displays the prompt in Result Reporting so you can select the prompt to fill in the component.

SNOMED CODE
This feature is specific to Anatomic Path tests. When attached to a result, it allows
selection of SNOMED codes for result reporting. Enter SNOMED options for
SNOMED initiated auto T-coding: A-automatically, P-by prompt, or M-manually.

SECURITY LEVEL SPECIFIC MENU
This feature allows menus to be defined based on user security level, that is, for a
given security level, a specific menu displays for resulting this component. To use this
option, enter Security Level Specific Menu.

List each security level and ID code for which a specific menu wll be defined and follow
this with the actual menu name (refer to the Laboratory Menu - Result worksheet in
Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR
Laboratory Reference Guide* for this information). In addition to the security level-
specific menus, also specify the default menu to display for security levels not listed.

TABLE SELECTION
This feature is similar to the Multiple Table Selections option in that a table can be
accessed for result entry. However, it does not provide a choice of multiple options.
Only one option can be selected per result.

Enter Table Selection plus the name of the result table (obtained from the Result Table
worksheet). Indicate the table entry method by entering **1** or **2** (see the explanation
under the Multiple Table Selections option).

TEMPLATE PROCESSING
Template processing is used only with Cancer Protocols. This processing allows the
user to choose a cancer protocol from a defined list while in Result Entry. When
Template Processing is chosen, *Template Processing* is displayed in the field. Only
one component per test code may be defined with Template Processing.

This option does not display unless the SNOMED CT$^{®}$ field is defined as *Yes* in the
Anatomic Path Processors.

WORD PROCESSING
Word Processing results enable you to use the Softkey Editor word processor or an
interfaced PC-based word processing package to enter long textual results and/or use
standard result text.

Enter **A** for all standard result test. If a specific group of standard result text is to
display for this result, see the explanation at the beginning of this section labelled Text-
Result Subgroup.

To use this option, enter Word Processing on the worksheet and one of the following
to indicate how the standard result text is to be displayed:

1. Based on a subgroup name - Enter the subgroup name under the Based On
    column

2. Based on an ID field - Enter the component number of the ID field under the Based On column

3. Based on the ID code of the current user - Enter *User* under the Based On column

The Interpretive Word Processing component is the recipient (target) component of Standard Result Text based on Interpretive parameters. Please refer to the Interpretive Parameters Worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide.*

NOTE: The Special Test Information worksheet in Appendix B of this volume shows a reference type for Ref Lab Interface Referral. This option applies to *General* tests only.

SYSTEM FLAGS

Use the System Flags worksheet located in Chapter 1: Flags/Utilities in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* to complete the following:

MISCELLANEOUS CHARGING
Check Yes if Miscellaneous Charging is to be allowed on the system. The Miscellaneous Charging processor allows charges to be applied or credited to an account for procedures or other chargeable items associated with an ordered test but not included in the test's price.

HISTORY CARDFILE

Use the History Cardfile Flags worksheet located in Chapter 1: Flags/Utilities in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* to define the parameters required for use of the History Cardfile processors.

PROFESSIONAL BILLING

Use the Professional Billing Worksheet in Appendix B: Worksheets in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* to define the parameters required to use the Professional Billing processors.

DATA RETENTION PARAMETERS

Use the Data Retention Parameters worksheet located in Chapter 1: Flags/Utilities in the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide* to complete the following:

Define one per laboratory department.

MISC. CHARGE/CREDIT RETENTION (1-N-R)
Enter the number of days (from two to seven) to retain miscellaneous charges and credits on-line. You can view miscellaneous charges captured per account based on the number of retention days. Consider the volume of charges to be captured and the disk storage required when selecting your response.

ANATOMIC PATH PARAMETERS

Use the Anatomic Path Parameters worksheet to collect the following information. Complete a separate worksheet for each department.

DEPARTMENT CODE (3-A-R)
Enter the three-letter code for the department.

SNOMED DISPLAY/PRINT
Indicate the format in which SNOMED information will be displayed in Patient Inquiry and printed on reports by checking:

   Code Only - if only the code is to display/print

   Text Only - if only the text is to display/print

   Both - if both code and text are to display/print

AUTO-PROCESS HT AT LOGIN (1-A-R)
Indicate whether default histotech procedures should be automatically processed (labels printed, workload and miscellaneous charges captured) during Case Login when blocks are defined by checking Yes or No.

SNOMED CT
Indicate whether SNOMED CT functionality is to be used. Once defined as *Yes,* the field cannot be edited again.

SNOMED CT AP Subset
Indicate whether access to the AP Subset of the SNOMED CT concepts or the full SNOMED CT concepts when resulting the SNOMED result in AP Result reporting and Review Queue.

AUTO-DISPLAY T-CODE TABLE FOR SNOMED ENTRY
Indicate whether the T-code table should automatically display upon general category selection, that is, you are not prompted to enter a hyphen (**-**) for T-code table display in results entry.

AUTO T-CODE (1-A-R)
Auto-assignment of T-codes (topography codes) can be processed when specimen types associated with a case are entered into the system (order/accessioning, histotech processing, result reporting).

Enter **Y** to activate auto T-coding.

INDICATOR
If the previous auto T-code field is set to Yes, enter the character used to indicate text for auto T-coding.

You must enter an indicator in this field to have auto T-coding from results available. Select one of the following indicator characters (@,\,&,%,~,^,<,>,|).

HISTOTECH NUMBER
Indicate the type of histotech numbering scheme you wish to use by checking:

NOTE: Once you select the scheme to use, it **cannot** be changed.

Default - This is the original histotech numbering scheme composed of a specimen letter and a block/slide number. For example, A1 indicates block 1 for specimen A, B3 is block 3 for specimen B.

Alternate - This numbering scheme assigns a block letter (slide number) regardless of the specimen type. For example, block A indicates the first block for a specimen, block B indicates the second block, block Z indicates the 26th block for a specimen, block AA indicates the 27th block for a specimen, BB the 28th block and ZZ indicates the 52nd and last definable block for a specimen.

RECUT DESIGNATOR (6-A-O)
Enter up to six alphabetic characters to print on recut/additional slide labels when a process is used more than once in a block.

NOTE: This is only available for Bar Coded histotech labels and only when using the Alternate numbering scheme.

CARDFILE PREVIOUS CASE (1-A-R)
Indicate whether or not previous case history prints with the Draft Long Report. If the field is active, the previous case information as stored in the History Cardfile prints in the Anatomic Pathology Draft Past History report.

PREVIOUS CASE SEARCH (4-AN-C)
This field determines the length of the History Cardfile search for previous case information to be printed in the Anatomic Pathology Draft Past History Report with the Draft Long Report. The test collection date/time is compared with this field to determine which accessions are eligible for printing. This field allows the entry of a numeric value representing or All.

NOTE: The History Cardfile search for previous case information may require increased system utilization based on the time length defined in this parameter.

COMPARISON SEARCH WINDOW (4-C-R)
This field sets the length of the search window for the GYN Comparison processor. The length of the search for previous case results on a patient is defined as a set number of days back from the current system date.

Enter up to four digits to define the number of days, an **A** for All, or **N** for None. Entering None inactivates GYN Comparison processing and sets Field 11 to N/A.

Entering zero (0) days in this field sets the comparison window to only search the current day for eligible cases. This field is required.

REVIEW QUEUE COMPARISON (1-A-C)
This field activates the prompt that allows you to go directly to the GYN Comparison processor for a case, when accepting results in the review queue.

When activated, the prompt displays for all cases that meet the GYN comparison criteria. Once the GYN comparison study is complete for the test, you are returned to the review queue for processing of additional entries.

CASE LOGIN PARAMETERS

Use the Case Login Parameter worksheet to define the Case Login functionality available within each section. Case Login processing is a combination of the base system order and accession processors with modifications to streamline the process for the pathology section. AP type tests that have a case number pool assigned are processed through this processor. Multiple sections can use Anatomic Path test types (such as GYN Cytology, Non-GYN Cytology, Histology). This enables you to customize the system to meet the different workflows in each section.

DEPARTMENT CODE (3-A-R)
Enter the three-letter code for the department.

POSSIBLE CASE NUMBER POOLS (MULTIPLY-R)
This field determines which tests display in the Case Login processor for the previously defined cases. It also controls which tests can be ordered through the Case Login processor in each section. Enter case number pools that are assigned to tests to be logged in through Case Login processing.

Security Levels

The following fields allow each site the necessary security levels for all the functionality available through case login.

CASE # OVERRIDE (2-N-R)
Enter the minimum security level required to override a case number in the CaseLogin processor.

CASE MERGE (2-N-R)
Enter the minimum security level required to use the merge option for a case in the Case Login processor.

HT PROCESSING (2-N-R)
Enter the minimum security level required to access the Histotech Processing processor directly once a case has been logged into the system through the Case Login processor.

MISC CHARGE/CREDIT (2-N-R)
Enter the minimum security level required to access the Miscellaneous Charge/Credit processor directly once a case has been logged into the system through the Case Login processor.

PROFESSIONAL FEE (2-N-R)
Enter the minimum security level required to access the Professional Fee processor directly once a case has been logged into the system through the Case Login processor.

RESULT REPORTING (2-N-R)
Enter the minimum security level required to access the Result Reporting processor directly once a case has been logged into the system through the Case Login processor.

Previous Order Window Information

The advantage of defining the previous information for each day of the week for each section in the laboratory allows you the opportunity to establish the screen flow to meet your work flow requirements. Some laboratories have separate part-time staff who handle the Miscellaneous Charges or Professional Fee Billing only on certain days of the week.

The window of days can be changed to support the surgery workload. If surgical staff is at a minimum on weekends, some specimens from Friday surgery may not be received by the laboratory until Monday; during the week, all specimens from surgery are received on the same day. You can make the previous window include information for the previous four days. Some laboratories may have particularly heavy days for cytology or histology and staff who place the orders and enter results at the same time in a batch mode if many outpatient specimens are received for cytology on a certain day. The system can be set to accommodate different workflow practices on different days of the week for each section of the laboratory.

WEEK DAY (DISPLAY ONLY)
For each week day complete the following:

WINDOW (DAYS) (2-N-R)
Enter the number of days (between 0 and 99) for viewing previously ordered Anatomic Path test type tests. This flag controls the time frame to display previously ordered AP tests when entering the Case Login processor.

CASE # (1-A-R)
Enter **Y** to have the system automatically assign the case number through the Case Login processor. If you enter **N**, the system prompts you to enter the appropriate case number during the Case Login process.

HISTO (1-A-R)
This field allows you to enter Histotech Processing after accepting the Case Login screen. Enter **A** for Automatically, **N** for Never, or **P** for Prompt.

If you select **P** for Prompt, enter **Y** for a default of *Yes*, **N** for a default of *No*, or leave blank for no default.

MISC (1-A-R)
This field allows you to place miscellaneous charges. Enter **A** for Automatically, **N** for Never, or **P** to be Prompted for entry.

If you select **P** for Prompt, enter **Y** for a default of *Yes*, **N** for a default of *No*, or leave blank for no default.

PROFEE (1-A-R)
This field allows you to enter Professional Fee Billing information. Enter **A** for
Automatically, **N** for Never, or **P** to be Prompted for entry.

If you select **P** for Prompt, enter **Y** for a default of *Yes*, **N** for a default of *No*, or leave
blank for no default.

RESULT (1-A-R)
This field allows you to enter Result Reporting information. Enter **A** for Automatically,
N for Never, or **P** to be Prompted for entry.

If you select **P** for Prompt, enter **Y** for a default of *Yes*, **N** for a default of *No*, or leave
blank for no default.

CASE NUMBER POOLS

An Anatomic Path Case Number is assigned to each specimen as it is accessioned in STAR Laboratory. It serves to further identify accessioned specimens so that they can be sorted, stored, and easily retrieved for later use. The case number consists of a case number pool code, indicating the case number pool name, and a number that identifies the accessioned specimen.

The case number pool appears on accession labels. A single case number pool can be associated with more than one test within an accession.

The purpose of numbering pools is to aid in sorting and in long-term storage of specimens. They can also be a useful tool for cataloging surgical specimens in cytology or histology.

POOL CODE (1-A-R)
Enter a unique alpha code. This code should contain no punctuation and be kept as short as possible. This code concatenates with the case number pool number and prints on labels, appears in Patient Inquiry and prints on various reports.

DESCRIPTION (19-C-R)
Each case number pool name should be a unique, alphabetic name no more than nineteen (19) characters long and should include no digits or punctuation.

CURRENT VALUE (10-N-R)
The value of the last assigned number.

RESET IF POOL NUMBER IS GREATER THAN (10-N-O)
If the pool is to be recycled after a certain number is reached, a Recycling Value should be indicated. This represents one less than the maximum value to be reached before the case number pool begins a new cycle.

RESET POOL NUMBER TO (10-N-O)
The value entered here should be the number at which the new case number pool cycle begins when it is reset.

FREQUENCY (SPECIAL FORMAT-O)
The last item Frequency, is normally not completed if a Reset Value was chosen. However, it must be completed if case number pools are to be recycled on a timed basis. The choices for frequency are:

1. Hours

2. Days

3. Weeks

4. Months

5. Quarters

6. Semesters (1/2 years)

7. Years

You must be as specific as possible for frequencies. Examples of recycling frequency values that might be used are indicated as follows:

• Every eight hours

• Once per day, at midnight

• Once daily at 6:00 a.m.

• Once monthly on the first day of the month, at midnight

• Once yearly, on January 1 at midnight

NEXT RESET DATE (8-NP-O)
The system will automatically calculate this field; however, it can be edited if needed. If, for example during training, you did not want the number pool to recycle until live, you would set the live date as the next recycle date.

NO. OF LABELS (2-N-R)
Enter the default number of labels to print for each case number in the Reserve/ Generate Case #'s and the Print/Reprint Case # Labels processors.

WORKLOAD/QC (1-A-O)
This field determines the case types that are eligible for cytology workload and for quality control processing. The field is set to *No* prior to entering the builder.

The system displays the following prompt:

Activate cytology workload/QC for this case number pool? (Y/N) [Y]--

HISTOTECH PROCESSES

Generally, once the pathologist performs the gross evaluation of the specimen, a section (or sections) of the specimen is submitted for processing in histology. The number of blocks, types of stains, and other procedure-specific information needed by the histotechnologist is referred to as Histotech Processes. The Histotech Processes worksheet is used to collect the information associated with each HT process.

Complete a separate worksheet for each department.

DEPARTMENT CODE (3-A-R)
Enter the three-letter code for the department.

CODE (10-AN-R)
Enter the code for the process.

DESCRIPTION (30-AN-R)
Enter the description of the histotech process.

NOTE: The next three fields, number of replicates per block, block thickness, and number of slides per histotech process, can be defined as defaults or designated for entry when processing or adding this HT process to an accession.

NO. OF REPLICATES (2-AN-R)
Enter one of the following:

1. The number of times the process will be performed per block. (If more than one replicate is defined for the process for a given block, replicate billing is automatically captured (if defined) at processing.)

2. **P** - to allow the number to be entered at Processing.

3. **A** - to allow the number to be entered when Adding this process to a block.

THICKNESS (2-AN-R)
Enter one of the following:

1. The thickness to cut the block.

2. **P** - to allow the number to be entered at Processing.

3. **A** - to allow the number to be entered when Adding this process to a block.

NO. OF SLIDES PER BLOCK (3-AN-R)
Enter one of the following:

1. Indicate the number of slides to be setup for this process per block.

2. **P** - to allow the number to be entered at Processing.

3. **A** - to allow the number to be entered when Adding this process to a block.

PRINT SLIDE DESIGNATOR (1-A-O)

When using bar code histotech labels, you have the option of printing a slide designator (1/2, for example, which means the first of two slides). Enter **Y** to print the slide designator; enter **N** not to print. (This is not an option for conventional labels since slide designators always print on dot matrix HT labels.)

PRINT PROCESS NAME (1-A-O)

When using bar code histotech labels, you have the option of printing the histotech process label text on the slide. Enter **Y** to print label text; enter **N** not to print. (This is not an option for conventional labels since the histotech process label text always prints on dot matrix HT labels.)

NO. OF LABELS PER SLIDE (3-AN-O)

Enter the number of labels per slide to print at processing. The number of labels printed is calculated by:

(# of replicates) X (# of slides/block) X (# of labels/slide) = total # labels printed

   (Field 3)   (Field 5)   (Field 8)

The field numbers in this calculation refer to the Histotech Processes screen described in Chapter 2: Maintenance Functions in the *Anatomic Pathology Module* of the *STAR Laboratory Reference Guide* . For example, if a process is defined to have two slides/block and to be replicated twice per block, enter **1** to print a total of four labels.

LABEL TEXT (10-AN-O)

Indicate the text to print on the label (usually identifies the type or name of the HT process).

LABEL IDENTIFIER (1-A-O)

Indicate which of the following to print on the slide by entering:

- **S** for specimen type

- **P** for patient unit number

- **N** for number pool (if **N**, enter number pool)

Block Workload Information

NUMBER OF WORKLOAD COUNTS PER BLOCK (U-N-O)

Enter the number of counts to record when workload is captured at processing for this block. The system will capture 1 slide per block for block procedure codes that include 1 slide.

WORKLOAD PROCEDURE CODE (TABLE/CODE-N-O)
Enter CAP procedure code for the block workload. It must be defined in the Workload
Procedure table (General Table Data).

Block workload is calculated as follows:

(# of replicates) X (# of counts/block) X (CAP workload units) = block workload

Slide Workload Information

NO. OF COUNTS PER SLIDE (U-N-O)
Enter the number of counts for workload to be captured for each slide.

PROCEDURE CODE (TABLE LOOKUP-O)
Enter the CAP procedure code for capturing slide workload. It must be defined in the
workload procedure table (General Table Data).

Slide workload is calculated as follows:

(# of replicates) X (# of slides/block) X (# of counts/slide) X (CAP workload units) =
slide workload

Billing Information

To automatically capture charges for this histotech procedure, assign a Miscellaneous
Charge code to both the single process and to the replicate. These items have
previously been defined by your laboratory. Refer to the Miscellaneous Charge Items
worksheet in the Tables chapter of the *General Applications Volume* of the *STAR
Laboratory Reference Guide* for this information.

PROCESS BILLING
Complete this field to capture process billing.

Section Code (TABLE/CODE-O)
Enter the section code for process billing.

Miscellaneous Charge Code/Description/Price (TABLE/CODE-O)
Enter the Miscellaneous Charge Item code for this process.

REPLICATE BILLING
Complete this field to capture replicate billing.

Section Code (TABLE/CODE-O)
Enter the section code for replicate billing.

Miscellaneous Charge Code/Description/Price (TABLE/CODE-O)
Enter the Miscellaneous Charge Item code for replicates of this Histotech process.
The replicate charge is captured when this procedure is performed in multiples per
block.

HISTOTECH PROCESSES PER TEST

Because the HT processes performed are usually based on the type of specimen, the Anatomic Path module provides the capability of establishing default processes by specimen type and by test code. For each Anatomic Path test (for all or selected specimen types) default Histotech/Cytotech processes can be assigned so that blocks and processes are defined automatically at accessioning. (These processes can be manually deleted or additional ones defined in histotech processing, if necessary.)

If the department flag (Auto-Process Histotech Processes at Accessioning) and the auto-process flag for default process are set, the block(s) will be automatically processed; that is, labels print and workload units and miscellaneous charges are captured at accessioning.

Use a separate Histotech Processes per Test worksheet for each test code.

TEST CODE/NAME
Enter the test code and test name.

SPECIMEN CODE/NAME (OPTIONAL)
Default HT processes can be defined for all or selected specimen types for this test. The specimen type(s) defined on this worksheet must be among those assigned to the test in the Master Test file. A default specimen type can be used to accommodate all specimen types which are not specified. The use of a default specimen type or any specimen type is optional.

Indicate the specimen code(s) or use the first line for the default.

NUMBER OF BLOCKS
Enter the number of blocks to be defined for this specimen type.

HISTOTECH PROCESS
For each block that is performed, a default set of processes can be established. (Processes can also be added or deleted during histotech processing.) Only processes defined on the A/P - Histotech Processes worksheet can be used. Refer to that worksheet to obtain HT codes. Multiple processes can be defined for each specimen type.

NOTE: If any of the following fields are to be specified at processing, an **N** must be entered in the Process Flag column for that line:

- Number of Replicates

- Thickness

- Number of Slides

AUTO PROCESS
When a block is processed, labels are printed and workload and miscellaneous charge data is captured. Processing can be set to occur automatically at accessioning or at user command.

If the defaults for this HT process are set and auto-processing is desired, enter a **Y** for yes. The Auto Process HT at Accession flag must also be set.

If auto-processing is not desired for this HT process, enter an **N**. Remember, if the system is to prompt the user for any information at processing, this flag must not be set.

NUMBER OF REPLICATES
If the number of replicates is always the same, enter the number of times the process is to be replicated per block in this column. If the number should be specified at the time of processing, enter **P** and do not set the auto process flag to Yes.

THICKNESS
If the thickness of the section should be specified at processing, enter **P** and do not set the auto process flag to Yes. The system will prompt the technologist to enter the thickness during processing. If the thickness is always the same for the specimen type, enter the number of relative thickness.

NUMBER OF SLIDES
Enter the number of slides to be set up for this process per block. This number determines how many slide labels are produced. If the system should prompt the user at processing, enter **P** and do not set the Auto Process HT at Accession flag to Yes.

PRINT SLIDE DESIGNATOR (1-A-O)
This field is only applicable if bar coded histotech labels are to be used. If the slide designator should print on the label, enter **Y**. If it is not to print, enter **N**. The slide designator always prints on conventional dot matrix labels.

PRINT PROCESS DESCRIPTION (1-A-O)
This field is only applicable if bar coded histotech labels are to be used. If the process name (label text) is to print on the label, enter **Y**. If it is not to print, enter **N**. The process name always prints on conventional dot matrix labels.

HP AUDIT RETENTION

HP AUDIT RETENTION
This option allows you to define how long the Histo/Cytotech Audit information should be retained on the system per facility. A maximum value of 30 days will be permitted to retain the audit data.

WORKLOAD/QUALITY CONTROL

The Workload/Quality Control processor is used to view, add, or change the maintenance options included in the Cytology Workload/Quality Control feature of the system. This processor is accessed by selecting Maintenance - Anatomic Path from the Maintenance Functions menu. The following options are included in this processor:

- Cytology Personnel

- Diagnosis Categories

- Discrepancy Categories

- GYN Specimen Types

- Repeat Queue Results

- Workload/Quality Control Parameters

- Manual Workload/QC Deletion

For detailed information on these options, see the Maintenance Functions chapter of this volume.

Cytology Personnel

SCREENER NAME (TABLE LOOKUP-R)
This field contains the screener name and ID code from the employee file.

MAXIMUM SLIDE COUNT (4-N-R)
This field contains the maximum slide count that can be screened in a 24-hour period. The field accepts a 3-digit numeric entry, that can be entered in increments of 0.5; for example, 99.5 or 999.

ACTIVE QC (1-A-R)
This field enables you to activate QC for a specific screener. If you enter **Y** or press ENTER at this prompt, QC is activated. If you select **N**, an *X* displays in the QC N/A column of the table. The X indicates that the QC feature is deactivated for that screener.

Diagnosis Categories

CODE (DISPLAY ONLY)
This field displays the code. You can record it on your worksheet.

DESCRIPTION (36-AN-R)
This field enables you to enter a description of the category. You will get an error message if the description has already been used.

ACTIVE (1-A-R)
This field enables you to activate a specific diagnosis category. If you enter **Y** or press ENTER, the Diagnosis Category option is activated. If you enter **N**, an X displays in the Not Active column of the list. The option is deactivated for the specific diagnosis category.

Discrepancy Categories

CODE (DISPLAY ONLY)
This field displays the code. You can record it on your worksheet.

DESCRIPTION (36-AN-R)
This field enables you to enter a description of the category. You get an error message if the description entered has already been used.

ACTIVE (1-A-O)
This field enables you to activate a specific discrepancy category. If you enter **Y** or press ENTER, the Discrepancy Category option is activated. If you enter **N**, an X displays in the Not Active column of the table. The option is deactivated for the specific discrepancy category.

Repeat Queue Results

NAME OF TEST
This field displays the name of the test. You can record it on your worksheet.

TEST CODE
The field displays the test code. You can record it on your worksheet.

COMPONENT
This field enables you to define components for the Repeat Queue Results processor for the selected test.

PROCESS
This field enables you to enter the process you want to use to file results. You can enter **A**(Autofill) for components that do not require interpretation of the case, **D**(discrepancy) for components that should be checked for discrepancies in results entered through result reporting and the Repeat Queue, or **N**(none) for components that do not need checking.

Workload/Quality Control Parameters

ACTIVE (1-A-R)
This field determines whether this feature will be activated. You can enter **Y** or **N**.

PERCENT QC (3-N-R)
This field enables you to enter the volume level (percentage of total) of negative GYN cases to be selected by the system for QC processing. The default is *10%*. You can enter up to 100%.

NOTE: See the Maintenance Functions chapter in this volume for a detailed discussion of random selection.

AUTO HIGH RISK (1-A-R)
This field determines whether all cases defined as high risk will automatically be sent to the Repeat Queue.

NOTE: Setting this field to *Yes* results in additional cases being added to the Quality Control check process. If all high risk entries are automatically sent to the Repeat Queue, they are not included in the percent QC defined in Field 2.

DEFAULT HIGH RISK (1-A-O)
This field enables you to define a default when you enter a high risk definition on a case through the application. You can define this default based on your patient population. If you do not define the default, the field will be blank.

NUMBER OF SLIDES (2-N-O)
This field enables you to define the default used when you are prompted to enter the number of slides on a case through the application. You can enter *1* through *99* for the number of slides. If this field is left blank, the application will not have a default for the Number of Slides field.

NUMBER OF COUNTS (4-NC-O)
This field enables you to define the default used when you are prompted to enter slide counts on a case through the application. You can enter *0.5* through *99*, in increments of *0.5*, for the number of actual slide counts expected for each case. If this field is left blank, the application will not have a default for the Number of Counts field.

WORKLOAD/QC PROMPT (1-A-R)
This field determines if users who are not defined in the cytology personnel table (usually non-technical staff members) are prompted to enter QC and workload information. Options are Y for Yes and N for No. If you enter **Y**, users not defined in the cytology personnel table are prompted for QC and workload information when entering patient results in Result Reporting. If you enter **N**, the only users prompted for a screener ID are those who are defined in the cytology personnel table (both active and inactive). A person not defined in the cytology personnel table cannot enter screener workload information for another person.

NEGATIVE DIAGNOSIS CATEGORY/QC (TABLE LOOKUP-R)
The field defines which diagnosis category from the Diagnosis Categories maintenance processor is used to identify GYN cases as eligible for random selection for the QC process.   When you select a category, the Diagnosis Category code displays in the field.

WORKLOAD/QC CHANGES (TABLE LOOKUP-R)
This field enables you to enter any defined security level or selection from the table. The selected security level appears with code in brackets in the field. The system requires a defined security level to make certain changes to workload and QC.

8-HOUR CHECK (1-A-R)
This field enables you to enter **Y** or **N** to activate the 8-hour check for screener workload. When this field is set to *Yes,* the system automatically makes the 8-hour check when evaluating workload for the current 24 hours.

You must enter your results in real time--screen a case and then enter the results for that case. If your procedure does not include entry of results in real time, this field should be set to *No.* The system still monitors the maximum counts for the 24 hours, but will not invoke the check for maximum in less than 8 hours.

SNOMED CODES

NOTE: There are no worksheets necessary for SNOMED CT usage.

An abbreviated version of the SNOMED dictionary is supplied with STAR Laboratory. A list can be printed (refer to the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide* for print instructions) and used to determine the codes to add, edit or delete. Use the worksheets provided here to add dictionary entries. Worksheets must be completed in this order:

- General Categories

- M-codes

- T-codes

General Categories

CODE (2-N-R)
Enter the general category code.

DESCRIPTION (20-AN-R)
Enter the general category description.

M-codes

Use the SNOMED M-codes worksheet to collect the following information:

CODE (7-AN-R)
Enter the M-code.

DESCRIPTION (60-C-R)
Enter the M-code description.

GROUPS
Indicate the General Category (one or more) to which this M-code belongs.

ALTERNATES 1-3 (20-AN)
Enter the alternate names for M-codes. Alternate names entered are cross-referenced to the main M-code definition.

T-codes

Use the SNOMED T-codes worksheet to collect the following information:

CODE (7-C-R)
Enter the T-code.

DESCRIPTION (60-C-R)
Enter the T-code description up to 60 A/N characters.

GROUPS
Indicate the General Category (one or more) to which this T-code belongs.

DEFAULT GROUP (3-NR)
Enter the group of T-codes that display when auto T-coding is activated. Only one of the defined groups may be defined as a default. A table of the selected group numbers with descriptions displays for selection of a default.

SPECIMENS (3-N-O)
Select valid specimens that can be cross-referenced to the T-code. Multiple selections are allowed. The codes for the defined specimens display in the field. The maximum number of specimens allowed per T-code is 20.

ALTERNATE NAMES (20-AN)
Enter the alternate names for T-codes. Alternate names entered cross-reference to the main T-code definition.

M-CODE
To make diagnostic coding easier and faster, T- and M-code combinations can be established for those most commonly used by the laboratory. In order to link codes, one Master T-code must be defined **without** an M-code. Then subsets of that T-code can be combined with a predefined M-code. Enter the M-code for this T-code combination.

NOTE: The base SNOMED glossary does not include any T & M combinations or Miscellaneous codes.

MISC/ALT CODE
The miscellaneous code is used for ICD codes or any other coding scheme which reflects the T- and M-code combination. Enter miscellaneous/alternate code.

LONG REPORT PARAMETERS BY SECTION

Complete this worksheet if you use the Long Report format for an Anatomic Pathology type section. An Anatomic Pathology type section is one that has case number management or histotech processing associated with the section or has an Anatomic Pathology type test within the section range. Use a separate worksheet for each department.

For instructions to complete this worksheet and the actual worksheet form, refer to the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide*.

LONG REPORT PARAMETERS

A separate Long Reports Parameters worksheet must be defined for each test code utilizing the Long Report for Anatomic Pathology. Within the body of the report, the test results, result print order, placement of result name, and the line feeds between each result must be defined.

For instructions to complete this worksheet and the actual worksheet form, refer to the *Maintenance Worksheets Volume* of the *STAR Laboratory Reference Guide*.

Chapter 2 - Maintenance Functions

STAR Laboratory Reference Guide - Anatomic Pathology Module
October 2011   *Release 17.0*   *2–1*
Proprietary to McKesson - Subject to Confidentiality Agreement

Illustrations

INTRODUCTION

The Flags/Utilities - System Options must be set by your McKesson representative prior to build. The Flags/Utilities - Cardfile processor instructions are located in Chapter 1: Flags/Utilities in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

The following Table Data - General files must be defined prior to building Anatomic Pathology files:

- • Container Types

- • Miscellaneous Charge Items

- • Ordering Priorities (for each department)

- • Result Components

- • Result Unit Codes

- • Special Instructions

- • Specimens *

- • Send Out Laboratories

- • Workload Files

NOTE: The specimen table should contain any specimen that might be used in Anatomic Pathology. If your STAR Laboratory system is multidepartment and one department does not have the Anatomic Pathology module, use the Table Exclusion maintenance function option to exclude pathology specimens from the table for the other department(s).

The following tables must be built using the Table Data - Department processors prior to building Anatomic Pathology files:

- • Laboratory Menu - Main

- • Laboratory Menu - Section *

- • Laboratory Menu - Bay

- • Laboratory Menu - Results

- • Result Table Types

- • Result Tables

- Slide Pools

NOTE: The Anatomic Pathology section is built like all other sections of the department. If Miscellaneous Billing is to be used, include a SIM code range for the Miscellaneous Charge Items. Following is a list of the functions that can be added to the Anatomic Pathology section menu:

- Anatomic Path Order Management

- Anatomic Path Result Reporting

- Case Login

- History Cardfile

- Histotech/Cytotech Processing

- Histotech/Cytotech Processing Report

- Cytology QA

- Miscellaneous Charge/Credit

- Miscellaneous Charge Report

- Quality Control/Workload

- Professional Billing Input

- Review Queue Reporting

ANATOMIC PATHOLOGY PROCESSORS

You can build components for Anatomic Pathology tests using the Result Component processor located under Maintenance-General Test. You do not have to create a Number of Blocks component since the number of blocks defined per specimen displays on the Results Entry screen and on all patient reports (if the flag is set). You can build test files using the Maintenance-General Test processors for each Anatomic Path test.

Anatomic Pathology processors are accessed by selecting Maintenance - Anatomic Path from the Maintenance Functions menu. See the following screen example.

```
              General Hospital Maintenance Functions Processor
                                           Thu Jun 02, 2005 10:43 am

 Page:01                   Laboratory Maintenance Functions
 ( 1) Employee Data                      (18) Maintenance - Report/Printer/Fax
 ( 2) Archiving Parameters               (19) Maintenance - Sales Commission
 ( 3) Collection Walk Order              (20) Maintenance - User Preferences
 ( 4) HELP Text Edit                     (21) Maintenance - Workload
 ( 5) Maintenance - Adv Bld Bank Int     (22) Maintenance Types
 ( 6) Maintenance - Advanced Micro       (23) Maintenance Types Listing
 ( 7) Maintenance - Anatomic Path        (24) Table Data - Department
 ( 8) Maintenance - Barcode              (25) Table Data - General
 ( 9) Maintenance - Contract Billing     (26) Table Exclusions - General
 (10) Maintenance - Equip/Instrument     (27) Table Types - Department
 (11) Maintenance - Flags/Utilities      (28) Table Types - General
 (12) Maintenance - General Test         (29) Unlock accession number
 (13) Maintenance - Interface            (30) Utility - Incomplete work file
 (14) Maintenance - Lookup Grps/Chk5     (31) Utility - Recancel Test
 (15) Maintenance - PC Downloading       (32) Utility - SNOMED CT Load
 (16) Maintenance - QC
 (17) Maintenance - Recall Mgmt

 Enter choice--
```

If your system is multidepartment, you must make the appropriate table selections before proceeding.

STANDARD RESULT TEXT

The following menu contains the options specific to the Anatomic Pathology module. Each option is indexed alphabetically by the order in which the build should occur. The Standard Result Text processor is presented here because standard result text and subgroups must be built prior to building the Anatomic Path tests to which they are assigned.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                      Wed Jun 01, 2005 03:06 pm

                    Laboratory Anatomic Path Functions            Page:01
( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters           (19) Z - Standard Result Text
( 3) B - Case number pools               (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files

 Enter choice--
```

Standard Result Text is a predefined document that uses word processing during result reporting. This result can be greater than 220 characters long. The standard result text defined is used as a model for the result or for the interpretation information based on another result. The word processing capability allows you to change, add to, or delete text to reflect the specific information for the resulting patient's test.

The STAR Laboratory system enables you to create multiple standard result text documents per department. For each laboratory department, these documents can be grouped into subgroups. These subgroups can be by ID of the person resulting the test or by another subgroup name. For more information on subgroups refer to "STANDARD RESULT SUBGROUP" on page 2-26.

This processor is also located on the Table Data-Department menu.

The following table can display multiple pages and enables you to select only one option.

```
 General Hospital Maintenance Functions Processor
Community Lab                                 Mon Jun 12, 1995 01:22 pm
Standard Result Text

     Code          Description                Edit by      Edit Date   Page:01
( 1) CARDIACA      Cardiac Profile,Abnormal   Tech, Tommy  12/04/94 1201
( 2) CARDIACN      Cardiac Profile,Normal     Tech, Tommy  12/04/94 1401
( 3) NEGATIVE      Drug Screens, Negative     Tech, Tommy  12/03/94 1801
( 4) POSITIVE      Drug Screens, Positive     Tech, Tommy  12/03/94 1201
( 5) CKINTERP      Interpretation for CK Iso  Tech, Tommy  12/03/94 1401
( 6) LDHINTER      Interpretation for LDH Iso Tech, Tommy  12/03/94 1501
( 7) LIPIDA        Lipid Profile, Abnormal    Tech, Tommy  12/03/94 1701
( 8) LIPIDN        Lipid Profile, Normal      Tech, Tommy  12/03/94 1601




Enter option to edit, add(A) or delete(D)--
```

This screen displays a table of the standard result text documents defined for the department. This screen accesses the edit, add, and delete functions for the documents.

The Edit function changes the description of the standard result text and updates the actual word-processing document.

The Add function creates a new standard result text code, description, and document.

The Delete function removes a standard result text code, description, and word-processing document that is no longer used.

Edit

The Standard Result Text Edit function enables you to update the description of the standard result text or to edit the text for the document.

```
 General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 01:22 pm
Standard Result Text

( 1)Code           : CARDIACN
( 2)Description    : Cardiac Profile, Normal

( 3)Edit by        : King,Ruth A.
( 4)Edit date      : 04/28/95 1126
( 5)Text           : Defined




Enter field number or '/' starting field number ---

 [Help]   [List]   [Next]   [Previous]   [Date]   [Time]   [Exit]   [LogOff]   [View]
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for the standard result text. If you access this field, the following message displays:

Error: Field cannot be edited!

2. DESCRIPTION (25-C-R)
The description displays in this field. The description can be edited using the // editor. If the description matches that of another standard result text for the test, the system displays the following message and allows editing of the description:

Description already in use!

The description displays:

- In results entry, when you enter the standard result text code after the table of standard results, text displays for word-processing results entry.

- When you are building the standard result subgroups.

3. EDIT BY (DISPLAY ONLY)
This field is automatically completed by the system and cannot be edited. This field contains the name of the person who previously edited the information on this screen or edited the text of the document.

4. EDIT DATE (DISPLAY ONLY)
This field is automatically completed by the system and cannot be edited. This field contains the date and time that the information on this screen or the text of the document was previously edited.

5. TEXT (SPECIAL PROCESSING-R)
This field displays *Defined* if result text has been defined for this summary. The text is required for acceptance of this screen.

When you access this field, the Softkey Editor or Word Processing Interface is invoked. If text has been defined, that text may be edited using either tool. If no text has been defined, new text can be entered.

WARNING: If an unfilled textual result field is selected and no changes are made, the field will not be filled in and no textual result data will be retained for the field. For example, if you select one or more precanned text files for a textual result field but make no changes to the text, the selected text fields will not be retained for the result field. To retain changes to textual results, no matter which type of STAR word processing is used, you must make a change to the text.

For information on the Softkey Editor, refer to Chapter 10: Softkey Editor in the *General Information Volume* of the *STAR Laboratory Reference Guide.* For information on the Windows-based Word Processing interface, refer to Chapter 4: Word Processing Interface in the *STAR Navigator User's Guide*.

When you use the Word Processing Interface, the uploaded file is checked for information. If this file is empty, the system displays *Undefined* in this field.

If you exit the Softkey Editor or Word Processing Interface without entering text, the previous screen redisplays and the Test field still displays *Undefined*. In this case, you cannot accept the screen and the system displays the following error message:

Standard Result Text must be entered in order to file!

When you complete all fields and accept the screen, the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

When you enter **Y** or press ENTER to accept the screen, the system displays the following message:

Filed!

Enter **N** to edit.

Impact

After you complete this screen, the standard result text is immediately available to:

- Be added to a subgroup

- Be used in result reporting

Add

Enter **A** to add a new standard result text.

If no standard result text has been previously defined, system displays the following screen:

```
General Hospital Maintenance Functions Processor
Community Lab                                  Mon Jun 12, 1995 01:22 pm
Standard Result Text




















Enter standard result text code--
```

Enter the code of the standard result text. The code can be up to 12 characters and must be unique for the laboratory department. The system displays the code in uppercase.

When you enter a code that is already in use, the system displays the edit screen. To view this screen refer to "Edit" on page 2-9.

When you enter a new code, the system displays the following screen:

```
 General Hospital Maintenance Functions Processor
Community Lab                                    Mon Jun 12, 1995 01:22 pm
Standard Result Text - Chemistry

( 1)Code        : CPK > 500
( 2)Description  :

( 3)Edit by      :
( 4)Edit date    :
( 5)Text         :









Enter description--
```

For information on the fields on this screen refer to "Edit" on page 2-9.

Impact

After the Standard Result Text has been accepted, it is available for:

- Adding to a subgroup

- Using in result reporting for word processing results that will display all documents for the test.

Delete

If a Standard Result Text becomes obsolete, you can use the delete function to remove the code, description, and the text. This will not affect any of the patient results that used this Standard Result Text as a model.

```
                  General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 01:22 pm
Standard Result Text

    Code               Description                Edit by      Edit Date  Page:01
( 1) CARDIACA          Cardiac Profile,Abnormal   Tech, Tommy  12/04/94 1201
( 2) CARDIACN          Cardiac Profile,Normal     Tech, Tommy  12/04/94 1401
( 3) NEGATIVE          Drug Screens, Negative     Tech, Tommy  12/03/94 1801
( 4) POSITIVE          Drug Screens, Positive     Tech, Tommy  12/03/94 1201
( 5) CKINTERP          Interpretation for CK Iso  Tech, Tommy  12/03/94 1401
( 6) LDHINTER          Interpretation for LDH Iso Tech, Tommy  12/03/94 1501
( 7) LIPIDA            Lipid Profile, Abnormal    Tech, Tommy  12/03/94 1701
( 8) LIPIDN            Lipid Profile, Normal      Tech, Tommy  12/03/94 1601




Enter option to edit, add(A) or delete(D)--
```

When you enter **D** for delete, the system displays the following prompt:

Enter option to delete--

If more than one page of standard result text exists, you can enter a slash (*/*) to access
the next page.

Enter the option number for the text you want to delete. In this example, the Cardiac
Profile, Abnormal standard result text is selected. The system checks whether the
result text is used in a subgroup. If it is in a subgroup, the following screen displays:

```
General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 01:22 pm
Standard Result Text

Warning: Deletion removes Standard Result Text from Subgroups as well!

Page:01  CARDIACN - Cardiac Profile, Normal is part of the following subgroups:
( 1) Cardiac Profiles
( 2) CPK Interpretations
( 3) Dr Smith's CK Interpretations








Delete CARDIACN  Cardiac Profile, Normal? (Y/N)[N]--
```

This table displays up to 28 subgroups in a two-column format. The system truncates the descriptions of the subgroups to 25 characters. The subgroups display in alphabetic order in the left-most column first, and then continue in the second column. If you continue with the delete of the standard result text that has subgroup assignments, the system displays the following message:

CARDIACN-Cardiac Profile, Normal and subgroup associations deleted!

If the standard result text does not have any subgroup assignments, the system displays the following message:

CARDIACN-Cardiac Profile, Normal deleted!

If you do not want to delete this standard result text, enter **N** for No or press ENTER.

Impact

When a standard result text is deleted, the system:

- Deletes the code and description of the standard result text

- Deletes the text

- Deletes the standard result text from all subgroups

- Is no longer available for display in result reporting

NOTE: If a standard result text is assigned as part of the interpretive reporting parameters and the SRT is deleted, it is not deleted from the interpretive reporting parameters. You must remove the triggering criteria for that standard result text. For more information on interpretive report parameters, refer to Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

In result reporting, if a trigger criteria for interpretive reporting is met and the SRT assigned to the trigger has been deleted, the system displays the prompt for word processing.

STANDARD RESULT TEXT RTF FILES

The Standard Result Text RTF files function allows you to generate Rich Text Format (RTF) versions of the Anatomic Pathology Standard Result Text files. The RTF versions of the precanned text files are then available for use in the Windows-based word processing interface. This function is available when you select the Maintenance - Anatomic Path option.

NOTE: You must have a security level of 80 or higher and be signed into STAR Laboratory using STAR Navigator to access this function. The McKesson Windows-based word processing interface must also be installed along with a McKesson-supported Windows word processor.

```
                       General Hospital Maintenance Functions Processor
 Laboratory                                           Wed Jun 01, 2005 03:06 pm

                       Laboratory Anatomic Path Functions              Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Select the Standard Result Text RTF Files option. This processor is also located on the Table Data Department menu.

Upon entering the function, the following warning message displays:

Warning!This function will create Rich Text Format (RTF) versions of precanned text files for use in the Windows-based word processing interface. Only the precanned text files for the selected facility or department will be processed.

All of the implementation steps for the Windows-based word processing interface should be completed BEFORE using this function.

Do you wish to continue? (Y/N) [N]--

To exit the Standard Result Text RTF Files function, enter **N**. To proceed to the Standard Result Text RTF Files screen, enter **Y**.

The Standard Result Text RTF Files Processor displays.

```
 General Hospital Standard Result Text RTF Files Processor
Community Lab                                     Mon Jun 12, 1996 01:22 pm
Standard Result Text Print

(1) Department          :  General Hospital
(2) Files to Process    :  43
(3) Word Processor      :  Microsoft Word 6.0 for Windows
(4) Overwrite?          :  No









Enter field number or '/' starting field number--
```

Field Explanations

1. DEPARTMENT (TABLE LOOKUP-R)
This field is used to display the name of the selected department. If you have access to more than one department and would like to select another one, select this field. The list of departments you can access displays. Select the department for which you want to process summary result text.

2. FILES TO PROCESS (DISPLAY ONLY)
This field is used to display the number of summary result text files that are to be processed for the selected department.

3. WORD PROCESSOR (TABLE LOOKUP-R)
This field is prefilled with the name of the word processor that you selected in the Windows Word Processing User Preferences function. To display the list of available word processors, enter a hyphen (**-**). Select the word processor to use to create the RTF versions of the summary result text files.

4. OVERWRITE? (1-A-R)
This field is used to indicate whether or not to replace existing RTF versions for the summary result text files. The default is *No.* Selecting this field displays the following warning and prompt:

Warning!Answering "Yes" will cause the existing RTF versions of the precanned text files, along with any fonts and formatting characteristics, to be lost because the files will be replaced.

Overwrite existing RTF versions of the precanned text? (Y/N) [N]--

If you do not want the existing RTF versions of the summary result text files to be replaced, enter **N**. To overwrite (replace) the files, enter **Y**.

When the screen is accepted, the system begins processing the summary result text files. If the selected Windows word processor is not loaded, STAR loads the word processor for you.

The number of files to be processed displays on the screen. The following message displays showing the status:

Processing files! Please wait!

If a summary result text file is being updated elsewhere, a message and prompt display:

File is in use! Retry(R), Abort(A), or Continue(C) with next file?--

NOTE: There is a timeout period of two hours that allows you to leave your PC without having to worry about missing messages.

Take one of the following actions:

- To retry processing the file, enter **R**.

- To abort and exit the function, enter **A**.

- To skip the file and continue the processing with the next file, enter **C**.

If you entered **A**, the following message displays:

Precanned text file processing aborted! Press NL to continue--

Press ENTER to return to the list of Anatomic Path Maintenance options.

If you entered **C**, you can restart the function with the Overwrite? field set to No. Any summary result text files that do not have an RTF version will have one created if they are still not being revised.

When all of the summary result text files are processed, the system displays the following message and prompt:

Precanned text file processing completed! Press NL to continue--

Press ENTER to return to the list of Anatomic Path Maintenance options.

STANDARD RESULT TEXT PRINT

The Standard Result Text documents can be printed individually, in multiple documents, or by subgroup. This printout of the documents provides hard copy documentation of your reporting protocol per laboratory section. This function is available when you select the Maintenance - Anatomic Path option.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                           Wed Jun 01, 2005 03:06 pm

                       Laboratory Anatomic Path Functions           Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Select the Standard Result Text Print option. This processor is also located on the Table Data Department menu.

```
                    General Hospital Maintenance Functions Processor
 Community Lab                                         Mon Jun 12, 1995 01:22 pm
 Standard Result Text Print

  1 Options to Print                    2 Printer
    All                                   West side Printer Near AP Lab












 Enter field number or '/' starting field number--
```

Field Explanations

1. OPTIONS TO PRINT (1-A-R)

Standard Result Text documents can be printed individually, in multiples, by subgroup, or all together. When this field is accessed, the system displays the table of Standard Result Text with the following prompt:

> *Enter option(s) to print, subgroup selection (S), or all (A) documents--*
>   *end selection(NL)*

If you choose to print one document, the SRT code displays in the field. If you choose to print more than one document, Multiple displays in the field. If you choose to print all documents, All displays in the field.

If you choose to print documents by subgroup, the table of subgroups displays. When you select one subgroup, the code displays in the field suffixed with Subgroup(s). When you select more than one subgroup, Multiple Subgroup(s) displays in the field. When you select all subgroups, All Subgroup(s) displays.

2. PRINTER (TABLE LOOKUP-C)

The system prints the report on the General Laboratory Printer. After you select the printer and the screen is accepted, the system displays the following message:

> *Printing!*

Output

The hard copy of Standard Result Text documents the reporting of the standard word processing text. The report can include all documents or selected documents. The report is sorted by Standard Result Text description for those reports that have more than one SRT selected. The report is sorted alphabetically by description of the subgroup when more than one subgroup is selected.

Header

The first line of the reports contains the print date and time, title, and page number. The second line contains the laboratory department. The third and fourth line contain the inclusion criteria. This criteria is:

- • All documents within the laboratory department

- • All documents for a subgroup within the laboratory department

- • All documents for selected subgroups within the laboratory department

- • Selected documents within the laboratory department

- • A single document

Body of Report

The body of the report contains the code and description of the Standard Result Text and the actual text.

At the end of the report, the system prints the *End of Report* message.

The following report example shows all Standard Result Text documents in a department.

Figure 2.1 Standard Result Text for all Documents (ALGRLGR0)

```
 Printed: 05/07/95 1549              Standard Result Text                    Page: 01
                                     Community Laboratory
                                      For all documents

     -------------------------------------------------------------------------------
     Appendix, Microscopic (APPXM)

     This is the microscopic description for appendix.

     -------------------------------------------------------------------------------
     Appendix,Normal (APPX)

     The appendix is * by * cm, weighs * grams, is * in color,
     and appears * in character.

     -------------------------------------------------------------------------------
     Autopsy - Adult (PADLT)

     General Description:
          This is the body of a  _____  weighing _____  and by
     actual measurement _____ cm. long, properly identified as the
     above named patient; with _____ scalp hair; with _____ irides;
     with _____ symmetrically dilated to _____ mm.

          The body is with(out) palpable thyroid gland, cervical,
     supraclavical, axillary or inguinal lymph nodes; with the chest
     _____.  The breasts are_____.  The abdomen is
     _____.

           There is (no) evidence of external injuries_____.

           There is _____ posterior postmortem lividity; with _____
      postmortem rigidity; and with _____ residual body heat.

      Primary Incision:
           The subcutaneous fat in the midline of the trunk in front is
       _____ coarsely lobulated, and at the level of the umbilicus
       has a thickness of _____cm..  The skeletal muscles on the front
       of the trunk are _____  and the muscular development is
       _____. The lymph nodes in the right and left axillary
      fossae are_____.

          The peritoneum
     is_____.

          The urinary bladder
     is_____.

          The spleen
     is_____.

          The lower margin of the left lobe of the liver is _____ cm.
     _____ the tip of the xiphoid process in the midline.  The lower
     margin of the right lobe of the liver is _____ cm. _____ the costal
     margin in the right anterior axillary line.  There are _____
     changes in the lesser space of the peritoneum.  The foramen
     epiploicum is _____. The appendix vermiformis is
     _____.

                                    (Continued)
```

The following report example illustrates printing a Standard Result Text subgroup.

If more than one subgroup was selected, the report is sorted alphabetically by subgroup description. The standard result text documents sorts alphabetically by description. Each subgroup begins on a new page.

Figure 2.2 Standard Result Text for a Subgroup (ALGRLGR0)

```
 Printed: 05/07/95 1549              Standard Result Text              Page: 01
                                     Community Laboratory
                            For Subgroup 123X Laboratory, Manager

    --------------------------------------------------------------------------------
    Appendix, Microscopic (APPXM)

    This is the microscopic description for appendix.

    --------------------------------------------------------------------------------
    Appendix,Normal (APPX)

    The appendix is * by * cm, weighs * grams, is * in color,
    and appears * in character.

    --------------------------------------------------------------------------------
    Autopsy - Adult (PADLT)

    General Description:
         This is the body of a  _____  weighing _____  and by
    actual measurement _____ cm. long, properly identified as the
    above named patient; with _____ scalp hair; with _____ irides;
    with _____ symmetrically dilated to _____ mm.

         The body is with(out) palpable thyroid gland, cervical,
    supraclavical, axillary or inguinal lymph nodes; with the chest
    _____.  The breasts are_____.  The abdomen is
    _____.

         There is (no) evidence of external injuries_____.

         There is _____ posterior postmortem lividity; with _____
    postmortem rigidity; and with _____ residual body heat.

    Primary Incision:
         The subcutaneous fat in the midline of the trunk in front is
    _____ coarsely lobulated, and at the level of the umbilicus
    has a thickness of _____cm..  The skeletal muscles on the front
    of the trunk are _____ and the muscular development is
    _____. The lymph nodes in the right and left axillary
    fossae are_____.

         The peritoneum
    is_____.

         The urinary bladder
    is_____.

         The spleen
    is_____.

         The lower margin of the left lobe of the liver is _____ cm.
    _____ the tip of the xiphoid process in the midline.  The lower
    margin of the right lobe of the liver is _____ cm. _____ the costal
    margin in the right anterior axillary line.  There are _____
    changes in the lesser space of the peritoneum.  The foramen
    epiploicum is _____. The appendix vermiformis is
    _____.

                                   (Continued)
```

The following report example illustrates printing one Standard Result Text document.

Figure 2.3 Standard Result Text Individual Document (ALGRLGR0)

```
Printed: 05/10/95 1334            Standard Result Text                  Page:01
                                  Community Laboratory
                                 Individual Document Print
                                  For UB50 Uterus BSO
     --------------------------------------------------------------------------
     Uterus BSO (UBSO)

     The first specimen, labeled "mesenteric lymph node", consists of a
     single fragment of tan lymph node measuring    mm in the largest
     dimension.  Frozen section shows_____.  It is entirely
     submitted in___.

     The second specimen consists of a resected uterus and the attaches
     bilateral fallopian tubes and ovaries.  The right tube measures___cm
     in length.  The right ovary measures _____ cm in size.   Representative
     sections are submitted in__.  The left tube measures __cm in length.
     the left ovary measures ____ cm in size.  Representative sections are
     submitted in__.  The uterus weighs  grams and measures __ x __ cm in
     size.  On cut sections, the endometrium is less than __mm in thickness.
     The myometrium measures __cm in the thickest area.  Sections of uterine
     cervix are submitted in __.  Sections of the body of the uterus are
     submitted in __through__.

     The third specimen consists of a segment of rectosigmoid and the
     attached anal tissue.  The entire specimen measures __cm in length.
     The anal muscoa and skin measure __cm in length.  Right above the
     dentate line, a longitudinal depressed area is seen.  This area measures
     ___cm in length and __cm wide. Sections of the proximal margin of
     resection are submitted in __.  Sections of the distal margin of
     resection are submitted in __ through __.  The entire rectal lesion is
     submitted in ___ through __.   The anal mucosa shows a __ mm, light
     yellowish submucosal nodule just below the dentate line.  It is
     submitted in __.  A small firm lymph node measuring __mm in size is
     present within the soft tissue surrounding the rectal lesion.
     Sections of this lymph node and anal soft tissue are submitted in __.


                                 End of Report!
```

STANDARD RESULT SUBGROUP

The Standard Result Subgroup groups Standard Result Text documents. These groupings can be based on the ID of the person resulting the test or by another subgroup name, such as specimen type, diagnosis, or any other category established by the laboratory.

The subgroups based on the ID of the person resulting the tests are generally used for pathologists who have unique ways of reporting textual findings. The other type of subgroup is typically at the section level. For example, some Standard Result Text documents may be unique to Cytology and others unique to Anatomic Pathology.

```
                        General Hospital Maintenance Functions Processor
 Laboratory                                           Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions              Page:01
( 1) A - Anatomic Path Parameters          (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters             (19) Z - Standard Result Text
( 3) B - Case number pools                 (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files

 Enter choice--
```

Select the Standard Result Subgroups option from the Laboratory Anatomic Path Functions menu. This processor is also located on the Table Data Department menu.

A screen displays with the list of defined standard result subgroups. If you have no subgroups defined, the system displays the following prompt:

Enter Subgroup code or ID(I) specific code--

```
                 General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 01:22 pm
Standard Result Subgroups


        Code           Description              Edit by          Edit Date  Page:01
( 1) ANATOMIC       ANATOMIC PATHOLOGY       Smith,Janet F    11/09/94 0935
( 2) CARDIAC-CK     CARDIAC CK COMMENTS      Smith,Janet F    11/15/94 1532
( 3) CARDIAC-LD     CARDIAC LD COMMENTS      Smith,Janet F    11/15/94 1532
( 4) HIV            HIV INTERP VALUES        Smith,Janet F    11/12/94 1735
( 5) HIV NEG        HIV Negative Screen      Smith,Janet F    11/12/94 1735
( 6) HIV POS        HIV Positive Screen      Smith,Janet F    11/12/94 1734
( 7) PAPDX          PAP SMEAR DIAGNOSIS      Smith,Janet F    11/12/94 1749
( 8) A NEG          RHNEG COMMENT FOR A NEG  Smith,Janet F    11/12/94 1743
( 9) A2 NEG         RHNEG COMMENT FOR A2 NEG Smith,Janet F    11/12/94 1744
(10) A2B NEG        RHNEG COMMENT FOR A2B NEG Smith,Janet F   11/12/94 1745
(11) AB NEG         RHNEG COMMENT FOR AB NEG Smith,Janet F    11/12/94 1743
(12) O NEG          RHNEG COMMENT FOR O NEG  Smith,Janet F    11/12/94 1745




Enter option to edit, add(A) or delete(D) subgroup--
```

This screen displays a table of the standard result subgroups defined for the
department. This screen accesses the add, edit, and delete functions for the
documents.

The Add function creates a new standard result subgroups code, description, and
document.

The Edit function changes the description of the standard result subgroups and
updates the actual word processing document.

The Delete function removes a standard result subgroups code, description, and word
processing document that is no longer used.

Add

When you select the add(A) option from the Standard Result Subgroups screen, the
system displays the following prompt:

   Enter Subgroup code or ID(I) specific code--

The subgroup code you enter at this prompt displays on the next screen. Enter up to
12 characters. The system displays the code in uppercase. The format of the code
can include numerics, alphabetic character, and punctuation. To access the list of
laboratory users, enter **I** and select the user. That user's ID code becomes the code
for the subgroup.

NOTE: A subgroup with the code of *i* or *I* is not allowed.

After you enter the subgroup code, the system displays the edit screen.

Edit

The Edit function enables you to build or modify subgroups for Standard Result Text documents by completing the fields on the following screen.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                     Mon Jun 12, 1995 01:22 pm
Standard Result Subgroup

 1 Code               2 Description          3 Edit by              4 Edit date
   122                  Smith II,Jon           Johnson,Deb J           04/30/95 1012


 5 Grouped Standard Result Text
   Code          Description
   APPXM       -  Appendix, Microscopic
   PADLT       -  Autopsy - Adult
   PGAPA       -  Appendix - Appendicitis
   PGAPN       -  Appendix, Normal
   PGBRS       -  Breast (Mastectomy)
   PGGLB       -  Gall Bladder
   PGINT       -  Intestine
   PGNDL       -  Needle Biopsy
   APPX        -  Normal Appendix
   PGSKB       -  Skin Biopsy
   UBSO        -  Uterus BSO


Enter field number or '/' number to edit--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The subgroup name you entered on the previous screen displays. It cannot be edited.
If this field is accessed, the system displays the following message:

Error: Field cannot be edited !

2. DESCRIPTION (25-C-R)
Enter the description of this subgroup. If this description is already used within the laboratory department, the system displays the following message:

Description already used!

The system displays the following prompt:

Enter description--

Up to 25 characters may be entered.

3. EDIT BY (DISPLAY ONLY)
The system automatically completes this field, which cannot be edited. This field contains the name of the person who previously edited or added information on this screen, or previously added or deleted standard text documents.

4. EDIT DATE (DISPLAY ONLY)
The system automatically completes this field, which cannot be edited. This field contains the date and time that the information on this screen was previously edited or added, or the date and time that the Standard Result Text document was previously added or deleted.

5. GROUPED STANDARD RESULT TEXT (SPECIAL PROCESSING-R)
This field is used to add and delete Standard Result Text documents for this group. The system displays the following prompt:

Enter Standard Result Text code or - for table--

At least one Standard Result Text document must be added to the group before the group is accepted. There is no limit to the number of Standard Result Text documents that can be added to a group.

When you complete all fields and accept the screen, the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

When you enter **Y** or press ENTER to accept the screen, the system displays the following prompt:

Filed!

Enter **N** if you do not want to accept the changes to this screen.

Impact

The Standard Result Subgroup is available to assign to a result, using word processing in the Results and Normals maintenance processor. The subgroup is also available for printing standard result text documents using the Standard Result Text Print processor.

Delete

You can delete a subgroup by selecting the **D** option from the original prompt in the Standard Result Subgroup processor.

```
                General Hospital Maintenance Functions Processor
Community Lab                                    Mon Jun 12, 1995 01:22 pm
Standard Result Subgroups


        Code          Description              Edit by        Edit Date  Page:01
( 1) ANATOMIC      ANATOMIC PATHOLOGY        Smith,Janet F   11/09/95 0935
( 2) CARDIAC-CK    CARDIAC CK COMMENTS       Smith,Janet F   11/15/95 1532
( 3) CARDIAC-LD    CARDIAC LD COMMENTS       Smith,Janet F   11/15/95 1532
( 4) HIV           HIV INTERP VALUES         Smith,Janet F   11/12/95 1735
( 5) HIV NEG       HIV Negative Screen       Smith,Janet F   11/12/95 1735
( 6) HIV POS       HIV Positive Screen       Smith,Janet F   11/12/95 1734
( 7) PAPDX         PAP SMEAR DIAGNOSIS        Smith,Janet F   11/12/95 1749
( 8) A NEG         RHNEG COMMENT FOR A NEG    Smith,Janet F   11/12/95 1743
( 9) A2 NEG        RHNEG COMMENT FOR A2 NEG   Smith,Janet F   11/12/95 1744
(10) A2B NEG       RHNEG COMMENT FOR A2B NEG  Smith,Janet F   11/12/95 1745
(11) AB NEG        RHNEG COMMENT FOR AB NEG   Smith,Janet F   11/12/95 1743
(12) O NEG         RHNEG COMMENT FOR O NEG    Smith,Janet F   11/12/95 1745




Enter option to edit, add(A) or delete(D) subgroup--
```

When you select a subgroup to delete, the system displays a message with the code and description of the standard result subgroup:

8093-Dr. John Smith II deleted!

The system returns to the list of standard result subgroups and the original (edit/add/delete) prompt.

When you complete all fields and accept the screen, the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

When you enter **Y** or press ENTER to accept the screen, the system displays the following prompt:

Filed!

You can enter another subgroup. Enter **N** to edit.

Impact

When a standard result text is deleted, the system:

- Deletes the code and description of standard result text

- Deletes the text

- Deletes the standard text from all subgroups

- Is no longer available for display in result reporting

Printing a Standard Result Subgroup Report

As you exit the Standard Result Subgroup processor, the system displays the following prompt:

Do you want a printed list? (Y/N) [N]--

If you enter **Y** to print, the system displays a list of general report printers for your selection. See the following example of a printed Standard Result Subgroup Report.

Figure 2.4 Standard Result Subgroup Report (ALGRLGR0)

```
 Printed: 05/07/95 1409              Standard Result Subgroups              Page:01
                                      Community Laboratory

   Subgroup (Code)                           Standard Result Text Documents
   --------------------------------------------------------------------------------
   Andres,Jem J (122)                        Appendix - Appendiciti (PGAPA)
                                             Appendix, Microscopic (APPXM)
                                             Appendix, Normal (PGAPN)
                                             Autopsy - Adult (PADLT)
                                             Breast (Mastectomy) (PGBRS)
                                             Gall Bladder (PGGLB)
                                             Intestine (PGINT)
                                             Needle Biopsy (PGNDL)
                                             Normal Appendix (APPX)
                                             Skin Biopsy (PGSKB)
                                             Uterus BSO (UBSO)

   ANNETT,JAMES A (111)                      Abnormal CPK (CPKABNORM)
                                             Normal CPK (CPKNORM)

   BARNARD,DIANE (001)                       Abnormal CPK (CPKABNORM)
                                             Normal CPK (CPKNORM)

   BROWN,GHFGHJ (156)                        None defined

   CPK Interpretations (CPK)                 Abnormal CPK (CPKABNORM)
                                             Normal CPK (CPKNORM)

   LDH Interpretations (LDH)                 Abnormal LDH (LDHABNO)
                                             Normal LDH (LDHNORM)

                              End of Report
```

Report Layout

The Standard Result Subgroup report is sorted first alphabetically by description of the subgroups, then alphabetically by the standard result text.

Report Header

REPORT PRINTED DATE AND TIME
The first field in the report header is the date and time the report was printed. The date and time are left justified on the report.

REPORT NAME
The name of this report, *Standard Result Subgroups,* prints centered on the same line with the Report Printed Date And Time field.

PAGE NUMBER
The page number prints right justified on the same line with the Report Name field.

DEPARTMENT NAME
The laboratory department name prints centered on the second line of the report header.

Report Body

SUBGROUP NAME/CODE
The first column of data is the subgroup name followed by the subgroup code in parentheses.

STANDARD RESULT TEXT DOCUMENT NAME/CODE
The second column of data contains the standard result text document names followed by the document code in parentheses.

If a subgroup has more than two standard result text documents, and the report has the space to print only one of the document names, the subgroup and standard result text document names print on the following page.

TEST FILES

Test files must be built prior to assigning histotech processes per test and defining the Long Report for each test code. Certain fields within the test builders are specific to Anatomic Pathology tests. Only these fields are covered in this document. Refer to the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide* for further details on building test files.

```
                General Hospital Maintenance Functions Processor
                                           Thu Jun 02, 2005 10:43 am

Page:01                     Laboratory Maintenance Functions
( 1) Employee Data                     (18) Maintenance - Report/Printer/Fax
( 2) Archiving Parameters              (19) Maintenance - Sales Commission
( 3) Collection Walk Order             (20) Maintenance - User Preferences
( 4) HELP Text Edit                    (21) Maintenance - Workload
( 5) Maintenance - Adv Bld Bank Int    (22) Maintenance Types
( 6) Maintenance - Advanced Micro      (23) Maintenance Types Listing
( 7) Maintenance - Anatomic Path       (24) Table Data - Department
( 8) Maintenance - Barcode             (25) Table Data - General
( 9) Maintenance - Contract Billing    (26) Table Exclusions - General
(10) Maintenance - Equip/Instrument    (27) Table Types - Department
(11) Maintenance - Flags/Utilities     (28) Table Types - General
(12) Maintenance - General Test        (29) Unlock accession number
(13) Maintenance - Interface           (30) Utility - Incomplete work file
(14) Maintenance - Lookup Grps/Chk5    (31) Utility - Recancel Test
(15) Maintenance - PC Downloading      (32) Utility - SNOMED CT Load
(16) Maintenance - QC
(17) Maintenance - Recall Mgmt

Enter choice--
```

Access the Maintenance - General Test menu. If your system is multidepartment, you must select the appropriate department before continuing.

Main Information/Labels

The first fields specific to Anatomic Pathology tests are located under the Main Information/Labels processor.

```
          General Hospital Administration Maintenance Functions Processor
Laboratory                                           Mon Sep 17, 2001 01:51 pm

Page:01                 Laboratory Test Maintenance Functions
( 1) A - Result Components               (18) Maintenance types - Test
( 2) B - Create NEW TEST                 (19) Maintenance types list - Test
( 3) C - Result and Normals              (20) Z - Charge Component/Rept Def
( 4) C - Service Item Maintenance        (21) Z - Component/Test Xref
( 5) D - Calculations                    (22) Z - Default Section/Test Xref
( 6) D - Cell Counter - Keypad Assign    (23) Z - Hemogram display for test
( 7) D - Cell Counter - Parameters       (24) Z - Main Information/Labels
( 8) D - Crosslinks                      (25) Z - Partials for Pat. Inquiry
( 9) E - Cleared Results                 (26) Z - Update test from components
(10) E - Group Assign - Instrument       (27) Z - Utility - Delinquent Criteria
(11) E - Group Assign - Worksheet        (28) Z - Utility - Duplicate/Conflict
(12) E - Interdepartment Test Codes      (29) Z - Utility - Overlap Report
(13) E - Review Queue                    (30) Z - Utility - Panel Definition Re
(14) E - Test Method Assignment
(15) F - Format Exception Report
(16) F - Interp Reporting Parameters
(17) F - Long Report

Enter choice--
```

Select this processor. The following prompt displays:

Enter test code or first letters `-` --

```
            General Hospital Maintenance Functions Processor
Community Lab                                        Mon Jun 12, 1995 01:22 pm
Section - Anatomic Pathology
Bay - SPT-Anatomic Pathology
GROSS AND MICRO Options                                     Test Code - 4401

( 1) ALLSTAR Information
( 2) Basic Test Information
( 3) Special Test Information

( 4) Collection Labels
( 5) Accession Labels
( 6) Interdepartment Referral/Sendout Labels




Enter option(s) to edit Lab(L) or all(A)--
```

Indicate the Anatomic Path test, using one of the table entry techniques described in
Chapter 4: Information Entry Techniques in the *General Information Volume* of the
STAR Laboratory Reference Guide.

BASIC TEST INFORMATION

The screen displays the section, bay and test code/name in the upper left of the
screen. Select the Basic Test Information option from this menu. The system displays
the following screen:

```
                    General Hospital Maintenance Functions Processor
Community Lab                                        Mon Jun 12, 1995 01:22 pm
Section - Anatomic Pathology
Bay - SPT-Anatomic Pathology
GROSS AND MICRO Options                                       Test Code - 4401
 1 Test Name                         2 Short Name          3 Test Type
   GROSS AND MICROSCOPIC               G&M                  -> Anatomic Path
 4 Default Sect  5 Possible Specimens                    6 Default Specimen
   HIS            TABLE                                     3 A-Line
 7 Specimen Collect Requirements    8 Max Spec Age  9 Order Category/Sample Size
                                                       R,A,S
10 Performing Bay(s),Section(s)                         11 Orderable Test
   7-HIS                                                   Table & Code
12 History Cardfile       13 Cardfile Print Queue   14 Range Heading
   Automatic                 Yes                           Default
15 Misc Charge Pro Fee     16 Pro Fee Processing
   Yes                       Yes
( 1) General
( 2) Advanced Microbiology
( 3) Anatomic Pathology
( 4) Advance Blood Bank

Enter option --
```

Field Explanations

NOTE: For detailed information on fields not explained in this section, refer to the
Maintenance Functions Volume I of the *STAR Laboratory Reference Guide.*

3. TEST TYPE (1-N-R)
This field displays *Anatomic Path*, if the test type selection from the table is Anatomic
Pathology.

SPECIAL TEST INFORMATION

From the Maintenance Functions processor, select the Special Test Information
processor.

```
                General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 01:22 pm
Section - Pathology
Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC Results and Normals                  Test Code - 4401

( 1) ALLSTAR Information
( 2) Basic Test Information
( 3) Special Test Information

( 4) Collection Labels
( 5) Accession Labels
( 6) Interdepartment Referral/Sendout Labels




Enter option(s) to edit, Lab(L) or all(A)--
```

Only the Anatomic Path Case Number Pool, Single Column Primary, and T-Code
Specimen Selection fields are documented here. Refer in the *Maintenance Functions
Volume I* of the *STAR Laboratory Reference Guide* for an explanation of the other
fields on this screen.

```
                General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 01:22 pm
Section - Pathology
Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC Results and Normals                  Test Code - 8586
 1 Test Type          2 Master Test              3 Reference Type
   Anatomic Path         ANATOMIC PATH TEST        N/A
 4 Number Pools                                 5 Anatomic Path Case Number Pool
   S                                              S Surgical
 6 Single Col. Primary 7 Inq. results in Rev.Q  8 Inq. Result Display security
   Yes                   Yes                      Yes
 9 Display Partials    10 Panic Report Security 11 T-Code Specimen Selections
   Yes
                                                 Specimen Display
12 Security Crosslinks    13 Incomplete  14 Delinquent   15 Resulting   16 Patient
Inquiry
                             Yes           15 Days         Yes            Yes




Enter field number or '/' starting field number--
```

Field Explanations

5. ANATOMIC PATH CASE NUMBER POOL (TABLE LOOKUP-R)
The Anatomic Path Case Number Pool is used to assign a case number to each
Anatomic Path test at login. When this field is accessed, a table of case number pools

displays. Select a single case number pool from the list by entering the option number. The case number format is:

First character of case number pool code_____Year - Case Number sequence number. Examples include: S93-100, C93-199.

6. SINGLE COLUMN PRIMARY FORMAT
For each test indicated as an Anatomic Pathology test type, this field defaults to *Yes* and cannot be edited.

11. T-CODE SPECIMEN SELECTION (1-A-O)
This field is used to select the location of defined specimens for the auto T-coding process. The following prompt displays if the department-level flag is set to allow auto T-coding and an indicator character has been added at the department level:

   Select T-Code specimens from login(L), histotech(H), or result entry(R)--

If an indicator at the department level is not entered, but auto T-Coding is allowed, the following prompt displays:

   Select T-Code specimens from login(L) or histotech(H)--

This field can only be accessed if the test type is Anatomic Pathology and the department level flag is set to allow auto T-coding. If the test is not an Anatomic Path test type, or the department flag is not set to allow auto T-coding, N/A displays in the field, and the system does not allow the field to be edited.

If the test meets the necessary criteria, based on the option selected, the following options display in the field:

   L - Login   H - Histotech   R - Result Entry

Results and Normals

Access the Results and Normals processors used to assign results to tests. Both special processing options required to accommodate the resulting features of anatomic path tests, as well as the History Cardfile field are located within this processor.

```
         General Hospital Administration Maintenance Functions Processor
Laboratory                                          Mon Sep 17, 2001 01:51 pm

Page:01                  Laboratory Test Maintenance Functions
( 1) A - Result Components              (18) Maintenance types - Test
( 2) B - Create NEW TEST                (19) Maintenance types list - Test
( 3) C - Result and Normals             (20) Z - Charge Component/Rept Def
( 4) C - Service Item Maintenance       (21) Z - Component/Test Xref
( 5) D - Calculations                   (22) Z - Default Section/Test Xref
( 6) D - Cell Counter - Keypad Assign   (23) Z - Hemogram display for test
( 7) D - Cell Counter - Parameters      (24) Z - Main Information/Labels
( 8) D - Crosslinks                     (25) Z - Partials for Pat. Inquiry
( 9) E - Cleared Results                (26) Z - Update test from components
(10) E - Group Assign - Instrument      (27) Z - Utility - Delinquent Criteria
(11) E - Group Assign - Worksheet       (28) Z - Utility - Duplicate/Conflict
(12) E - Interdepartment Test Codes     (29) Z - Utility - Overlap Report
(13) E - Review Queue                   (30) Z - Utility - Panel Definition Re
(14) E - Test Method Assignment
(15) F - Format Exception Report
(16) F - Interp Reporting Parameters
(17) F - Long Report

Enter choice--
```

When you select the Results and Normals option from the menu, the system displays the following:

```
         General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 02:26 pm
Section - Pathology                                Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

   S=Special Proc'ing,R=Recall Mgt    17 Results for Test 5050        Page:01
( 1) S10689A Date of Surgery          (15) S10696A#Review Queue
( 2)  10690A Physician                (16) S10513A Released By
( 3)  10508A*Clinical History         (17)  10515A*SNOMED Code 3
( 4)  10691A Specimen Source
( 5) S10498A*Frozen Section
( 6) S10509A Gross Description
( 7) S10499A Grossed by
( 8) S10504A*Microscopic Exam
( 9) S10500A*Read by
(10) S10488A Diagnosis
(11) S10505A*SNOMED Code 1
(12) S10514A*SNOMED Code 2
(13)  10384A*Comment
(14) S10703A#Transcriptionist

Enter option to edit or add(A)--
```

The Result and Normals function allows editing of an individual component without having to select the edit feature and then address the component to edit. The following prompt displays for a test that has been resulted:

Enter option to edit or add (A)--

When you access this screen for a test that has not been resulted, the following prompt displays:

Enter option to edit, add(A), delete(D) or move(M)--

When you select an option, the system displays the following screen:

```
        General Hospital Administration Maintenance Functions Processor
Laboratory                                        Mon Sep 17, 2001 01:54 pm
Section - Pathology                               Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Date of Surgery                   Component #: 10689A

 1 Required/Optional        2 External/Internal      3 History Cardfile
   Required                   External                 Yes
 4 Special Processing
   Date and/or time - Jan 02, 1986
 5 Workload                                          6 Addendum Only


                    * COMPONENT PARAMETERS - DISPLAY ONLY *
 7 Delta Check              8 Valid Range            9 Valid Values
   Not Defined                Not Defined              Not Defined
10 Panic Values            11 Normal Ranges
   Not Defined                Not Defined
12 Recall Management                               13 Number of Decimals


Enter field number or '/' starting field number--
```

Field Explanations

Fields 1 through 3 and 7 through 12 on the Results and Normals screen are typically specified at the time the test is created. For more information on these fields, refer to Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide.*

4. SPECIAL PROCESSING (SPECIAL FORMAT-R)
Once the test has been resulted, you can change only special processing options of the same type of data storage. For example, you cannot change the component defined as word processing to any other special processing option. Nor can you change a test defined as any special processing option *other than word processing,* to word processing.

If a test has not been resulted, the system displays a table of all possible component options for the test type. Once you result the test, the system displays only the options that do not affect the storage of previously resulted components.

The following is a detailed explanation of options available for this field. The SNOMED Code option is restricted to Anatomic Path tests only.

(1) AUTO FILL ID
Select this Special Processing option. The following prompt displays. (No default exists.)

Auto fill and allow table(T) or menu(M) or no(N) edit? --

When this option is defined, in result entry the result field automatically fills with the ID of the person signed on to the terminal. Indicate how, if allowed, this file can be edited by entering:

- **T** to allow edits by selecting an ID from a table. When this option is selected, a list of Defined Tables displays for selection. Select the table to use to edit this result field. The Special Processing field displays *Auto fill ID* plus the table description.

- **N** to prevent the ID from being edited. When this option is selected, *Auto fill ID* displays in the Special Processing field.

- **M** to allow edits by selecting from a menu. When this option is selected, the following prompt displays:

    Select result menus from current section(C) or all(A)? [current section]--

Enter:

- **C** or press ENTER to display Result Menus built for this section only.

- **A** to display all existing result menus.

Select the menu to display when editing this result. The Special Processing field displays *Auto fill ID* plus the menu description.

(2) AUTO FILL ID/REQUIRED COMPLETE
This option is identical to option 1, Auto Fill ID, except that it also controls the appearance of a prompt in reporting. The prompt is:

Prevent release of this report? [N]--

When this option is attached to a result, this prompt appears upon selection of a report in a review queue. Auto fill ID/required complete is generally reserved for the Release by result component in tests set up for Review Queues. Refer to Chapter 6: Test Processing in the *General Applications Volume I* of the *STAR Laboratory Reference Guide* for further details.

To assign this option to a result, enter **2**. The ID of the person signed on is automatically captured in result entry. No other response is required. When this option is selected, the Special Processing field displays Auto fill ID/required complete.

(3) COMMENT PROCESSING

When you assign comment processing to a component and an accessioning comment is present, the system displays the comment in result reporting so you can select the comment to fill in the component.

(4) DATE AND/OR TIME

If this is a date and/or time result, enter **4**. A list of Date/Time Formats displays for selection along with the following prompt:

Enter option for date/time display [1 Jan 86 0900] --

Select the desired display type. The Special Processing field displays Date and/or time - followed by the date/time option selected. This field only controls how the date and time display once entered. Within result entry, you are allowed to enter date/time entries, using data entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

(5) FREE FORM TEXT

This is the default for this field and allows free text entry of numeric and textual results. Select option 5 or press ENTER for the default. The Special Processing field displays *Free form text.*

(6) ID SPECIFIC MENU

This feature allows you to assign result menus to specific individuals so that, within result entry, the menu which displays depends on either the person signed on or an ID entered in another result field. When this option is selected, the following prompt displays:

Enter `I` for User ID or `R` for result determined ID [R]--

Enter:

- **I** to determine the menu by the ID of the person signed on. The list of Result Menus for this section displays for selection. Select the menu to use as the default for this result (the one to display when a specific menu is not indicated). The Employee table then displays for selection.

    Select employees to define ID specific menus-

    Select the employee(s) to assign ID-specific menus. Once employee selection is complete, a list of Result Menus displays and, one by one, the prompt displays each selected employee and allows you to select the menu to display for that ID. The Special Processing field displays *ID Specific Menu - User ID.*

- **R** to define the menu to display based on a previous result. The screen lists all the results for this test. Select an ID result (one that will contain an ID code

upon result entry) from the list. A list of Result Menus for this section displays. Select the menu to be used as the default for this result.

Upon menu selection, the Employee Table displays for selection plus the following prompt:

Select employees to define ID specific menus--

Select as many employees as needed to set up ID-specific menus. Once employee selection is complete, a list of Result Menus displays and, one by one, the prompt presents each selected employee and allows you to define the menu to display when that user is resulting this test. The Special Processing field displays *ID Specific Menu - Result determined.*

(7) MENU SELECTION ID
Assigning this option requires that the result always be an ID result. A menu of IDs must be selected to display at result entry.

Select result menus from current section(C) or all(A)? [current]--

Enter **C** or press ENTER to display Result Menus built for this section only or enter **A** to display all existing Result Tables. Select the menu to display when entering this result. Menu Selection ID plus the menu description displays in the Special Processing field when this option is selected.

(8) MENU SELECTION
This option causes a result menu to display within result entry. Enter **8** to select this option. The following prompt displays:

Select result menus from current section(C) or all(A)? [current]--

You must indicate which menu to display. Enter **C** or press ENTER to select result menus from this section only, or enter **A** to select from all result menus. Enter the option number of the menu to display. You can only select one menu. Menu Selection plus the menu description displays in the Special Processing field when this option is selected.

(9) MULTIPLE TABLE SELECTIONS
This option allows result entry by multiple selections from a table. Enter **8** and select from the list of Defined Tables displayed on the screen. The table selected here will display at result entry. Upon table selection, the following prompt displays:

Allow code entry/alpha lookup from table? (Y/N) --

To automatically display the table at result entry, enter **N**; the Special Processing field displays Multiple table selections. To allow table lookup by code entry and/or alpha lookup, enter **Y**; the Special Processing field displays Multiple table selections plus the name of the selected table.

(10) PROMPT PROCESSING

When you assign prompt processing to a component and a prompt response comment is present, the system displays the prompt in result reporting so you can select the prompt to fill in the component.

(11) SNOMED CODE

SNOMED code special processing restricts the number of SNOMED Codes to 50 per component. You can also select the word processing component or components used for specimen definition with the auto T-coding process, when you have auto T-coding set to automatic or prompt.

After you select the SNOMED Code result type, a test-level flag determines the location for the selection of specimens for auto T-coding. If auto T-coding is allowed for this test (after you select the SNOMED CODE result type), the following prompt displays:

Initiate auto T-coding automatically(A), by prompt(P) or manual(M)--

One of the following displays, based on the option selected:

    Automatically - SNOMED Code - Auto

    Prompt - SNOMED Code - Prompt

    Manual - SNOMED Code - Manual

The Automatic option means the system automatically displays the first defined specimen for T-coding in result reporting, based on T-code definitions. If multiple specimens are defined, the additional specimens display automatically with corresponding T-code definitions.

If you select the prompt option, the specimens defined to be auto T-coded display in result reporting. The system allows you to select an individual specimen, add a new specimen, or delete an existing specimen from the list.

The manual option requires you to select a group prior to selecting T-codes in result reporting. Specimens are not used with this option. No automatic T-coding occurs with this option.

NOTE: If SNOMED CT is active, the only option for this field is *Manual*. If this field is previously set to Automatic or Prompt, the setting is ignored and the system performs as if the setting is Manual.

If the test-level flag is set to NOT allow auto T-coding for this test, SNOMED Code - Manual displays in the field.

If the test-level flag is set to select the specimens for auto T-coding from result entry, and the field is set to automatically (auto - A) or by request (prompt - P) auto T-code,

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an additional table displays with a list of all the word processing result type components for this test. One or multiple components can be selected. The word processing components selected are used for defining the specimens that are used for auto T-coding in result reporting.

This field uses the multiple table selection. When you enter this field in edit mode, the previously selected word processing components are highlighted.

The list of components may exceed one screen. In this situation, the bottom line of the screen reflects the location:

> *end selection(NL) next page (/)*

> or

> *end selection(NL) previous Page (/p)*

(12) SECURITY LEVEL SPECIFIC MENU
This feature allows you to assign result menus to specific security levels so that, within result entry, the menu that displays depends on the security of the person signed. Enter **12** to assign this option to the result. The list of Result Menus for this section displays for selection. Select the menu to use as the default for this result (the one to display when the user's security level is not one assigned to a specific menu). The Security Levels table then displays for selection.

> *Select Security Levels to define specific menus-*

Select the security level(s) to assign specific menus. Once selection is complete, a list of Result Menus displays and, one by one, the prompt displays each selected security level and allows you to select the menu to display for that level. The Special Processing field displays *Security Level Specific Menu -*.

(13) TABLE SELECTION
This option allows result entry by selection from a table. It is identical to option 9 except that only one selection can be made from the table. Enter **13** and select from the list of Defined Tables displayed on the screen. The table selected here will display at result entry. Upon table selection, the following prompt displays:

> *Allow code entry/alpha lookup from table? (Y/N) --*

To automatically display the table at result entry, enter **N**, the Special Processing field displays Table selection. To allow table lookup by code entry and/or alpha lookup, enter **Y**, the Special Processing field displays Table selection plus the name of the selected table.

(14) TEMPLATE PROCESSING
Template processing is used only with Cancer Protocols. This processing allows the user to choose a cancer protocol from a defined list while in Result Entry. When

Template Processing is chosen, *Template Processing* is displayed in the field. Only one component per test code may be defined with Template Processing.

This option does not display unless the SNOMED CT field is defined as *Yes* in the Anatomic Path Processors.

(15) WORD PROCESSING

NOTE: Please refer in the *Maintenance Functions Volume* of the *STAR Laboratory Reference Guide* for Word Processing/Interpretive Reporting information.

This option allows result entry by word processing. The system displays the following prompt:

Access all Std Result Text(A), Interpretive(I) or limit to a subgroup(S)? [A]--

You can use any of three types of word processing options:

- One option is to display *all* of the Standard Result Text documents in result reporting when this component is resulted for this test. If you want all of the documents to display, enter **A** for all. When you enter **A**, the system displays the following in this field:

  Word Proc. - All Std Result Text

- The second option is to use the *interpretive reporting* parameters to complete this component with a Standard Result Text document. The interpretive reporting parameters enable you to complete this field with a pre-defined standard result text based on the value of another result component in the test. Enter **I** to use Standard Result Text based upon interpretive reporting. When you enter **I,** the system displays the following in this field:

  Word Proc. - Interpretive Parameters

- The third option is to limit the display of available Standard Result Text to a *subgroup*. Enter **S** for subgroups. These subgroups can be categorized by ID type, based on result field or general subgroup type. The ID type of subgroup displays only when the person resulting the test has established a subgroup using their ID code as the subgroup code. A subgroup based on the results of another component can display in this result field. A general subgroup type is not ID code-specific, nor based on results of another component. An example of a general subgroup type is PAP Interpretations.

  If you select subgroups as the word processing option, the system displays the following prompt:

  Specific subgroup(S), based upon result(R) or current(C) ID subgroup?[C]--C

Enter **C** or press ENTER to display the subgroup that matches the ID code of the person currently signed on and resulting this test. The system displays *Word Proc.-Std Result Text for Current ID* in the Special Processing field:

```
          General Hospital Administration Maintenance Functions Processor
Laboratory                                         Mon Sep 17, 2001 01:54 pm
Section - Pathology                                Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Date of Surgery                    Component #: 10689A

 1 Required/Optional        2 External/Internal        3 History Cardfile
   Required                   External                    Yes
 4 Special Processing
   Date and/or time - Jan 02, 1986
 5 Workload                                         6 Addendum Only


                        * COMPONENT PARAMETERS - DISPLAY ONLY *
 7 Delta Check             8 Valid Range              9 Valid Values
   Not Defined               Not Defined                Not Defined
10 Panic Values           11 Normal Ranges
   Not Defined               Not Defined
12 Recall Management                                13 Number of Decimals


Enter field number or '/' starting field number--
```

Enter **S** to display the table of subgroups and to select a subgroup to display when this result component is accessed in result reporting.

Specific subgroup(S), based upon result(R) or current(C) ID subgroup? [C]--

The system displays the subgroups for your selection:

```
          General Hospital Maintenance - General Test Processor
Laboratory                                         Mon Jun 12  1995 03:43 pm
Section - Pathology                                Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Diagnosis                          Component #: 10488A

 1 Required/Optional        2 External/Internal        3 History Cardfile
   Required                   External                    Yes
 4 Special Processing

 5 Workload                                         6 Addendum Only
Page:01                 Standard Result Subgroups for LAB
( 1) FROZ-FROZEN SECTION SUBGROUP
( 2) B444-1-B444 LAB PATHOLOGIST
( 3) 5 IR OPTIONS-5 OPTIONS RESULT
( 4) ANATOMIC-ANATOMIC PATHOLOGY




Enter choice--
```

In this example, the frozen section subgroup was selected. The system displays *Word Proc.-Std Result Subgroup FROZEN* in the Special Processing field:

```
        General Hospital Administration Maintenance Functions Processor
Laboratory                                      Mon Sep 17, 2001 01:54 pm
Section - Pathology                             Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Date of Surgery                 Component #: 10689A

 1 Required/Optional      2 External/Internal      3 History Cardfile
   Required                 External                 Yes
 4 Special Processing
   Date and/or time - Jan 02, 1986
 5 Workload                                      6 Addendum Only


                    * COMPONENT PARAMETERS - DISPLAY ONLY *
 7 Delta Check            8 Valid Range            9 Valid Values
   Not Defined              Not Defined              Not Defined
10 Panic Values          11 Normal Ranges
   Not Defined              Not Defined
12 Recall Management                             13 Number of Decimals


Enter field number or '/' starting field number--
```

Enter **R** to define the component whose result will define the subgroup displayed in this result field.

Specific subgroup(S), based upon result(R) or current(C) ID subgroup? [C]--

The system displays the table of results for your selection:

```
        General Hospital Maintenance - General Test Processor
Laboratory                                      Mon Jun 12, 1995 03:43 pm
Section - Pathology                             Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Diagnosis                       Component #: 10488A

 1 Required/Optional      2 External/Internal      3 History Cardfile
   Required                 External                 Yes
 4 Special Processing

 5 Workload                                      6 Addendum Only
Page:01              Results for GROSS AND MICROSCOPIC - TISSUE
( 1) 10690- Physician
( 2) 10508-*Clinical History
( 3) 10691- Specimen Source
( 4) 10499- Grossed by
( 5) 10500-*Read by
( 6) 10384-*Comment
( 7) 10696-#Review Queue
( 8) 10515-*SNOMED Code 3

Enter choice--
```

The components that you can select are those that do not have the following special processing attached:

- • Word Processing

- • Units X Matched

- • Date/Time

- • SNOMED Code

- • Auto Fill

- • Auto Filled Required

In this example, the specimen source result was selected. The system displays *Word Proc.-SRT based on result Specimen Source* in the Special Processing field:

```
        General Hospital Administration Maintenance Functions Processor
Laboratory                                       Mon Sep 17, 2001 01:54 pm
Section - Pathology                              Bay - HIS-Pathology Bay
GROSS AND MICROSCOPIC - TISSUE Results and NormalsTest Code - 5050

Component Name: Date of Surgery                  Component #: 10689A

 1 Required/Optional        2 External/Internal      3 History Cardfile
   Required                   External                 Yes
 4 Special Processing
   Date and/or time - Jan 02, 1986
 5 Workload                                       6 Addendum Only


                    * COMPONENT PARAMETERS - DISPLAY ONLY *
 7 Delta Check              8 Valid Range          9 Valid Values
   Not Defined                Not Defined            Not Defined
10 Panic Values            11 Normal Ranges
   Not Defined                Not Defined
12 Recall Management                              13 Number of Decimals


Enter field number or '/' starting field number--
```

When STAR Laboratory finds a match between the result in the Specimen Source field and a standard result subgroup code, the system displays that subgroup in the Gross Description field in result reporting.

Refer to the Special Processing Options in Results and Normals table under Results and Normals in Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide* to view the table that describes the special processing options in Results and Normals. The columns across the table specify the special processing options that are defined for a component. Once a test is resulted, only results stored in the same format (the same types of special processes) are allowed as changes to the components.

The processes listed down the left side of the table are possible special processing options. A *Y* in the table indicates that the option is allowed when you change the

special processing. An *N* in the table indicates that the option does not display as possible editing options for a resulted test.

For example, if you define components with *free form text* as the special processing option, refer to the column heading labels at the top of the table and find the Free Form Text column. Checking all entries in that column you find that once a test is defined as *free form text,* you can change the field to:

- Comment processing

- ID specific menu

- Menu selection ID

- Menu selection

- Multiple table sections

- Prompt processing

- Security level specific menu

- Table selection

- Units X-match processing

NOTE: Recall Management special processing is defined in the Result Components maintenance processor. If this option is present in the Special Processing field, it cannot be changed through this processor.

SPECIAL PROCESSING OPTIONS IN RESULTS & NORMALS			
1. Auto Fill ID	5. Free Form Text	9. Multiple Table Sections	13. Table Selection
2. Auto Fill ID/Req'd Comp	6. ID Specific Menu	10. Prompt Processing	14. Template Processing
3. Comment Processing	7. Menu Selection ID	11. SNOMED Code	15. Word Processing
4. Date and/or Time	8. Menu Selection	12. Security Level Specific Menu	

The preceding numbers correspond to the given numbers on the chart below.

Options Display in Table	Test Resulted with Special Processing Option															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	Y	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N
2	Y	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N
3	N	N	N	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
4	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N
5	N	N	Y	N	N	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
6	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
7	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
8	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
9	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
10	N	N	Y	N	Y	Y	Y	Y	Y	N	N	Y	Y	N	Y	Y
11	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N
12	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
13	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
14	N	N	N	N	N	N	N	N	N	N	N	N	N	Y	N	N
15	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	Y
16	N	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	Y	N	N	Y

5. WORKLOAD (TABLE LOOKUP-C)
Access to this field depends on how the Workload Type field in the Test/Collection Workload processor (located on the Maintenance - Workload menu) is defined for this test.

If workload is assigned at the test level, this field displays the CAP procedure code defined and cannot be edited here. If workload is not to be captured for this test, the field displays two asterisks (**) and cannot be edited. If workload is by result, select the procedure code from the Procedure table.

6. ADDENDUM ONLY (1-A-O)
This field determines whether the result will be included with addendum only reports.

ANATOMIC PATH PARAMETERS

Access the Anatomic Pathology processors by selecting Maintenance - Anatomic Pathology from the Maintenance Functions menu. If your system is multidepartment, you must make the appropriate table selections before proceeding.

```
                General Hospital Maintenance Functions Processor
                                           Thu Jun 02, 2005 10:43 am

Page:01                    Laboratory Maintenance Functions
( 1) Employee Data                    (18) Maintenance - Report/Printer/Fax
( 2) Archiving Parameters             (19) Maintenance - Sales Commission
( 3) Collection Walk Order            (20) Maintenance - User Preferences
( 4) HELP Text Edit                   (21) Maintenance - Workload
( 5) Maintenance - Adv Bld Bank Int   (22) Maintenance Types
( 6) Maintenance - Advanced Micro     (23) Maintenance Types Listing
( 7) Maintenance - Anatomic Path      (24) Table Data - Department
( 8) Maintenance - Barcode            (25) Table Data - General
( 9) Maintenance - Contract Billing   (26) Table Exclusions - General
(10) Maintenance - Equip/Instrument   (27) Table Types - Department
(11) Maintenance - Flags/Utilities    (28) Table Types - General
(12) Maintenance - General Test       (29) Unlock accession number
(13) Maintenance - Interface          (30) Utility - Incomplete work file
(14) Maintenance - Lookup Grps/Chk5   (31) Utility - Recancel Test
(15) Maintenance - PC Downloading     (32) Utility - SNOMED CT Load
(16) Maintenance - QC
(17) Maintenance - Recall Mgmt

Enter choice--
```

This menu contains the options specific to the Anatomic Pathology module. Each option is indexed alphabetically by the order in which the build should occur.

```
                General Hospital Maintenance Functions Processor
Laboratory                                 Wed Jun 01, 2005 03:06 pm

                    Laboratory Anatomic Path Functions          Page:01
( 1) A - Anatomic Path Parameters     (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters        (19) Z - Standard Result Text
( 3) B - Case number pools            (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files

Enter choice--
```

Access the Anatomic Path Parameters processor. The following screen displays:

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                          Wed Jun 01, 2005 03:35 pm


  1 SNOMED Display/Print             2 Auto Process HT at Login
    Both Code & Text                   Yes
  3 SNOMED CT                        4 SNOMED CT AP Subset

  5 Auto display T-Code Table for SNOMED Entry   6 Auto T-Code  7 Indicator
    Yes                                            Yes              @
  8 Histotech Number                9 Recut Designator
    Default                           RECUT
 10 Cardfile Previous Case         11 Previous Case Search
    Both                               5 days
 12 Comparison Search Window       13 Review Queue Comparison
      N2 days                          No

 14 Download File Path



 Enter field number or '/' starting field number--
```

Field Explanations

1. SNOMED DISPLAY/PRINT (1-A-R)
Indicate the format in which SNOMED information will be displayed in Patient Inquiry and printed on reports by entering one of the following letters. (There is no default.)

- **C** - if only the SNOMED code is to display/print

- **T** - if only the SNOMED text is to display/print

- **B** - if both the SNOMED code and text are to display/print

When SNOMED CT is active, the recommended setting is (**B**)oth.

2. AUTO-PROCESS HT AT LOGIN (1-A-R)
Indicate whether default histotech procedures should be automatically processed (labels printed, workload and miscellaneous charges captured) when the case is logged in to the system. This field is required. The following prompt displays:

Auto process histotech processes at login? (Y/N)--

Enter **Y** (Yes) to automatically process histotech processes at login. Enter **N** (No) if you do not want to automatically process at login. The default is *No.*

3. SNOMED CT (1-A-R)
When this field is accessed the following prompt is displayed:

Use SNOMED CT (Y/N)?-

If you enter **N**, *No* is displayed in the field. If you enter **Y**, *Yes* is displayed in the field and you are able to utilize SNOMED CT functionality. Once defined as *Yes,* the field cannot be edited again.

The system checks for existence of the SNOMED CT (concepts) database (%SCT) in order for this parameter to be defined as *Yes.* If the database does not exist, the following error message is displayed:

Error: No SNOMED CT file exists!

If the field is defined as *Yes*, functionality currently used by SNOMED II is disabled. The functionality affected is related to Auto Display Of The T-Code Table, Auto T-coding, and its associated indicator.

4. SNOMED AP SUBSET (1-A-R)
This field is reversible.

When this field is accessed, the following prompt is displayed:

Use SNOMED CT AP Subset (Y/N) [Y]--

If you enter **Y**, you only have access to the AP Subset of the SNOMED CT concepts when resulting the SNOMED result in AP Result reporting and Review Queue.

If you enter **N**, you have access to the full SNOMED CT concepts file when resulting the SNOMED result in AP Result Reporting and Review Queue.

5. AUTO-DISPLAY T-CODE TABLE FOR SNOMED CODE ENTRY (1-A-R)
Indicate whether the T-code table should automatically display upon general category selection; you are not prompted to enter a hyphen (**-**) for T-code table display. This field is required. The following prompt displays:

Auto display T-code table for SNOMED result entry? (Y/N) [Y]--

Enter **Y** to display T-code table automatically. Enter **N** to prompt for T-code table display. The default is Yes.

NOTE: If field 3, SNOMED CT, is defined as *Yes,* this field is filled with *N/A* and cannot be edited.

6. AUTO T-CODE (1-A-R)
This field is used to determine whether auto T-coding is allowed in the resulting of SNOMED code components for this department. This field is required. The following prompt displays:

Allow auto T-Coding? (Y/N) [N]--

The default for this prompt is **N**. If you enter **N**, No displays in the field.

NOTE: If field 3, SNOMED CT, is defined as *Yes,* this field is filled with *N/A* and cannot be edited.

7. INDICATOR

The character entered in this field is used in resulting Word Processing result components that are searched for T-code specimens. If the Auto T-Code field is set to *Yes*, the Indicator field becomes available with the following prompt:

Enter character (@,\,&,%,~,^,<,>,|) to indicate text for auto T-Coding--

The Indicator field is not required. You must enter an indicator in this field to have auto T-coding from results available.

If the Auto T-Code field, is set to No, *N/A* is displayed in Auto-Display T-Code Table For SNOMED Code Entry field. If the SNOMED CT field is defined as *Yes,* this field is filled with *N/A* and cannot be edited. However, if this field is defined with an indicator when the SNOMED CT field is defined as *Yes*, the indicator remains. Review of historical reports where the indicator was previously used is not affected.

8. HISTOTECH NUMBER (1-A-R)

Indicate the type of histotech numbering scheme you wish to use by entering:

- **D** for the default histotech numbering scheme composed of a specimen letter and a block/slide number.

- **A** for the alternate numbering scheme which assigns a block letter (slide number) regardless of the specimen type.

The default histotech numbering scheme (**D** above) is composed of a specimen letter and a block/slide number. For example, A1 indicates block 1 for specimen A, B3 is block 3 for specimen B.

The alternate numbering scheme assigns a block letter (slide number) regardless of the specimen type. For example, block A indicates the first block for a specimen, block B indicates the second block, block Z indicates the 26th block for a specimen, block AA indicates the 27th block for a specimen, BB the 28th block and ZZ indicates the 52nd and last definable block for a specimen.

NOTE: Once your system is LIVE, the scheme selected **cannot** be changed.

9. RECUT DESIGNATOR (6-A-O)

Enter up to six alphabetic characters to be printed on recut/additional bar code slide labels when a process is used more than once in a block.

NOTE: This can only be used for Bar Coded histotech labels when using the Alternate numbering scheme.

10. CARDFILE PREVIOUS CASE (1-A-R)
This field determines if you are prompted to print previous cardfile information through results reporting and/or at case login. When you access the field, the following prompt displays:

Print previous history at draft(D), case login(L), both(B), or none(N)--

If you enter Draft, Login, or Both, the following prompt displays to determine the default that displays when print previous cardfile information is requested:

Use default response of yes(Y) or no(N)? (NL for no default)--

To set a default for when you are prompted to print previous cardfile information, enter Y for a default of Yes or N for a default of No. A user defined default is not required. Press ENTER for no default. You are prompted to enter **Y** or **N**.

If you do not want to be prompted, enter **N** for None. None is displayed in the Cardfile Previous Case field and N/A is displayed in the Previous Case Search field.

11. PREVIOUS CASE SEARCH (4-AN-C)
This field determines the length of the History Cardfile search window for previous case information to be printed during case log in and/or along with the Draft Long Report when you are accepting Anatomic Pathology results. The test collection date/time is compared with this field to determine which accessions are eligible for printing. When you access this field the following prompt displays:

Enter number of days for previous case search or All(A)--

With a numeric entry, the number and the word days display in the field and indicate a History Cardfile search for a specific number of days prior to the current date. If you enter **A**, the word All displays in the field and indicates a search of the entire History Cardfile. The History Cardfile search crosses all patient accounts and is limited to Anatomic Pathology type tests only.

NOTE: The History Cardfile search for previous case information may require increased system utilization based on the length of time defined in this parameter.

12. COMPARISON SEARCH WINDOW (4-C-R)
This field sets the length of the search window for the GYN Comparison processor. The length of the search for previous case results on a patient is defined as a set number of days back from the current system date.

The search includes all eligible cases that are either in history cardfile (including backloaded data) or active patient data from all departments and facilities that meet the GYN Comparison search criteria. The search is based on the collection date for all eligible cases. The following prompt displays:

Enter number of days for comparison search, all(A) or none(N)--

Enter up to four digits to define the number of days, an **A** for All, or **N** for None. Entering None inactivates GYN Comparison processing and sets Field 11 to N/A. Entering zero (0) days in this field sets the comparison window to only search the current day for eligible cases. This field is required.

13. REVIEW QUEUE COMPARISON (1-A-C)
This field activates the prompt that allows you to go directly to the GYN Comparison processor for a case, when accepting results in the review queue.

When activated, the prompt displays for all cases that meet the GYN comparison criteria. Once the GYN comparison study is complete for the test, you are returned to the review queue for processing of additional entries. The following prompt displays:

Perform comparison study through review queue? (Y/N)--

Enter **Y** to be prompted through the application to perform a GYN comparison on the case once results are filed through the review queue processor. Enter **N** not to be prompted.

If **Y** is entered, the following prompt to determine the default for the review queue comparison prompt displays:

Use default response of yes(Y) or no(N)? (NL for no default)--

Enter **Y** to display a default of *Yes* when prompted to perform a GYN comparison from the review queue. Enter **N** to display a default of *No*. A user defined default is not required. Pressing ENTER to bypass the default definition for the prompt.

If the Comparison Search Window field is set to None, then *N/A* displays in this field and it cannot be edited.

Upon completion of all required fields, the following prompt displays:

Accept this screen?(Y/N) [Y]--

Accept the screen by entering **Y** or pressing ENTER. Enter **N** to edit.

14. DOWNLOAD FILE PATH
This field allows you to define a default download file path to use when downloading the CAP Cancer Protocols and SNOMED AP Subset onto a workstation hard drive. The following prompt is displayed when the field is accessed:

Enter drive and directory to download from-

Enter the desired drive and directory where you want the protocol files downloaded.

Impact

- • The Anatomic Parameters are set.

- • The Histotech Numbering scheme cannot be changed once your system goes LIVE.

CASE LOGIN PARAMETERS

The system displays the following screen when you select the Case Login Parameters option from the Maintenance - Anatomic Path menu.

This builder is built at the section level. Multiple sections use Anatomic Path test types (such as GYN Cytology, Non-GYN Cytology, Histology). You can customize the system to meet the different workflows in each section. If any fields in this builder have been previously defined, that information displays.

```
                   General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 01:22 pm

Sections                               Previous Order Window Information  Page:01
( 1)Administration
( 2)Blood Bank
( 3)Chemistry
( 4)Central Processing
( 5)Cytology-GYN                                      Defined
( 6)Cytology-Non-GYN                                  Defined
( 7)Front Office
( 8)Hematology
( 9)Microbiology
(10)Histology                                         Defined
(11)Send Outs
(12)Serology
(13)Urinalysis



Enter choice --

```

The department displays in the upper left hand corner of the screen. The first column of information is a display of all defined sections for the selected department. The second column displays *Defined* if Field 10 on the next screen has been defined.

Sections that do not display *Defined* in the second column and have attached the Case Login option to the section menu default to four days for the previous order window.

All defined sections for the selected department display on this screen. This enables you to have the case login functionality in any section of the laboratory. In some situations, Central Processing or the Front Desk Office area may order and login the pathology cases.

When you select a section from the previous screen, the system displays the following screen:

```
               General Hospital Maintenance Functions Processor
Community Lab                                          Mon Jun 12, 1995 01:22 pm
Histology

 1 Case Number Pools     2 View Clin Questions
   A,C,S                          Yes
 3 High Risk                    4 Edit By              5 Edit Date/Time
   No                             Jones, Bill             08/03/93 1347
                              Security Levels
 6 Case # Override         7 Case Merge              8 HT Processing
   Lab System Manager        Lab System Manager        Lab System Manager
 9 Misc Charge/Credit     10 Professional Fee       11 Result Reporting
   Supervisor (50)           Dpt. Secretary (15)       Senior (40)


   Previous Order Window Information
12 Week day      Window(days)   Case #   Histo    Misc     Profee    Result
   Sunday            4            Yes     Auto     Never    Never     Never
   Monday            4            Yes     Auto     Auto     Auto      Auto
   Tuesday           3            Yes     Prompt   Prompt   Prompt    Prompt
   Wednesday         3            Yes     Auto     Never    Never     Auto
   Thursday          3            Yes     Prompt   Prompt   Prompt    Never
   Friday            3            No      Never    Never    Never     Never
   Saturday          4            No      Prompt   Prompt   Never     Prompt

Enter field number or '/' starting field number--
```

When you define the previous information for each day of the week for each section in the laboratory, you can set the screen flow to meet your work flow requirements. Some laboratories have separate part-time staff who place the miscellaneous or professional fee billing only on certain days of the week.

The window of days can be changed to support the surgery workload. If surgical staff is at a minimum on the weekends, some specimens from Friday surgery may not be received by the laboratory until Monday, while during the week, all specimens for the surgery are received on the same day. If a laboratory has particularly heavy days for cytology or histology, staff may place the orders and enter results at the same time in a batch mode. This could occur if many outpatient specimens that are received for cytology on a particular day.

Field Explanations

1. POSSIBLE CASE NUMBER POOLS (TABLE SELECTION-R)
This field displays a table of defined case number pools and is a required field. Multiple selections can be defined. Once the selections are made from the table, the codes display in the field. This field determines which tests display in the Case Login processor for the previous order window information. It also controls which tests can be ordered through the Case Login processor in each section.

The system displays the following prompt:

Enter option(s) for allowable case number pool(s)--

2. VIEW CLIN QUESTIONS (1-A-R)
This field determines if the prompt to display Clinical Order Detail Information displays during case login. The Clinical Questions Active flag in the Flags - General Department processor must be set to Yes for you to access this field. Entering **Y** sets this field to Yes and allows you to be prompted to view Clinical Order Detail Information during case login. Entering **N** sets this field to No and results in Clinical Order Detail Information not displaying during case login. You are not prompted to view the information, regardless of whether or not there are Clinical Questions associated with this test. The default for this field is *No.* The system displays the following prompt:

> *View clinical questions at login? (Y/N) [N] --*

3. HIGH RISK (1-A-R)
This field is used to activate the High Risk prompt during case login for all cases eligible for Cytology Workload/QC. If high risk information is entered during case login, the high risk flag for the case is pre-set for Cytology Workload/QC. The following prompt displays:

> *Prompt for high risk after case login? (Y/N)--*

Enter **Y** to be prompted to enter high risk information at the end of case login. If you do not want to be prompted, enter **N**.

The Y/N default for the high risk prompt is defined in the Cytology Workload/QC Parameters maintenance processor. The setting in this field will be ignored by the system if Cytology Workload/QC is inactive.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the user who last edited this screen.

5. EDIT DATE/TIME (DISPLAY ONLY)
This field reflects the system date and time of the last edit for this screen (relates to the Edit By field).

SECURITY LEVELS

The following fields allow each site the necessary security levels for all the functionality available through case login.

6. CASE # OVERRIDE (TABLE SELECTION-R)
This field defines the minimum security level required to override a case number in the Case Login processor and is a required field. A table displays the defined security levels.

The system displays the following prompt:

> *Enter case # override security level or '-' for table--*

The security level can be defined by entering the code or by selecting from the Security Levels Table.

7. CASE MERGE (TABLE SELECTION-R)
This field defines the minimum security level required to use the merge option for a case in the Case Login processor and is a required field. A table displays the defined security levels.

The system displays the following prompt:

Enter case merge security level or '-' for table--

The security level can be defined by entering the code or by selecting from the Security Levels Table.

8. HT PROCESSING (TABLE SELECTION-R)
This field defines the minimum security level required to access the Histotech Processing processor directly once a case has been logged into the system through the Case Login processor. A table displays the defined security levels.

The system displays the following prompt:

Enter histotech processing security level or '-' for table--

The security level can be defined by entering the code or by selecting from the Security Levels Table.

9. MISC CHARGE/CREDIT (TABLE SELECTION-R)
This field defines the minimum security level required to access the Miscellaneous Charge/Credit processor directly once a case has been logged into the system through the Case Login processor. A table displays the defined security levels.

The system displays the following prompt:

Enter miscellaneous charge/credit security level or '-' for table--

The security level can be defined by entering the code or by selecting from the Security Levels Table.

10. PROFESSIONAL FEE (TABLE SELECTION-R)
This field defines the minimum security level required to access the Professional Fee processor directly once a case has been logged into the system through the Case Login processor. A table displays the defined security levels.

The system displays the following prompt:

Enter professional fee security level or '-' for table--

The security level can be defined by entering the code or by selecting from the Security Levels Table.

11. RESULT REPORTING (TABLE SELECTION-R)
This field defines the minimum security level required to access the Result Reporting processor directly once a case has been logged into the system through the Case Login processor. A table displays the defined security levels.

The system displays the following prompt:

Enter result reporting security level or '-' for table--

The security level can be defined by entering the code or by selecting from the security levels table.

PREVIOUS ORDER WINDOW INFORMATION

SCROLLING SCREEN (SPECIAL FORMAT-O)
The function keys used in this screen are as follows:

F6 Reset F7 Exit   ?

WEEK DAY (DISPLAY ONLY)
This field is display only. The days of the week display so you can select the appropriate setting for the previous order window.

WINDOW (DAYS) (2-N-R)
This field allows the entry of 0 to 99 days for viewing previously ordered Anatomic Path test type tests. This is a required field. This field controls the time frame to display previously ordered AP tests when entering the Case Login processor.

The prompt for this field is as follows:

Enter number of days to search for previously ordered tests (0-99)--

CASE # (1-A-R)
This field enables you to enter Yes or No. If you enter **Y**, the system automatically assigns the case number through the Case Login processor. If you enter **N**, the system prompts you to enter the appropriate case number during the Case Login process. This is a required field.

The prompt for this field is as follows:

Auto assign case number in case login? (Y/N)--

HISTO (1-A-R)
This field enables you to enter Automatically, Never, or Prompt. If you enter **A**, you automatically enter Histotech Processing after you accept the Case Login processor.

If you enter **N**, you eliminate the check to see if histotech processing should be entered after you accept the Case Login processor.

The prompt for this field is as follows:

> *Enter histotech processing automatically(A), by prompt(P), or never(N)--*

If you enter **P**, the following prompt displays:

> *Use default response of yes(Y) or no(N)? (NL for no default)--*

You have the option to define a default response to the prompt or require entry of a specific response each time.

MISC (1-A-R)
This field enables you to access the Miscellaneous Charges/Credit processor directly after accepting the Case Login screen. You can enter Automatically, Never, or Prompt.

The following prompt displays:

> *Enter misc charge processor automatically(A), by prompt(P), or never(N)--*

If you enter **P**, the following prompt displays:

> *Use default response of yes(Y) or no(N)? (NL for no default)--*

You have the option to define a default response to the prompt or require entry of a specific response each time.

PROFEE (1-A-R)
This field enables you to enter the Professional Fee Billing processor after accepting the Case Login Screen. You can enter Automatically, Never, or Prompt.

The following prompt displays:

> *Enter pro fee processor automatically(A), by prompt(P), or never(N)--*

If you enter **P**, the following prompt displays:

> *Use default response of yes(Y) or no(N)? (NL for no default)--*

You have the option to define a default response to the prompt or require entry of a specific response each time.

RESULT (1-A-R)
This field enables you to enter the Result Reporting processor after accepting the Case Login Screen. You can enter Automatically, Never, or Prompt.

The following prompt displays:

Enter result reporting processor automatically(A), by prompt(P), or never(N)--

If you enter **P**, the following prompt displays:

Use default response of yes(Y) or no(N)? (NL for no default)--

You have the option to define a default response to the prompt or require entry of a specific response each time.

CASE NUMBER POOLS

The Case Number Pools processor is used to create and maintain a pool of numbers for assignment to Anatomic Path test types only. This processor is located under Maintenance - Anatomic Path and Table Data - Department.

```
                  General Hospital Maintenance Functions Processor
 Laboratory                                           Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions          Page:01
 ( 1) A - Anatomic Path Parameters         (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters            (19) Z - Standard Result Text
 ( 3) B - Case number pools                (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Upon selection of this processor, the following prompt displays:

> *Enter case # pool code--*

Enter a single alphabetic character to be used as the pool code. Up to 26 case number pools can be defined for a single department. You can enter a hyphen (**-**) to display and select from a table of case number pools if any are defined.

Upon selection or entry of a code, the following screen displays:

```
                  General Hospital Maintenance Functions Processor
 Community Lab                                        Mon Jun 12, 1995 01:22 pm
 Case Number Pools
 ( 1)Case # Pool Code : S
 ( 2)Description      : Anatomic Path
 ( 3)Current Value    : 4123
 ( 4)Reset if Pool # >:
 ( 5)Reset Pool # to  : 1
 ( 6)Frequency        : 1year365th day @ 12:01 am
 ( 7)Next Reset       : Friday 31 December 1993 12:01am

 ( 8)No. of labels    : 2
 ( 9)Workload/QC      : No
 (10)Histo/Cyto       : Histology
 (11)Edit by          : Rong,Marguerite L
 (12)Edit date        : 07/27/95 1508




 Accept this screen? (Y/N/D) [Y]--
```

Field Explanations

1. CASE # NUMBER POOL CODE (DISPLAY ONLY)
This field contains the entered or selected case number pool code.

2. DESCRIPTION (20-AN-R)
This field contains the description of the case number pool code.

3. CURRENT VALUE (U-AN-O)
Enter the number to start with when you build. This field can be edited with caution.
When you use this case number pool, this number increments with each accession of
a test that uses this case number pool. The current value is the number that prints on
the next accession that uses this case number pool.

4. RESET IF POOL # > (U-N-O)
Enter the maximum case number pool value if you reset the number. If you are using
the frequency to reset the number, do not complete this field. If the pool is to be
recycled after a certain number is reached, a recycling value should be indicated.

5. RESET POOL # TO (U-N-O)
Enter the reset number that will be used when the maximum number has been
reached. If you are using the frequency to reset the number, do not complete this field.

6. FREQUENCY (SPECIAL PROCESSING)
This field displays the frequency criteria. For more information on how to set up the
criteria for the frequency, refer to "Edit the Frequency" on page 2-67.

7. NEXT RESET (SPECIAL PROCESSING)
The system automatically calculates this field; however, it can be edited if necessary.
This field contains the date and time on and at which the case number pool number is
reset to the value entered in the Reset Pool # to field. Use the standard date and time
entry procedure if you are editing this field.

8. NO. OF LABELS (2-N-R)
Enter the default number of labels to print for each case number in the Reserve/
Generate Case #'s and the Print/Reprint Case # Labels processors. The default is one
(1). Upon completion of all required fields, the following prompt displays:

Accept this screen?(Y/N) [Y]--

Enter **Y** or press ENTER to accept the information. The system displays the following
message:

Filed!

Enter **N** to return to the Edit field prompt.

9. WORKLOAD/QC (1-A-O)
This field determines the case types that are eligible for cytology workload and for quality control processing. The field is set to No prior to entering the builder.

The system displays the following prompt:

Activate cytology workload/QC for this case number pool? (Y/N) [Y]--

10. HISTO/CYTO (1-A-R)
This field is used to define cases that are eligible for GYN Comparison processing. The following prompt displays:

Define this case number pool as cytology(C), histology (H) or neither(N)--

Enter **C** or **H** to define this case number pool as eligible for GYN comparison studies. Enter **N** to exclude this case number pool from GYN comparison. This field is a required field.

NOTE: If a GYN comparison is performed on a test while its case number pool is set to either Cytology or Histology and then the flag is set to Neither, the case number is not a valid entry, if individually entered to print the GYN Comparison report. If the comparison qualifies as part of a defined date range for a GYN Comparison report, the comparison information is included on the report.

Edit the Frequency

Select the Frequency field to edit the frequency for the case number pool reset. The system displays the following screen:

```
                    General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 01:22 pm
Case Number Pools



Frequency Options

( 1) Hours
( 2) Days
( 3) Weeks
( 4) Months
( 5) Quarters
( 6) Semesters (1/2 Year)
( 7) Years




Enter new time unit between pool recycles (NL for no check by time)--
```

The case number pool number can be recycled based on hours, days, weeks, months, quarters (three months), semesters (six months), or years.

Select the option you want or press ENTER if you do not want the frequency check by time. The system returns you to the previous screen.

The frequency options are explained as follows:

- Hours

    Enter the number of hours in each period.

- Days

    Enter the number of days in each period.

    Enter the time of day (if you enter one digit, the system prompts you to specify whether it is a.m. or p.m.).

- Weeks

    Enter the number of weeks in each period.

    Enter the day of the week (first three letters of the day or the number of the day - 1=Monday).

    Enter the time of the day.

- Months

    Enter the number of months in each period. The system then prompts you to:

    Enter by weekday (W) or by No. of days into period (N)?--

    If you enter **W**, the system prompts you to:

    Enter the week of month (1-4).

    Enter the day of the week.

    Enter the time of day.

    If you enter **N**, the system prompts you to:

    Enter the number of days into period.

    Enter the time of day.

- Quarters

    Enter the number of quarters in each period. The system then prompts you to:

    Enter by weekday (W) or by No. of days into period (N)?--

    If you enter **W**, the system prompts you to:

    Enter the week of month (1-4).

    Enter the day of the week.

    Enter the time of day.

    If you enter **N**, the system prompts you to:

    Enter the number of days into period.

    Enter the time of day.

- Years

    Enter the number of years in each period. The system then prompts you to:

    Enter by weekday (W) or by No. of days into period (N)?--

    If you enter **W**, the system prompts you to:

    Enter the week of month (1-4).

    Enter the day of the week.

    Enter the time of day.

    If you enter **N**, the system prompts you to:

    Enter the number of days into period.

    Enter the time of day.

Delete

When an existing case number pool code is accessed, the edit screen displays. Pressing ENTER without making any changes to the screen causes the delete prompt to display

Delete? (N)--

To delete, enter **Y**. The system displays the following prompt:

Enter delete(D) from file or file(F) as deleted [F]--

To completely delete the code, enter **D**. To file this code as deleted (inactivate), enter **F** or press ENTER.

Reactivate

To reactivate a code previously filed as deleted, enter the old code at the prompt:

Enter number pool code--

Upon entry of a file as a deleted code, the system responds:

Enter delete(D) from file or activate(A)--

To completely delete the code, enter **D**. To reactivate this code, enter **A**. The system displays the following message:

Activated!

Impact

The parameters for this case number pool are set and take effect immediately.

HISTOTECH PROCESSES

Each histotech procedure (HT process) used in the Anatomic Path module must be defined using the Histotech Processes processor. Once defined, these processes can be added as defaults per test code for automatic label generation and billing/workload capture at accessioning. Or, they can be defined on a per specimen basis, using the Histotech Processing option on the Anatomic Pathology section menu.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                         Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions          Page:01
( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters           (19) Z - Standard Result Text
( 3) B - Case number pools               (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files

 Enter choice--
```

Access the Histotech Processes option.

Edit/Add

You have several options at the edit/add prompt.

```
                    General Hospital Maintenance Functions Processor
 Community Lab                                      Mon Jun 12, 1995 01:22 pm
 Histotech Processes

















 Enter code for histotech process--
```

To edit an existing code, use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

To add a new HT process, enter the code. The code can be up to ten alphanumeric characters. Verify your entry and, if correct, enter **Y** at the following prompt:

Add this code `CYT`? (Y/N) [Y]--

Once **Y** is entered, the Histotech Process screen displays for entry of all data required to define a new HT process.

Enter **N** to return to the original prompt.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                          Mon Jun 12, 1995 01:22 pm
Histotech Processes
 1 Histo Process Code     2 Histotech Process Description
   CYT                       Cyto smr, from fluid
                          Process Information
 3 No. of replicates      4 Thickness              5 No. of slides/block
   1                        1                         2
 6 Print Slide Designator  7 Print Process Name

 8 No. of Labels/slide     9 Label Text            10 Label Identifier
   2                         Cyto st                   Patient Number
                          Block Workload Information
11 No. of cts./block  12 Workload Procedure Code
   1                     88192-Cyto smear and/or cell block, prep from fluid,ce
                          Slide workload Information
13 No. of cts./slide  14 Workload Procedure Code

    Process Billing                            Replicate Billing
15 Code     Descript.       Price      16 Code      Descript.        Price
   4478 CYTO SMEAR NON GYN -   $15.00

Enter field number or '/' starting field number--
```

Field Explanations

1. HISTO PROCESS CODE (DISPLAY ONLY)
The code indicated on the previous screen displays in this field. This field cannot be edited.

2. HISTOTECH PROCESS DESCRIPTION (30-AN-R)
Enter the description of the histotech process.

NOTE: The next three fields, number of replicates per block, block thickness and number of slides per histotech process, can be defined as defaults or designated for entry when processing or adding this HT process to an accession.

3. NO. OF REPLICATES (2-AN-R)
Enter your selection from:

- The number of times the process will be performed per block. (If more than one replicate is defined for the process for a given block, replicate billing is automatically captured (if defined) at processing.)

- **P** - to allow the number to be entered at Processing.

- **A** - to allow the number to be entered when Adding this process to a block.

4. THICKNESS (2-AN-R)
Enter your selection from:

- The thickness to cut the block.

- **P** - to allow the number to be entered at Processing.

- **A** - to allow the number to be entered when Adding this process to a block.

5. NO. OF SLIDES / BLOCK (3-AN-R)
Enter your selection from:

- Indicate the number of slides to be setup for this process per block.

- **P** - to allow the number to be entered at Processing.

- **A** - to allow the number to be entered when Adding this process to a block.

6. PRINT SLIDE DESIGNATOR (1-A-O)
When using bar code histotech labels, you have the option of printing a slide designator (1/2, for example, which means the first of two slides). Enter **Y** to print the slide designator; enter **N** not to print. (This is not an option for conventional labels since slide designators always print on dot matrix HT labels.)

7. PRINT PROCESS NAME (1-A-O)
When using bar code histotech labels, you can print the histotech process label text (Field 9) on the slide. Enter **Y** to print label text; enter **N** not to print. (This is not an option for conventional labels since the histotech process label text always prints on dot matrix HT labels.)

8. NO. OF LABELS/SLIDE (3-AN-O)
Enter the number of labels per slide to print at processing. The number of labels printed is calculated by:

(# of slides/block) X (# of replicates) X (# labels/slide) = total # labels printed

    (Field 5)(Field 3)(Field 8)

For example: If a process is defined to have two slides/block and to be replicated twice per block, enter **1** to print a total of four labels.

NOTE: The numeric value of Field 5, Number of slides/block, is the default for this field.

NOTE: For bar code labels the number of labels calculated here for the AP test will be multiplied by the number of labels defined for the corresponding bar code format.

9. LABEL TEXT (10-AN-O)
Indicate the text to print on the label (usually identifies the type or name of the HT process).

10. LABEL IDENTIFIER (1-A-O)
Indicate which of the following to print on the slide by entering:

- **S** for specimen type

- **P** for patient unit number

- **N** for number pool (if N, enter number pool)

11. NO. OF CTS/BLOCK (U-N-O)
Enter the number of counts to record when workload is captured at processing for this block.

12. WORKLOAD PROCEDURE CODE (TABLE LOOKUP-O)
Enter CAP procedure code for the block workload. It must be defined in the Workload Procedure table (General table).

13. NO. OF CTS/SLIDE (U-N-O)
Enter the number of counts for workload to be captured for each slide.

14. WORKLOAD PROCEDURE CODE (TABLE LOOKUP-O)
Enter the CAP procedure code for capturing slide workload. It must be defined in the workload procedure table.

Slide workload is calculated as follows:

(# of replicates) X (# of slides/block) X (# of counts/slide) X (CAP workload units) = slide workload

15. PROCESS BILLING (TABLE LOOKUP-O)
To automatically capture charges for this histotech procedure, assign a Miscellaneous Charge code to both the single process and to the replicate. Select the section code from the table displayed. The Miscellaneous Charge Items assigned to this section display for selection.

Indicate the Miscellaneous Charge Item code to capture when this histotech procedure is processed. Use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR*

Laboratory Reference Guide. The code, description and price (assigned to this item) display in this field.

NOTE: This field must be defined to capture processing billing. Manual credit may need to be done if the MISC Charge Item is deleted.

16. REPLICATE BILLING (TABLE LOOKUP-O)
Indicate the section code for replicate billing. The Miscellaneous Charge table corresponding to your selection displays. Indicate the Miscellaneous Charge Item code for replicates of this Histotech process.

Use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.* The code, description and price (assigned to this item) display in this field. Replicate charges are captured when this procedure is performed multiple times per block.

NOTE: This field must be defined to capture replicate billing. Manual credit may need to be done if the MISC Charge Item is deleted.

Upon completion of all required fields, the following prompt displays:

Accept this screen?(Y/N) [Y]--

Accept the screen by entering **Y** or pressing ENTER. Enter **N** to edit.

Delete

If, upon selecting a previously defined HT process for edit, you press ENTER without making any changes, the following prompt displays.

```
                General Hospital Maintenance Functions Processor
Community Lab                                    Mon Jun 12, 1995 01:22 pm
Histotech Processes
 1 Histo Process Code     2 Histotech Process Description
   CYT                       Cyto smr, from fluid
                          Process Information
 3 No. of replicates       4 Thickness                5 No. of slides/block
   1                         1                           2
 6 Print Slide Designator  7 Print Process Name

 8 No. of Labels/slide     9 Label Text              10 Label Identifier
   2                         Cyto st                    Patient Number
                          Block Workload Information
11 No. of cts./block  12 Workload Procedure Code
   1                      88192-Cyto smear and/or cell block, prep from fluid,ce
                          Slide workload Information
13 No. of cts./slide  14 Workload Procedure Code


    Process Billing                          Replicate Billing
15 Code     Descript.        Price      16 Code      Descript.          Price
   4478 CYTO SMEAR NON GYN -   $15.00

Delete? (N)--
```

Enter **Y** to delete. Enter **N** to return to the prompt that allows you to enter a new code or edit an existing code. When **Y** is entered, the following prompt displays:

> *Enter delete(D) from file or file(F) as deleted [F]--*

To completely delete this HT process from the system, enter **D**. To file the process as deleted (it can subsequently be reactivated), enter **F** or press ENTER for the default.

NOTE: A histotech process should not be completely deleted from the system once it is used in a live environment. It may be inactivated without affecting previous cases.

Print

If, upon initial entry to this processor, you press ENTER instead of entering a code, the following prompt displays which allows you to print a list of HT processes.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                          Mon Jun 12, 1995 01:22 pm
Histotech Processes










Do you want a printed list? (Y/N)--
```

To return to the initial Anatomic Path menu, press N. To print a list, press Y. The following code displays:

> *Enter code(C) sequence or alphabetic(A) [A]--*

To arrange the list by code sequence, press **C**. To sort alphabetically by description, press **A** or press ENTER for the default. The following prompt displays:

> *Include entries filed as deleted? (Y/N)--*

To include HT codes previously filed as deleted, press **Y**. To exclude these inactive codes, press **N**. The printer selection screen displays listing the default and all alternate printers available for this report. Select a printer or press ENTER for the default.

LONG REPORT PARAMETERS

Please refer to the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide* to specify how the system provides Long Reports for Anatomic Pathology.

HISTOTECH PROCESSES/TEST

For each Anatomic Pathology test, default Histotech/Cytotech processes can be assigned so that blocks and processes are defined automatically at accessioning.

```
                  General Hospital Maintenance Functions Processor
 Laboratory                                           Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions          Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files


 Enter choice--
```

Access the Histotech Processes function to define HT processes per test. Next, indicate the test code to be assigned the processes. Use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*. In this example, the test Tissue - Gross Exam was selected.

NOTE: The test **must** be defined as an Anatomic Pathology test type.

The following screen displays upon test selection.

```
                  General Hospital Maintenance Functions Processor
 Community Lab                                         Mon Jun 12, 1995 01:22 pm

 Page:01      Specimens with Histotech processes - TISSUE - GROSS EXAM
 ( 1) Default












 Enter option to edit or add(A)--
```

For the selected test, the screen displays all specimens for which histotech processes
have been defined. If no specimens have been defined, the Default option displays in
dim video. If specimens were assigned in Main Test Information processor, only those
specimen types should be used to assign Histotech Processes. You can edit a
specimen or the default by entering the option number or add a new specimen by
entering **A**.

In this example, no specimens are defined. Option 1, Default specimen type, was
selected for editing.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
   Specimen: Default




















None defined, Enter Histotech Processes for default specimen? (Y/N) [Y] --

```

HT processes assigned to the default specimen will be defined for all specimens that
do not have specific processes defined. If no processes have been defined for the
default, the preceding message displays. Enter **Y** or press ENTER to continue with HT
definition. Enter **N** to return to the previous screen.

In this example, **Y** was entered to define HT processes for the default specimen.

You are then prompted:

Enter number of blocks to be defined [1] --

Enter a number from 1 to 99 indicating the number of blocks to define for this specimen
type (in this case the default specimen). The default is *1*. The screen following this
screen automatically displays.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                           Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
   Specimen: Default

Page:01                 Histotech Processes for Community Lab
( 1) CYT-Cyto smr, from fluid
( 2) FILTER-Filter preparation
( 3) FRS-Frozen Section
( 4) GIEMSA-Giemsa Stain
( 5) HE-H & E Stain
( 6) IRON-Iron Stain








   Enter choice--
```

The Histotech Processes table built for your laboratory displays for the current
department. Select an option by entering the option number.

In this example, Option 1, CYT-Cyto smr, from fluid, was selected.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                           Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
   Specimen: Default

 1 Histotech process
   CYT-Cyto smr, from fluid
 2 Auto Process   3 #Replicates  4 Thickness    5 #Slides
   Yes              1              1              1
 6 Print Slide Designator   7 Print Process Description
   No                        No






Accept this screen? (Y/N/D) [Y]--
```

Field Explanations

1. HISTOTECH PROCESS (DISPLAY)
The histotech process selected on the previous screen displays in this field. It cannot
be edited.

2. AUTO PROCESS (1-A-O)

If this flag and the department flag (Auto-Process Histotech Processes at Accessioning) are set to *Yes*, blocks will be automatically processed; that is, labels printed, workload captured and miscellaneous charges captured, at accessioning. To automatically process at accessioning, enter **Y** or press ENTER. To require the process step as a manual entry, enter **N**.

3. #REPLICATES (2-N-R)

If the number of replicates is to always be the same, enter the number (from 1 to 99) of times the process is to be replicated per block. The default is *1*. If the number should be specified at the time of processing, enter **P** and do not set the auto process flag to Yes. If you attempt to set this Field to *P* when the Auto Process field is set to Yes, the following message displays:

> *AUTOPROCESSED, can not define when processed!*

4. THICKNESS (3-N-R)

If the thickness is always the same for this specimen type, enter a number corresponding to the relative thickness. If the thickness of the section should be specified at processing, enter **P** and do not set the auto process flag to Yes. The system prompts the technologist to enter the thickness during processing. There is no default for this field.

5. #SLIDES (3-N-R)

Enter the number of slides to print for this process per block. The default is *1*. If the system should prompt the user at processing, enter **P** and do not set the auto process flag to Yes.

6. PRINT SLIDE DESIGNATOR (1-A-O)

This field is only applicable if bar coded histotech labels are to be used. If the slide designator should print on the label, enter **Y**. If it is not to print, enter **N**. There is no default for this field. The slide designator always prints on conventional dot matrix labels.

7. PRINT PROCESS DESCRIPTION (1-A-O)

This field is only applicable if bar coded histotech labels are to be used. If the process name (label text) is to print on the label, enter **Y**. If it is not to print, enter **N**. The default is *No*. The process name always prints on conventional dot matrix labels.

Upon completion of all required fields, the following prompt displays:

> *Accept this screen?(Y/N) [Y]--*

Accept the screen by entering **Y** or pressing ENTER. Enter **N** to edit.

Impact

The parameters are set for this HT process for this specimen or default.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                           Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
   Specimen: Default                                      No. Blocks: 1

Page:01
( 1) Cyto smr, from fluid









Enter option to edit, add(A), # of blocks(N) or delete(D)--
```

The preceding screen displays once the process is accepted for this specimen. Notice
the test code and name on the fourth line and the specimen type and number of blocks
on the fifth line. You have the following options:

- Enter an option number to edit the parameters

- Enter **A** to add a new process to this specimen type

- Enter **N** to redefine the number of blocks for this specimen type

- Enter **D** to delete this specimen type

When **D** is entered, the following prompt displays:

Delete specimen type completely?(Y/N) --

Enter **Y** to delete the specimen type and all the processes defined for it. Enter **N** to
return to the previous screen. There is no default for this prompt.

```
                  General Hospital Maintenance Functions Processor
Community Lab                                         Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
Page:01     Specimen's with Histotech processes - TISSUE - GROSS EXAM
( 1) Default








Enter option to edit or add(A)--
```

This screen displays upon initial selection of a test within the Histotech Processes/Test processor. To add a specimen type, enter **A**.

The following prompt displays:

Enter spec code or `-` for table -- 29

Indicate the specimen type to add, using one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

In this example, the specimen type Abscess, code 29, was entered.

```
                  General Hospital Maintenance Functions Processor
Community Lab                                         Mon Jun 12, 1995 01:22 pm

   Histotech Processes per test code 4415-TISSUE - GROSS EXAM
   Specimen: Abscess









Enter Histotech Processes for Abscess? (Y/N) [Y] --
```

Notice the new specimen type displays on the fifth line. Enter **Y** or press ENTER to verify the specimen and proceed with histotech process assignment. The steps for assigning HT processes are the same as previously described for the default specimen. Enter **N** to return to the initial specimen screen.

HP AUDIT RETENTION

This option allows you to define how long the Histo/Cytotech Audit information should be retained on the system by facility. A maximum value of 30 days is permitted to retain the audit data.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                        Wed Jun 01, 2005 03:06 pm


                          Laboratory Anatomic Path Functions           Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Select **C - HP Audit Retention** and the following screen displays:

```
            General Hospital Maintenance - Anatomic Path Processor
 Laboratory                                        Thur Sept 5, 2002 05:28 pm
 HP Audit Retention Parameters

    Facility   Retention Days for Histotech Audit
       A           5
       B           7
       C           1
       D           1












             Enter number of days to retain audit data (1-30) [7]--
               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?

```

Field Explanations

FACILITY (DISPLAY ONLY)
Facilities defined for the system automatically populates this field.

RETENTION DAYS FOR HISTOTECH AUDIT (SCROLLING SCREEN)
When this column is accessed the following prompt displays:

> *Enter number of days to retain audit data (1-30) [7]--*

If the value input is zero or a number greater than 30, the system displays the following error message:

> *Error: Entry out of range!*

Press the F7 key to exit the screen. The system displays *Field!*

Since the audit may contain numerous histo/cytotech processes for each patient, the audit may impact disk space if the information is retained for more than 30 days.

WORKLOAD/QUALITY CONTROL

The Workload/Quality Control processor is used to view, add, or change the maintenance options included in the Cytology Workload/Quality Control feature of the system. This processor is accessed by selecting Maintenance - Anatomic Path from the Maintenance Functions menu. See the following screen example.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                        Wed Jun 01, 2005 03:06 pm

                          Laboratory Anatomic Path Functions          Page:01
( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters           (19) Z - Standard Result Text
( 3) B - Case number pools               (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files

 Enter choice--
```

When you select this processor, the following menu displays.

```
                    General Hospital Maintenance - Anatomic Path Processor
 Community Lab                                     Fri Jan 12, 1996 05:56 pm

                    Workload/Quality Control Maintenance Functions      Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Results for Comparison
( 7) Workload/Quality Control Parameters
( 9) Z - Manual Workload/QC Deletion




 Enter choice--
```

Cytology Personnel

Use this option to view, add, or change personnel defined as screeners (employees who perform the actual microscopic examination on cytology specimens). You can also set the maximum number of slides allowed for each screener for a 24-hour period

and define specific screeners as exempt from the QC process. Screeners listed in this table can result tests that have a case number pool activated for capture of Cytology Workload/Quality Control information.

Once a screener has captured workload, that screener can be deactivated but not deleted from the system. Only active screeners are eligible for workload capture, but all screeners are eligible for management reporting.

Select Cytology Personnel on the Workload/Quality Control Maintenance Functions menu. If no active screeners exist, a blank screen displays with the following prompt:

Enter screener ID code or '-' for table--

This prompt enables you to enter an active Screener ID code from the employee table. A hyphen (**-**) entry displays a table of valid employee IDs that can be selected.

Once you enter a valid screener ID code, the system displays the following screen:

```
                    General Hospital Maintenance - Anatomic Path Processor
Community Lab                                       Mon Jun 12, 1995 06:30 pm
 Cytology Personnel

 1 Screener Name               2 Maximum Slide Count    3 Active QC
   BROWN, CINDY [7141]













 Enter allowable slide count for 24 hours--
```

Field Explanations

1. SCREENER NAME (TABLE LOOKUP-R)
This field contains the screener name and ID code from the employee file.

2. MAXIMUM SLIDE COUNT (4-N-R)
This field contains the maximum slide count that can be screened in a 24-hour period. The field accepts a 3-digit numeric entry, that can be entered in increments of 0.5; for example, 99.5 or 999.

The system displays the following prompt:

Enter allowable slide count for 24 hours--

3. ACTIVE QC (1-A-R)

This field enables you to activate QC for a specific screener. The system displays the following prompt:

Activate QC for this screener? (Y/N) [Y]--

If you enter **Y** or press ENTER at this prompt, QC is activated. If you select **N**, an X displays in the QC N/A column of the table. The X indicates that the QC feature is deactivated for that screener.

The system displays the following prompt to accept the screen:

Accept this screen? (Y/N) [Y]--

NOTE: During result reporting, negative GYN cases normally considered eligible for random selection for the QC process will *not* be considered for selection on screeners defined in this processor as *QC not active.* Workload capture for the same cases and screeners is not affected.

If screeners already exist, the screen displays the existing screener name and ID code, maximum slide count, and QC activation status.

The system displays the following prompt:

Enter option to edit, add(A) or deactivate(D)--

```
                  General Hospital Maintenance Functions Processor
Community Lab                                    Mon Jun 12, 1995 06:22 pm
 Cytology Personnel

          Screener                    Max Sld Count      QC N/A       Page:01
( 1) ABRAMS,HARRY [444]                    99
( 2) BROWN,CINDY [7141]                    48
( 3) GARDNER,JANE [7989]                   48
( 4) HESTER,SUE [B222]                     100
( 5) LANE,JOE [B444]                       100              X
( 6) MASON,PAM [7535]                      26
( 7) TESTA,MIKE [4205]                     16





Enter option to edit, add(A) or deactivate(D)--
```

EDIT

You can edit a screener on the Cytology Personnel screen by entering the option number. The screener information appears with the following prompt:

Enter field number or '/' starting field number--

After you enter and accept the changes to the desired field(s), press ENTER. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** or press ENTER to accept the screener information. The system displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

ADD

Two scenarios exist in which you can add a screener to the Cytology Personnel table.

The first scenario involves a screener who has not been activated. Select the add(A) option. The system displays the following prompt:

Enter screener ID code or '-' for table--

When you enter the screener ID code, the system displays the following prompt:

Enter allowable slide count for 24 hours--

When you complete the Maximum Slide Count field, the system displays the following prompt:

Activate QC for this screen? (Y/N) [Y]--

After you enter and accept your selection for the Active QC field, press ENTER. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

If you enter **Y**, the system displays the following message:

Filed!

If you enter **N**, the system displays the following prompt:

Enter field number or '/' starting field number--

The second scenario involves a screener who has been deactivated. Select the add(A) option. The system displays the following prompt:

Screener code #### is not active! - Activate? (Y/N)--

If you enter **Y**, the system displays the following message:

Activated!

If you enter **N**, the system displays the following prompt:

Enter screener ID code or '-' for table--

Make any changes, if applicable. Otherwise, press ENTER and the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** to accept the screen. The system displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

DEACTIVATE

You can deactivate a screener from the Cytology Personnel table by entering **D**. The table of screeners reappears with the following prompt:

Enter option to deactivate--

After you enter and accept the option, the system displays the following message:

Deactivated!

The entry no longer exists on the table.

REACTIVATE

To reactivate a screener ID code, refer to the second scenario of the Add option.

Impact

This option results in viewing, adding, activating, deactivating, and editing screeners. It also provides a method of updating the maximum number of slides allowed for each screener in a 24-hour period and provides that specific screeners be defined as exempt from the QC process. Inactive screeners can be included on Management Reports, but are not eligible for workload capture once they are defined as inactive.

Diagnosis Categories

Use this option to define diagnosis categories. The categories built will be used for Management Reports and for concurrent quality control review. Using these

categories for Management Reports provides continued flexibility in the Patient Reporting process (by not requiring standard results). The categories also provide a means of sorting information at the case level for management/quality control needs.

You can define as many diagnosis categories as you choose. However, if you keep the number of categories to a minimum, the reports being generated will contain more meaningful results.

One category must be defined as the indicator that the GYN case is negative or normal. The system uses this category to flag GYN cases as eligible for random selection for the QC process. GYN cases defined with a diagnosis category that is not negative are not considered for random selection for the QC process. To see Workload/Quality Control Parameters for additional information on this feature refer to .

Once a diagnosis category is assigned to a case, the category can be deactivated but not deleted from the system. Only active diagnosis categories are eligible for selection during Workload/QC processing. All diagnosis categories are included on Management Reports.

To define diagnosis categories, select Diagnosis Categories on the Workload/Quality Control Maintenance Functions menu.

```
General Hospital Maintenance - Anatomic Path Processor
Community Lab                                   Mon Jun 12, 1995 05:56 pm


              Workload/Quality Control Maintenance Functions       Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Workload/Quality Control Parameters
( 7) Z - Manual Workload/QC Deletion








     Enter choice--
```

If no active diagnosis categories codes exist, a blank screen displays with the following prompt:

Enter diagnosis category code--

The diagnosis category code can be an alphanumeric string up to six characters in length. When you enter a diagnosis category code, the system displays the following screen:

```
General Hospital Maintenance Functions Processor
Community Lab                              Mon Jun 12, 1995 01:22 pm
 Diagnosis Categories

( 1)Code          : NEG
( 2)Description   : Negative
( 3)Active        :

( 4)Edit by       :
( 5)Edit date/time:






Enter diagnosis category description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code. It cannot be edited.

2. DESCRIPTION (36-AN-R)
This field enables you to enter a description of the category. The system displays the following prompt:

> *Enter diagnosis category description--*

If the description entered has already been used, the following message displays:

> *Description already used!*

3. ACTIVE (1-A-R)
This field enables you to activate a specific diagnosis category. The system displays the following prompt:

> *Activate diagnosis category? (Y/N) [Y]--*

If you enter **Y** or press ENTER, the Diagnosis Category option is activated. If you enter **N**, an X displays in the Not Active column of the list. The option is deactivated for the specific diagnosis category.

The system displays the following prompt to accept the screen:

> *Accept this screen? (Y/N) [Y]--*

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who made the last edits to the screen.

5. EDIT DATE/TIME (DISPLAY ONLY)
This field displays the date and time of the last edits to the screen. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

If diagnosis category codes already exist, the screen displays existing Codes, Descriptions, and Not Active indicators. The system displays the following prompt:

Enter option to edit, add(A) or delete(D)--

```
                  General Hospital Maintenance Functions Processor
 Community Lab                                     Mon Jun 12, 1995 01:22 pm
  Diagnosis Categories


          Diagnosis Categories                     Not Active          Page:01
 ( 1) NEG   -Negative                                  X
 ( 2) POS   -Positive
 ( 3) SUSP  -Suspicious










 Enter option to edit, add(A) or delete(D)--
```

EDIT

You can edit the Diagnosis Category Screen by entering the Diagnosis Category option number from the table. The desired diagnosis category information appears with the following prompt:

Enter field number or '/' starting field number--

After you enter and accept the changes to the desired field(s), press ENTER. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** or press ENTER to accept the screen information. The system displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

ADD

You can add a diagnosis category to the table by entering **A**. The system displays the following prompt:

Enter diagnosis category code--

The diagnosis category code appears on the Diagnosis Category entry screen with the following prompt:

Enter diagnosis category description--

After you enter and accept the description, the system displays the following prompt:

Activate diagnosis category ? (Y/N) [Y]--

After you enter and accept your selection to the Active field, press ENTER. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** to accept the information. The system displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

DELETE

You can delete a diagnosis category that is not attached to any case (patient results) from the table by entering **D**. The table of eligible diagnosis categories reappears with the following prompt:

Enter option to delete--

After you enter and accept the option, the system displays the following message and the entry no longer exists on the table:

Deleted!

If all defined categories have been attached to a case (patient results), you cannot delete any categories. If you select the Delete option in this situation, the following message displays:

No entries defined!

Impact

Diagnosis categories are used for sorting data on Cytology Workload/Quality Control Management Reports. The one category selected as the negative GYN indicator will be used by the system to determine which tests are eligible for random selection into the Quality Control check process.

Once a diagnosis category is assigned to a case, it can be deactivated but not deleted from the system. Only active diagnosis categories are eligible for selection during Workload/QC processing. All diagnosis categories are included on Management Reports.

Discrepancy Categories

Use this option to define discrepancy categories used to categorize discrepancies found between results entered through result reporting and the Repeat Queue for tests sent to the Discrepancy Queue.

When result discrepancies of cases processed through the Discrepancy Queue have clinical significance, you must define the discrepancy, using categories defined for management reporting. These categories enable you to define the severity of the discrepancy for quality assurance purposes.

Once a discrepancy category is assigned to a case, the category can be deactivated, but not deleted. Only active discrepancy categories are eligible for selection during Discrepancy Queue processing. All discrepancy categories are included on Management Reports.

```
                    General Hospital Maintenance - Anatomic Path Processor
 Community Lab                                          Mon Jun 12, 1995 05:56 pm


                    Workload/Quality Control Maintenance Functions          Page:01
 ( 1) Cytology Personnel
 ( 2) Diagnosis Categories
 ( 3) Discrepancy Categories
 ( 4) GYN Specimen Types
 ( 5) Repeat Queue Results
 ( 6) Workload/Quality Control Parameters
 ( 7) Z - Manual Workload/QC Deletion






 Enter choice--
```

To use this feature, select Discrepancy Categories on the Workload/Quality Control Maintenance Functions menu. If no active discrepancy categories codes exist, a blank screen displays with the following prompt:

Enter discrepancy category code--

Discrepancy codes can be up to six alphanumeric characters. When you enter a
discrepancy category code, the system displays the following screen:

```
                    General Hospital Maintenance Functions Processor
Community Lab                                        Mon Jun 12, 1995 01:22 pm
 Discrepancy Categories

( 1)Code          : MIN
( 2)Description   : Minor
( 3)Active        :

( 4)Edit by       :
( 5)Edit date/time:













 Enter discrepancy category description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code. It cannot be edited.

2. DESCRIPTION (36-AN-R)
This field enables you to enter a description of the category. The system displays the
following prompt:

  Enter discrepancy category description--

If the description entered has already been used, the following message displays:

  Description already used!

3. ACTIVE (1-A-O)
This field enables you to activate a specific discrepancy category. The system displays
the following prompt:

  Activate discrepancy category? (Y/N) [Y]--

If you enter **Y** or press ENTER, the Discrepancy Category option is activated. If you
enter **N**, an X displays in the Not Active column of the table. The option is deactivated
for the specific discrepancy category.

The system displays the following prompt to accept the screen:

  Accept this screen? (Y/N) [Y]--

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who made the last edits to the screen.

5. EDIT DATE/TIME (DISPLAY ONLY)
This field displays the date and time of the last edits to the screen. The system displays
the following prompt to accept the screen:

Accept this screen? (Y/N) [Y]--

If discrepancy category codes already exist, the screen displays existing Codes,
Descriptions, and Not Active indicators with the following prompt:

Enter option to edit, add(A), or delete(D)--

```
                  General Hospital Maintenance Functions Processor
Community Lab                                       Mon Jun 12, 1995 01:22 pm
 Discrepancy Categories


         Discrepancy Categories                        Not Active        Page:01
( 1) MIN - Minor                                            X
( 2) MOD - Moderate
( 3) SER - Severe










Enter option to edit, add(A) or delete(D)--
```

EDIT

You can edit the Discrepancy Category Screen by entering the Discrepancy Category
option number from the table. The desired discrepancy category information appears
with the following prompt:

Enter field number or '/' starting field number--

After you enter and accept the changes to the desired field(s), press ENTER. The
system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** or press ENTER to accept the discrepancy category information. The system
displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

ADD

You can add a discrepancy category to the table by entering **A**. The system displays the following prompt:

Enter discrepancy category code--

The discrepancy category code appears in the Discrepancy Category entry screen with the following prompt:

Enter discrepancy category description--

After you enter and accept the description, the system displays the following prompt:

Activate discrepancy category ? (Y/N) [Y]--

After you enter and accept your selection to the Active field, press ENTER. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** to accept the information. The system displays the following message:

Filed!

Enter **N** to return to the Edit field prompt.

DELETE

You can delete a discrepancy category from the table by entering **D**. A discrepancy category not assigned to any case (patient results) is eligible for deletion. The table of eligible discrepancy categories reappears with the following prompt:

Enter option to delete--

After you enter and accept the option, the system displays the following message and the entry no longer exists on the table:

Deleted!

If all defined categories have been attached to a case, you cannot delete any categories. If you select the Delete option, the following message displays:

No entries defined!

Impact

This option enables you to define the severity of clinically significant result discrepancies through discrepancy categories. Once a discrepancy category is assigned to a case, it can be deactivated, but not deleted. Only active discrepancy categories are eligible for selection during Discrepancy Queue processing, but all discrepancy categories are included on Management Reports.

GYN Specimen Types

Use this option to define specimens as gynecologic specimens to flag cytology cases as GYN in QC processing. The cases with these specimens (as primary specimens) will be eligible for random selection by the system for concurrent QC processing. These definitions also determine how Management Reports will sort statistical data.

```
                    General Hospital Maintenance - Anatomic Path Processor
Community Lab                                          Mon Jun 12, 1995 05:56 pm


                    Workload/Quality Control Maintenance Functions        Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Workload/Quality Control Parameters
( 7) Z - Manual Workload/QC Deletion




 Enter choice--
```

To use this option, select GYN Specimen Types on the Workload/Quality Control Maintenance Functions menu. If no active GYN specimen types exist, a blank screen displays with the following prompt:

Enter specimen type or '-' table--

This prompt enables you to enter the specimen type from the Specimen Table. A hyphen (**-**) entry displays a table of valid specimen types. You can select and enter one or more specimen types from the table.

Once a valid specimen type is entered and accepted, the system displays the following message:

Filed!

If GYN specimen types already exist, the screen displays the existing table. The system displays the following prompt:

Enter option to deactivate or add (A)--

```
General Hospital Maintenance Functions Processor
Community Lab                                    Mon Jun 12, 1995 01:22 pm
 GYN Specimen Types


                              GYN Specimen Types                    Page:01
( 1) 4-Cervix
( 2) 5-Cervical Smear
( 3) 88-Pap Smear









Enter option to deactivate or add(A)--
```

DEACTIVATE

You can deactivate a GYN specimen type by entering the GYN specimen type option
number from the table. If the GYN specimen has not been attached to patient data
through the application, the system deletes the entry and displays the following
message:

> *Delete (Specimen Type) - are you sure? (Y/N)--*

Enter **Y** to delete the GYN specimen type. The system displays the following message:

> *Deleted!*

If you enter an option to deactivate and the specimen has been defined to a patient
result (at the case level) for quality control, the following message displays:

> *Deactivated!*

ADD

Two scenarios exist for adding GYN specimen types to the GYN Specimen Types
Table.

The first scenario involves selecting a specimen from the Specimen Table for entry in
the GYN Specimen Type Table. The selected specimen has not previously been
added and deactivated from this table. Select the add(A) option. The system dsplays
the following prompt:

> *Enter specimen type or '-' for table--*

This prompt enables you to enter the specimen type from the Specimen Table. A hyphen (**-**) entry displays a table of valid specimen types. You can select and enter one or more specimen types. When you enter the specimen type, the system displays the following message and the entry is added to the table:

> *Filed!*

The second scenario involves reactivating a GYN specimen type that has been deactivated. Select the add(A) option. The system displays the following prompt:

> *Enter specimen type or '-' for table --*

When you enter the specimen type, the following prompt displays:

> *GYN specimen #### is not active! - Activate? (Y/N)--*

If you enter **Y**, the system displays the following message:

> *Activated!*

If you enter **N**, the system returns you to the list of defined GYN specimens to either select another entry to deactivate or to add a new specimen type.

Impact

This option enables you to define GYN specimen types using existing specimens from the Specimen Table. Only cases with a GYN specimen type as the primary specimen type are eligible for random selection for the QC process. The GYN specimen types defined here are also included on Management Reports.

Repeat Queue Results

Use this option to define the methods by which test components are processed through the Repeat Queue. All components on tests processed through this Queue are resulted in one of the following ways:

- The results are autofilled with results entered through result reporting.

- The results are entered in the Repeat Queue and are checked for discrepancies.

- The results are entered in the Repeat Queue and are not checked for discrepancies.

```
                    General Hospital Maintenance - Anatomic Path Processor
Community Lab                                           Mon Jun 12, 1995 05:56 pm


                    Workload/Quality Control Maintenance Functions        Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Workload/Quality Control Parameters
( 7) Z - Manual Workload/QC Deletion




    Enter choice--
```

To use this option, select Repeat Queue Results on the Workload/Quality Control
Maintenance Functions menu. A blank screen displays with the following prompt:

   Enter test code or '-' for table--

This prompt enables you to enter a code for an Anatomic Path Type test. A hyphen
(**-**) entry displays a table of valid Anatomic Path Type test codes that you can select.

When you enter a valid test code, the system displays the following screen and prompt:

   Autofill(A), check for discrepancy(D) or none(N)--

DEFINE REPEAT QUEUE PROCESSING

```
                    General Hospital Maintenance Functions Processor
Community Lab                                           Mon Jun 12, 1995 01:22 pm
 Repeat Queue Results


        CTYOLOGY SMEAR, GYN                                 Test code - 5010
    Component                              Process
     Clinical Data                        Auto
     Specimen Adequacy                     Auto
    *Explanation                          Auto
     Diagnosis                            Disc
    *Categorization                       Disc
    *Hormonal Evaluation                  Disc
     Maturation Index                     Disc
     Recommendations
     Estrogen Regimen
     SNOMED Code 1                        Disc
    #Review Queue                         Auto
     Reviewed by



             Autofill(A), check for discrepancy(D) or none(N)--
             F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

You can define components for the Repeat Queue Results processor by selecting one of the following options:

- If you enter **A**(Autofill), the system flags the component to autofill with original results (from result reporting) when viewed through the Repeat and Discrepancy Queues. The system displays *Auto* in the Process column.

  This option automatically fills in the results entered through result reporting when the test is processed through the Repeat Queue. These components are not eligible for edit in the Repeat Queue.

  You should use the Autofill option for components that do not require interpretation of the case, such as clinical information obtained at the time the specimen was received, date of surgery, and so forth.

- If you enter **D**(discrepancy), the system flags the component to be checked for discrepancies in results entered through result reporting and the Repeat Queue. The system displays *Disc* in the Process column.

  You should use the Discrepancy option for any field that is clinically significant to the reported results.

- If you enter **N**(none), the system does not check for discrepancies. You can enter a result through the Repeat Queue processor that is different from the results entered through result reporting. This option should be used for components such as Reviewed By, Released By, and so forth.

  NOTE: The None option resets an existing Auto or Disc setting from the Process column. The Process column remains blank.

When you complete your selection(s), press **F7**. The system displays the following prompt:

   Accept this screen? (Y/N) [Y]--

Enter **Y** or press ENTER to accept the information. The system displays the following message:

   Filed!

Enter **N** to return to the screen for further definition of components.

If no components on the test are defined for discrepancy checking, the following prompt displays and you are returned to the screen for input:

   No component(s) defined for discrepancy check!

If you enter the screen on a test previously defined for discrepancy checking, make no changes to the component processing, and press **F7** to exit, the following prompt displays:

> *Delete? (Y/N) [N] --*

Enter **Y** to reset the entire test and deactivate discrepancy checking. The Process column for all components on the test will be blank. Enter **N** to return to the Workload/ Quality Control Maintenance Functions Screen for another selection.

NOTE: If you are using an ordering test that is different from the resulting test (interdepartment test) and/or are using a *master/subordinate* setup, both tests must be defined in this processor with the same selections for identical components.

Results for Comparison

Use this option to define which test components are eligible for GYN Comparison processing.

To use this option, select Results for Comparison from the Workload/Quality Control Maintenance Functions Processor menu. The following prompt displays:

> *Enter test code or `-` for table--*

This prompt enables you to enter the test code for an Anatomic Path type test. A hyphen (**-**) entry displays a table of valid AP type tests.

When you enter a valid AP test, the following screen displays with a listing of all result components for the test.

```
                  General Hospital Maintenance - Anatomic Path Processor
Community Lab                                        Tue Jan 23, 1996 03:00 pm
 Results for Comparison


        CYTOLOGY,GYN SMEAR                            Test code - 5014
 Component                            Process
   Clinical Data                      Display
   Specimen Adequacy
  *Explanation
   Diagnosis                          Display
   Categorization                     Display
   Recommendations                    Display
   SNOMED Code 1                      Display
 #Review Queue
 #Transcriptionist
   Reviewed by                        Display




                     Display(D) for comparison or none(N)--
               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

This processor allows you to define which components are displayed during GYN Comparison processing. Only those result components defined as Display are included.

Enter **D** (Display) or **N** (None) for each component.

- **D** marks the component for display during GYN comparison processing. Display appears in the Process column.

- **N** excludes the component from the GYN comparison process. The Process column displays blank.

Enter **F7** to exit the scrolling screen. The following prompt displays:

Accept this screen? (Y/N) [Y]--

Enter **Y** to store the information on the system. The following message displays:

Filed!

Enter **N** to return to the scrolling screen for additional edits.

Impact

Changes in this processor only effect new GYN comparisons. All information logged for previous GYN comparisons is maintained by the system in their original format based on settings for each test at the time the comparison was performed.

Workload/Quality Control Parameters

Use this option to perform the following tasks:

- Activate workload and QC processing.

- Set the volume level for random selection of cases for the QC process.

- Activate auto high risk processing.

- Set the high risk default used to define individual cases.

- Set the department default for number of slides per case.

- Set the department default for number of slide counts per case.

- Define the negative GYN diagnosis category for QC processing.

- Set the security level for Discrepancy processing, QC process deletions, and workload/QC updates.

- Activate the 8-hour workload check.

You can activate Cytology workload and quality control and set the percent of cases to be randomly selected for the QC process with this option. Most regulatory agencies require at least a 10% blind concurrent review. The system randomly selects cases in real time during result reporting.

Only GYN cases with a negative diagnosis category are eligible for random selection. The specific negative diagnosis category used for this purpose is selected from the Diagnosis Categories maintenance processor and is also defined in this processor.

You can activate auto high risk processing with this option. If activated, the system sends all cases defined as high risk (during result reporting) to the Repeat Queue. These cases will not be included in the percent of randomly selected negative GYN cases also sent to the Repeat Queue for processing. A high risk default (Y/N) can also be defined in this processor.

You can define defaults for number of slides and slide counts per case with this option. As a result, the number of keystrokes required when entering information on the Workload/QC screen are reduced.

You can activate the 8-hour workload check. In addition to the CLIA '88 24-hour workload limit, each screener's maximum slide count must be performed in no less than 8 hours. The 8-hour check option monitors the screener's slide count rate by tracking the rate of result entry.

If results are entered in a *batch mode* (entering results at the end of the shift), the 8-hour check cannot be used. If results are entered in a *real time* mode (as soon as each case examination is complete) the system can check the 8-hour limit for each screener.

To use this option, select Workload/Quality Control Parameters on the Workload/Quality Control Maintenance Functions menu.

```
                    General Hospital Maintenance - Anatomic Path Processor
Community Lab                                       Mon Jun 12, 1995 05:56 pm

                    Workload/Quality Control Maintenance Functions        Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Workload/Quality Control Parameters
( 7) Z - Manual Workload/QC Deletion







    Enter choice-
```

The Workload/Quality Control Screen displays with the following prompt:

Enter field number or '/' starting field number--

```
            General Hospital Maintenance - Workload/Quality Control Processor
Community Lab                                       Mon Jun 12, 1995 10:58 am
 Workload/Quality Control

 1 Active          2 Percent QC      3 Auto High Risk   4 Default High Risk
   Yes               50 %              Yes                No

 5 Number of Slides                  6 Number of Counts  7 Workload/QC Prompt
   2                                    2.0                     Yes

 8 Negative Diagnosis Category/QC     9 Workload/QC Changes
   NEG                                  Pathologist [55]

10 8-Hour Check          11 Edit by              12 Edit date/time
   No                       Brown,Cindy              03/10/95 0933




 Enter field number or '/' starting field number--
```

Field Explanations

1. ACTIVE (1-A-R)
This field determines whether this feature will be activated. The system displays the following prompt:

Activate cytology workload/QC? (Y/N)--

2. PERCENT QC (3-N-R)
This field enables you to enter the volume level (percentage of total) of negative GYN cases to be selected by the system for QC processing. When you enter this field, the system displays the following prompt:

Enter percent of cases to be sent to repeat queue [10]--

The default is 10%. You can enter up to 100%.

NOTE: The processor used to randomly select eligible GYN cases for QC is driven by a built-in statistical utility known as a *random number generator*. This utility performs a percentage-based random selection *in real time* as the results for each test are accepted. Since all statistical utilities involve a probability factor, the percentage of cases selected by the system at the end of any given day may not equal the value set in this maintenance processor. The system can only approximate the desired value.

Achieving a true percentage would require a process that is neither random nor done in real time and would require holding all work until the end of the day. This function enables all cases *not* randomly selected for QC processing to be reported as soon as they are completed. Because of the probability factor, the outcome produced by this random selection process are greatly affected by the volume of cases screened. Lower volumes will produce greater variances.

The defined percentage value used in this algorithm can be adjusted up or down. To achieve a desired outcome over time, actual random selection values should be monitored, using the Screener GYN QC Report and adjustments made in this maintenance processor. This approach will help you meet the annual reporting requirements of CLIA'88.

3. AUTO HIGH RISK (1-A-R)
This field determines whether all cases defined as high risk will automatically be sent to the Repeat Queue. The system displays the following prompt:

Send all high risk to repeat queue? (Y/N)--

NOTE: Setting this field to *Yes* results in additional cases being added to the Quality Control check process. If all high risk entries are automatically sent to the Repeat Queue, they are not included in the percent QC defined in Field 2. Cases sent to the Repeat Queue using this process will be in the QCC status.

4. DEFAULT HIGH RISK (1-A-O)
This field enables you to define a default when you enter a high risk definition on a case through the application. You can define this default based on your patient population. If you do not define the default, the field will be blank. The system displays the following prompt:

Enter the default for the high risk prompt (Y/N)--

5. NUMBER OF SLIDES (2-N-O)
This field enables you to define the default used when you are prompted to enter the number of slides on a case through the application. You can enter *1* through *99* for the number of slides. If this field is left blank, the application will not have a default for the Number of Slides field. The system displays the following prompt:

Enter default number of slides per case (1-99)--

6. NUMBER OF COUNTS (4-NC-O)
This field enables you to define the default used when you are prompted to enter slide counts on a case through the application. You can enter *0.5* through *99*, in increments of *0.5*, for the number of actual slide counts expected for each case. If this field is left blank, the application will not have a default for the Number of Counts field. The system displays the following prompt:

Enter default slide count per case (0.5-99)--

7. WORKLOAD/QC PROMPT (1-A-R)
This field determines if users who are not defined in the cytology personnel table (usually non-technical staff members) are prompted to enter QC and workload information. Options are **Y** for Yes and **N** for No. If you enter **Y**, users not defined in the cytology personnel table are prompted for QC and workload information when entering patient results in Result Reporting. If you enter **N**, the only users prompted for a screener ID are those who are defined in the cytology personnel table (both active and inactive). A person not defined in the cytology personnel table cannot enter screener workload information for another person. The system displays the following prompt:

Prompt non-screeners for workload/qc information? (Y/N)--

8. NEGATIVE DIAGNOSIS CATEGORY/QC (TABLE LOOKUP-R)
The field defines which diagnosis category from the Diagnosis Categories maintenance processor is used to identify GYN cases as eligible for random selection for the QC process. The system displays the following prompt:

Enter diagnosis category or '-' for table --

When you select a category, the Diagnosis Category code displays in the field.

9. WORKLOAD/QC CHANGES (TABLE LOOKUP-R)
This field enables you to enter any defined security level or selection from the table. The selected security level appears with code in brackets in the field. The system requires a defined security level to make certain changes to workload and QC. Such changes include the following:

- Deleting cases from the Repeat Queue

- Making changes in the Update Workload Information processor

- Evaluating Discrepancy Queue information

The system displays the following prompt:

Enter security level or '-' for table--

10. 8-HOUR CHECK (1-A-R)
This field enables you to enter **Y** or **N** to activate the 8-hour check for screener workload. When this field is set to *Yes*, the system automatically makes the 8-hour check when evaluating workload for the current 24 hours. This process fulfills the regulation that the maximum slide count for the 24-hour period cannot be completed in less than 8 hours.

You must enter your results in real time--screen a case and then enter the results for that case. If your procedure does not include entry of results in real time, this field should be set to *No*. The system still monitors the maximum counts for the 24 hours, but will not invoke the check for maximum in less than 8 hours.

The system displays the following prompt:

Activate 8-hour check for workload monitoring? (Y/N)--

11. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who made the last edits to the screen.

12. EDIT DATE/TIME (DISPLAY ONLY)
This field displays the date and time the last information was filed for this screen. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Impact

This option activates the Cytology QC/Workload option and enables you to set certain parameters and department defaults related to this feature.

Manual Workload/QC Deletion

This option enables you to manually delete Cytology Workload/QC information from the system up to and including a specific end date when disk space is a problem. The system automatically deletes Cytology Workload and QC information once an accession is archived. If your archive period is long or disk space is a problem, you can use this option to delete a block of Workload/QC information.

NOTE: Once the data is deleted, the Management Reports will not include the deleted data.

To use this option, select Manual Workload/QC Deletion on the Workload/Quality Control Maintenance Functions menu.

```
                   General Hospital Maintenance - Anatomic Path Processor
Community Lab                                          Mon Jun 12, 1995 05:56 pm

                 Workload/Quality Control Maintenance Functions          Page:01
( 1) Cytology Personnel
( 2) Diagnosis Categories
( 3) Discrepancy Categories
( 4) GYN Specimen Types
( 5) Repeat Queue Results
( 6) Workload/Quality Control Parameters
( 7) Z - Manual Workload/QC Deletion






 Enter choice--
```

The following screen displays with a warning on deleting data.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                         Mon Jun 12, 1995 02:50 pm
 Manual Workload/QC Deletion




            WARNING - Before proceeding with a manual deletion, verify
                    needed workload and quality control data is available
                    with printed reports!









Continue? (Yes/N)--
```

The system displays the following prompt:

Continue? (Yes\N) --

If you enter **Yes**, the system checks the beginning date of Cytology Workload/QC that is stored and prompts for an END date. The following prompt displays:

Enter END date for deletion --

When you enter a valid End date, the following message displays:

Workload/Quality Control data deleted!

Once the deletion of data is completed, the following message displays on the console log. The deletion is ID specific and department specific.

*LE (ID X) Cytology Workload/QC deleted for Laboratory thru 02/11/95 0000

If you enter **N**(o), the system returns you to the Workload/Quality Control Maintenance Functions menu.

Go Live Utility

If this option appears on your screen, the Cytology Workload/QC option has not been implemented.

This utility is designed to eliminate build duplication. The table and parameter information can be built in the Test ID. Once this utility is activated, the information is moved automatically to the Live ID.

NOTE: This utility can be executed only once. After the utility is executed, the option is removed from the menu.

The following table and parameter information is moved from the Test ID to the Live ID when this utility is initiated:

- Case Number Pool Workload/QC indicator

- Cytology Personnel

- Diagnosis Categories

- GYN specimen Types

- Repeat Queue Results

- Workload/QC Parameters

The test code and specimen type information used in the GYN Specimen Types and Repeat Queue Results maintenance processors must be the same in both IDs. The case number pools must be the same for both the Test and Live IDs. The test code setup and the specimen table must be in sync for this utility to complete correctly. The same case number pools must be defined in both IDs.

The activation flag located in Maintenance Functions> Maintenance - Anatomic Path> Q-Workload/Quality Control> Workload/Quality Control Parameters is automatically set to *No* when the information is moved from the Test ID to the Live Id.

Once you select the *Go Live Utility* option, the system displays the following message and prompt:

WARNING: This utility should only be used when you are ready to go LIVE with cytology workload/qc. This function will move all cytology workload/ac maintenance files from ID 2 to ID 1. Verify the tables and parameters for cytology workload/qc are correct!

Continue? (Yes/N)--

This function also sets each case number pool's Workload/QC indicator according to the current setting in ID 2. Verify the Workload/QC indicators are correct at the case number pool level. The function can only be executed once. It is removed from the system upon completion.

ANATOMIC PATH TEST REPORT

The Anatomic Path Test Report is a utility to help you determine which tests are defined as Anatomic Path test types. This report prints for all departments.

NOTE: If you have implemented Anatomic Pathology prior to the 13.1 release, this report should be used to evaluate which tests should no longer be defined as Anatomic Path test types. Word processing and the Long Report are now available for General Test types.

Tests that have been defined as an AP Test type in the past to allow word processing should be changed to General Test types. AP test types with case number pools assigned can no longer be accessioned through general accessioning. This could impact work flow in other sections of the laboratory. This report provides a clear picture of which tests should remain as AP test types.

```
                     General Hospital Maintenance Functions Processor
 Laboratory                                          Wed Jun 01, 2005 03:06 pm

                          Laboratory Anatomic Path Functions              Page:01
 ( 1) A - Anatomic Path Parameters       (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters          (19) Z - Standard Result Text
 ( 3) B - Case number pools              (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Select the Anatomic Path Test Report from the Maintenance - Anatomic Path menu. The system displays the following flow of prompts:

The first prompt allows you to select the default or assign alternate printer if defined for the General Report report type.

Enter option number of alternate printer [default printer]--

The next prompt initiates the printing of the report:

Print Anatomic Path Test report? (Y/N) [Y]--

If you enter **Y**, the system displays the following message:

Report Printing!

If you enter **N**, the system returns to the Maintenance - Anatomic Path menu.

The report includes the following information:

Header Information

The Date/Time of the report is in the upper left hand corner.

The page number is in the upper right hand corner.

The report name is in the center of the second line.

The department name is below the report name.

Body of Report

The following columns of information are included in the report:

SECT
The section is in the first column.

CODE
The test code is in the second column.

DESCRIPTION
The test code description is in the third column.

CASE # POOL
The case number pool assigned to the testcode is in the fourth column. (This field may be blank if there is no case number pool assigned.)

HT PROC
Yes displays in the fifth column if histotech processes are defined for the test code. (If no histotech processes are defined, the field is empty.)

LONG REPORT
Yes displays in the sixth column if a Long Report is defined for the test code. (If no Long Report is defined, the field is empty.)

WP COMP
Yes displays in the seventh column if one or more word processing components are defined for the test code. (If no word processing components are defined, the field is empty.)

If multiple departments exist and no AP test types are found for a department, the report header information prints and the system prints the following message in the body of the report.

No AP Test Types found for this dept!

Figure 2.5 Anatomic Pathology Test Report (ALGRLGR0)

```
06/12/95  1040                                                        Page 1
                          Anatomic Pathology Test Report
                            Dept:   Community Lab

Sect    Code    Description                  Case # Pool    HT Proc    Long Rp  WP Comp
----------------------------------------------------------------------------------

CHE     2000    CK ISOENZYME                                             Yes      Yes
CYT     3009    CYTOLOGY, PAP                     C                      Yes      Yes
SPT     5050    GROSS & MICRO                     S         Yes          Yes      Yes



















                                  End of Report
```

HISTOTECH PROCESSES REPORT

To run the Histotech Processes report, select the Z - Histotech Processes Report option from the Anatomic Path Maintenance Functions menu.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                         Wed Jun 01, 2005 03:06 pm

                       Laboratory Anatomic Path Functions           Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files


 Enter choice--
```

You can print all processes on the system or individual processes. At the following prompt, enter **I** or press ENTER if you want to print a report containing individual processes.

> *Print all(A), or individual process(I)? [I]--*

The system prompts you to enter the process codes you want to print on the report:

> *Enter process code to print--*

Enter the process code you want to print or enter a hyphen (**-**) to display a table of codes for your selection. You cannot specify multiple codes directly at the prompt. Instead, enter a hyphen (**-**) to select multiple codes from the table.

When you enter one process code at the prompt, the system displays the codes along with the process description. If this is not the process you want to print on the report, enter **N** to return to the previous prompt. Enter **Y** or press ENTER to confirm the process.

> *Code CYT - CYTO SMR, FROM FLUID, correct? (Y/N) [Y]-- Y*

The system displays the default printer and enables you to select an alternate printer for the report:

```
General Hospital Maintenance Functions Processor
                                        Mon Jun 12, 1995 10:40 am




                        Default GENERAL REPORTS printer
                        3RD FLOOR PRINTER (port # 71)

                                Alternate Printers
( 1) Port # 105 - OUTSIDE COMPUTER ROOM
( 2) Port # 116 - 3RD FLOOR SECOND PRINTER
( 3) Port # 137 - MAIN LABORATORY PRINTER
( 4) Port # 246 - FRONT OFFICE
( 5) Port #  44 - COLLECTIONS PRINTER


Enter option number of alternate printer [Port #71]--
```

Press ENTER to accept the default printer or enter another option to select an alternate printer. The system displays the following message:

Process now printing!

If you want to print a report containing all processes on the system, enter **A** at the following prompt:

Print all(A), or individual process(I)? [I]-- **A**

You can include inactive processes on the report by entering **Y** at the following prompt:

Include inactive (Y/N)? [N]-- **Y**

Enter **N** or press ENTER to exclude inactive processes from the report.

See the following example of the Histotech Processes Report.

Figure 2.6 Histotech Processes Report (ALGRLGR0)

```
                                   Community Lab
                             Mon Jun 12, 1995 03:09 pm
                          Histotech Processes Calculation Report


                                                             Page: 1
     Process Code:        HE
     Process Description:  H&E
     ****************************************************************************
     ---------------
     BLOCK WORKLOAD:  88528 - Sections, Paraffin
     ---------------
       No. of         No. of
     Replicates  x  Counts/Block  x  Units  =  Workload
     ----------     ------------     -----     --------
         1              1            4.5         4.5


     ---------------
     SLIDE WORKLOAD:  88326 - Stain Only, H&E
     ---------------
       No. of         No. of            No. of
     Replicates  x  Slides/Block  x  Counts/Slide  x  Units  =  Workload
     ----------     ------------     ------------     -----     --------
         1              2                1             3.0         6.0


     ---------------
     LABELS PRINTED:
     ---------------
       No. of         No. of            No. of            No. of
     Replicates  x  Slides/Block  x  Labels/Slide  =  Labels Printed
     ----------     ------------     ------------     --------------
         1              2                1                  2


     ==============================================================================
     Process Code:        AHE
     Process Description:  Additional H&E
     ****************************************************************************
     ---------------
     BLOCK WORKLOAD:  No procedure defined
     ---------------
       No. of         No. of
     Replicates  x  Counts/Block  x  Units  =  Workload
     ----------     ------------     -----     --------
         1


     ---------------
     SLIDE WORKLOAD:  88326 - Stain Only, H&E
     ---------------
       No. of         No. of            No. of
     Replicates  x  Slides/Block  x  Counts/Slide  x  Units  =  Workload
     ----------     ------------     ------------     -----     --------
         1              2                1             1.5         3.0


     ---------------
     LABELS PRINTED:
     ---------------
       No. of         No. of            No. of            No. of
     Replicates  x  Slides/Block  x  Labels/Slide  =  Labels Printed
     ----------     ------------     ------------     --------------
         1              2                1                  2


     ==============================================================================
     P - Define value at Process time (calculation value = 1)
     A - Define value at Add time     (calculation value = 1)
     * - Value exceeds maximum of 99  (calculation value = display value)
                              ***End of Report***
```

Report Layout

Report Header

DEPARTMENT NAME
The name of the laboratory department prints on the first line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the second line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Histotech Processed Calculation Report*. This field prints below the Date/Time Printed field and is centered on the report.

PAGE NUMBER
The page number prints on the second line below the Report Title field. This field is right justified.

Report Body

The report body consists of up to two processes per report page. The report prints a row of equals signs (=) between the first and second processes on a page. Each process consists of the Block Workload, Slide Workload, and Labels Printed section.

In some histotech fields you can specify that the value be entered at processing or when adding the process to a block. This report prints *P* in these fields when you specify that the value be entered at processing, and prints *A* in these fields when you specify that the value be entered when adding the process to a block. If the report uses these fields to calculate workload or the number of labels printed, the system substitutes a value of 1 for these fields in the calculation. Refer to "HISTOTECH PROCESSES" on page 2-71 for more information on specifying these values.

The report also prints an asterisk (*) beside any field that exceeds a maximum value of 99. The report footer contains a legend that explains the calculation values for the letters P, A, and the asterisk (*). Refer to "PRINT LEGEND" on page 2-122 for more information on the field explanations.

PROCESS CODE
The process code prints on the first line for each process on the report. This field is left justified.

PROCESS DESCRIPTION
The process description prints below the Process Code field and is left justified. A line of asterisks (*) prints below this field to separate the Process Code and Process Description fields from the remainder of the process information.

Block Workload Section

BLOCK WORKLOAD CODE AND DESCRIPTION
The report prints a line of hyphens (-) above and below the BLOCK WORKLOAD field label. If you defined block workload for this process, this field consists of the block workload procedure code followed by a hyphen (-), and the block workload procedure description. If you did not define block workload for this process, the report prints *No procedure defined* in this field.

BLOCK WORKLOAD NUMBER OF REPLICATES
This field prints below the Block Workload Code And Description field. If you defined block workload for this process, this field contains the number of times the process is performed per block. If you did not define block workload for this process, this field contains a value of 1.

BLOCK WORKLOAD NUMBER OF COUNTS/BLOCK
This field prints to the right of the Block Workload Number Of Replicates field. If you defined block workload for this process, this field contains the number of counts when workload is captured at processing for this block. If you did not define block workload for this process, this field is blank.

BLOCK WORKLOAD UNITS
This field prints to the right of the Block Workload Number Of Counts/Block field. If you defined block workload for this process, this field contains the number of CAP workload units. If you did not define block workload for this process, this field is blank.

BLOCK WORKLOAD
This field is labeled *Workload* and prints to the right of the Block Workload Units field. If you defined block workload for this process, the value in this field is the result of multiplying together the number of replicates, the number of counts per block, and the CAP workload units. If you did not define block workload for this process, this field is blank.

Slide Workload Section

SLIDE WORKLOAD CODE AND DESCRIPTION
The report prints a line of hyphens (-) above and below the SLIDE WORKLOAD field label. If you defined slide workload for this process, this field consists of the slide workload procedure code followed by a hyphen (-), and the slide workload procedure description. If you did not define slide workload for this process, the report prints *No procedure defined* in this field.

SLIDE WORKLOAD NUMBER OF REPLICATES
This field prints below the Slide Workload Code And Description field. If you defined slide workload for this process, this field contains the number of times the process is performed per slide. If you did not define slide workload for this process, this field contains a value of 1.

SLIDE WORKLOAD NUMBER OF SLIDES/BLOCK
This field prints to the right of the Slide Workload Number Of Replicates field. If you defined slide workload for this process, this field contains the number of slides per workload block. If you did not define slide workload for this process, this field is blank.

SLIDE WORKLOAD NUMBER OF COUNTS/SLIDES
This field prints to the right of the Slide Workload Number Of Slides/Block field. If you defined slide workload for this process, this field contains the number of counts per workload slide. If you did not define slide workload for this process, this field is blank.

SLIDE WORKLOAD UNITS
This field prints to the right of the Slide Workload Number Of Counts/Slide field. If you defined slide workload for this process, this field contains the number of CAP workload units. If you did not define slide workload for this process, this field is blank.

SLIDE WORKLOAD
This field is labeled *Workload* and prints to the right of the Block Workload Units field. If you defined slide workload for this process, the value in this field is the result of multiplying together the number of replicates, the number of slides per block, the number of counts per slide, and the CAP workload units. If you did not define slide workload for this process, this field is blank.

Labels Printed Section

LABELS PRINTED HEADING
The report prints a line of hyphens(-) above and below the LABELS PRINTED section header. This header is left justified and prints below the Slide Workload section of the report.

LABELS PRINTED NUMBER OF REPLICATES
This field prints below the LABELS PRINTED section header and contains the number of replicates printed on the labels.

LABELS PRINTED NUMBER OF SLIDES/BLOCK
This field prints to the right of the Labels Printed Number Of Replicates field and contains the number of slides printed on the labels per block.

NUMBER OF LABELS/SLIDE
This field prints to the right of the Labels Printed Number Of Slides/Block field and contains the number of labels printed per slide.

NUMBER OF LABELS PRINTED
This field prints to the right of the Number Of Labels/Slide field. The value in this field is the result of multiplying together the number of replicates, number of slides per block, and number of labels per slide.

Report Footer

PRINT LEGEND
The report prints a legend at the bottom of the last page of the report describing the meaning of the letters *P* and *A* and the asterisk (*) when they print in histotech fields on the report. When the report performs calculations using these fields, a value of 1 is used for any field containing the letters P or A and the printed value is used for any field containing an asterisk. The asterisk flags a field as having exceeded the maximum limit of 99.

END OF REPORT
The report prints ****End of Report**** at the bottom of the last page of the Histotech Processes Calculation Report.

SNOMED CODES

A microglossary of the SNOMED dictionary is supplied with STAR Laboratory. The SNOMED Codes processor can be used to add, edit or delete entries.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                         Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions          Page:01
 ( 1) A - Anatomic Path Parameters       (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters          (19) Z - Standard Result Text
 ( 3) B - Case number pools              (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Access the SNOMED Codes processor.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                         Fri Jun 03, 2005 01:53 pm













 Edit General Categories(G), T-codes(T) or M-codes(M)--
```

Indicate the SNOMED table to access by entering **G** for General Categories, **T** for T-codes, or **M** for M-codes.

SNOMED GENERAL CATEGORIES

SNOMED GENERAL CATEGORIES displays in the upper left of the following screen.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                     Mon Jun 12, 1995 02:25 pm
SNOMED GENERAL CATEGORIES












        Enter SNOMED general category--
```

Indicate the new or existing general category code. To edit an existing code, use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

To add a new code, enter the code (must be less than three numeric characters). In this example, the new code 90 was entered. The system displays the following prompt:

Add this code [##]? (N)--

Enter **Y** or press ENTER to proceed. Enter **N** to exit. If **Y** is entered, the following screen displays:

```
                    General Hospital Maintenance Functions Processor
Community Lab                                     Mon Jun 12, 1995 02:25 pm
SNOMED GENERAL CATEGORIES
( 1)CODE         : 90
( 2)DESCRIPTION  : SAMPLE CODE DESCRIPTION
( 3)EDIT BY      : #02157









        Enter description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The general category code displays. This field cannot be edited.

2. DESCRIPTION (20-AN-R)
Enter the general category description. When you complete all required fields, the
system displays the following prompt:

Accept this screen? (Y/N'D'elete) [Y]--

Accept the screen by entering **Y** or pressing ENTER. The following message displays:

Filed!

You can then enter another general category code. Enter **N** to edit. Enter **D** to delete.
This deletion works the same as the one described next.

If, within this screen, you press ENTER without making any changes to an existing
SNOMED general category, the system displays the following prompt:

Delete? (N)--

To delete, enter **Y** and the system displays the following prompt:

Enter 'D'elete From File OR 'F'ile as Deleted (F)--

If your system is LIVE, you should use the File as Deleted option. Enter **D** to
completely delete the category or **F** to file as deleted (inactivate).

```
                    General Hospital Maintenance Functions Processor
 Community Lab                                    Mon Jun 12, 1995 02:25 pm
 SNOMED GENERAL CATEGORIES




 Do you wish a printed list? [N]--
```

This screen displays if you enter **G** for general category and press ENTER when the screen requests you to enter a code. To print a list, enter **Y**. To exit, enter **N** or press ENTER. If **Y** is entered, the next screen displays a list of alternate printers available for this report. Select a printer or press ENTER for the default.

SNOMED M-CODES

Indicate the SNOMED table to access by entering **G** for General Categories, **T** for T-codes, or **M** for M-codes. In the following example, **M** is entered.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                          Fri Jun 03, 2005 01:53 pm




















 Edit General Categories(G), T-codes(T) or M-codes(M)--
```

Notice SNOMED `M` CODE displays in the upper left of the following screen.

```
                    General Hospital Maintenance Functions Processor
 Community Lab                                        Mon Jun 12, 1995 02:26 pm
 SNOMED `M` CODES

















 Enter SNOMED `M` code--
```

Indicate the new or existing M-code. To edit an existing code, use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

To add a new code, enter the code. In this example, the new code D-0133 was entered. The system displays the following prompt:

> *Add this code [##]? (N)--*

Enter **Y** or press ENTER to proceed. Enter **N** to exit. If **Y** is entered, the following screen displays.

```
                    General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 02:26 pm
SNOMED M-Codes
( 1)Code        : D-0110
( 2)Description : Bacterial infection, NOS
( 3)Groups      : 02,04,08,15,75

( 4)Alternate 1 :
( 5)Alternate 2 :
( 6)Alternate 3 :

( 7)Edit By     : #30573




Enter field number of '/' starting field number--
```

Field Explanations

1. CODE (7-N-R)
The M-code displays. This field cannot be edited.

2. DESCRIPTION (60-C-R)
Enter the M-code description.

3. GROUPS (TABLE LOOKUP)
Select the General Category (one or more) to which this M-code belongs from the displayed list of SNOMED Groups.

4-6. ALTERNATE 1-3 (20-AN)
These fields allow the definition of alternate names for M-codes. Alternate names entered are cross-referenced to the main M-code definition.

The system displays the following prompt:

> *Enter new alternate M-Code description one--*

When you complete all required fields, the system displays the following prompt:

Accept this screen? (Y/N'D'elete) [Y]--

Accept the screen by entering **Y** or pressing ENTER. The following message displays:

Filed

Please wait, Updating T&M Combination!

You can then enter another M-code. Enter **N** to edit. Enter **D** to delete. This deletion works the same as the one described next.

If you press ENTER without making any changes to this screen, the system displays the following prompt:

Delete? (N)--

To delete, enter **Y** and the system displays the following prompt:

Enter Delete (D) From File or File as Deleted (F)--

If your system is LIVE, it is recommended that you use the file as deleted option. Enter **D** to completely delete the M-code or **F** to file as deleted (inactivate). The system displays the following prompt:

Please wait, Deleting T&M Combination

```
                    General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 02:27 pm
SNOMED `M` CODES

















Do you wish a printed list? [N]--
```

This screen displays if you enter **M** for M-code and press ENTER when the screen requests you to enter a code. To print a list, enter **Y**. To exit, enter **N** or press ENTER. If **Y** is entered, the next screen displays a list of alternate printers available for this report. Select a printer or press ENTER for the default.

SNOMED T-CODES

Enter **T** at the following prompt to create, edit, or delete a T-code.

```
                 General Hospital Maintenance Functions Processor
 Laboratory                                        Fri Jun 03, 2005 01:53 pm














     Edit General Categories(G), T-codes(T) or M-codes(M)--
```

The system displays the following prompt:

   Enter SNOMED `T` code-- **-**

Enter the code of up to 7 characters. The standard format is T-NNNNN. To edit an existing code, use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

```
                 General Hospital Maintenance Functions Processor
 Community Lab                                      Mon Jun 12, 1995 02:26 pm
 SNOMED `T` CODES
 ( 1)Code        : T-04000
 ( 2)Description  : Breast
 ( 3)Groups       : 09,10,15
 ( 4)Default Group: 15
 ( 5)Specimens    : 34,45,67,246

 ( 6)Alternate  1 :
 ( 7)Alternate  2 :
 ( 8)Alternate  3 :

 ( 9)M-Code       : M-00100 - Normal tissue, NOS
 (10)Misc/Alt Code:
 (11)Edit By      : #30793




     Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The T-code entered on the previous screen displays. This field cannot be edited.

2. DESCRIPTION (60-C-R)
Enter the T-code description of up to 60 alphanumeric characters.

3. GROUPS
Select the General Category (one or more) to which this T-code belongs. Assigning a T-code to one or more General Categories determines the category it displays in results entry.

4. DEFAULT GROUP (3-NR)
This field determines the group of T-codes that display when auto T-coding is activated. Only one of the defined groups may be defined as a default. A table of the selected group numbers with descriptions displays for selection of a default. The system displays the following prompt:

> *Enter default group or '-' for table--*

5. SPECIMENS (3-N-O)
This field allows you to select valid specimens that can be cross-referenced to the T-code. When you access this field, the system displays the following prompt:

> *Enter specimen type or `-` for table--*

Multiple selections are allowed. The codes for the defined specimens display in the field. The maximum number of specimens allowed per T-code is 20.

6-8. ALTERNATE NAMES (20-AN)
These fields allow the use of alternate names for T-codes. Entering an alternate name cross-references the main T-code definition. When you access these fields, the system displays the following prompt:

> *Enter new alternate T-Code description (insert number)--*

9. M-CODE
To make diagnostic coding easier and faster, T- and M-code combinations can be established for those most commonly used by the laboratory. In order to link codes, one Master T-code must be defined without an M-code. Then subsets of that T-code can be combined with a predefined M-code. See the note for the Misc/Alt Code field.

Enter the M-code for this T-code combination or use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

10. MISC/ALT CODE
The miscellaneous code is used for ICD CM codes or any other coding scheme which reflects the T- and M-code combination. Enter the miscellaneous/alternate code.

NOTE: The base SNOMED glossary does not include any T & M combinations or Miscellaneous codes.

Upon completion of all required fields, the system displays the following prompt:

Accept this screen? (Y/N'D'elete) [Y]--

Accept the screen by entering **Y** or pressing ENTER. The following message displays:

Filed

Please Wait, Updating T&M Combinations!

You can then enter another general category code. Enter **N** to edit. Enter **D** to delete. If you press ENTER without making any changes to this screen, the system displays the following prompt:

Delete? (N)--

To delete, enter **Y** and the system displays the following prompt:

Enter Delete (D) From File or File as Deleted (F)--

If your system is LIVE, you should use the File as Deleted option. Enter **D** to completely delete the T-code or **F** to file as deleted (inactivate).

The following screen displays if you enter **M** for M-code and press ENTER when the screen requests you to enter a code. To print a list, enter **Y**. To exit, enter **N** or press ENTER. If **Y** is entered, the next screen displays a list of alternate printers available for this report. Select a printer or press ENTER for the default.

```
                  General Hospital Maintenance Functions Processor
Community Lab                                      Mon Jun 12, 1995 02:26 pm
SNOMED `T` CODES








          
          
          
          
          
Do you wish a printed list? [N]--
```

SNOMED CT CANCER PROTOCOLS

SNOMED CT Cancer Protocols is located under Laboratory Anatomic Path Functions to give you the capability to upload and format the College of American Pathologists (CAP) Cancer Protocols to STAR.

Through existing tools, you are able to download needed cancer protocols from the SNOMED checklist CD to your PC.

NOTE: The download file path is defined in the Download Protocol File Path field under Maintenance - Anatomic Path>Anatomic Path Parameters.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                      Mon Jun 13, 2005 11:07 pm


                    Laboratory Anatomic Path Functions           Page:01
 ( 1) A - Anatomic Path Parameters      (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters         (19) Z - Standard Result Text
 ( 3) B - Case number pools             (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Select **SNOMED CT Cancer Protocols** and the following processors are available:

•   Transmit CAP Protocol to STAR

•   Process Downloaded Files

•   Setup Protocol Template

•   Assign Component Lines

•   Test Protocol Template

•   Activate/Delete Template Version

Transmit CAP Protocol to STAR

This process uploads the Cancer Protocols into STAR.

```
              General Hospital Z - SNOMED CT Cancer Protocols Processor
                                                   Mon Jun 13, 2005 11:08 am
   Z - SNOMED CT Cancer Protocols Input Options

              Option No.  Option
              ----------------------------------------

                  1          Transmit CAP Protocol to STAR
                  2          Process Downloaded Files
                  3          Setup Protocol Template
                  4          Assign Component Lines
                  5          Test Protocol Template
                  6          Activate/Delete Template Version

   Enter option number--
```

Select **Transmit CAP Protocol to STAR** to begin the protocol upload and the
following screen is displayed:

```
              General Hospital - Transmit CAP Protocol to STAR Processor
                                                   Mon Jun 13, 2005 11:24 am

    This function is used to download CAP Protocols to STAR.

    The ascii text file ( .txt) must first be loaded on your workstation.
    You may enter the location of the file on your workstation, if the file
      is not in the default folder: c:\temp\snomedct

    If you accept the default or enter a path with an "*", the system will
      give you a list to choose from.


      Enter the folder path and file name [c:\temp\snomedct]
```

Press ENTER or enter the name of the required directory and a list of .txt files to
choose from is displayed on the following screen:

```
                       General Hospital - Download CAP Protocol Processor
                                                        Mon Jun 13, 2005 11:26 am
     Page:01                                                ##=Current Choices

                           SNOMED CT Cancer Protocol (text file)
     ( 1) RELEASEADRENAL04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 2) RELEASEAMPVAT04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 3) RELEASEANUS04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 4) RELEASEBLADDER04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 5) RELEASEBONEMAR04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 6) RELEASEBRAIN04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 7) RELEASEBREAST04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 8) RELEASECOLON04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     ( 9) RELEASEENDOMET04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (10) RELEASEEOSPH04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (11) RELEASEEXBIL04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (12) RELEASEFALLOP04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (13) RELEASEGALLBLAD04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (14) RELEASEGILYMPHJAN04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (15) RELEASEHEART04RDCODED_CKLST_TABDELIMITED_20040731.TXT
     (16) RELEASEHODGKIN04RDCODED_CKLST_TABDELIMITED_20040731.TXT



      Enter number of the file to upload to STAR-
                  next pg(/ or PG DN) Search (TAB)
```

Choose one file and the status of the upload is displayed in a pop-up window as shown below:

Once the upload process is complete, the *Upload complete* message is displayed on the top left of the screen and you are returned to the SNOMED CT Cancer Protocols menu.

If there are no items for download found in the desired directory, the following screen and error message are displayed. You are then returned to the SNOMED CT Cancer Protocols menu.

```
                     General Hospital - Download CAP Protocol Processor
                                                     Mon Jun 13, 2005 11:28 am

     This function is used to download CAP Protocols to STAR.

     The ASCII text file ( .txt) must first be loaded on your workstation.
     You may enter the location of the file on your workstation,
       if the file is not in the default folder: C:\temp\SNOMED CT\.txt

     If you accept the default or enter a path with an "*",
       the system will give you a list to choose from.


       Enter the folder path and file name [C:\temp\SNOMED CT\.txt]




                         No text files found in specified folder!
```

NOTE: If you press period (.) ENTER while you are in the processor, you are returned to the SNOMED CT Cancer Protocols menu.

Process Downloaded Files

This processor is used to create files on STAR that support the use of CAP cancer protocol to enter results for tests in Anatomic Pathology. This processor allows you to:

- Process an uploaded file in order for STAR to format it for use in Result Reporting.

- Assign a user friendly name to the protocol in order for it to be easily recognized in the application.

- Delete unwanted files before they are processed.

```
              General Hospital Z - SNOMED CT Cancer Protocols Processor
                                                     Mon Jun 13, 2005 11:08 am
   Z - SNOMED CT Cancer Protocols Input Options

              Option No.  Option
              ---------------------------------------

                    1        Transmit CAP Protocol to STAR
                    2        Process Downloaded Files
                    3        Setup Protocol Template
                    4        Assign Component Lines
                    5        Test Protocol Template
                    6        Activate/Delete Template Version




   Enter option number--
```

Select **Process Download Files** and the following screen is displayed:

```
            General Hospital  - Process Downloaded Files Processor
                                          Thu Apr 17, 2008 04:25 pm

  This function is used to create files on STAR that will support the use
  of CAP cancer protocol to enter results for tests in Anatomic Pathology.

  You may select from the list of protocols which have been downloaded
  to STAR.

 Page:01                    CAP Protocols to be processed
 ( 1) RELEASEADRENALGLAND2_08RDCODED_CKLST_DELIMITED_20080131.TXT
 ( 2) RELEASEBLADDER05RCODED_CKLST_DELIMITED_20060131.TXT
 ( 3) RELEASEBREAST1_08RDCODED_CKLST_DELIMITED_20080131.TXT
 ( 4) RELEASECOLON05RDCODED_CKLST_DELIMITED_20060131.TXT
 ( 5) RELEASECOLON15_07RDCODED_CKLST_DELIMITED_20070731.TXT
 ( 6) RELEASEENDOMET05RDCODED_CKLST_DELIMITED_20060131.TXT
 ( 7) RELEASEHEART05RDCODE_CKLST_DELIMITED_20060131.TXT
 ( 8) RELEASEHEART44_07RDCODED_CKLST_DELIMITED_20070731.TXT
 ( 9) RELEASEKIDNEY05RDCODED_CKLST_DELIMITED_20060131.TXT
 (10) RELEASELUNG49_07RDCODED_CKLST_DELIMITED_20080131.TXT
 (11) RELEASEWILMS05R_CKLST_DELIMITED_20060131.TXT

 Enter number of the protocol to process
```

The next step in processing is to give each protocol a user recognizable name to be used in the application. To do this, choose one protocol from the list to process. Only one selection can be made at a time.

After the protocol is selected, a prompt similar to the following is displayed:

> *RELEASEADRENALGLAND2_08RDCODED_CKLST_DELIMITED_20080131.TXT*

> *Delete(D) or Process(P) --*

If you enter **D**, the file is removed from the system and the following message is displayed.

> *Deleted!*

NOTE: Deleted files can be transmitted again using the *Transmit CAP Protocol to STAR* processor.

If you enter **P**, the following screen is displayed:

```
              General Hospital - Process Downloaded Files Processor
                                              Thu Apr 17, 2008 05:07 pm

   This function is used to create files on STAR that will support the use
   of CAP cancer protocol to enter results for tests in Anatomic Pathology.



   You have selected ADRENALGLAND2

   Please see the visible text column of the Checklists Table in Microsoft
   Access Database SNOMED CT - Encoded CAP Cancer Checklists for a suggested
   name of this protocol.

                          Adrenal gland: Resection

   Warning: Use only the dash (-) or space characters when applicable in the
   CAP Cancer Protocol name to avoid resulting issues! Do not use colons,
   semi-colons, parentheses etc..


  Enter CAP Cancer Protocol name--
```

On this screen, the message *You have selected 'XX'* is displayed mid-screen. This
message shows the abbreviated protocol name you have selected from the
downloaded file name. Also, you are referred to the visible text column of the
Checklists Table in Microsoft Access Database SNOMED CT - Encoded CAP Cancer
Checklists to assist in naming the protocol.

The following warning about allowable characters is displayed:

> *Warning: Use only the dash (-) or space characters when applicable in the
> CAP Cancer Protocol name to avoid resulting issues! Do not use colons,
> semi-colons, parentheses etc..*

At the bottom of this screen, the following prompt is displayed:

> *Enter CAP Cancer Protocol name--*

Enter the protocol name and press ENTER. The first 30 characters entered are filed.
To exit the processor press period (.) ENTER. The following message is displayed
when the template processing is complete:

> *Completed!*

The processed protocol is removed from the list and you are returned to the *SNOMED
CT Cancer Protocols* menu.

After the protocol is processed, wherever the protocol name is displayed, the user-
defined name followed by the protocol number with the version number in parenthesis
is displayed:

```
                    General Hospital - Process Downloaded Files Processor
                                                    Fri Apr 18, 2008 01:22 pm

    This function is used to create files on STAR that will support the use
    of CAP cancer protocol to enter results for tests in Anatomic Pathology.




    You have selected ADRENALGLAND2

    Please see the visible text column of the Checklists Table in Microsoft
    Access Database SNOMED CT - Encoded CAP Cancer Checklists for a suggested
    name of this protocol.

                            Adrenal gland: Resection

    Warning: Use only the dash (-) or space characters when applicable in the
    CAP Cancer Protocol name to avoid resulting issues! Do not use colons,
    semi-colons, parentheses etc..


 Enter CAP Cancer Protocol name-Adrenal Gland Resection
                                   Completed!
```

If all the files have been processed or there are no files existing, the following screen and error message are displayed. You are then returned to the SNOMED CT Cancer Protocols menu.

```
                    General Hospital - Build CAP Protocol Files on STAR Processor
                                                    Mon Jun 13, 2005 11:38 am

    This function is used to create files on STAR that will
    support the use of CAP cancer protocol to enter results
    for tests in Anatomic Pathology.

    You may select from the list of protocols which have been
    downloaded to STAR:


  Page:01                    CAP Protocols to be processed      ##=Current Choices






                               No entries defined!
```

If the downloaded file is not formatted properly, the following screen and errormessage are displayed. You are then returned to the SNOMED CT Cancer Protocols menu.

```
              General Hospital - Build CAP Protocol Files on STAR Processor
                                                    Tue Jun 14, 2005 10:45 am

    This function is used to create files on STAR that will
    support the use of CAP cancer protocol to enter results
    for tests in Anatomic Pathology.

    You may select from the list of protocols which have been
    downloaded to STAR:


    Page:01                    CAP Protocols to be processed      ##=Current Choices




                          Sequence error in download file
```

Setup Protocol Template

This processor allows you to:

- Define what protocol items are displayed in Result Reporting and what protocol
  items print on patient reports.

- Designate what type of processing occurs for each line of the protocol in Resulting
  Reporting.

- Turn on and off auto-coding of results.

NOTE: This processor is not department specific. If multiple lab departments exist,
they must agree on the Protocol template setup. The protocols are shared
between lab departments.

```
              General Hospital Z - SNOMED CT Cancer Protocols Processor
                                              Mon Jun 13, 2005 11:08 am
Z - SNOMED CT Cancer Protocols Input Options


          Option No.  Option
          ---------------------------------------

              1       Transmit CAP Protocol to STAR
              2       Process Downloaded Files
              3       Setup Protocol Template
              4       Assign Component Lines
              5       Test Protocol Template
              6       Activate/Delete Template Version




Enter option number--
```

Select **Setup Protocol Template** and the following screen is displayed:

```
                General Hospital  - Setup Protocol Template Processor
                                             Tue Jun 14, 2005 10:49 am
   You may use Up/Down arrows, PageUp, PageDown, or the Enter key to navigate
     Type a "?" to display this page.
 * Enter a letter next to each line in the protocol - designating
     N - Never show this line
     D - Display in results entry but do not include in report
     R - always include this line in the Report
     C - include this line Conditionally if it is selected with an X
     C+n C-n - include line Conditionally if line at offset n is included
     P - Display this line in the report and Prompt for related input
     S - This line is part of a group from which a Single line may be selected
     M - This line is part of a group from which Multiple lines may be selected
 * You may also indent or edit a template line:
     T - Tab this line to indent
     E - Edit the text in this line (Navigate edit line with Left and Right
         arrows. Use Down arrow to Delete, Up arrow to Insert)
     ' - will toggle CT coding off, or back on, for this line.




 Press NL--
```

When the above screen is displayed, press ENTER or the screen times out and takes
you to the following screen. A list of available protocols is displayed on the following
screen.

```
                General Hospital Protocol Template Processor
                                             Fri Apr 18, 2008 01:22 pm






 Page:01                   CAP Protocols for definition       ##=Current Choices
 ( 1) ADRENAL GLAND(2,16)
 ( 2) ANUS (5,19)
 ( 3) BLADDER (8,22)
 ( 4) ESOPHAGUS(19,34)
 ( 5) HEART (44,59)
 ( 6) PERITONEUM (55,70)


 Enter number of protocol to define--
```

Choose only one protocol and the following screen is displayed. Previously defined
protocols are displayed for edits to be made. To exit the processor press period (.)
ENTER.

```
                      General Hospital Protocol Template Processor
                                                   Tue Jun 14, 2005 10:59 am
      N   Surgical Pathology Cancer Case Summary (Checklist)
      N   Applies to malignant cardiac tumors only
      N   No AJCC/UICC staging system
      N   January 2003
      N   HEART: Resection
      N   Patient name:
      N   Surgical pathology number:
      N   Note: Check 1 response unless otherwise indicated.
      N   MACROSCOPIC
      D   SPECIMEN TYPE
      S   ___ Excisional biopsy
      P   ___ Other (specify): ____not coded
      S   ___ Not specified
      D   TUMOR SITE (check all that apply)
      M   ___ Pericardium
      M   ___ Right ventricle
      M   ___ Left ventricle
          ___ Right atrium
          ___ Left atrium
          ___ Other (specify): ___not coded
```

For every line in the protocol, the .txt file is displayed for you to define how it is processed.

In the above screen, the lines that have been previously defined have a letter to the left of the line. The lines that are blank have not yet been defined. For items that are too long to display on a single line, the information wraps to the next line.

To navigate through this screen, use the up and down cursor arrows as well as PAGE UP and PAGE DOWN buttons. To exit the processor, press period (.) ENTER.

Various definitions are available for each line and are described as follows. Upper and lower case entry is permitted; letters are converted to upper case if lower case entry is used.

- **N** - This line is never displayed online or printed on a patient's report.

- **D** - This line is displayed in resulting, but is not printed on a patient's report.

- **R** - This line auto codes the item with the CAP defined SNOMED CT code and is printed on a patient's report.

- **C** - Allows you to conditionally define whether the line is shown in resulting and/or printing. For example, if an item is chosen that has an associated comment, use this definition to define the item line and comment line(s). The system auto codes the item with the CAP defined SNOMED CT code

- **C+n, C-n** - Allows you to include the next or previous line if line C is selected. Using this function allows you to include text that is continued on multiple lines. When the

protocol is initially processed, lines are automatically marked to indicate a continuation of text. Youcan override this withanother function, such as N, in order for the line to not be displayed. If reported, the system auto codes the item with the CAP defined SNOMED CT code.

- **P** - This line auto codes the item with the CAP defined SNOMED CT code and is displayed in resulting. For example, this definition is used when no underscore exists at the front of a line, but information is required elsewhere in the line.

- **S** - Only one item is permitted for resulting in a series of items. Use this definition to indicate only one choice is permitted. When in use, the system does not allow more than one item in the series to be resulted and auto codes the item with the CAP defined SNOMED CT code.

- **M** - Multiple items are permitted for resulting in a series of items. Use this definition to indicate multiple choices are permitted. When in use, the system allows more than one item in the series to be resulted and auto codes the items with the CAP defined SNOMED CT codes.

- **T** - Number of spaces to indent (0 - 22). The default is four. You can edit the number of tabbed spaces. If an edit to the default occurs, the new number of spaces is reflected throughout the template build.

- **E** - Allows the user to edit the text in the line. All text in the line can be completely deleted using this option.

- **'** - Entering an apostrophe toggles auto-coding on and off. This function is used in combination with one of the other functions. If an apostrophe (') is entered, the following prompt is displayed with the applicable SNOMED code on the line.

  AutoCode line 371439000 is On - Set to Off? (Y/N) [Y]-

  The actual prompt depends on how the line is currently set. If auto-coding is currently off, the following prompt is displayed:

  AutoCode line 371439000 is Off - Set to On? (Y/N) [Y]-

- **?** - If you enter a question mark, the information screen is displayed.

If an incorrect character is entered, the following prompt is displayed:

  Designate line as N, D, R, C, P, S, M or - Enter E, T- ? for help--

Once definitions are completed, the message *End of template* is displayed and you are returned to the SNOMED CT Cancer Protocols menu.

Assign Component Lines

This processor allows you to:

- Choose one protocol at a time for mapping.

- Use special characters to define a component line start/stop.

- Prompt for test code selection.

- Display a list of word-processing components.

This processor is department specific. Each lab department can have different components in their tests and can set up different line assignments.

```
             General Hospital Z - SNOMED CT Cancer Protocols Processor
                                              Tue Jun 14, 2005 11:15 am
 Z - SNOMED CT Cancer Protocols Input Options

             Option No.  Option
             ---------------------------------------

                 1        Transmit CAP Protocol to STAR
                 2        Process Downloaded Files
                 3        Setup Protocol Template
                 4        Assign Component Lines
                 5        Test Protocol Template
                 6        Activate/Delete Template Version




 Enter option number--
```

Select **Assign Component Lines** and the following screen is displayed:

```
                    General Hospital Assign Component Lines Processor
                                                    Tue Jun 14, 2005 11:21 am

  This function allows you to associate lines with specific components used
  in results entry.

  You should enter an open bracket ([) next to the first line for a component
  Then move down to the last line and enter a closed bracket (]).

  If there is only one line for the component enter an exclamation mark (!)
  before the line.

  Use the 'DEL' key to remove a marker.

  You may use the Up and Down cursor arrows to navigate when making changes.




 Press NL--
```

Once you press ENTER, the following screen of available protocols is displayed. Previously defined protocols are displayed for edits to be made. To exit the processor press period (.) ENTER.

```
                    General Hospital Assign Component Lines Processor
                                                    Fri Apr 18, 2008 01:22 pm




 Page:01                    CAP Protocols for definition        ##=Current Choices
 ( 1) ADRENAL GLAND(2,16)
 ( 2) ANUS (5,19)
 ( 3) BLADDER (8,22)
 ( 4) ESOPHAGUS(19,34)
 ( 5) HEART (44,59)
 ( 6) PERITONEUM (55,70)


 Enter number of protocol to define--
```

When a protocol is chosen, you are prompted to enter a test code. The test code, the first letters of the test code followed by a hyphen (-), or a single hyphen (-) can be entered for a list of all test codes displayed in a table. If a test code is chosen that does not contain a word processing component, the message *No word processing components are defined for test code: (nnnn)* is displayed where *nnnn* gives the test code number entered.

Once a qualified test code is entered, the protocol text is displayed. Enter a left bracket ([) next to the first line to include it in the component. A table of word processing components to choose from is displayed:

```
                    General Hospital Assign Component Lines Processor
                                                Fri Apr 18, 2008 01:22 pm


    Surgical Pathology Cancer Case Summary (Checklist)
    Applies to invasive carcinomas only
    Based on AJCC/UICC TNM, 6th edition
    January 2003
 [  BREAST: Excision Less Than Total Mastectomy (Includes Wire-Guided Locali<
    Patient name:
    Surgical pathology number:
Page:01              Which component begins on this line?    ##=Current Choices
( 1) 10517 -  Gross Description
( 2) 11092 -  Microscopic Exam
( 3) 11091 -  Diagnosis
( 4) 10516 -  Protocol Report




Enter number of component--
```

When the component is chosen the phrase *<begin and the component number>* is displayed on the line where the left bracket ([) was entered. When the right bracket (]), which notifies the system that the data is completed for the chosen component, is entered, *<end and the component number>* is displayed.

If a left bracket ([) is defined, but the corresponding right bracket (]) is not, the system does not file the left bracket. Therefore, a partial component build is prohibited.

```
                    General Hospital Assign Component Lines Processor
                                                Tue Jun 14, 2005 11:42 am


    Surgical Pathology Cancer Case Summary (Checklist)
    Applies to invasive carcinomas only
    Based on AJCC/UICC TNM, 6th edition
    January 2003
    BREAST: Excision Less Than Total Mastectomy (Includes Wire-Guided Localiz
    Patient name:
    Surgical pathology number:
    Note: Check 1 response unless otherwise indicated.
 [  MACROSCOPIC                                              <begin 10516>
    SPECIMEN TYPE
    ___ Excision
    ___ Mastectomy
    ___ Other (specify): ____not coded
 ]  ___ Not specified                                        <end 10516>
    LYMPH NODE SAMPLING
    ___ No lymph node sampling
    ___ Sentinel lymph node(s) only
    ___ Sentinel lymph node with axillary dissection
    ___ Axillary dissection
    SPECIMEN SIZE (for excisions less than total mastectomy)
```

Arrow keys, PAGE UP and PAGE DOWN keys are used to move through lines and pages. Press period (.) ENTER to exit the processor. Assignments to the protocol are filed.

If an incorrect character or question mark (**?**) is entered, the following message is displayed:

> *Designate first line as [, last line as] --.*

An exclamation point (!) is used to designate a single line beginning and ending. For example, a *COMMENT(s)* line in the protocol may be mapped to an Addendum component. Using an exclamation point files all information in the single *COMMENT(s)* line of the protocol into the Addendum component.

Use the DEL key to remove a bracket and corresponding line assignment. Removing one bracket (left or right) removes both left and right brackets.

You may change a line assignment once it has been filed. If the system detects a current line assignment, the following prompt is displayed:

> *Replace current range? (Y/N) [N]-*

If you enter **Y**, both current beginning and ending brackets are removed and you can replace it with a new range.

If you enter **N**, the current line assignment is maintained.

```
            General Hospital Assign Component Lines Processor
                                          Tue Jun 14, 2005 12:30 pm

 *VENOUS/LYMPHATIC (LARGE/SMALL VESSEL ) INVASION (V/L)
    *___  Absent
    *___  Present
    *___  Indeterminate
    *MICROCALCIFICATIONS (check all that apply)
    *___  Not identified
    *___  Present in DCIS
    *___  Present in invasive carcinoma
    *___  Present in nonneoplastic tissue
    *___  Present in both tumor and nonneoplastic tissue
    *ADDITIONAL PATHOLOGIC FINDINGS
  ! *COMMENT(S)                                          <11091>
    BreastCAP Approved
    CAP ApprovedBreast
    *  Data elements with asterisks are not required for accreditation purpose for
    the Commission on Cancer. These elements may be clinically important,
```

When all lines have been defined, pressing ENTER at the last line of the protocol takes you back to the SNOMED CT Cancer Protocols menu.   You can also use period (.) ENTER to exit the processor at any line.

Test Protocol Template

The Test Protocol Template option allows you to simulate resulting of a protocol and its associated line definitions. Once the simulation is completed, you can go back to the Setup Protocol Template processor and make adjustments.

```
              General Hospital Z - SNOMED CT Cancer Protocols Processor
                                             Mon Jun 13, 2005 11:08 am
 Z - SNOMED CT Cancer Protocols Input Options


          Option No.  Option
          ---------------------------------------

              1          Transmit CAP Protocol to STAR
              2          Process Downloaded Files
              3          Setup Protocol Template
              4          Assign Component Lines
              5          Test Protocol Template
              6          Activate/Delete Template Version




 Enter option number--
```

Select **Test Protocol Template** and if all lines are defined, the following screen is displayed:

```
                    General Hospital Test Template Processor
                                             Fri Apr 18, 2008 01:22 pm






 Page:01                      Select Template to Test       ##=Current Choices
 ( 1) ADRENAL GLAND(2,16)
 ( 2) ANUS (5,19)
 ( 3) BLADDER (8,22)
 ( 4) ESOPHAGUS(19,34)
 ( 5) HEART (44,59)
 ( 6) PERITONEUM (55,70)


 Enter number of protocol to test--
```

You can choose a template defined by the name of the protocol. Previously defined protocols are displayed for edits to be made. To exit the processor, press period (.) ENTER.

If a protocol template does not have every line defined from the Setup Protocol Template processor, the following message is displayed:

> *Problem with template line status.*

Once the template is chosen, it is displayed for you to enter data on lines requiring data entry. Items that are displayed in dim video are not reported on a patient's case. Each line functions as defined in the Setup Protocol Template processor.

The screen below shows the template for the Adrenal Gland.txt template.

```
Select an entry (X) or enter data at the cursor
     Lines that are dim (like this) are not reported

January 2003
ADRENAL CORTICAL CARCINOMA: Resection

MACROSCOPIC
SPECIMEN TYPE
____  Subtotal adrenalectomy
____  Total adrenalectomy
____  Other (specify): _____not coded
____  Not specified
LATERALITY
____  Right
____  Left
____  Not specified.

TUMOR SIZE
Greatest dimension: ____ cm
*Additional dimensions: ____x ____ cm
____  Cannot be determined (fragmented specimen)
TUMOR WEIGHT: ____ g
MICROSCOPIC
```

As you process each page, a new page with five lines from the previous page is displayed. The previous line that is displayed is to assist with continuity of groups.

When the last line in the template has been processed, *End of data input* is displayed and you are taken back to the SNOMED CT Cancer Protocols menu.

Activate/Delete Template Version

This processor allows activation of the protocol template by test code when activation is required by you. Also, the template can be deleted when no longer in use.

NOTE: Because this processor is department specific, but the protocols themselves are not department specific, a template version can only be removed from the system if all departments using the template have deleted it by using this processor from their department menu. If one department is still using the template, the delete function can only remove the component line designation and test code activation for the deleting department.

```
                General Hospital Z - SNOMED CT Cancer Protocols Processor
                                             Mon Jun 13, 2005 11:08 am
       Z - SNOMED CT Cancer Protocols Input Options

                Option No.  Option
                ---------------------------------------

                    1        Transmit CAP Protocol to STAR
                    2        Process Downloaded Files
                    3        Setup Protocol Template
                    4        Assign Component Lines
                    5        Test Protocol Template
                    6        Activate/Delete Template Version




       Enter option number--
```

Select **Activate/Delete Template Version** and the following screen is displayed with
a list of protocol templates that have assigned component lines.

```
                General Hospital Set Active Version Processor
                                             Fri Jan 28, 2011 01:02 pm



       Page:01                  CAP Protocols to Activate/Deactivate
       ( 1) BREAST DEC 09 EDITS (1,1)
       ( 2) COLON RECTUM EXC BIOPSY (14,29)
       ( 3) COLON AND RECTUM RESECTION (16,31)
       ( 4) ADRENAL GLAND RES (2,16)
       ( 5) AMPULLA OF VATER (259032,2)
       ( 6) HODGKINS (273037,2)
       ( 7) AMPULLA OF VATER-PANCREAT-DUOD (4,18)
       ( 8) HODGKIN 2008 (45,60)
       ( 9) LUNG BIOPSY (49,64)
       (10) LUNG RESECTION (50,65)
       (11) BREAST (567037,6)
       (12) COLON (568033,6)
       (13) LIVER (578031,6)
       (14) PROSTATE GLAND (TUR) (64,79)


       Select protocol--
```

Once the protocol is chosen, the following prompt is displayed:

> *Delete(D) or Edit(E) LIVER (578031,6)--*

ACTIVATING A PROTOCOL

If you enter **E** at the previous prompt, the following screen is displayed:

```
            General Hospital  - Activate/Delete Template Version Processor
                                               Fri Jan 28, 2011 01:02 pm

                              Protocol # - 578031,6
  1 Protocol Name
    LIVER
    Activate Protocol
  2 Test Code  Test Name                        Active
    5052       SURG PATH GROSS AND MICRO         No
    5055       SURGICAL PATHOLOGY                No
    5065       SNOMED                            No









                              Activate protocol? (Y/N)--
                   F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

Screen Headings

PROTOCOL #
The protocol number is displayed in the center of the screen.

Field Explanation

1. PROTOCOL NAME (30-C-R)
The name of the protocol selected on initial entry is displayed in this field. This field can be edited. Acceptable entries are alphanumeric characters and a hyphen (-).

ACTIVATE PROTOCOL (SCROLLING SCREEN)
When this field is accessed, the following scrolling screen functions are displayed:

F1Prev Page F2Next Page F6 Reset F7 Exit   ?

For more information on scrolling screen processing, refer to the Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

Scrolling Screen

2. TEST CODE (DISPLAY ONLY)
This is the list of test codes that have been assigned component lines for this protocol.

TEST NAME (DISPLAY ONLY)
This is the list of tests that have been assigned component lines for this protocol.

ACTIVE (1-A-R)

Each test assigned to the protocol can be activated individually. When this field is accessed, the following prompt is displayed:

Activate protocol? (Y/N)-

This field is automatically set to *No*. To activate the protocol for the test, enter **Y**. This makes the protocol available for result entry. If set to *No*, the protocol is not displayed for selection in the CT Protocol result in AP Result Entry.

When you exit the scrolling screen processor, the following prompt is displayed if edits are made:

Accept this screen? (Y/N) [Y]-

If you enter **Y**, the edits are accepted and filed. The following message is displayed and you are returned to the SNOMED CT Cancer Protocols menu:

Filed!

If you enter **N**, the following prompt is displayed:

Enter field number or '/' starting field number-

Press period (.) ENTER to exit the processor without filing edits.

DELETING A PROTOCOL

If you enter **D** to delete from the prompt, *Delete(D) or Edit(E) LIVER (578031,6)--*, the following prompt is displayed:

Are you sure? (YES/N)-

If you enter **N**, the processor is exited and you are returned to the SNOMED CT Cancer Protocol menu.

You must enter the word **Yes** In order to delete the protocol. The following message is displayed:

Protocol (Name,version) deleted!

Impact

The impact of the delete function is different depending on whether there are more than one lab departments active for SNOMED CT.

Single Department (within the facility or active for SNOMED CT)
When a protocol is deleted, it is completely removed from the system. The protocol can be transmitted again using Transmit CAP Protocol to STAR and processed again using Process Downloaded Files.   The following occurs:

- **Activate/Delete Template Version** - The protocol is no longer active for any test and is no longer available for selection in this processor.

- **Test Protocol Process** - The protocol is no longer available for selection in this processor.

- **Assign Component lines** - Result component line assignment is removed and the protocol is no longer available for selection in this processor.

- **Setup Protocol Template** - Functional line designation is removed and the protocol is no longer available for selection in this processor.

Multi-Department (where more than one department is active for SNOMED CT)
When a protocol is deleted by one department and still active in another department, the protocol is not completely removed from the system. Only the department-specific setup is affected. The functional line designation in Setup Protocol Template is unaffected as it is shared among all departments. The following occurs:

- **Activate/Delete Template Version** - The protocol is no longer active for any test, in that department, and is no longer available for selection in this processor.

- **Test Protocol Process** - The protocol is no longer available for selection in this processor.

- **Assign Component lines** - Result component line assignment is removed and the protocol is no longer available for selection in this processor.

If all active departments delete the protocol, the following occurs after the last department completes the delete function just as if a single department performed the deletion. The protocol is completely removed from the system. The protocol can be transmitted again using Transmit CAP Protocol to STAR and processed again using Process Downloaded Files.

- **Activate/Delete Template Version** - The protocol is no longer active for any test and is no longer available for selection in this processor.

- **Test Protocol Process** - The protocol is no longer available for selection in this processor.

- **Assign Component lines** - Result component line assignment is removed and the protocol is no longer available for selection in this processor.

- **Setup Protocol Template** - Functional line designation is removed and the protocol is no longer available for selection in this processor.

If there are no protocols and test codes existing for activation, *No Entries Defined* is displayed on the protocol list screen.   You are then returned to the SNOMED CT Cancer Protocol menu.

SNOMED CT HIERARCHY

The SNOMED CT file has over 360,000 concepts. When performing a single or double word search in Anatomic Path Result Reporting, hundreds of concepts are listed for you to sort through.

As an alternative, SNOMED CT Hierarchy is located under Laboratory Anatomic Path Functions to provide efficient searching functionality. Under this tool there are two processors, Update SNOMED CT Hierarchies and Assign SNOMED CT Hierarchies for Resulting, to limit and/or exclude some of the hierarchies in which to search. The exclusions are user-defined outside of result reporting using maintenance functions. Search limits can be further utilized within result reporting at the time of SNOMED coding.

```
                     General Hospital Maintenance Functions Processor
 Laboratory                                         Wed Jun 01, 2005 03:06 pm


                        Laboratory Anatomic Path Functions            Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files


 Enter choice--
```

Select **SNOMED CT Hierarchy** to access the two processors.

Update SNOMED CT Hierarchies

This processor creates a file of SNOMED CT hierarchies and sub-hierarchies from the SNOMED CT concepts file that you can activate for use in Anatomic Path Result Reporting.

```
                 General Hospital Z - SNOMED CT Hierarchy Processor
                                              Thu Jun 02, 2005 03:58 pm
 Z - SNOMED CT Hierarchy Input Options

             Option No.  Option
             ----------------------------------------
                 1       Update SNOMED CT Hierarchies
                 2       Assign SNOMED CT Hierarchies for Resulting












 Enter option number--
```

From the SNOMED CT Hierarchy Input Options menu, select **Update SNOMED CT Hierarchies**. The following screen is displayed:

```
                 General Hospital Update SNOMED CT Hierarchies Processor
                                              Thu Jun 02, 2005 03:59 pm
   Update SNOMED CT Hierarchies




                            ATTENTION

   This processor will update the SNOMED CT enabled Lab department with the SNOMED
   Clinical Terms Concept upper level hierarchies per updated CD version.








 Do you wish to continue? (Y/N)--
```

The following prompt is displayed:

> *Do you wish to continue? Y/N-*

If you enter **Y**, the process of creating new hierarchies from the SNOMED CT concepts file immediately begins and the following messages are displayed:

> *Updating SNOMED Clinical Terms Concept Hierarchies!*

Assign SNOMED CT Hierarchies for resulting!

If you enter **N**, the screen returns to the SNOMED CT Hierarchies Input Options menu.

When the update is complete, the hierarchies and sub-hierarchies file is created and previously created hierarchies and sub-hierarchies are overwritten. When the initial SNOMED CT concepts CD is loaded or when updated versions to the SNOMED CT concepts are loaded, this process must run to re-create the updated hierarchies.

Assign SNOMED CT Hierarchies for Resulting

This processor is used to activate the SNOMED CT hierarchies for use in Anatomic Path resulting reporting. Once the hierarchies are created by activating the hierarchy, it becomes available for searches in Anatomic Path Result Reporting. If the hierarchy is not active, it is unavailable for searches.

```
                General Hospital Z - SNOMED CT Hierarchy Processor
                                             Thu Jun 02, 2005 03:58 pm
 Z - SNOMED CT Hierarchy Input Options


         Option No.  Option
         ----------------------------------------
             1       Update SNOMED CT Hierarchies
             2       Assign SNOMED CT Hierarchies for Resulting














 Enter option number--
```

From the SNOMED CT Hierarchy Input Options menu, select **Assign SNOMED CT Hierarchies for Resulting**. The following screen is displayed:

```
              General Hospital Assign SNOMED CT Hierarchies for Resulting Processor
                                                 Thu Jun 02, 2005 04:00 pm
       SNOMED CT Hierarchies


                SNOMED CT Hierarchies                     Active          Page:01
  ( 1) Attribute                                            X
  ( 2) Body Structure                                       X
  ( 3) Clinical finding
  ( 4) Context-dependent category
  ( 5) Environment and geographic locations
  ( 6) Events
  ( 7) Observable Entity
  ( 8) Organism
  ( 9) Pharmaceutical/biologic product
  (10) Physical force
  (11) Physical object
  (12) Procedure/intervention
  (13) Qualifier value
  (14) Social context
  (15) Special concept
  (16) Specimen

  Enter option to edit
                        next pg(/ or PG DN)  Search(TAB)
```

The system displays a list of the hierarchies created using the Update SNOMED CT Hierarchies processor.

SNOMED CT Hierarchies
This field indicates the SNOMED CT Hierarchies created from Updating SNOMED CT Hierarchies.

Active
This field indicates whether the hierarchy is active for resulting.   An X in the field indicates it is active.

When this screen is accessed, the following prompt is displayed:

> *Enter option to edit*
> > *next pg(/ or PG DN) Search(TAB)*

Select the option number you want to edit. If more than 16 entries are available, you are able to page down by entering a slash (*I*) or for a previous page, by entering slash P (*/P*).

Once you select one of the hierarchy options, the following screen is displayed:

```
              General Hospital Assign SNOMED CT Hierarchies for Resulting Processor
                                          Wed Apr 09, 2008 11:51 am
     SNOMED CT Hierarchies

   ( 1)Code          : 4
   ( 2)Description   : Body structure
   ( 3)Active        : Yes
   ( 4)CD Version    : 20060731

   ( 5)FSN Tag 1     : body structure
   ( 6)FSN Tag 2     : cell
   ( 7)FSN Tag 3     : cell structure
   ( 8)FSN Tag 4     : morphologic abnormality
   ( 9)FSN Tag 5     :
   (10)FSN Tag 6     :
   (11)FSN Tag 7     :
   (12)FSN Tag 8     :
   (13)FSN Tag 9     :

   (14)Edit by       : Smith, Fred M
   (15)Edit date/time: 08/15/07 0855

   Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field cannot be edited. This is a system-generated numeric code.

2. DESCRIPTION (DISPLAY ONLY)
This field cannot be edited. The description is created automatically from the
SNOMED CT Hierarchies.

3. ACTIVE (1-A-R)
This is the only editable field on the screen. Once you have accessed this field, you
can enter either **Y** for Yes or **N** for No. Y is the default.

If you enter **Y**, this hierarchy is active for use in Result Reporting. The hierarchy is
available to you in Anatomic Path Result Reporting when performing searches through
the concepts file.

If you enter **N**, this hierarchy is not available for searches. The hierarchy is not seen
in the application.

NOTE: You can activate a hierarchy and still have the option not to select it for a
search in result entry.

4. CD VERSION (DISPLAY ONLY)
This field cannot be edited. This is the CD version number from the SNOMED
Concepts CD from which the hierarchy file is created.

5 - 13 FSN TAG [n] (DISPLAY ONLY)
These fields cannot be edited. The Fully Specified Name (FSN) tag is a sub-hierarchy created by the system when the hierarchy file is generated.   Each hierarchy has at least one FSN tag. Hierarchies with more than one FSN (fields 6-13) allow you to selectively search through one or multiple sub-hierarchies in resulting.

14. EDIT BY (DISPLAY ONLY)
The name of the user who made the last edit to the screen is displayed in this field.

15. EDIT DATE/TIME
The system date and time of the last edit to the screen is displayed in this field.

SNOMED CT AP SUBSET LOAD

The SNOMED CT AP Subset Load processor is located under Laboratory Anatomic Path Functions. It is used to load the SNOMED AP Subset onto STAR. When activated, it works in the same manner as the SNOMED CT core concepts file. If the AP Subset is used, the number of concepts through which to search is reduced from approximately 360,000 to 70,000.

NOTE: You can activate the SNOMED AP Subset in Anatomic Path Parameters.

The SNOMED CT Hierarchies processors can also be used with the AP Subset to further refine search capabilities. If you do not activate individual hierarchies, you have access to all the hierarchies within the AP Subset.

NOTE: The SNOMED CT AP Subset must be purchased from CAP. For further information, please see the following Web site: http://www.snomed.org/ products/content/subsets.html.

```
                    General Hospital Maintenance Functions Processor
Laboratory                                          Wed Jun 01, 2005 03:06 pm

                        Laboratory Anatomic Path Functions              Page:01
( 1) A - Anatomic Path Parameters          (18) Z - Standard Result Subgroups
( 2) B - Case Login Parameters             (19) Z - Standard Result Text
( 3) B - Case number pools                 (20) Z - Standard Result Text Print
( 4) B - Histotech Processes
( 5) C - Histotech Processes/Test
( 6) C - HP Audit Retention
( 7) Maintenance Types - Anatomic Path
( 8) Maintenance Types List - AP
( 9) Q - Workload/Quality Control
(10) Z - Anatomic Path Test Report
(11) Z - Histotech Processes Report
(12) Z - SNOMED Codes
(13) Z - SNOMED CT AP Subset Load
(14) Z - SNOMED CT Cancer Protocols
(15) Z - SNOMED CT Hierarchy
(16) Z - Specimen/T-code Report
(17) Z - Standard Result RTF Files


Enter choice--
```

Select **SNOMED CT AP Subset Load** and the following screen is displayed:

```
              General Hospital - Transmit SNOMED CT AP Subset to STAR Processor
                                                Tue Jun 28, 2005 04:13 pm

   This function is used to download SNOMED CT AP Subset to STAR.

   The ascii text file ( .txt) must first be loaded on your workstation.
   You may enter the location of the file on your workstation, if the file
     is not in the default folder: C:\temp\SNOMEDCT\




     File name: SCT_SUBSETMEMBERS_AP_20050131.TXT


     Enter the folder path [C:\temp\SNOMEDCT\]
```

The default path can be defined under Anatomic Path Parameters in the Download File Path field or you can enter a path at the prompt:

Enter the folder path [c:\temp\SNOMEDCT\]

> **NOTE:** The file name comes from CAP and cannot be changed.

Once the AP Subset is loaded, see "Update SNOMED CT Hierarchies" on page 2-154 under SNOMED CT HIERARCHY. As an optional step, use the Assign SNOMED CT Hierarchies for Resulting to activate some hierarchies.

SPECIMEN/T-CODE REPORT

The Specimen/T-Code Report option from the Anatomic Pathology maintenance functions menu helps you determine the crosslinks defined between the specimen table and T-codes.

```
                       General Hospital Maintenance Functions Processor
 Laboratory                                         Wed Jun 01, 2005 03:06 pm

                         Laboratory Anatomic Path Functions              Page:01
 ( 1) A - Anatomic Path Parameters       (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters          (19) Z - Standard Result Text
 ( 3) B - Case number pools              (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

When you select this option, you have the ability to view or print the information for one specimen or all specimens. The system displays the following prompt:

Select all(A) or an individual specimen(I) [A]--

The default is to select all specimens (**A**) for review.

If you enter **I**, for an individual specimen, the system displays the following prompt:

Enter specimen code or '-' for table--

After you select the specimen(s), the next prompt displays:

Display(D) or Print(P) [D]--

The default is to display the report to the screen. The display to the screen follows the same format as the printed report.

If you enter **P**, you are prompted for printer or alternate printers. The Specimen/T-Code Report is 80 columns wide and uses the General Report definition.

If the report is longer than one page, the appropriate page breaks are included with the following displaying at the end of the page:

(Continued)

The last line of the report displays the following:

End of Report!

The format of the report is as follows:

Figure 2.7 Specimen T-Code Report (ALGRLGR0)

```
 Mon Jun 12, 1995 09:12 am                                      Page   1
                        Specimen/T-Code Report

Specimen                    T-Code(s)                    Default Group
-------------------------------------------------------------------------
89 - Bone Marrow            T-06000 Bone Marrow          67 - Bone Marrow

92 - Breast                 T-04000 Breast               45 - Breast
                            T-04010 Female Breast        68 - Upper Body

















                                  End of Report!
```

Field Explanations

DATE/TIME
The date and time the report is generated.

REPORT NAME
The report name is Specimen/T-Code Report.

SPECIMEN
This column displays/prints the specimen type associated with the T-Code builder.
The specimen type has a maximum length of 20 characters.

T-CODE(S)
The T-Codes that display/print are those T-Codes that have the specimen defined in
the T-Code builder. The T-Codes are 7 characters in the standard format T-NNNNN,
followed by a maximum 25-character length alphanumeric description.

DEFAULT GROUP
The Default Group is the third column of displayed/printed information. The Default
Group is a two-number identifier, followed by a maximum 14-character length
alphanumeric description.

MAINTENANCE TYPES - ANATOMIC PATH

The Maintenance Types-Anatomic Path processor allows you to control who uses the processors within the Anatomic Pathology Maintenance functions by restricting access based on security level. Select Maintenance Types - Anatomic Path.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                            Wed Jun 01, 2005 03:06 pm


                        Laboratory Anatomic Path Functions         Page:01
 ( 1) A - Anatomic Path Parameters       (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters          (19) Z - Standard Result Text
 ( 3) B - Case number pools              (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files


 Enter choice--
```

The system displays the Anatomic Path Build/Maintenance Types menu. Select Maintenance Types-Anatomic Path from the following menu.

```
                    General Hospital Maintenance Functions Processor
 Laboratory                                            Thu Jun 02, 2005 10:30 am
 Anatomic Path Build/Maintenance Types
 Page:01             Anatomic Path Build/Maintenance Types
 ( 1) A - Anatomic Path Parameters       (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters          (19) Z - Standard Result Text
 ( 3) B - Case number pools              (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files


 Enter choice or add(A)
```

The screen is identified with Anatomic Path Build/Maintenance Types appearing on the third line. Each Anatomic Path maintenance processor displays for selection.

Select the processor to edit by entering the corresponding option.

```
                    General Hospital Maintenance - Anatomic Path Processor
Community Lab                                     Mon Jun 12, 1995 02:19 pm
Anatomic Path Build/Maintenance Type
( 1)Description    : Maintenance Types - Anatomic Path

( 2)Security Level : 80
( 3)Edit by        :
( 4)Edit date      :










 Enter field number or '/' starting field number--
```

Field Explanations

1. DESCRIPTION (DISPLAY ONLY)
This is the description of the maintenance function as it appears on the Anatomic Path
Maintenance menu. This field cannot be edited.

2. SECURITY (2-N-R)
Enter the security level to allow access to this function. This is a free-text field. The
default is the highest user-security level defined on your system.

3. EDIT BY (DISPLAY ONLY)
This field automatically fills with the ID of the person entering the information.

4. EDIT DATE (DISPLAY ONLY)
This field automatically fills with the date of the change and/or addition. When you
complete all required fields, the system displays the following prompt:

Accept this screen?(Y/N) [Y]--

Accept the screen by entering **Y** or pressing ENTER. Enter **N** to edit.

Impact

Only authorized personnel (those with a security level higher than the one defined) can
access these options.

MAINTENANCE TYPES LIST-ANATOMIC PATH

The maintenance types list provides a printed copy or screen display of the Anatomic Pathology maintenance functions and the associated security levels specified using the Maintenance Types processor.

```
                   General Hospital Maintenance Functions Processor
 Laboratory                                        Wed Jun 01, 2005 03:06 pm


                        Laboratory Anatomic Path Functions          Page:01
 ( 1) A - Anatomic Path Parameters        (18) Z - Standard Result Subgroups
 ( 2) B - Case Login Parameters           (19) Z - Standard Result Text
 ( 3) B - Case number pools               (20) Z - Standard Result Text Print
 ( 4) B - Histotech Processes
 ( 5) C - Histotech Processes/Test
 ( 6) C - HP Audit Retention
 ( 7) Maintenance Types - Anatomic Path
 ( 8) Maintenance Types List - AP
 ( 9) Q - Workload/Quality Control
 (10) Z - Anatomic Path Test Report
 (11) Z - Histotech Processes Report
 (12) Z - SNOMED Codes
 (13) Z - SNOMED CT AP Subset Load
 (14) Z - SNOMED CT Cancer Protocols
 (15) Z - SNOMED CT Hierarchy
 (16) Z - Specimen/T-code Report
 (17) Z - Standard Result RTF Files

 Enter choice--
```

Access the Maintenance Types List from the preceding menu.

```
              General Hospital Maintenance - Anatomic Path Processor
 Community Lab                                     Wed Jun 01, 2005 03:07 pm
 Anatomic Path Build/Maintenance Types

















 Do you want a printed(P) list or display(D) [D]--
```

Enter **P** to generate a hard copy of this report. The screen displays the default printer and a list of alternate printers defined for this report. Enter **D** or press ENTER to display the report on your CRT.

```
              Laboratory Anatomic Path Build/Maintenance Functions
                                         Wed Jun 01, 2005 03:08 pm


     ------------------------------------*------------------------------------
     |        Description                 Security       Routine     Screen   |
     ------------------------------------*------------------------------------
      ( 1)   A - Anatomic Path Parameters      80          PP^LABSPR
      ( 2)   B - Case Login Parameters         80            ^LABSLP
      ( 3)   B - Case number pools             80         LCN^LABLVW
      ( 4)   B - Histotech Processes           80         LHP^LABLVW
      ( 5)   C - Histotech Processes/Test      80            ^LABSPS
      ( 6)   C - HP Audit Retention            85            ^LABHPA
      ( 7)   Maintenance Types - Anatomic Path  80           ^LABLF51
      ( 8)   Maintenance Types List - AP       80          P^LABLF51
      ( 9)   Q - Workload/Quality Control      80            ^LABLF52
      (10)   Z - Anatomic Path Test Report     80            ^LABAPR
      (11)   Z - Histotech Processes Report    80            ^LABHPR
      (12)   Z - SNOMED Codes                  80            ^LABLSN
      (13)   Z - SNOMED CT AP Subset Load      80            ^LABSC10
      (14)   Z - SNOMED CT Cancer Protocols    80          NK^%A       lamsct
      (15)   Z - SNOMED CT Hierarchy           80          NK^%A       lamhsct
      (16)   Z - Specimen/T-code Report        80            ^LABLSNR
     Press NL--
```

The screen displays the Anatomic Pathology maintenance processors and the minimum security level required to access each.

Chapter 3 - Applications

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October 2011   *Release 17.0*   *3–1*
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Illustrations

ANATOMIC PATHOLOGY FLOW

The typical activity flow for Anatomic Pathology specimens is:

1. Specimen Received and Logged In/Test Ordered (Case Login)

2. Gross Examination (Pathologist)

3. Gross Examination Results Entered via Standard Result Text, Soft-Key Editor

4. Histotech Procedures Selected

5. Histotech Procedures Processed

6. Microscopic Examination (Pathologist/Cytologist)

7. Microscopic Examination Results Entered via Standard Result Text, Soft-Key Editor

8. Report Reviewed and Released (Review Queue)

9. Long Report Generated

The following discussion covers the processors used to accomplish the preceding activities.

AP tests can be ordered through the same process as General Test Types; in addition, AP tests can be ordered using the menu selection Anatomic Path Order Management. From this menu, select the Case Login processor. The Case Login processor accommodates all methods of case number assignment for AP tests.

After patient lookup, previous pathology exams for x number of days is displayed (user-defined based on day of the week). You have the option to modify (edit or add-on) an existing case, check a previously ordered procedure, merge a new order into an existing case, or order a new procedure.

The order/accession processing for AP tests is a one-screen process called Case Login, with the option (based on day of the week) of manually assigning case numbers or having the system automatically generate sequential case numbers. Orders placed and not logged by pathology (either from the Laboratory or Patient Care) are not assigned case numbers until they are logged into the system.

Multiple specimens per case can be defined at the time the specimens are logged into the system. This allows you to define multiple default histotech processes for each specimen entered on the case. The system automatically defines the blocks and processes for each defined specimen type. This feature also increases the flexibility in defining the logged specimens for use in auto T-coding result reporting. The system can include all specimens defined at login and displays them in result reporting for auto T-coded entries based on flag settings.

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Once a case has been logged into the system, you can access Histotech Processing, Miscellaneous Charges, Professional Fee Billing, and/or Result Reporting automatically or by responding to the appropriate prompts.

NOTE: Batch entry of histotech processes for a defined set of blocks is available through the use of the Histotech Processor function. Please refer to "HISTOTECH PROCESSING" on page 3-111 description for further information.

The case number assigned to the specimen at login includes the case number pool number for the test and is cross-referenced to the login number. The format of the case number is as follows:

alpha character of number pool code_year_"-"_number pool number

Examples:

A93-100=Anatomic path number pool, year 1993, number pool number 100

C93-189=Cytology number pool, year 1993, number pool number 189

At case number entry points, case numbers that are defined for the current calendar year would be *S93-100.* The system accepts the *S100* and makes the appropriate interpretation. This eliminates the need for three keystrokes each time a current year case number is entered in the system. The system continues to accept the complete entry of number and year. When the entry does not include a "-", the system interprets it as current year.

Various functions occur as a result of Case Login. These functions depend on the initial design of the system and include the following:

1. If default histotech processes are defined for the test code(s) logged in, **and** the department flag is set for *Auto Process*, blocks are defined and processed automatically at login. *Processing* means histotech labels are produced and workload and miscellaneous charges are captured (if defined for the process).

2. If default histotech processes are defined for the testcode(s), but the flag is turned off for Auto Process, the individual histotech procedures are defined at login but must be processed through Histotech Processing.

NOTE: You cannot accession an anatomic pathology test type test through the Accession processor. When you select Accessioning and attempt to enter the accession number of an AP test, the system displays the following message:

Accn# #### must be logged in through Case Login!

Add-on orders through accessioning are also modified for AP test types. An AP test type cannot be added to an existing order through the Accession processor. If you select an AP test to be added on, the system displays the following error message:

   AP test types must be ordered through Case Login!

In Accessioning, entering an accession number of an AP test followed by an *X* to indicate that the specimen is to be rejected results in the following message:

   Accn# #### must be specimen rejected through Case Login!

ORDER ENTRY

Once all tests have been ordered, you have the option to prompt for accessioning. If accession is selected, the process continues to build and displays the message indicating an accession is being built. When the system finds an AP test, the following message displays and the AP test type is omitted from accessioning:

Accn# #### must be logged in through Case Login!

All AP test types must be logged into the system. This process occurs through Case Login. After the test is logged in, the system updates the status to Specimen Received.

If there are other remaining tests, the process continues.

Processing AP Test Type Orders

The following table clarifies which tests can be processed though the Case Login processor.

The following test types are included:

- Anatomic Path Test Type **with** a case number pool (CNP) assigned

- Anatomic Path Test Type **without** a case number pool (CNP)assigned

- General /Advanced Microbiology/Advanced Blood Bank Test Types*

*These test types are grouped together and referred to as General Test types in the following table.

Order Sets (Test Type Combinations)	Login	Accession	Batch Accession
General Tests	No	Yes	Yes
AP Tests with CNPs	Yes	No	Yes
AP Tests without CNPs	No	Yes	Yes

NOTE: For CMS-Compliant outpatients refer to "CMS COMPLIANCE CHECKING (OPCD)" on page 3-96.

ACCESSIONING

As stated at the beginning of this section, you must login specimens through the Case Login processor. The ability to accession an anatomic pathology test type test through the Accession processor is not allowed.

NOTE: Anatomic Pathology test types without case number pools assigned must be accessioned through Accessioning.

General Test types must be accessioned through Accessioning.

When you select Accessioning and attempt to enter the accession number of an AP test, the system displays the following message:

  Accn# #### must be logged in through Case Login!

An AP test type cannot be added to an existing order through accessioning. If you select an AP test to be added on, the system displays the following error message:

  AP test types must be ordered through Case Login!

Entering an accession number of an AP test followed by an X to indicate that the specimen is to be rejected results in the following message:

  Accn# #### must be specimen rejected through Case Login!

NOTE: For CMS-Compliant outpatients refer to "CMS COMPLIANCE CHECKING (OPCD)" on page 3-96.

COLLECTION BATCH MANAGEMENT

Although AP test types cannot be individually accessioned, AP type tests can be batch accessioned. Select Collection Batch Management from the section menu, then select Batch Management.

This type of processing does not support any of the features unique with the Case Login processor. Once a test has been accessioned through Batch Management, additional information can be added through the Case Login processor such as additional specimens or add-on orders.

Using Batch Management to process AP tests is in the system to accommodate tests in other sections of the lab that are not processed as pathology specimens (but are used for other features of the AP test type, such as Case Number Pool).

Selecting a batch that has been printed through Batch Management results with display of the following screen:

```
General Hospital Batch Management Processor
                                          Wed Oct 06, 1993 06:35 am

Batch # 267              Date Created - 10/05/93 0000          ID -
Opt  Locn      Patient         Accn No Opt  Location   Patient        Accn No
(1)  LD-03    BROWN, BILLY       1379
(2)  LD-03    SMITH, JANE        1559
(3)  LD-03    JONES, JOHN        1681
(4)  LD-03    JOHNSON, ROBERT    2142
(5)  LD-03    BLUE, JASON        2143
(6)  LD-03    SOLOMON, SUSAN     2377
(7)  4303-02  SILVA,COLE         1813
(8)  3303-02  WILLIAMS, JULIE    1380




Accession batch(B), single(S), fill(F), reject(J) or uncollected(U)--
```

The batch (B) option processes a batch that can include AP type tests. The test reaches a specimen received status, and the appropriate case number is automatically assigned.

NOTE: Interdepartmental AP tests can be batch accessioned, but the case number is not assigned until the Check In process is completed.

The single (S) option is not available for AP type tests. If you select an option that has an AP type test, the system displays the following message:

Accn# #### must be logged in through Case Login!

The reject (J) option is not available for AP type tests. If you enter an AP type test accession, the system displays the following message:

Accn# #### must be specimen rejected through Case Login!

The fill (F) option is not available for AP tests. If an AP test is part of the batch, the system displays the following message for the test:

Accn# #### must be logged in through Case Login!

REVISE ORDER

The fields that can be edited for an AP type test follow the same guidelines as other test types except for the specimen and specimen modifier.

The specimen type and specimen modifier cannot be edited through this processor. Adds, edits, or deletes tospecimens and specimen modifiers must be handled through the Case Login processor.

```
              General Hospital Front Office Revise Order Information Processor
                                           Thu Jan 15, 2009 09:04 am
Unit #       Name             Sex Birthdate  Room    Physician      Srv ICD Status
A000000027 JONES, ROBERT   M  02/18/1970 2104-02 SMITH, SUSAN  ERS 10  I/P 86
                          Accession # - 1642
 1 Priority        2 Specimen Type     3 Specimen Modifier    4 Collect Time
   TODAY             A-Line                N/A                   05/19/93 1032
 5 Collector   6 Accession Comment         7 Edit By          8 Edit Date/Time
   #31721
   Code    Description              Section      Coll Period    Status
     Ordering Comment                       Ordering Diagnosis
 9    Ordering Physician
   5050   GROSS AND MICROSCOPI    HIS-Pathology    N/A          Spec Recd

      SMITH, JOHN




Enter field number or '/' starting field number--
```

The following accession level information is edited through the Revise Order processor and follows the current guidelines stated in the *General Applications Volume I* of the *STAR Laboratory Reference Guide.*

- Collector

- Collection Date/Time

- Accession Comment

- Ordering Diagnosis

- Ordering Physician

NOTE: For CMS-Compliant outpatients refer to "CMS COMPLIANCE CHECKING (OPCD)" on page 3-96.

ANATOMIC PATHOLOGY ORDER MANAGEMENT

The Anatomic Pathology Order Management (APOM) function replaces the Case Number Management function from previous versions of the module.

```
                          General Hospital Pathology Processor
                                            Thu Aug 19, 2004 12:54 pm
        Pathology Input Options


                 Option No.  Option
                 ---------------------------------------
                      1       Patient Inquiry
                      2       Order Entry
                      3       Case Login
                      4       Anatomic Path Order Management
                      5       Histo/Cytotech Processing
                      6       Histo/Cytotech Processing Report & Audit
                      7       Recall Management
                      8       Anatomic Path Result Reporting
                      9       Review Queue Reporting
                     10       History Cardfile - Network
                     11       Miscellaneous Charge/Credit
                     12       Professional Billing Input
                     13       Cytology QA
                     14       Long Reports Batch
                     15       Incomplete Work Report
                     16       Histo/Cyto Process Audit & Rpt
        Enter option number--
```

Case Login provides direct access to case login processing.

The processing for AP Order Management is the same as for the submenu selection Case Login. The addition of this function at two levels accommodates the different workflows for the pathology department. Both functions may not be required on all section menus.

The section level function Case Login is used when case numbers are auto-assigned and other options available with the selection of Anatomic Path Order Management are not required. The AP Order Management function is necessary if it is important to track the case numbers currently in the unassigned case number pool.

If you manually assign case numbers, then use the submenu Case Login processor after selecting the Anatomic Path Order Management function. This allows easy access to other processors that are required when case numbers are manually assigned.

When you select the Anatomic Path Order Management function from the section menu, the system displays the following screen:

```
 General Hospital Anatomic Path Order  Management Processor
                                      Fri Apr 16, 1993 10:34 am
Pathology Anatomic Path Order Management Input Options

         Option No.  Option
         ----------------------------------------
             1       Reserve/Generate Case #'s
             2       Case Login

             3       Unassigned Case #'s
             4       Print/Reprint Case # Labels
             5       Delete Unassigned Case #'s

             6       Pathology Log Report

             7       Long Reports Batch




Enter option number--
```

There are five options available:

Reserve/Generate Case #s
This option allows you to reserve a list of alternate numbers.

Case Login
This option accommodates all methods of case number assignment.

Unassigned Case #'s
This option allows you to review unassigned case numbers and resolve any associated problems.

Print/Reprint Case # Labels
This option allows you to print or reprint case number labels.

Delete Unassigned Case #'s
This option allows you to delete reserved, but unassigned, case numbers.

Pathology Log Report
This option allows you the ability to print a Pathology Log Report.

Long Reports Batch
This option allows you the ability toprint/reprint Long Report batches and to review the reports for the section that are ready to be printed in the next Long Report batch.

Reserve/Generate Case #'s

The Reserve/Generate Case #'s option allows the ability to reserve a list of alternate numbers. Alternate numbers are needed in a situation such as when the department

receives a large number of biopsies from an outpatient setting at the same time. The option to assign alternate numbers gives you the flexibility of not having to assign consecutive numbers to these cases, which is important for quality assurance purposes.

After you select this function from the Anatomic Path Order Management menu, you enter a case number pool or make a selection from the case number pool table. After you complete the entry or selection, the system displays the following screen:

```
  General Hospital Reserve/Generate Case #'s Processor
                                          Mon Apr 19, 1993 10:24 am

 1 Case # Pool
   Surgical Specimens
 2 Number of case #'s to reserve      3 Alternate sequence of #'s
   10                                   Yes
 4 Print labels   5 # of Labels/Case #   6 Printer
   Yes              1                      AVAILABLE (Port #67)




  Enter field number or '/' starting field number--
```

Field Explanations

1. CASE # POOL (DISPLAY ONLY)
This field displays the description of the case number pool selected for reserving case numbers.

2. NUMBER OF CASE #'S TO RESERVE (4-N-R)
This field defines the number of case numbers to reserve. Up to 9999 case numbers can be reserved at one time. The system displays the following prompt:

Enter number of case#'s to reserve--

3. ALTERNATE SEQUENCE OF #'s (1-A-R)
This field provides an option for the sequence of the case numbers to be reserved. The system displays the following prompt when you enter the field:

Alternate sequence of numbers (Y/N) [N]--

The default is *No.* If you select the default, a sequential list of numbers is reserved by the system, beginning with the next available system-generated case number for that case number pool.

If you select Yes, the system reserves a list of alternate sequence numbers beginning with the next available system generated number for that case number pool. The difference is that the system assignment of case numbers for this pool begins with the next number after the first alternate number and continues to auto-assign numbers in the sequence of available numbers. Please refer to the following example steps.

Example

1   Select **Y** to reserve Alternate Case numbers (S93-100, S93-102, S93-104).

2   Select the option to use case login and have the system auto-assign the next case number.

The system assigns the next case number, S93-101.

3   Again select to use case login and have the system auto-assign the next case number.

The system assigns S93-103.

4. PRINT LABELS (1-A-R)
This field indicates whether or not case number labels print. This processor allows for reserving case numbers without printing labels. If desired, no labels can ever be printed, thereby allowing the use of manual pre-printed case number labels or the case number labels can be printed later in a batch fashion using the Print/Reprint Case # Labels function. The system displays the following prompt:

Print labels? (Y/N) [N]--

If you enter **Y**, labels are printed. If you enter **N**, no labels are printed.

5. # OF LABELS/CASE (2-N-R)
Enter the number of labels per case number to print. The default is the number of labels defined for the case number pool. The system displays the following prompt:

Enter number of labels/case # to print [1]--

If you enter **N** in Field 4, this prompt displays *N/A* and Field 5 is not active. If you enter **Y** in Field 4, this prompt displays the number of labels.

6. PRINTER (TABLE LOOKUP)
This field automatically displays the default printer defined for histotech labels. An alternate printer can be selected.

Accept this screen? (Y/N) [Y]--

Enter **N** to edit the fields. If you enter **Y**, the following message displays:

Processing and Printing

Impact

When you accept the screen, Case Numbers are reserved in the system for future assignment to patients and orders. If an unassigned case number is entered in Patient Inquiry, Histotech Processing, or Anatomic Path Result Reporting, the following error message displays:

> *S930-20 not an assigned case #!*

Output

When you accept the screen, the case number labels print in one of two label types: bar code or dot matrix. Bar code labels print if you are using bar code histotech labels. Dot matrix labels print if you are using dot matrix histotech labels.

The dot matrix label contains a single field: Case Number.

NOTE: The case number includes the sequence number for the test and is cross-referenced to the accession number. The format of the case number is:

First character of case number pool code_Year_"-"_Sequence number

Examples:
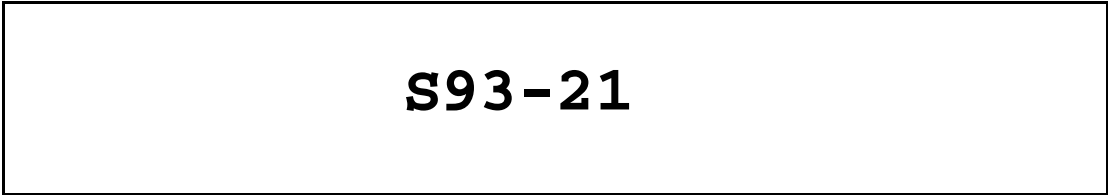
S93-100 = Anatomic Path sequence number, year 1993, number 100C93-189 = Cytology sequence number, year 1993, number 189

Bar code labels contain the human readable print of the case number and the bar code for the case number.

The number of labels that print for each case number is defined based on the case number pool. For example, you may want three labels for the Surgical case number pool (one each for the requisition, specimen container, and log book) and four for the Pap case number pool (one each for the requisition, log book, and each of two slides).

An example of the dot matrix case number label is as follows:

Figure 3.1 Dot Matrix Case Number Label Example (ALHTLHT0)

```
S93-21
```

An example of the bar code case number label is as follows:

Figure 3.2 Bar Code Case Number Label Example (ALBHLBH0)

```
                          S93-21
                   ||   ||||  ||
```
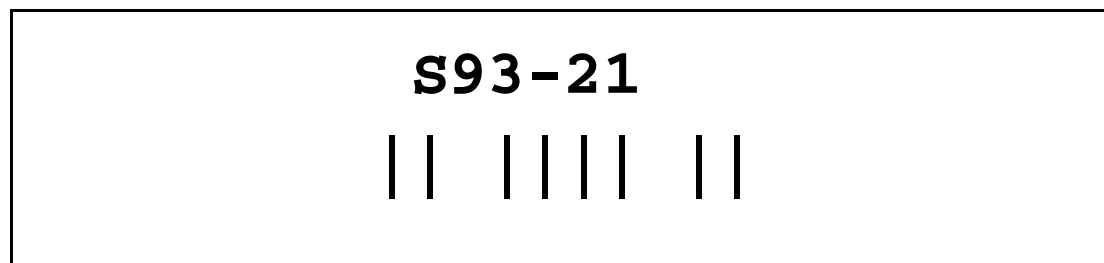
Case Login

The Case Login processor accommodates all methods of case number assignment. Any anatomic pathology type test that has a case number pool defined must be logged in through the Case Login processor to reach a status of *Specimen Received*.

The first available screen in this processor is used to enter the name or identifier for the patient. The prompt allows you to enter the accession number or case number if you need to add-on a test, modify specimens, or modify other case information when the case number is known. If you enter an accession number or case number, you bypass the previous order window processing and immediately access the Case Login Order screen.

NOTE: You can also enter the Nurse Collect number at the prompt by typing**NCXXX** (*X* to represent the specific numbers).

```
General Hospital Case Login Processor
                                           Thu Jul 22, 1993 02:44 pm












 Enter accession #, `[`case #,`*`account # or `&`unit #--
    patient name (Last,First M), `-`SS#, `%`name for soundex or `=` for current
```

If you enter a case number or accession number in which the tests are in a status of specimen received, the system displays the following message before accessing the Case Login screen:

No test(s) to login! Add-on Orders only allowed!

If changes are being made to a case in the processor and the case number or accession number is entered elsewhere in the system, the system displays the following message:

Accession number #### currently being edited!

If you enter an accession number that contains tests of a test type other than Anatomic Path, the system displays the following message before returning to the patient prompt:

Accn# XXXX must be accessioned through accessioning!

NOTE: The previous message also displays if an accession number is entered that has an Anatomic Path Test type but does not have a case number pool assigned.

If you enter an accession number or case number that was ordered through another department, the system displays the following message before returning to the patient prompt:

Accn# XXXX not ordered thru this department - LAB, belongs to - LAC
Must be in the department - LAC for further login processing!

If you enter an accession number or case number that has a test in a status of Backloaded, Cardfile or Archived, the system displays the following message before returning to the patient prompt:

Test(s) on accession have been archived/backloaded!
No further processing allowed!

If you enter an accession number or case number that has a status of Order Cancelled, Order Rejected, Accession Cancelled, or Rejected, the system displays the following message before returning to the patient prompt:

No test(s) to login! All test(s) cancelled/rejected!
No further processing allowed!

If you enter an accession number or case number that has no tests in an Ordered status, or if none of the tests on the accession are in your section and the accession contains the maximum number of tests per accession, the system displays the following message before returning to the patient prompt:

No test(s) to login! Maximum number of tests per accession reached!

If you enter an accession number or case number that has no tests in an Ordered status, or if none of the tests on the accession are in your section and you **have not** reached the maximum number of tests per accession, then you can add tests to the case.

If you have previously logged in at least one test for the case, the system displays the following message:

No test(s) to login! Add-on orders only allowed!

After this message, the system displays the case login order screen.

Specimen rejection processing for AP type tests is allowed if you enter the accession number followed by an **X** at the prompt.

If you enter an accession number followed by an **X** for a non-AP type test (or AP type test without a case number pool assigned), the system displays the following message:

Accn# #### must be specimen rejected through accessioning!

If you enter the patient name, unit number, or account number, the system searches for previously ordered AP type tests and accesses the Case Login Index screen with those tests displayed.

The system displays the following message while searching for previously ordered AP tests:

<< Searching previous (insert number of days) day(s) >>

If no previous work is available in the previous window search, the entry of the patient name or unit number accesses the screen to select an account number. After selecting an account number, the next screen is the Case Login Order screen.

The screen that allows you to select an account number after the patient has been selected does **not** display at this point in the processor **if** previous work is available in the selected search window. The account number is known when you select an option from the Case Login Index screen. When you place a new order from the Case Login Index screen, the system displays the screen with all active accounts to determine the appropriate account for the new order.

No LAB orders or charges may be placed on an account for a preadmission testing (PAT) patient type when the Charge/Order field in the Patient Type table in STAR Patient Care is set to Disallow. When the patient name, unit number, account number, or social security number is entered in any order or charge processor in STAR Lab, the following error message is displayed:

Error: Charges/orders not allowed. Update flag in Admissions!

However, the disallow charges/orders flag for the patient type can be overwritten at the account or visit level. When the Disallow Charges/Orders field on the Miscellaneous page in the Admission processor is defined as Yes, the patient type is set to disallow charges or orders. When the field is changed to No, charges and orders may be placed on the account in STAR Laboratory. After the field is changed to No and the screen is

accepted, the field can no longer be edited. Likewise, if the PAT with orders disallowed has a patient type change (such as becomes admitted), the Disallow Charges/Orders flag no longer applies to the account.

In Anatomic Pathology, the Date of Service is determined for Anatomic Pathology tests and associated histotech processes when the case is logged in and/or when histotech processes are executed.

- The Date of Service for the test is the Collection Date for a new order processed via Case Login. If Histotech Processing is defined as *Automatic*, then the Collection Date for the test is the Date of Service for any associated histotech processes.

- For an add-on order, the Collection Date for the original test is the Date of Service for the new order. If Histotech Processing is defined as *Automatic,* then the Collection Date for the original test is the Date of Service for any associated histotech processes on the new order.

CASE LOGIN INDEX SCREEN

The Case Login Index screen displays all anatomic path type tests ordered on the selected patient that are within the window defined in the Case Login parameters builder for the section. The case number pools of the tests that display and those that can be ordered from the section are also defined in this builder at the section level. The tests are displayed in reverse chronological order.

NOTE: Tests that have been cancelled or rejected do not display on this screen.

```
                    General Hospital Case Login Processor
                                           Thu Jan 15, 2009 09:04 am
     Unit #      Name            Sex Birthdate  Room    Physician    Srv ICD Status
     A000000027 JONES, MARY       M  02/18/1970 2104-02 JOHNSON, JOHN ERS 10  I/P 28

                             Previous Order Window
                                                              Page:01
     Opt #    Case#    Acc #  Test Name              Date/Time       Status
     ( 1)   S93-50    1234   GROSS & MICROSCOPIC    03/22/93 1440    Spec Rec
     ( 2)                    TISSUE - GROSS EXAM    03/22/93 1440    Partial
                            *Spec Type: Ovary - Left
     ( 3)   S93-40    1231   GROSS & MICROSCOPIC    03/21/93 1035    Spec Rec
                            *Spec Type: Tissue Biopsy-LEFT LUNG
     ( 4)             1217   GYN CYTOLOGY           03/21/93 1007    Ordered
                            Spec Type: PAP
     ( 5)   C93-211   2099   NON-GYN CYTOLOGY       03/19/93 0600    Done
                            Spec Type: Bronchial washing




     Enter opt to login, view multiple specimens(S), merge cases(M) or order(O)--
                             next page(/)
```

This processor is designed to address AP test types at the case level. The intent is to view each case as an individual episode.

The option column has a number for each ordered test. The information displayed after you select an option is at the accession level. Selecting option 1 or option 2 in the previous screen results in the display of the same accession level information.

The case number column may or may not be defined. This depends on the status of the tests on the case.

Specimens are now attached at the case level. Specimen Type always displays on this screen without consideration of the flag settings. An asterisk displays in front of the specimen type if multiple specimens have been defined for the case.

The displayed date and time reflect the requested time, if the test is in an ordered status. If the test is in a specimen received or higher status, the date/time displayed is the collected date and time.

If you press ENTER at this prompt, the system returns to the patient selection screen.

Option Number to Login

If you enter an option number to login and any test on the accession has Clinical Order Detail Questions and the Clinical Order Detail flag in Case Login Parameters is set to Yes the system displays the Clinical Questions screen:

```
          General Hospital Front Office Specimen Accession Processor
                                             Thu Jan 15, 2009 09:04 am
 Unit #      Name             Sex Birthdate  Room    Physician     Srv ICD Status
 A0000000944LEVINE,ANN         F  1945/02/03 2103-1  ADAIR,FRANK C FAM 10  I/P 29
                                 Tests Ordered    Accession # 1151
   1 Opt           Test       Description                 Section
     (1)           1699       DORIS MANUAL TEST           HCU-Misc Hematolo
     (2)           3093       SODIUM/POTASSIUM,SER        CHM-ASTRA







 View/edit clin questions for all(A), none(N), or selected(S) tests? [A]--
```

The first 2 lines are standard screen headers. The 3rd and 4th lines contain the unit #, Patient Name, Sex, Birthdate, Room Number, Physician, Service, and patient status headers and corresponding information. Line 5 contains the Tests Ordered header, with the Accession number. Line 6 starts the list of test on the accession. The system displays up to 16 of the ordered tests associated with the entered accession number. If all tests do not fit on one screen, enter **S** for select and the selection screen displays all tests. You cannot edit, add or delete tests from this screen.

NOTE: If you enter a specimen number to be rejected (you enter the accession number followed by an X), you are not prompted to view the Clinical Order Details information.

Field Explanations

OPTION NUMBER (DISPLAY ONLY)
This field displays the option number of the displayed test. The tests are ordered by test code number.

TEST CODE (DISPLAY ONLY)
This field displays the test code of the test.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the test.

SECTION (DISPLAY ONLY)
This field displays the section the test is to be performed in. If the test is associated with a Bay, the bay name displays with the section.

You are given 3 methods with which to view or edit the information. You can enter an:

- • A   to display or edit all tests on the accession.

- • S   to select tests from the list to view or edit.

- • N   not to display or edit any of the Clinical Ordering information.

After you select the test and the method to view or edit the information, the Clinical Order Details Information screen displays:

NOTE: For information on the edit option refer to Clinical Order Details Edit in Chapter 2: Order Management in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

```
      General Hospital Central Processing Revise Order Information Processor
                                              Thu Jan 15, 2009 09:04 am
 Unit #      Name           Sex Birthdate  Room    Physician     Srv ICD Status
 A0000000944LEVINE,ANN       F  1945/02/03 2103-1  ADAIR,FRANK C FAM 10  I/P 55
                                 Clinical Questions  Accession #1135
   1 Item                               2 Order No.
     3093 SODIUM/POTASSIUM,SER            0001
   3 Priority   Request Date/Time      4 Specimen Source     5 Modifier
     STAT       06/16/95 1024             BLOOD
   6 Dosage schedule
     01|The patient is on a dose schedule of 16 mg Q4H. Her last dose was given
     02|at approximately 0650.
     03|
                 Last Revision by Hutchinson,Brenda 08/25/95 1142
   7 Clinical Question            Response
     Patient weight                120
     Patient Status                Stable



         F1           F2          F3      F4    F5         F6          F7     F10
    Delete Line  Insert Line  Center  Exit  Store Line  Restore Line  Pack  Help
```

The first 2 lines are the standard screen headers. The 3rd and 4th lines contain the unit #, Patient Name, Sex, Birthdate, Room Number, Physician, Service, and patient status headers and corresponding information. Line 5 contains the Clinical Questions header, with the Accession number.

Field Explanations

1. ITEM (DISPLAY ONLY)
This field contains the code and description of the ordered test.

2. ORDER NO. (DISPLAY ONLY)
This field contains the order number associated with the displayed order.

3. PRIORITY (DISPLAY ONLY)
This field contains the order priority.

4. SPECIMEN SOURCE (DISPLAY)
This field contains the specimen source entered when the order was placed.

5. MODIFIER (DISPLAY ONLY)
This field contains the modifier, if entered, for the specimen source. If not entered, N/A displays.

6. PARAGRAPH (DISPLAY ONLY)
This field displays the description and responses to the paragraph Clinical Ordering Question. The system uses standard text processing to display up to 3 lines of 70 characters each.

If no paragraph question is attached to this test, Field 6 displays the following header Paragraph.

7. SCROLLING SCREEN
The system uses a scrolling screen to display the description and responses to the non-paragraph Clinical Ordering Questions. On this screen, you are not able to insert any additional questions or delete any of the existing questions. The questions display in the order they were added to the SIM item in the Clinical Ordering Details Processor.

> **CLINICAL QUESTION (DISPLAY ONLY)**
> This field contains the question description for each Clinical Ordering Question. The questions display in order they were added to the SIM item.

> **RESPONSE (DISPLAY ONLY)**
> This field contains the response to the question entered during the Order Entry process.

When viewing questions and responses that take up more than one screen, you can page forward by pressing the F2 key. You can also page backwards by pressing the F1 key. Press the F5 key to view the audit on any edited response. For further information on viewing the audit refer to Clinical Order Details Edit - View Audit in Chapter 2: Order Management in the *General Applications Volume I* of the *STAR Laboratory Reference Guide.*

To exit the display press the F7 key and the following prompt displays:

> *Enter field number, or '/' starting field number--*

Press ENTER to exit the screen.

Upon exiting the Clinical Order Details Information screen, the Case Login Order screen displays and allows you to precede with Case Login. The processor functionality has not changed.

```
            General Hospital Pathology Case Login Processor
Acc# 5315                                    Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician     Srv ICD Status
A000000439 LEVINE,CARLEY    F  04/06/1957 NSY-11   DOCTOR,ATTEND MED 10  I/P 180
  1 Priority       2 Collection Time       3 Collector       4 Workload
    STAT         ->                          #64267
  5 Case Number    6 Copy To          7 Edit By          8 Edit Date/Time
    Auto           Defined
  9 Print Previous                      10 Previous Info Printer

 11 Specimen Type        Specimen Modifier        Receive Date/Time
    *Cervix                                        08/18/95 1727
 12 Accession Comment                   13 Default Printer
                                           301-3 Printer Area (Port #246)
    Code   Description                   Ordering Physician        CP
 14   Order Comment                        Ordering Diagnosis
    5118   RECALL CYT W/ CAT 3            DOCTOR,ATTENDINGXXXXXXXXX  N/A
                                         002.2-PARATYPHOID FEVER B




 Enter collection date and/or time--
```

If you select an option from the Case Login Index screen the system collects and displays the information from the ordering process in the Case Login Order screen:

```
            General Hospital Histology Specimen Order Processor
                                             Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician     Srv ICD Status
A000000027 JONES, JULIE     F  03/04/1965 1103-01 SMITH,ROBERT  EMR 10  I/P 19
 1 Priority       2 Collection Time        3 Collector       4 Workload
   TODAY          03/22/93  1512           LAB               None
 5 Case Number    6 Copy To          7 Edit By          8 Edit Date/Time
   Auto           N/A
 9 Print Previous                      10 Previous Info Printer

11 Specimen Type        Specimen Modifier        Receive Date/Time
   *PAP                                           03/22/93  1512
12 Accession Comment                   13 Default Printer
                                         301-3 (PRINTER CLOSET IN HALLWAY)
14 Code  Description                   Ordering Physician        CP
   Order Comment                         Ordering Diagnosis
   5010  GYN CYTOLOGY                  JACKSON,ALEXANDER         N/A
      ORDERING COMMENT                 041.9-BACTERIAL INFECTION NOS



              Enter test code or first letter(s)`-`--
      F1 Prev Page  F2 Next Page  F3 Insert  F4 Delete  F6 Reset  F7 Exit ?
```

For field explanations on the Case Login Order screen, refer to .

NOTE: The specimen type indicator (*) displays in the Specimen Type field to indicate that multiple specimen types have been defined on this accession.

Interdepartment tests have additional conditions. For more information refer to "Interdepartmental Tests" on page 3-88.

When tests are in an Ordered status (tests have been ordered through another processor):

- The system prompts you to complete the additional information for the screen:

    - The Force Assignment or Override options are available when the case number is automatically assigned and you have sufficient security.

    - If the section is set for manual case number assignment, you must enter the case number at this time.

- Additional tests can be ordered (if you enter additional tests on this screen, the additional tests are not filed until the process is complete and the accession is in a specimen received status); only tests that have the same case number pool assignment can be added on to an existing order; no panel tests can be ordered.

- Multiple specimens/modifiers and receive date/time can be added or deleted (the system also allows modification of the primary specimen); changes to the Primary Specimen/Modifier are updated to STAR Patient Care.

- Histotech processes defined in the builder to be assigned at the time the test becomes specimen received are only evaluated when the status of the test changes from Ordered to Specimen Received; additional updates to specimens once the test is in a Specimen Received status do not activate the automatic definition of histotech processes.

When test(s) on the case are in a Specimen Received Status and you select from the Case Login Index screen, the system allows the following through the Case Login Order screen:

- ordering additional tests; only tests that have the same case number pool assignment can be added-on to an existing order; no panel tests can be ordered

- adding specimen information; modifying or deleting existing specimens including receive date/time; changes to the Primary Specimen/Modifier are updated on STAR Patient Care

When test(s) on a case are in a Partial or higher status and you select from the Case Login Index screen, the system allows the following through the Case Login Order screen:

- ordering additional tests; only tests that have the same case number pool assignment can be added-on to an existing order; no panel tests can be ordered

- adding, but not deleting specimens; no information about existing specimens (modifier or receive date/time) can be changed

If the selected test is for an inactive account, the system displays the following message:

    Test is on an inactive account! Check procedures for possible manual charging.

Use the Revise Order processor to edit the following accession level information, following the current guidelines:

- Collector

- Collection Date/Time

Multiple Specimen Index Screen

If you enter **S** to view multiple specimens, the system displays a table which is formatted like the Case Login Index screen and includes only orders that have multiple specimens (asterisk in front of Spec Type) as shown in the following example:

```
                         General Hospital Case Login Processor
                                         Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician      Srv ICD Status
A000000027 JONES, MARY         F  02/18/1970 2104-02 JOHNSON, JOHN ERS 10  I/P 28
                              Multiple Specimen Index
                                                         ##=Current Choices
Opt #     Case#     Acc #  Test Name              Date/Time          Status
( 1)     S93-50     1234   GROSS & MICRSCOPIC     03/22/93 1440      Spec Rec
( 2)                       TISSUE - GROSS EXAM    03/22/93 1440      Partial
                       *Spec Type: Ovary - Left
( 3)     S93-40     1231   GROSS & MICROSCOPIC    03/21/93 1035      Spec Rec
                       *Spec Type: Tissue Biopsy-LEFT LUNG




Enter option(s) to view multiple specimens or (A)ll--
               end selection(NL)
```

The prompt allows the entry of one or more options or all displayed options. This screen can have multiple pages and allows you to move backward and forward in the table.

After you select the option(s) to view, the process to review multiple specimens is the same as that in Patient Inquiry.

A scrolling screen (display only) is used to display all specimens for the selected tests.

```
                    General Hospital Case Login Processor
                                          Thu Jan 15, 2009 09:04 am
  Unit #      Name            Sex Birthdate  Room     Physician      Srv ICD Status
  A000000027 JONES, MARY       F  02/18/1970 2104-02 JOHNSON, JOHN ERS 10  I/P 28
   Case#: S93-50             Acct #: A9303200004                    Blocks: 2
          Accession # 1234 GROSS & MICROSCOPIC
                                                   Collected: 07/13/93 1033
                        Multiple Specimens

       Specimen               Modifier                 Receive Date/Time
       Ovary                  Left                       03/14/93 1345
       Ovary                  Right                      03/14/93 1345
       Fallopian Tubes                                   03/14/93 1345
       Uterus                                            03/14/93 1500






                 F1Prev Page F2Next Page F7  Exit
```

The F1 and F2 function keys at the bottom of the screen are for multiple screens of specimens for a case. F7 moves to the next selected case if multiples were selected.

If you select all the cases, F7 returns you to the Case Login Index screen after displaying the last case.

When you select individual cases, F7 returns you to the Multiple Specimen Index screen after the last case. This allows you to select another case to display the multiple specimens.

Merging Cases

This functionality provides you with an automated method of correcting errors made in ordering when information on the previous window information screen is not reviewed.

This option is not for routine use. Security is attached to this field so that the frequency of this problem can be monitored. When this problem occurs, there is the possibility of generating an incomplete report for a patient or having duplicate reports generated for the same surgical case.

The following assumptions apply to the merge option:

- Merges occur at the accession level. If you select an option from an accession, all tests attached to the accession are handled together in the same manner.

- Tests that are in an Order Cancelled, Accession Cancelled, Specimen Rejection, Archive, Backload, or Cardfile status cannot be modified with the merge option in this processor.

- Only the first two of the following scenarios (I and II) are handled with the merge option available from the Case Login Index screen. The possible scenarios are listed with suggestions on how to handle each.

    Scenario I: A test is in an ordered status and needs to be added to another order that has a case number assigned (in a status of specimen received or higher). This might happen if tests are ordered from a different processor or when the person placing the order does not read the previous case information before placing another order. If specimens are different on the cases, all specimens are added to the case into which the information is merged.

    Scenario II: A test is in a specimen received status and needs to be added to another order that has a case number assigned (in a status of specimen received or higher).

    Scenario III: A test is in a partial or higher status and needs to be added to another order that has a case number assigned (in a status of specimen received or higher).

    Tests with a partial or done status that need to be moved to another case number must be handled manually. (You must use the cancel/credit processor and add-on an order to the correct case number). The results on this case may be available outside the laboratory and manual steps are needed to track this situation.

If you enter **M** at the prompt on the Case Login Index screen, the system displays the following screen without any tests that are in an Archived or Backloaded status.

NOTE: Interdepartmental tests are not available for use with the merge option.

```
                       General Hospital Case Login Processor
                                            Thu Jan 15, 2009 09:04 am
    Unit #       Name            Sex Birthdate   Room    Physician      Srv ICD Status
    A0000900851JONES, JULIE       F   03/04/1965 1103-1  SMITH,ROBERT   EMR 10  IP   19

                            Merge Processor
                                                                     Page:01
    Opt # Case#       Acc #   Test Name                 Date/Time          Status
    ( 1)  S93-268     2025    GROSS AND MICRO           07/09/93 1530      Spec Rec
                              *Spec Type:  Throat
    ( 2)  S93-254     2012    ANATOMIC PATH GROSS ONLY  07/09/93 0948      Spec Rec
                              *Spec Type: Tissue
    ( 3)  S93-247     2004    SURGICAL SPECIMEN         07/09/93 1123      Partial
    ( 4)                      GROSS AND MICRO           07/09/93 1123      Done
                              *Spec Type:  Throat
    ( 5)  S93-245     2002    SURGICAL SPECIMEN         07/09/93 1107      Spec Rec
    ( 6)                      GROSS AND MICRO           07/09/93 1107      Spec Rec
                              *Spec Type:  Throat
    ( 7)  S93-244     2000    SURGICAL SPECIMEN         07/09/93 1103      Spec Rec
    ( 8)                      GROSS AND MICRO           07/09/93 1103      Spec Rec
                              Spec Type:  Throat

    Enter option to move to new case number--
                              next page(/)
```

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The prompt for this screen is as follows:

Enter option to move to new case number--

If you enter an option in a partial or done status, the system displays the following error message:

Test is not available for merge processing! Use cancel/credit processor.

If the entered option is in a specimen received status, the system cancels all tests associated with the case (and applies credit, if applicable) and automatically adds the appropriate test(s) on to the correct case number. The system treats the case number as if the test(s) associated with it are cancelled and returns the unused case number to the reserve case number pool; the system displays the case number in dim video like other case numbers that have been previously assigned to cancelled tests.

If the option entered is in an ordered status, the system removes the test(s) from the current order and treats the test(s) like an add-on order to the new case number.

After you enter a valid option, the system displays the following screen:

```
                        General Hospital Case Login Processor
                                        Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room    Physician      Srv ICD Status
A0000900851JONES, JULIE    F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19

          From: S93-245
                                                                    Page:01
Opt # Case#       Acc #   Test Name               Date/Time        Status
( 1)  S93-268     2025    GROSS AND MICRO         07/09/93 1530    Spec Rec
                          *Spec Type:  Throat
( 2)  S93-254     2012    ANATOMIC PATH GROSS ONLY 07/09/93 0948   Spec Rec
                          *Spec Type:  Tissue
( 3)  S93-247     2004    SURGICAL SPECIMEN       07/09/93 1123    Partial
( 4)                      GROSS AND MICRO         07/09/93 1123    Done
                          *Spec Type:  Throat
( 5)  S93-245     2002    SURGICAL SPECIMEN       07/09/93 1107    Spec Rec
( 6)                      GROSS AND MICRO         07/09/93 1107    Spec Rec
                          *Spec Type:  Throat
( 7)  S93-244     2000    SURGICAL SPECIMEN       07/09/93 1103    Spec Rec
( 8)                      GROSS AND MICRO         07/09/93 1103    Spec Rec
                          Spec Type:  Throat


Enter option to be moved in to--
                              next page(/)
```

The system displays the previously entered case number (if defined) above the table display on the left side. If the option is in an Ordered status, the accession number displays where the case number currently displays.

The prompt for the screen is as follows:

Enter option to be moved in to--

If the option entered is the same option as you entered at the previous prompt, the system displays the following message:

Option cannot be merged into itself!

After displaying the error message, the system returns you to the previous prompt.

If the option entered has already reached the maximum number of tests for the accession, the system displays the following error message:

Max of [maximum number of tests for accession] have been ordered!

If the option entered is in an Ordered status, the system displays the following error message:

Cannot merge to order status!

When you enter a valid option, the system provides another opportunity to review the information entered (through the two previous prompts) on the following screen:

```
                     General Hospital Case Login Processor
                                      Thu Jan 15, 2009 09:04 am
  Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
  A0000900851JONES, JULIE    F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19




              From: S93-245              To: S93-244










                   Are you sure? (Y/N)--
```

The following prompt is the last opportunity to stop before merging the two cases:

Are you sure? (Y/N)--

If you answer No at the prompt, the system returns you to the Case Login Index screen at the prompt (to select options to login, view multiple specimens, order another test or merge case information).

If you answer Yes at the prompt, the system displays the following screen:

```
                          General Hospital Case Login Processor
                                         Thu Jan 15, 2009 09:04 am
 Unit #       Name            Sex Birthdate Room     Physician      Srv ICD Status
 A0000900851JONES, JULIE       F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19




               From: S93-245              To: S93-244

                          Merge in progress!

      Misc charges and profee billing merges must be handled manually!

        Histotech processes associated with S93-245 have been deleted!


                     Case S93-244 merge complete!
```

If histotech processes exist from the test merged into the final case number, the system displays the following message:

> *Histotech processes associated with [case number of test that was moved] have been deleted!*

After the merge is complete, the system returns to the Case Login Index screen.

Orders (accessions) that have been cancelled can be viewed in Patient Inquiry. When you select the test, the following screen displays:

```
                          General Hospital Case Login Processor
                                         Thu Jan 15, 2009 09:04 am
 Unit #       Name            Sex Birthdate Room     Physician      Srv ICD Status
 A930540001JONES, JULIE        F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19
 Case #:                    Acct #: A930540001
                    Accession #: 2002 SURGICAL SPECIMEN
 Specimen: Throat                                      Collected: 07/09/93 1107

                 This test has a status of Cancelled
                (AP merged test)








 Enter option--
                              * = Options
```

Transitions from Case Login

Based on the settings in the Previous Order Window builder, you have several options after you accept the entries on the Case Login Order screen. You can directly access Histotech Processing, Miscellaneous Charge, Professional Fee Billing, and Result Reporting processors from the Case Login processor.

NOTE: Additional flow to other processors is not available if no updates are processed from the case login order screen.

Your security level determines the additional processing available. The system prompts you to enter information in the processors allowed by your security level. The system does not display processors requiring a higher security level.

During periods of heavy system use, the automatic flow to additional processors may not include all the current updates just entered through case login.

The following screen flow represents the hierarchical scenario if all flags in the Previous Order Window builder are set to auto: Auto Histo --> Auto Misc --> Auto Profee --> Auto Result Reporting.

The system does not direct you with prompts. Accepting the Case Login Order screen causes the system to present the following flow of beginning screens (each function discussed briefly, with an example of the first screen).

Histotech Processing

If the section flag is set to prompt for entry into Histotech processing from Case Login, the system displays the following prompt:

   Enter histotech processes for this patient? (Y/N) [N]--

The default in the prompt is user-defined.

You enter the processor as if you entered the patient's name for entry.

```
                        General Hospital Case Login Processor
                                    Thu Jan 15, 2009 09:04 am
    Unit #      Name            Sex Birthdate Room    Physician      Srv ICD Status
    A0000900851JONES, JULIE      F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19


                                        Date: 07/09/93


    Opt #  Order#     Acc #  Test Name                      Time  Status
    Acct#: A9305400001
      1    0319       2025   GROSS AND MICROSCOPIC          1530  Ordered
    Case#: S93-268
      2    0316       2004   GROSS AND MICROSCOPIC          1123  Done
    Case#: S93-247
      3    0300       2000   GROSS AND MICROSCOPIC          1103  Spec Recd
    Case#: S93-244




                        All work listed for: 07/09/93
    Enter option number(s), `P` for previous day, Date, Test Lookup(L)--
```

You have the option to select any options within the histotech processor for this patient. If you exit back to a point in the processor that requires the input of a patient identifier (such as name or accession #), or complete the processing for the patient, the system checks to see if you want to access the next processor, Miscellaneous Charge/Credit.

Miscellaneous Charge/Credit

If the section flag is set to prompt for entry into Miscellaneous Charge/Credit from the previously-defined process, the system displays the following prompt:

Enter miscellaneous charges/credits for this patient? (Y/N) [N]--

The default in the prompt is user-defined.

The next screen (after Histotech processing) for this scenario is the following Miscellaneous Charge/Credit processor:

```
                    General Hospital Histology Case Login Processor
Accn#:0319                                    Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician     Srv ICD Status
A0000900851JONES, JULIE        F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19
                              Acct#: A9305400001








Enter Charge/Credit(C) or View(V) only [C]--
```

You may select any option within the Miscellaneous Charge/Credit processor for this patient. If you exit back to a point in the processor that requires the input of a patient identifier (such as name or accession #), or complete the processing for the patient, the system checks to see if you want to access the next processor, Professional Fee Billing.

Professional Fee Billing

If the section flag is set to prompt for entry into Professional Fee Billing from the previously-defined process, the system displays the following prompt:

   Enter professional fees for this patient? (Y/N) [N]--

The default in the prompt is user-defined.

The next screen (after Miscellaneous Charge processing) for this scenario is the following Professional Fee Billing processor. This provides an opportunity to determine what has been previously billed for this patient.

.

```
                            General Hospital Case Login Processor
Accn#:0319                                  Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate Room    Physician      Srv ICD Status
A0000900851JONES, JULIE        F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19

Professional Billing Search
 1 Start Date      2 End Date       3 Section
->
```

Enter date to begin search for tests with prof billing [oldest work]--

You may select any option within the Professional Billing processor for this patient. If you exit to a point in the processor that requires the input of a patient identifier (such as name or accession #), σ complete the processing for the patient, the system checks to see if you want to access the next processor, Result Reporting.

NOTE: If all flags are not set to yes, the screen flow continues with the same hierarchy of the flags that are set to yes.

Result Reporting

If the section flag is set to prompt for entry into Result Reporting from the previously-defined process, the system displays the following prompt:

   Enter result reporting for this patient? (Y/N) [N]--

The default in the prompt is user-defined.

The next screen (after Professional Fee Billing) for this scenario is the Result Reporting processor. If a method is attached, select the appropriate method before the system displays this screen.

```
                         General Hospital Case Login Processor
Accn#:0319                                    Thu Jan 15, 2009 09:04 am
Unit #       Name             Sex Birthdate Room    Physician     Srv ICD Status
A0000900851JONES, JULIE        F  03/04/1965 1103-1  SMITH, ROBERT EMR 10  IP  19

                                      Date: 07/09/93

Opt #  Order#     Acc #  Test Name                      Time  Status
Acct#: A9305400001
   1   0319        2025  GROSS AND MICROSCOPIC          1530  Spec Recd
 Case#: S93-268
   2   0316        2004  GROSS AND MICROSCOPIC          1123  Done
 Case#: S93-247
   3   0300        2000  GROSS AND MICROSCOPIC          1103  Spec Recd
 Case#: S93-244




                         All work listed for: 07/09/93
Enter option number(s), `P` for previous day, Date, Test Lookup(L)--
```

You may select any option within the Result Reporting processor for this patient. If you exit back to a point in the processor that requires the input of a patient identifier (such as name or accession#), or complete the processing for the patient, the system check to see if you want to return to the Case Login processor and be prompted for another patient.

Case Login Order Screen

If you enter **O** for a new order, the system displays a screen to select the account number, then displays the following Case Login Order screen. Another way to access this screen is to select an existing option from the Case Login Index screen.

Entering **O** requires the selection of an account number. If the patient has more than one account number, a screen with only the active account numbers for the selected patient displays for selection of the appropriate account. Once an account is inactive, tests can only be added-on to an existing order when the system accesses the Case Login Order screen.

NOTE: Panel tests, miscellaneous charges, or professional fee codes cannot be ordered through this processor. This processor is designed to support orderable AP test type tests that would be ordered from the pathology sections of the laboratory.

If the flag to print barcode accession labels is set to **Y** when you enter **O** for a new order in Case Login, both collection and accession labels print as barcode labels. If the flag is set to **N**, both collection and accession labels print as standard labels.

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```
            General Hospital Histology Case Login Processor
                                    Thu Jan 15, 2009 09:04 am
 Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000000027 JONES, MARY      F  02/18/1970 2104-02 SMITH, SUSAN  ERS 10  I/P 28
  1 Priority      2 Collection Time    3 Collector        4 Workload
    Routine         05/22/93 0515         LAB                NONE
  5 Case Number   6 Copy To          7 Edit By          8 Edit Date/Time
    Auto            N/A
  9 Print Previous                 10 Previous Info Printer

 11 Specimen Type      Specimen Modifier       Receive Date/Time
    Appendix                                    05/22/93 0530
 12 Accession Comment                13 Default Label Printer
                                        301-3 (PRINTER CLOSET IN HALLWAY)
    Code   Description                 Ordering Physician      CP
 14   Order Comment                      Ordering Diagnosis
    5050 Gross and Microscopic         Smith, John             N/A



 Enter field number of '/' starting field number--
```

The only tests that can be ordered from this screen are AP test type tests. The system checks the definition in the Case Login Parameters builder to determine which case number pool tests to allow. Tests with different case number pools can be ordered in the same transaction, if the case number field is set to auto-assign.

NOTE: Interdepartment tests have additional conditions. For more information refer to "Multidepartment Considerations" on page 3-87 and "Interdepartmental Tests" on page 3-88.

Field Explanations

1. PRIORITY (TABLE LOOKUP-R)
The priority code can be entered directly into the system or the system displays a table of priorities. The system displays the following prompt when you access the field.

Enter priority code or `-` for table--

After you select the priority, the system displays additional prompts as necessary to complete the information for the selection (as defined in the priority table).

2. COLLECTION TIME (DATE-R)
This field is blank if you have entered **O** for a new order, allowing back dating of the collection date and time. If you select an existing order to login, the system displays the actual collection date and time entered or the default value for the selected priority field. The system checks the flag (Flags/Utilities -->Flags -Order/Accession --> Accession Collect Display) to determine the time that displays in this field. You can edit this field. Refer in the *Maintenance Functions Volume* of the *STAR Laboratory Reference Guide* for further information.

3. COLLECTOR (19-AN-C)
This field operates as it does for accessioning. Please refer to Accession Processor in Chapter 4: Accessioning in the *General Applications Volume I* of the *STAR Laboratory Reference Guide* for further information.

4. WORKLOAD (U-C-O)
This field operates as it does for accessioning. Refer to the *General Applications Volume I* of the *STAR Laboratory Reference Guide* for further information.

5. CASE NUMBER (SPECIAL FORMAT-R)
The system determines the case number for the accession on the initial order in this field. This field can only be edited during the initial ordering process or the initial login process, if the case was ordered from another processor. If the number is auto-assigned by the system, the system displays the following:

Auto

Manual Case Number Entry
If you have set the flags that enable manual entry of the case number only, the system displays the following:

Enter reserved case number, `-` for table--

Both the complete case number format (such as S93-105) and the shorter format (such as S105) are acceptable entries for this field. The case number (in the complete format) displays in the Case Number field.

The system enables you to enter the reserved case number. If you don't know the case number you can enter a hyphen (**-**) to select from a table of available case number pools. The case number pools that the system displays are based on the section case login parameters.

Once you select a case number pool (or if there is only one case number pool allowed), the system displays the following table of the available reserved unassigned case numbers for the department:

```
                 General Hospital Unassigned Case #'s Processor
                                            Wed Feb 16, 1994 10:25 am
    Page:01             Unassigned Case #'s for Surgical Specimens
    ( 1) S93-46            (19) S93-97            (37) S93-117
    ( 2) S93-47            (20) S93-98            (38) S93-118
    ( 3) S93-48            (21) S93-99            (39) S93-119
    ( 4) S93-82            (22) S93-102           (40) S93-120
    ( 5) S93-83            (23) S93-103           (41) S93-121
    ( 6) S93-84            (24) S93-104           (42) S93-122
    ( 7) S93-85            (25) S93-105           (43) S93-123
    ( 8) S93-86            (26) S93-106           (44) S93-124
    ( 9) S93-87            (27) S93-107           (45) S93-125
    (10) S93-88            (28) S93-108           (46) S93-126
    (11) S93-89            (29) S93-109           (47) S93-127
    (12) S93-90            (30) S93-110           (48) S93-128
    (13) S93-91            (31) S93-111           (49) S93-129
    (14) S93-92            (32) S93-112           (50) S93-130
    (15) S93-93            (33) S93-113           (51) S93-131
    (16) S93-94            (34) S93-114           (52) S93-132
    (17) S93-95            (35) S93-115           (53) S93-133
    (18) S93-96            (36) S93-116           (54) S93-134

    Enter choice--
                    next page (/)
```

After you select from this screen, the case number displays in the Case Number field. The system checks the following if you selected the manual entry option for this field:

- If the case number entered is already assigned to another accession, the system displays the following message and prompts you to enter another case number:

    Case # S93-96 already assigned to Acc # 5050!

- If the case number entered is not reserved, the system displays the following message and prompts you to enter another case number:

    Case # S93-96 not reserved!

- If a case number is entered, the system only allows tests with the same case number pool in this order sequence. If a test is ordered that has a different case number pool assignment, the system displays the following message:

    Case number pool mismatch!

- If you set this field to allow manual case number entry, then interdepartmental tests cannot be ordered through the Case Login processor. The case number pools that are available for your selection are those from the ordering department. (Interdepartmental case number pools are assigned from the primary performing department.) The system displays the following message:

    Test code is interdepartment!

Automatic Case Number Assignment

If you set the section level flag to auto assign the case number and you enter this field, the system displays the following prompt:

System defined to auto-assign case number!

Enter override case number, '-' for table or force(F) assign next case #--

If you enter a hyphen (**-**) at this prompt, the system displays a table of case number pools which are valid for the section. The system displays the following once you select the case number pool:

Searching for reserved case #'s - Please wait!

Following this message the system displays a table of available unassigned (reserved) case numbers.

NOTE: The override option in this prompt is only available if the security level of the person signed on allows this functionality. If the security level does not allow override, the system displays the following prompt:

Enter case number pool for force assignment or '-' for table--

If you enter **F** to force assign the next case number, the system displays the next available number in the selected case number pool if only one case number pool is available for the section. If multiple case number pools are allowed for the section the system displays the following when you enter **F**:

Enter case number pool for force assignment or '-' for table--

You can enter the individual case number pool or enter a hyphen (**-**) to select from a table of available case number pools. The system displays case number pools allowed in this section based on the flags set in the Case Login Parameters maintenance processor. For more information on this processor refer to Chapter 2: Maintenance Functions in the *Anatomic Pathology Module* of the *STAR Laboratory Reference Guide*. If only one case number pool is allowed, the system will not display the preceding prompt.

If you leave this field set to Auto, enter test codes in the Code field, and then return to this field to initiate the Override or Force Print Assign options, the system displays the following:

Test(s) defined - Force/Override not allowed!

Auto Assign Scenario I: Case Number Override

If you need to assign a previously reserved case number for a specific order, it requires an override of the case number that would be assigned upon accepting this screen (after defining the appropriate case number pool).

NOTE: The override option is not available once a case number has been filed for the tests.

Override
Entering an override case number causes the system to make the following checks:

If you enter a case number already assigned to another accession, the system displays the following message and remains at the prompt to enter another case number:

Case # [full case number) already assigned to Acc # [accession number]!

If you enter a case number that is not reserved, the system displays the following message and remains at the prompt for entry of another case number:

Case # [full case number] not reserved!

If you enter a case number that is not from a valid case number pool for this section, the system displays the following message and remains at the prompt for entry of another case number:

Case number pool not valid for [section name]!

Using the Override function limits your ability to only order test codes in this episode that have the specific case number pool assigned.

Auto Assign Scenario II: Case Number Force Assign
The pathologist is waiting on the case number assignment and there are multiple specimens to be added to this order. To save time, the case number can be force assigned, which actually assigns the next available case number to this order. If you press ENTER to exit the screen before accepting the information, this number is placed in the reserved case number pool to be manually assigned at a later time.

Force Assign
Selecting the force assign option causes the system to make the following checks:

If you enter a case number pool that is invalid for this section, the system displays the following message and remains at the prompt for entry of another case number:

Case number pool not valid for [section name]!

NOTE: Once the forced case number displays on the screen, this number is no longer available for automatic assignment to another case if you exit out of the screen without accepting the information. The case number goes into the unassigned (reserved) case number pool and is available for manual entry or the override option for another order.

Using the Force Assign function limits your ability to only order test codes in this episode that have the specific case number pool assigned.

6. COPY TO (TABLE LOOKUP-R)
This field processes as it currently does in accessioning. On initial order, this field displays *N/A*. Once the order screen is filed and the case is redisplayed, the functionality is the same as in the Accession function. Refer to the *Maintenance Functions Volume I* of the *STAR Laboratory Reference Guide*.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited the login information.

8. EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time of the last edit to the login information.

9. PRINT PREVIOUS (1-A-R)
This field provides an option to print the patient's previous history cardfile information upon completion of the case login process. When the field is entered, the system displays the following prompt:

Print previous cardfile information? (Y/N) [user defined default]--

The optional user defined default is configured using the Anatomic Path Parameters maintenance processor.

To print, enter **Y**. You are prompted to enter the printer location in Field 10. If you don't want to print, enter **N**. Field 10 displays *N/A*.

10. PREVIOUS INFO PRINTER (TABLE LOOKUP-C)
This field defines the printer location for the history cardfile report. Available printers have a LRP definition (Draft Long Report).

If Field 9 has an entry of Yes, the default printer for Draft Long Report displays when no alternate printers are defined. If alternate printers are defined, you can select one or press ENTER to accept the default printer.

11. SPECIMEN TYPE (3-NC-R)
This field uses scrolling screen processing.

Scrolling Screen

The following function keys are used for the scrolling screen:

F1Prev Page F2Next Page F3 Insert F4 Delete F6 Reset F7 Exit

For information on scrolling screen processing, refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

NOTE: You cannot use the F3 key to edit or remove the primary specimen once the test status is Partial or higher. If you press F3 when the cursor is located on the primary specimen, the system displays the following message before returning you to the main Case Login screen:

Test(s) resulted! No edits allowed to primary specimen!

You must move the cursor to the line *below* the primary specimen to use the F3 key to delete a specimen.

When you complete all necessary fields, use the F7 key to exit the scrolling screen. The information is not filed until the screen is accepted. The information on the horizontal screen after you exit the scrolling screen is related to the primary specimen (specimen/specimen modifier/receive date/time).

The first entry is considered the Primary Specimen/Modifier. This information is passed to STAR Patient Care. Additional specimens (and modifiers) are available on STAR Lab. When you make any edits or inserts to the first specimen/modifier, that information is updated on STAR Patient Care.

A specimen may be entered multiple times with different modifiers, but if you enter an exact duplicate of specimen and specimen modifier, the system displays the following message:

Warning: Specimen/Modifier already assigned!

The system deletes the duplicate when the specimen order screen is accepted.

```
                 General Hospital Histology Case Login Processor
                                          Thu Jan 15, 2009 09:04 am
 Unit #      Name              Sex Birthdate  Room    Physician     Srv ICD Status
 A000000027 JONES, MARY      F  02/18/1970 2104-02 SMITH, SUSAN  ERS 10  I/P 28
  1 Priority        2 Collection Time      3 Collector       4 Workload
    Routine           05/22/93 0515          LAB               NONE
  5 Case Number     6 Copy To            7 Edit By         8 Edit Date/Time
    Auto              N/A
  9 Print Previous                     10 Previous Info Printer


 11 Specimen Type          Specimen Modifier        Receive Date/Time
    Appendix                                          05/22/93 0530
 12 Accession Comment                13 Default Label Printer
                                        301-3 (PRINTER CLOSET IN HALLWAY)
    Code    Description                Ordering Physician        CP
 14   Order Comment                      Ordering Diagnosis
    5050 Gross and Microscopic          Smith, John              N/A




 Enter field number of '/' starting field number--
```

At least one specimen must be entered in the Specimen Type field. Multiple specimens may be entered. The specimens are attached at the accession level and are not test-specific for anatomic path test types; as such, the test level specimen flag is not checked in this processor. The system displays all specimens in the specimen table. The number of specimens is unlimited. The first specimen entered is referred to as the Primary Specimen. This specimen is on the horizontal screen when you exit from the scrolling screen for this field. The system displays the following prompt when you enter this field:

> *Enter specimen type or '-' for table --*

A partial lookup from the table is possible for the previous prompt.

After the test has reached a status of specimen received, and you delete a specimen, the system displays the following warning message:

> *Warning: Histotech Processes may need to be deleted!*

If you defined default histotech processes to be added at login, you must delete them manually using the histotech processor.

If a test is in a specimen received status, and you add-on a specimen, the system displays the following message:

> *Warning: Histotech Processes may need to be updated!*

SPECIMEN MODIFIER (25-AN-O)
You must enter a specimen in the first field of the scrolling screen before this field can be accessed. Each defined specimen can have a specific modifier. If the first specimen has a modifier defined, it is referred to as the Primary Specimen Modifier. This specimen modifier is on the horizontal screen when you exit from the scrolling screen for this field. The system displays the following prompt when you enter this field:

> *Enter specimen modifier--*

Once the test has reached a status of specimen received, and you edit or delete a specimen modifier, the system displays the following warning message:

> *Warning: Histotech Processes may need to be modified!*

RECEIVED DATE/TIME (DATE-R)
This field tracks the time a specimen is received in the pathology section of the laboratory. The system displays the following prompt when you enter this field:

> *Enter date/time specimen received--*

Entering a future date causes the system to display the following message:

> *Error: Date in future!!*

The system automatically fills in the current date and time when you press ENTER through the field. The field can be edited at any time. A future date/time is not a valid entry.

This new tracking time at the specimen level is necessary for the pathology department, due to the ability to batch, enter AP cases with the use of manual assignment of case numbers. CAP requires that the pathology department track the time from receipt to the time the frozen section results are reported. The received time could not previously be tracked on the system if batch entry of AP cases is the process appropriate to the department work flow.

12. ACCESSION COMMENT (36-C-O)
This field operates as it does for accessioning. Please refer in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*. This field is controlled by department flags and the information on the screen can be overwritten based on the flag settings.

13. DEFAULT LABEL PRINTER (TABLE LOOKUP-R)
This field operates as it does for accessioning. The displayed printer is based on the accession label printer definition. A section defined accession label printer is used if it has been defined. If a section-specific printer is not defined, the default printer is used.

14. CODE (5-N-R)
This field uses scrolling screen processing.

Scrolling Screen

The fields in this scrolling screen are used to enter information about the tests that are being ordered through this processor.

The only tests that can be ordered from this screen are AP test type tests. The system checks the definition in the Case Login Parameters builder to determine which case number pool tests are allowed. Tests from multiple case number pools can be logged in through the same episode if the case numbers are automatically assigned by the system.

On the initial order through this processor, the following function keys are available:

   F1 Prev Page F2 Next Page F3 Insert F4 Delete F6 Reset F7 Exit ?

After a test has been logged in and you enter this screen to add-on additional tests, the following function keys are available:

   F1 Prev Page F2 Next Page F3 Add-On F6 Reset F7 Exit ?

The following fields are presented in the scrolling screen. Please refer in the *General Applications Volumes* of the *STAR Laboratory Reference Guide* for detail on these fields:

• DESCRIPTIONS (DISPLAY ONLY)

• ORDERING PHYSICIAN (25-C-R)

• CP (2-N-C)

• ORDERING COMMENT (36-C-O)

• ORDERING DIAGNOSIS (33-C-O)

> **NOTE:** For CMS-Compliant outpatients refer to "CMS COMPLIANCE CHECKING (OPCD)" on page 3-96.

Only the checks made by the system are presented in this volume.

When you access the Code field, the system displays the following prompt:

Enter test code or first letter(s)'-' --

If you enter a hyphen (**-**), the system displays a table of ONLY Anatomic Path type tests.

If you enter a test code that is not an Anatomic Path type test, the system displays the following message:

Test code must be Anatomic Path test type!

If you re-enter a test that is already ordered in the current episode, the system displays the following message:

[test code] already ordered!

If you enter an Anatomic Path test type test with a case number pool that is not allowed for this section, the system displays the following message:

Case number pool mismatch!

If you enter an Anatomic Path test type test that is not in the range of test codes for this section, the system displays the following message:

Invalid test code for this section!

If you enter an AP type test that is a panel test code, the system displays the following message:

Test code is a panel master!

If you enter a code that is not defined as a SIM item, the system displays the following:

Test code XXXX not on file!

If you enter an AP type test code that is defined as non-orderable, the system displays the following message:

Test code is non-orderable!

If you enter a code that is not defined for the ordering priority, the system displays the following message:

Test #### not set up for [ordering category] Priority!

If you have ordered a total of 50 tests, the system displays the following message:

Max of 50 tests has been ordered!

Adding-on a test to an existing order is only allowed when the case number pool is the same as the existing accession. If you enter an AP test with a different case number assignment, the system displays the following message:

Test not assigned to [case number pool description] case # pool!

The maximum number of tests per accession is checked with add-on orders. If the limit is reached, and another test is entered, the system displays the following message:

Accession has [number of tests] tests! No more can be added!

NOTE: When ordering AP tests through case login, the ordering comment can be edited. Once a test has reached a status of specimen received, the ordering comment cannot be edited.

The diagnosis for the add-on orders defaults with the working diagnosis. You can edit the ordering diagnosis for a test that you have entered. At the *Do you wish to edit Ordering Diagnosis? (Y/N) [N]--* prompt, enter the new ordering diagnosis for the test that you entered.

When you complete all of the necessary fields on the horizontal screen you are prompted as follows:

Accept? (Y/N) [Y]--

Once you accept the screen and the tests are ordered, the system displays the following message during processing:

<< Building Accession(s), please wait! >>

If you define histotech processes for entry at login, the system displays the following message displays:

Building case - please wait!

If you accept the screen, and tests have been ordered with the case number automatically assigned, the system displays the following message:

Case number [insert full display] [accession number] logged!
Press NL to continue--

Once the login screen is accepted, the system checks the test's case number pool and determines if the case is eligible for Cytology Workload/QC.

If display of the High Risk prompt during case login is active and the case is eligible for Cytology Workload/QC, the following prompt displays:

Consider this case high risk? (Y/N) [user defined default]--

Enter **Y** to enter the High Risk indicator required for Cytology Workload/QC processing. The high risk information entered is automatically displayed on the Cytology Workload/ QC capture screen through the resulting processors and is not entered again.

NOTE: The user defined Y/N default is configured in the Workload/Quality Control Parameters maintenance processor.

If the case is logged into the system, but is still in a specimen received status, entering Case Login again to make updates to the case, results in the system prompting you again for the high risk information. The default, at this point, is the previously entered value for the high risk prompt.

This prompt displays at the end of Case Login only while the test is in a specimen received status. Entering Case Login again for the test in a status greater than specimen received does not display the high risk prompt. At this point, the high risk information can only be edited through the Update Workload Information processor.

If the case has multiple tests, all tests must be in a specimen received status for the high risk prompt to be available through Case Login.

If the only screen change is to update specimen information, the system displays the following message (after you accept the screen):

Specimen information updated!

If you do not make any changes to the screen, the system displays the following message (after you accept the screen):

No updates to process!

The system does not invoke additional flow to other processors if no updates are processed from the case login order screen.

If you press period (.) ENTER to exit this screen, the system returns to the patient entry screen.

If histotech processes are defined for the ordered tests, the default histotech processes are attached to all defined specimens unless specific information is in the builder related to a specific specimen type. The sequence of the numbering for histotech processes is the same as the order of the tests.

After you order a test and it is available on the Specimen Index screen, different scenarios determine how these cases can be modified.

Edits to orders can be made based on the order status. Information that can be edited through this processor includes the following fields at the accession level:

• Case Number

• Copy To

• Collection Date/Time

• Specimen/Modifier Receive Date Time

Other accession level information can be edited through the Revise Order processor.

NOTE: For information on accessioning using Option Number to Login refer to the "Option Number to Login" on page 3-24.

Unassigned Case #'s

The Unassigned Case #'s processor is used to review unassigned case numbers and resolve problems associated with them. Unassigned case numbers can be reviewed on the CRT or printed in a report.

```
            General Hospital Anatomic Path Order Management Processor
                                              Fri Aug 06, 1993 02:05 pm
 Pathology Anatomic Path Order Management Input Options

            Option No.  Option
            ---------------------------------------
                1        Reserve/Generate Case #'s
                2        Case Login

                3        Unassigned Case #'s
                4        Print/Reprint Case # Labels
                5        Delete Unassigned Case #'s

                6        Pathology Log Report

                7        Long Reports Batch




 Enter option number--
```

Upon selection of the Unassigned Case #'s processor, the following prompt displays:

Enter case # pool code or `-` for table--

If you enter a hyphen (**-**) to display the table, a list of case number pool codes displays for selection. If you enter the pool code or select from the table, the following prompt displays:

Display(D) or Print(P) unassigned case #'s for (case number pool description) [D]--

If you enter **D** to display the list of unassigned case numbers the following message displays while compiling the list:

Please wait, gathering data....

The system begins to compile the list of unassigned case numbers. As more and more case numbers are used in the system, the time to compile the list of case numbers increase. After the system compiles the list of unassigned case numbers, the following screen displays:

```
                 General Hospital Unassigned Case #'s Processor
                                              Fri Aug 06, 1993 02:07 pm
    Page:01            Unassigned Case #'s for Surgicals
    ( 1) S93-7          (19) S93-27            (37) S93-45
    ( 2) S93-9          (20) S93-28            (38) S93-46
    ( 3) S93-10         (21) S93-29            (39) S93-47
    ( 4) S93-11         (22) S93-30            (40) S93-48
    ( 5) S93-12         (23) S93-31            (41) S93-49
    ( 6) S93-13         (24) S93-32            (42) S93-50
    ( 7) S93-14         (25) S93-33            (43) S93-51
    ( 8) S93-15         (26) S93-34            (44) S93-52
    ( 9) S93-16         (27) S93-35            (45) S93-53
    (10) S93-17         (28) S93-36            (46) S93-54
    (11) S93-18         (29) S93-37            (47) S93-55
    (12) S93-19         (30) S93-38            (48) S93-56
    (13) S93-20         (31) S93-39            (49) S93-57
    (14) S93-21         (32) S93-40            (50) S93-58
    (15) S93-22         (33) S93-41            (51) S93-59
    (16) S93-23         (34) S93-42            (52) S93-60
    (17) S93-24         (35) S93-43            (53) S93-61
    (18) S93-26         (36) S93-44            (54) S93-62


    Press NL to exit
                                   next page(/)
```

At this screen, you can press ENTER to exit the processor or enter slash (*/*) or slash P
(*/P*) to review multiple pages of unassigned case numbers. Unassigned case numbers
from cancelled tests display in dim video.

If you wish to print a report of the unassigned case numbers, enter **P** at the following
prompt:

> *Display(D) or Print(P) unassigned case #'s for (case number pool description) [D]--*

After entering **P**, a list of defined printers (General Reports) displays for selection and,
upon selection, the following message displays:

> *Printing!*

Output

The Unassigned Case Numbers report can be printed upon demand and is an 8-1/2 x
11 report. The report can be used in two ways. It can be printed after case numbers
have been reserved and then used as a worksheet. It can also be used as a
management tool to review the unassigned case numbers and then log the results of
the investigation.

The header of the report contains the report title, the print date and time, a page
number indicator and the case number pool name. The columns of the report consist
of *No.* (which indicates the option number of the unassigned case number) and *Case
#* (which contains the actual case number which is not assigned). If the case number
is assigned as a result of order cancellation, *C* prints before the blank space. The last

column of the report is a blank space which can be used for comments as you investigate why the case number is not assigned.

If the number of unassigned case numbers exceeds a single page, multiple pages will print. Up to 54 case numbers print on a single page. The option numbers associated with the unassigned case numbers continues to increment across multiple pages. For example, if there are 60 unassigned case numbers, then the option numbers on the first page are 1 to 54 and the option numbers on the second page are 55 to 60.

On the last page of the report, the message *End of Report* prints.

An example of the report follows.

Figure 3.3 Unassigned Case Numbers (ALGRLGR0)

```
                             Unassigned Case Numbers
                            Fri Aug 06, 1993 05:11 pm
                                                                     Page:  1
                          For Case # Pool:  Anatomic Pathology

             No.            Case #
            ------        ----------
               1          S93-7           C_____
               2          S93-9             _____
               3          S93-10            _____
               4          S93-23          C_____
               5          S93-29            _____
               6          S93-31            _____
               7          S93-35            _____
               8          S93-42            _____
               9          S93-47            _____
              10          S93-50            _____
              11          S93-51            _____
              12          S93-63            _____


                               End of Report
```

Print/Reprint Case # Labels

The Print/Reprint Case # Labels processor is used to print/reprint case number labels.

```
          General Hospital Anatomic Path Order  Management Processor
                                           Fri Apr 16, 1993 10:34 am
 Pathology Anatomic Path Order Management Input Options

           Option No.  Option
           ---------------------------------------
                1       Reserve/Generate Case #'s
                2       Case Login

                3       Unassigned Case #'s
                4       Print/Reprint Case # Labels
                5       Delete Unassigned Case #'s

                6       Pathology Log Report

                7       Long Reports Batch




 Enter option number--
```

Upon selection this processor, the following prompt displays:

> *Enter case # pool code or `-` for table--*

Enter a hyphen (**-**) to display a list of case number pool codes for selection. After definition of the case number pool code, the following prompt displays:

> *Enter case # to reprint or `-` for table of unassigned case #'s*

Enter the case number such as CYY-1234, where C is the case number pool code, YY is the last two digits of the year and 1234 is the case number. You can also enter the case number preceded by a left bracket ([). Entry of the specific case number allows you to reprint assigned or unassigned case numbers.

Enter a hyphen (**-**) to display a table of unassigned case numbers. Case numbers returned to the pool as a result of test cancellation display in dim video. From this table, you can select a single case number, multiple case numbers, a range of case numbers, or all case numbers to print/reprint labels. Using this pathway, only unassigned case numbers can be printed.

Upon case number(s) selection, the following prompt displays:

> *Enter number of labels/Case # to print [2]--*

Enter the number of labels per case number to print or press ENTER for the default.

NOTE: The number that displays for the default is the one defined for the case
number pool.

A list of printers displays for selection. Select a printer and the labels print.

Delete Unassigned Case #'s

The Delete Unassigned Case #'s processor is used to delete reserved but unassigned
case numbers. Only case numbers that have been reserved and are currently not
assigned to a patient can be deleted with this processor. Its primary function is to close
out case numbers at the end of the year. This processor can also be used to release
a block of case number when too many were reserved due to operator error.

```
          General Hospital Anatomic Path Order  Management Processor
                                               Fri Apr 16, 1993 10:34 am
 Pathology Anatomic Path Order Management Input Options


          Option No.  Option
          ---------------------------------------
              1       Reserve/Generate Case #'s
              2       Case Login

              3       Unassigned Case #'s
              4       Print/Reprint Case # Labels
              5       Delete Unassigned Case #'s

              6       Pathology Log Report

              7       Long Reports Batch




 Enter option number--
```

WARNING: In the latter case, the case number pool counter must be reset with
extreme caution. Specimen processing for anatomic pathology must be
suspended while this is being done.

If an individual case number is assigned to the wrong accession, cancel the tests to
return the case number to the unassigned case number pool. This makes the case
number available for use on another accession. Do not use the Delete Unassigned
Case #'s processor to correct individual ordering errors.

Upon selection of this processor, the following prompt displays:

  Enter case # pool code or `-` for table--

Indicate the case number pool using one of the table look-up routines described in
Chapter 4: Information Entry Techniques in the *General Information Volume* of the
STAR Laboratory Reference Guide.

Once you enter the case number the following prompt displays:

> *Enter case # to DELETE or `-` for table of unassigned case #'s--*

Enter the case number such as CYY-1234, where C is the case number pool code, YY is the last two digits of the year and 1234 is the case number. You can also enter the case number preceded by a left bracket ([). If the case number is assigned to a test, the following message displays:

> *Case # S93-1 assigned to accn # 1074, can not delete!*

If the case number is not reserved, the following message displays:

> *Case # S93-40 not reserved or assigned!*

Enter a hyphen (**-**) to display a table of unassigned case numbers. Case numbers returned to the pool as a result of test cancellation display in dim video. From this table, you can select a single case number, multiple case numbers, a range of case numbers, or all case numbers to delete. Upon case number(s) selection, the following prompts display for verification prior to deletion.

If a single case number is selected, the following prompt displays:

> *Are you sure you want to DELETE Case # S93-7? (Y/N) [N]--*

If multiple case numbers are selected from the table, the following prompt displays:

> *Are you sure you want to DELETE all selected case #'s (Y/N) [N]-*
> *   Case # pool - Surgical Specimens*

If you select to delete all unassigned case numbers for the case number pool, the following prompt displays:

> *Are you sure you want to DELETE all unassigned case #'s (Y/N) [N]-*
> *   Case # pool - Surgical Specimens*

To discontinue this process, enter **N** or press ENTER. To delete, enter **Y**. The following message displays:

> *Deleting!*

Impact

Upon completion of the accession process, the deleted case numbers:

- No longer appear in the display/printed list of unassigned case numbers

- Cannot be assigned to an order

Pathology Log Report

The Pathology Log Report is a management tool contained within the Anatomic Path Order Management menu. This report contains the following information on Anatomic Pathology tests: case number, accession date and time, accession number, patient name, specimen type(s), test status. The report can be sorted by case number pool or accession date and time. The report can also be defined to include only the primary specimen or all specimens assigned to the case.

In the Anatomic Pathology section, after selecting the Anatomic Path Order Management function, the following screen displays:

```
          General Hospital Anatomic Path Order Management Processor
                                             Thu Apr 13, 1995 04:45 pm
 Pathology Anatomic Path Order Management Input Options
          Option No.  Option
          ---------------------------------------
              1         Reserve/Generate Case #'s
              2         Case Login

              3         Unassigned Case #'s
              4         Print/Reprint Case # Labels
              5         Delete Unassigned Case #'s

              6         Pathology Log Report

              7         Long Reports Batch




  Enter option number--
```

Enter the option number for the Pathology Log Report.

If your laboratory services multiple facilities, select the facility for which you want to run the special report. The following screen displays:

```
          General Hospital Pathology Log Report Processor
                                             Mon Oct 16, 1995 01:19 pm

 1 Start Date           2 End Date        3 Case Number Pool(s)
   10/09/95               10/16/95          All
 4 Sort Method          5 Page Break      6 Specimen Detail
   Case Number Pool       Yes               Primary
 7 Hardcopy             8 Default Printer
   No                     Data Centre (Port #102)






 Enter field number or '/' starting field number--
```

Field Explanations

1. START DATE (DATE-R)
This field is based on accession date. Indicate the date the system should begin to search for Anatomic Pathology cases. For more information on date entry in this field refer to date/time entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.* When you access this field, the system displays the following prompt:

Enter date--

If the Start Date entered is after the date in the End Date field, the system displays the following error message:

Error: Invalid date!

2. END DATE (DATE-R)
This field is based on accession date. Indicate the date the system should stop searching for Anatomic Pathology cases. For more information on date entry in this field refer to date/time entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.* When you access this field, the system displays the following prompt:

Enter date--

If the End Date entered is before the date in the Start Date field, the system displays the following error message:

End Date BEFORE Start Date!

3. CASE NUMBER POOL(S) (TABLE SELECTION-R)
This field determines whether one, several or all case number pools are included within the report. This field displays a table of defined case number pool(s) based on those case number pool(s) activated for the current section under Case Login Parameters. When this field is entered the system automatically displays a list of valid case number pool(s) along with the following prompt:

Select case # pools to print (1, 3, 5-7), '-' choices to remove or [ALL] --
end selection(NL)

You can select one, multiple or all case number pools to be included in this report. If a single case number pool is selected, the code displays in this field. If multiple case number pools are selected and all options selected can be displayed, the codes display in this field otherwise, *Multiple* displays in the field. If you accept the default for all case number pools, *All* displays in this field.

4. SORT METHOD (1-A-R)
This field determines whether the system sorts the report by case number pool or accession date and time. When you access this field, the system displays the following prompt:

Sort by case number pool(C) or accession date(D) [C]--

If you enter **C** or take the default, the report is sorted by case number pool in ascending order. When case number sort is selected and multiple tests are assigned to a single case, the secondary sort is test code.

If you enter **D**, the report is sorted by accession date and time in chronological order. When accession date sort is selected and multiple tests are assigned to a single case, the secondary sort is case number in ascending order.

Generate this report in case number pool order to be used for an inspection or lab review. This is a good way to assure that no holes exist in your case numbers. Generate this report in accession date and time order prior to a known downtime situation. This report can be used to determine what case numbers have been assigned and the test status of cases already logged in.

5. PAGE BREAK (1-A-R)
This field determines whether the report page breaks at either a change in the case number pool if sorted by case number or a change in the accession date when sorting by accession date.

Upon entering the field, the system displays one of the following prompts depending on the sort method selected. If you selected the case number pool sort, the system displays the following prompt:

Page break at case number pool change?(Y/N) [Y]--

If you selected the accession date sort, the system displays the following prompt:

Page break at accession date change?(Y/N) [Y]--

6. SPECIMEN DETAIL (1-A-R)
This field determines whether only the primary specimen assigned during the case login process or all specimens associated with a specific case are included within the report.

Upon entering the field, the system displays the following prompt:

Print primary specimen only(P), or all specimens(A) [P]--

If you enter **P** or take the default, only the initial (primary) specimen assigned during the case login process prints on the report. If you enter **A**, the report includes all specimens assigned to a case.

7. HARDCOPY (1-A-R)
This field enables you to indicate whether you want a hard copy. Upon entering the field, the system displays the following prompt:

Hardcopy? (Y/N) [Y]--

Enter **Y** or take the default to generate a printed copy of the report. Enter **N** to review report online.

8. DEFAULT PRINTER (TABLE LOOKUP)
This field displays the description of the printer set up during system installation as the most common printer used for Histotech Process Reports (LHR). You can change the printer location by selecting this field's option number. The screen then displays a list of alternate printers defined for this report. Select another printer from the displayed choices.

If the parameters are acceptable, initiate the search by entering **Y** at the following prompt.

Accept this screen? (Y/N) [Y]--

To edit parameters or exit this processor, enter **N**.

If there is no data available, the system displays the following message:

No data for selected criteria!

Impact

Once you accept this screen, the system:

- Displays *Printing!* on the screen.

- Prints the Pathology Log Report on the printer specified in the default printer field.

- Returns you to the Anatomic Path Order Management menu.

Output

The Pathology Log Report prints according to the options defined during report generation on the designated printer. The following examples of the Pathology Log Report show the report first sorted by case number and then accession date/time.

If there is no data available, the system prints the following message on the report:

No report data for selected criteria!

Figure 3.4 Pathology Log Rpt - Case Number Sort/S Case Number Pool/Primary
Specimen (ALHRLHR0)

```
                          Hospital Name
                      Wed Jan 3, 1996 10:15 am                 Page 1
Pathology Log Report from 01/01/96 08:00 am to 01/03/96 10:00 am

Sorted by: Case Number
Case Number(s):S
Specimen(s): Primary

Case#      Accn#        Patient Name            Accn D/T      Dept Status
                        Test    Specimen Type
-----------------------------------------------------------------------
S96-1      12350        Walter,Stanley          01/01/96 0900 LAB  Done
                        5050    Appendix
S96-2      12367        Smith,Mary              01/01/96 1030 LAB  Done
                        5045    Uterus
S96-3      12390        Jones,Frederick         01/02/95 0800 LAB  Partial
                        5050    Lung Bx
S96-4      12400        Powell,Greg             01/03/95 0930 OLB  Ordered
                        5065    Skin Bx-Facial Mole

                         End of Report
```

Figure 3.5 Pathology Log Rpt - Accession Date Sort/C&S Case Number
Pools/All Specimens (ALHRLHR0)

```
                           Hospital Name
                    Wed Jan 3, 1996 10:15 am           Page 1
     Pathology Log Report from 01/01/96 08:00 am to 01/03/96 10:00 am

   Sorted by: Accession D/T
   Case Number(s): C,S
   Specimen(s): All

   Case#      Accn#       Patient Name              Accn Time    Dept Status
                          Test    Spec Type
   -------------------------------------------------------------------------
   Accessioned 01/01/96
   C96-1      12340       Murphy,Paul               1000         LAB  Done
                          5050    Bone Marrow
   C96-2      12353       Jones,Susan               1015         LAB  Done
                          5000    Pap Smear
   C96-2      12353       Beker,Mary                1015         OLB  Done
                          5010    Pap Smear

   S96-1      12350       Walter,Stanley            0900         LAB  Done
                          5050    Appendix
   S96-2      12367       Smith,Mary                1030         LAB  Done
                          5045    Uterus
                                  Ovary-Left
                                  Ovary-Right

   Accessioned 01/02/96
   S96-3      12390       Jones,Frederick           0800         LAB  Partial
                          5050    Lung Bx

   Accessioned 01/03/96
   S96-4      12400       Powell,Greg               0930         OLB  Ordered
                          5050    Skin Bx-Facial Mole

                             End of Report
```

Report Layout

Header Information

LINE 1
This line of the report displays the hospital name.

LINE 2
This line of the report displays the date and time the report printed and the page number.

LINE 3
This line of the report displays the name of the report and the date range for which this report was run.

LINE 4
This line of the report displays the description of the sort option selected during report generation. This report is sorted by case number pool or accession date/time. When sorting by accession date/time, only the accession time prints with the case information. When sorting by case number, both the accession date and the accession time prints with the case information. If the page break option was selected during report generation, the report page breaks at either a change in the case number pool if sorted by case number or accession date when sorting by accession date.

LINE 5
This line of the report displays the case numbers included on this report. This field is based on the case number pool codes selected during report generation.

LINE 6
This line of the report displays the specimen detail option selected at report generation.

Body of Report

The system displays cases which have been subsequently cancelled or rejected at the beginning of the Pathology Log Report.

CASE #
This is the case number for the test. Up to 10 characters print.

ACCN #
This is the accession number for the test. Up to 10 characters print.

PATIENT NAME
This is the patient's name in the LAST,FIRST M format. Up to 21 characters print.

ACCN D/T or ACCN TIME
This is accession date/time for a report sorted by case number. Up to 13 characters print. This is accession time for a report sorted by accession date. Up to 4 characters print.

DEPT

This is the department code for the primary performing laboratory department associated with this case. Up to 3 characters print.

STATUS

This is the test status associated with this case at the time of report generation. Up to 7 characters print.

TEST

This is the performing test code associated with this case. Up to 5 characters print.

SPECIMEN TYPE

This is the descriptive name of the specimen and the specimen modifier. Up to 33 characters print.

At the end of the report, the system prints the following message:

End of report!

If the report is greater than 1 page, the appropriate page breaks include the following display at the end of each page:

(Continued)

Long Reports Batch

The Long Reports Batch is a processor which is available in two areas of the STAR Laboratory system. It can be added as a section level function to any section menu for which you wish to print long reports in batch. It is also included as an option on the Anatomic Path Order Management menu.

Only tests in a Done status are eligible for the Batch Long Report processor.

If a test's long report is defined to print in the batch, you can view the results in Patient Inquiry, and if defined to print at the nursing station, a copy still prints.

The generation of Long Reports as part of the Physician Summary Batch is not affected. However, the Physician Summary Batch can be used to generate additional copies of the Long report that may be needed for multiple physicians.

In a multi department environment, interdepartment tests file to the Long Report batch based on the performing test code definition and print in the performing department only. You can print a Long Report in Patient Inquiry in both the ordering and performing departments.

The following processes are not supported through the Batch Long Report processor:

- Faxing

- Remote Print

- Printer Matrix

- Draft Long Report

- Previous Cardfile History Report

- Addendum Only Reports

In the Anatomic Pathology section, after selecting the Anatomic Path Order Management function, the following screen displays:

```
          General Hospital Anatomic Path Order Management Processor
                                          Thu Apr 13, 1995 04:45 pm
 Pathology Anatomic Path Order Management Input Options
          Option No.  Option
          ---------------------------------------
               1       Reserve/Generate Case #'s
               2       Case Login

               3       Unassigned Case #'s
               4       Print/Reprint Case # Labels
               5       Delete Unassigned Case #'s

               6       Pathology Log Report

               7       Long Reports Batch




 Enter option number--
```

NOTE: If you select the Long Reports Batch option and the batch print long reports field is not active for the designated section, the system displays the following error message and redisplays the section menu:

Batch Long Reports are not activated for SECTION!

The name of the section selected replaces SECTION in this message.

Enter the option number for the Long Reports Batch and the system displays the following screen:

STAR Laboratory Reference Guide - Anatomic Pathology Module
3–68   *Release 17.0*   *October 2011*
Proprietary to McKesson - Subject to Confidentiality Agreement

```
                 General Hospital Pathology Long Reports Batch Processor
                                                  Mon Sep 16, 1996 01:19 pm
     Pathology Long Reports Batch Input Options

               Option No.  Option
               ----------------------------------------
                  1        Print Long Report Batch
                  2        Current Batch Reports








     Enter option number--
```

There are two options available:

Print Long Report Batch
This option is used to print/reprint a Long Report batch in the designated section.

Current Batch Reports
This option allows you to review the number of long reports and the patients who have long reports filed and ready to be printed in the next Long Report batch in the designated section.

PRINT LONG REPORT BATCH

When you select the Print Long Report Batch option and a Long Report batch is currently being processed in the designated section, the system displays the following error message:

Batch for SECTION is currently printing!   Try later!

The name of the section selected replaces SECTION in this message.

Following this message, the system redisplays the Long Reports Batch menu.

If the system is not currently processing a Long Report batch, the system displays the following screen:

```
            General Hospital Pathology Long Report Batch Processor
                                                   Mon Sep 16, 1996 01:19 pm
Pathology Print Long Report Batch
 1 Print/Reprint              2 Case Number Pool(s)
   Print                        A,S
 3 # of Copies - I/P
   5
 4 Copy #/Sort Method - I/P
   C1/CS#, C2/Loc, C3/OrP, C4/PrN, C5/TD
 5 # of Copies - O/P
   2
 6 Copy #/Sort Method - O/P
   C1/CS#, C2/OrP
 7 Default Printer
   303.4 (Port # 76)
Reprint
 8 Batch                          9 Entire Batch?    10 Copy/Copies
   N/A                              N/A                  N/A




 Enter field number or '/' starting field number--
```

Field Explanations

1. PRINT/REPRINT (1-A-R)
This field identifies whether you want to process the current Long Report batch or to reprint a previously processed batch. When you access the field, the system displays the following prompt:

> *Print(P) or reprint(R) reports?--*

Enter **P** to process the current Long Report batch; the system displays *Print* in the field and the cursor moves to Field 2, Case Number Pool. Fields 8-10 display *N/A* and cannot be edited. If there is no current batch for the designated section and you enter **P**, the system displays the following message:

> *No pending reports for SECTION!*

Enter **R** to reprint a previously printed batch; the system displays *Reprint* in the field and the cursor moves to Field 8, Batch. Fields 2-6 display *N/A* and cannot be edited. Field 7 displays the defined default printer. If there are no previously printed batches and you enter **R**, the system displays the following message:

> *No batches in SECTION eligible for reprint!*

The name of the section selected replaces the SECTION in these messages.

2. CASE NUMBER POOL(S) (TABLE SELECTION-C)
This field allows you to identify the case number pools to include in the Long Report batch. The system automatically displays a table when a batch includes reports with or without multiple case number pools defined. If you are processing a batch containing only reports without case number pools defined, the system automatically displays *<No CNP>* in this field and cannot be edited. If only reports with a single case number pool code assigned exist in the batch, the system automatically displays the case number pool code in this field.

NOTE: If Field 1 Print/Reprint is defined as *Reprint*, this field displays *N/A* and cannot be edited.

A Long Report batch can include both tests that have and do not have case number pool assignments. When you access this field, the system automatically displays a table and the following prompt:

> *Enter choices (e.g. 1,7,5-9) or '-'choices to remove--*
> *end selection(NL) next page(/)*

```
Page:01                    Case Number Pool Selection           ##=Current Choices
( 1) <No CNP>                          ( 3) Bone Marrow
( 2) Autopsy                           ( 4) Cytology

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                          end selection(NL)  next page(/)
```

The table display includes a list of the case number pools assigned to reports in the current batch as well as the option *<No CNP>* to represent reports without case number pools defined. The casenumber pool option display includes the case number pool code and description in ASCII order by case number pool code.

Select one or more options from the table display. The system displays the case number pool code(s) and the *<No CNP>* option, if selected, in this field separated by commas. *Multiples Selected* displays in this field, if the case number pools selected exceed the field display length. If you edit this field, the table redisplays with the previous choices highlighted. To remove a choice, enter a hyphen (**-**) followed by the option to remove.

3. # COPIES-I/P (1-N-C)
This field allows you to define the number of copies of each Long Report to print in the batch for inpatients. When you access this field, the system displays the following prompt:

> *Enter number of inpatient copies to print (1-9)--*

Enter a number from 1 to 9, to print from one (1) to nine (9) Long Report copies.

An inpatient is defined as a patient with a patient type of inpatient. If the current location of the patient is *DIS*, the system uses the patient's most recent patient type to determine the number of copies to print.

NOTE: If Field 1 is defined as *Reprint*, then this field displays *N/A* and cannot be edited.

4. COPY #/SORT METHOD-I/P (SPECIAL PROCESSING-C)
This field allows you to define the sort method for each of the copies defined in Field 3 *# Copies-I/P*.

NOTE: If Field 1 is defined as *Reprint*, then this field displays *N/A* and cannot be edited.

When this field is accessed the system displays the following table listing for available sort options and the following prompt:

   Copy 'N' Sort option--

```
Page:01                     Long Report Sort Options
( 1) Account Number      ( 3) Location             ( 5) Patient Name
( 2) Case Number         ( 4) Ordering Physician   ( 6) Terminal Digit

Copy '1' Sort option--
```

The number of the copy selected replaces the *N* in this prompt. The Case Number option will be omitted from the table display if no case number pools have been selected in Field 2 Case Number Pool(s).

Select the sort option for the designated copy. After you define the sort for a designated copy, the system automatically redisplays the table and the next designated copy until you have defined a sort option for each of the copies defined in Field 3 *# Copies-I/P*.

The system then displays the copy number and abbreviation for the selected sorts in this field. The table below documents the abbreviations for the sort.

Sort Definition	Abbreviation
Account Number	AN
Case Number	CS#
Location	Loc
Ordering Physician	OrP
Patient Name	PtN
Terminal Digit	TD

If you attempt to exit this field and the copy/sort method information does not equal the number of copies defined in Field 3 *# Copies-I/P*, the system displays the following error message:

Error: Number of sorts defined does not match number of copies requested!

After the error message displays, the system displays the following prompt:

Re-enter sort criteria now? (Y/N)--

Enter **Y** to restart the sort method for each of the copies defined in Field 3 *# Copies-I/ P*. If you enter **N**, the system displays the following prompt to allow you to continue editing:

Enter field number or '/' starting field number--

5. # COPIES-O/P (1-N-C)
This field allows you to define the number of copies of each Long Report to print in the batch for outpatients. When you access this field, the system displays the following prompt:

Enter number of outpatient copies to print (1-9)--

An outpatient is defined as a patient with a patient type of outpatient or contract. If the current location of the patient is *DIS*, the system uses the patient's most recent patient type to determine the number of copies to print. If Field 1 Print/Reprint is defined as *Reprint*, this field displays *N/A* and cannot be edited. This field is only active when you define Field 1, Print/Reprint as *Print*.

6. COPY #/SORT METHOD-O/P (SPECIAL PROCESSING-C)
This field allows you to define the sort method for each of the copies defined in Field 5 *# Copies-O/P*.

NOTE: If Field 1 is defined as *Reprint*, then this field displays *N/A* and can not be edited.

When this field is accessed the system displays the following table listing for available sort options and the following prompt:

Copy 'N' Sort option--

The number of the copy selected replaces the *N* in this prompt.

```
Page:01                      Long Report Sort Options
( 1) Account Number      ( 3) Location            ( 5) Patient Name
( 2) Case Number         ( 4) Ordering Physician  ( 6) Terminal Digit

Copy '1' Sort option--
```

Select the sort option for the designated copy. After you define the sort for a designated copy, the system automatically redisplays the table and the next designated copy until you have defined a sort option for each of the copies defined in Field 5 *# Copies-O/P.*

The system then displays the copy number and abbreviation for the selected sorts in this field. The table below documents the abbreviations for the sort.

Sort Definition	Abbreviation
Account Number	AN
Case Number	CS#
Location	Loc
Ordering Physician	OrP
Patient Name	PtN
Terminal Digit	TD

If you attempt to exit this field and the copy/sort method information does not equal the number of copies defined in Field 5 *# Copies-O/P*, the system displays the following error message:

> **Error:** *Number of sorts defined does not match number of copies requested!*

After this error message displays, the system displays the following prompt:

> *Re-enter sort criteria now? (Y/N)--*

Enter **Y** to restart the sort method for each of the copies defined in Field 5 *# Copies-O/ P.* If you enter **N**, the system displays the following prompt to allow you to continue editing:

> *Enter field number or '/' starting field number--*

7. DEFAULT PRINTER (TABLE SELECTION-R)
This field displays the default printer for the Long Report. The printer location can be changed by selecting this field. When you access this field, the system displays the list of alternate printers for the section's long reports if defined.

8. BATCH (TABLE SELECTION-C)
This field allows you to reprint a previously printed batch and is a required field if Field 1 *Print/Reprint* is defined as *Reprint.* The system automatically displays a table of the previously printed Long Report batches in double column format in reverse chronological order.

NOTE: If Field 1 is defined as *Print*, then this field displays *N/A* and can not be edited.

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When you access this field, the system automatically displays a table and the following prompt:

Enter choice--

```
Page:01                         Batch Print Date/Time
( 1) 3-Tue Sep 24,1996 1612            ( 3) 1-Fri Sep 20,1996 1552
( 2) 2-Mon Sep 23,1996 1333            ( 4) 6-Mon Sep 18,1996 1424

Enter choice--
                                     next page(/)
```

The batch information displayed in this table is determined by the number of batches retained for reprint as defined in the Long Report Parameters field *Batches Active for Reprint*.

When a batch is selected from the table, the system displays the date/time of the batch creation in this field. If there is only one previously printed batch, the system automatically displays the batch information in this field.

9. ENTIRE BATCH? (1-A-C)
This field defines whether or not the system reprints the entire Long Report batch or selected copies from the designated batch. When you access this field, the system displays the following prompt:

Reprint the entire batch? (Y/N)--

Enter **Y**, to reprint the entire batch. Field 10 *Copy/Copies* displays *All* and cannot be edited. Enter **N**, if you want to select specific copies for reprint.

NOTE: This is a required field if Field 1, Print Reprint, is defined as *Reprint*.

10. COPY/COPIES (TABLE SELECTION-C)
This field allows you to reprint the specific copy or copies of a previously printed Long Report batch. When you access this field, the system automatically displays a table of the defined copies for the batch selected in double column format and the following prompt:

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
end selection(NL) next page(/)

```
Page:01    Copies for Batch 3 Created Mon Sep 16,1996 0900   ##=Current Choices
( 1) I/P-C1/Case Number              ( 3) I/P-C3/Ordering Physician
( 2) I/P-C2/Location                 ( 4) I/P-C4/Patient Name

Enter choice (e.g. 1,7,5-9) or '-'choices to remove--
                    end selection(NL)  next page(/)
```

Select one or more options from the table display to reprint selected copies. The system displays *Defined.* If you edit this field, the table redisplays with the previous choices highlighted. To remove a choice, enter a hyphen (**-**) followed by the option number to be removed. The copies selected for reprint prints in the order displayed in the table.

NOTE: This is a required field if Field 9 Entire Batch? is defined as *No.* When you define Field 1 - Print/Reprint field as *Print*, the system displays *N/A* in this field and this field cannot be edited. When you define Field 9 Entire Batch? as Yes, the system displays *All* in this field and it cannot be edited.

Upon completion of all required fields, the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

To accept the information displayed, press ENTER or enter **Y**. You may edit the fields by entering **N**. The system displays the following message:

Long Reports Batch compiling and printing!

IMPACT

Upon screen acceptance, the system performs the following processing:

- When printing the current Long Report batch, the system compiles the batch and prints the reports based on the parameters defined during report generation.

- When reprinting a batch, the system reprints the reports based on the parameters defined during the initial report generation.

OUTPUT

When you print the current batch of long reports or reprint an existing batch, the system generates two documents - the Copy Index and the individual patient Long Reports.

COPY INDEX

When the system prints the Long Report batch, each copy defined during report generation is sorted and printed as a mini-batch. In the following example, if three copies are defined for the inpatients and two copies for the outpatients with various sort options, the system prints five mini-batches in the order shown in the following table.

Copy/Sort Example	
Copy	**Sort**
I/P - Copy 1	Case Number
I/P - Copy 2	Ordering Physician
I/P - Copy 3	Location
O/P - Copy 1	Case Number
O/P - Copy 2	Ordering Physician

When the system prints the Long Report batch, the Copy Index for each mini-batch prints prior to its corresponding patient reports. The print order is determined by the sort method/copy information defined during report generation. The Copy Index, shown below, is an 8-1/2 X 11 report.

Figure 3.6 Copy Index /reprinted Long Report Batch sorted by Patient Name (ALSPLSP0)

```
                              Laboratory Name
                         Long Report Batch Copy Index
              I/P - Copy N/Sort Description Printed at: MM/DD/YY HHMM


  ***REPRINT***      Initial Print at: MM/DD/YY HHMM


  Patient Name       Case #      Unit #       Test Name               Location
                       Accn #      Account #                    Ordering Physician
  -------------------------------------------------------------------------------


  BROWN,MICHAEL      S95-119    A1234567890   GROSS & MICROSCOPIC   1E-100-01
                      1234567    A12345678                          WELBY,JOHN
  JONES,JENNIFER     S95-120    A9209777520   FROZEN SECTION          2N-305-01
                      34539933   A22334534                          KILDARE,JAMES
  SHARRELL,MARK      S95-123    A2239848333   GROSS & MICROSCOPIC   OPS
                      34540005   A22239442                          SIMMS,MARY




                                   End of Index
```

NOTE: Unless a specific report name is defined, then the system report name would be A_section code_LSP0. An example is AHISLSP0.

Report Layout

HEADER INFORMATION

LINE 1
This line contains the name of the laboratory department from which you are generating the batch of long reports and is centered on the line.

LINE 2
This line contains the name of the report Long Report Batch Copy Index and is centered on the line.

LINE 3
This line contains the definition of the specific copy for which the copy index is printing. The copy definition consists of the inpatient or outpatient designation along with the copy number and the sort defined for the copy. The format is as follows:

I/P - Copy 3/Ordering Physician

This line is printed left justified on line 3 of the report header.

Date and Time of Printing

This line also contains the date and time this report printed. The format is MM/DD/YY HHMM and prints at the right margin.

LINE 4
This line of the report is blank.

LINE 5
This line of the report only displays when a previously printed Long Report batch is reprinted. This line displays the date/time the Long Report batch printed in the following format: *Reprint***   Initial Print at: MM/DD/YY HHMM.*

LINE 6
This line of the report is blank.

BODY OF REPORT

The system displays the list of patient reports included in the specific copy (mini-batch). The order of the patient reports listed in the Copy Index is determined by the sort method/copy information defined during report generation.

Patient Name
This field contains the patient name in LAST,FIRST M format. The system prints up to 16 characters of the name and it is left justified.

Case #
This field contains the case number associated with the accession if the test is an Anatomic Path (AP) type test. The system prints up to nine characters left justified. If the report does not have a case number assigned, this field is blank.

Accn #
This field contains the accession number for the test. Up to 10 characters print right justified.

Unit #
This field contains the unit number (medical record number) preceded by the facility code. Up to 12 characters print left justified.

Account #
This field contains the account number preceded by the facility code. Up to 12 characters print left justified.

Test Name
This field contains the name of the test for which a long report is printing. The system prints up to 22 characters left justified.

Ordering Phy
This field contains the name of the ordering physician in LAST,FIRST M format. The system prints up to 13 characters.

Location
This field contains the current station, room and bed, if the patient is in-house and the patient type if the patient is not in a bed. Up to 12 characters print left justified.

At the end of the report, the system prints End of Index centered.

SORT INFORMATION

The print order for the Long Report batch is determined by the sort method/copy information defined during report generation. For each copy, you can define the sort. The sorts available are

- Account #

- Case Number

- Location

- Ordering Physician

- Patient Name

- Terminal Digit

Account Number

When you define a copy to use the account number sort, the system sorts the reports according to the following hierarchy:

Account Number	-	numeric order
Test Code	-	numeric order
Accession Number	-	numeric order

Case Number

When you define a copy to use the case number and multiple case number pools are included in the Long Report batch, the system sorts the reports according to the following hierarchy:

If the test has no case number,

Patient Name	-	alphabetic based on Last,First M
Account Number	-	ASCII order of the external account number
Test Code	-	numeric order
Accession Number	-	numeric order

If the test has a case number,

Case # Pool	-	alphabetic based on the case number pool code
Case #	-	numeric based on the case number
Test Code	-	numeric order

Location

When you define a copy to use the location sort, the system sorts the reports according to the following hierarchy:

If the patient's current or previous (if current is DIS) patient type is an inpatient;

if the patient's current location is in-house,

Nursing Station	-	ASCII order
Room-Bed	-	ASCII order
Test code	-	numeric order
Accession Number	-	numeric order

If the patient's current location is not in-house,

Patient Type	-	ASCII order
Patient Name	-	alphabetic based on LAST,FIRST M
Account #	-	if have multiple patients with same name; numeric order
Test code	-	numeric order
Accession Number	-	numeric order

If the patient's current or previous (if current is DIS) patient type is an outpatient or contract patient type,

If the patient=s current location is in-house,

Nursing Station	-	ASCII order
Room-Bed	-	ASCII order
Test code	-	numeric order
Accession Number	-	numeric order

If the patient=s current location is not in-house,

Patient Type	-	ASCII order
Patient Name	-	alphabetic based on LAST,FIRST M
Account #	-	if have multiple patients with same name; numeric order
Test code	-	numeric order
Accession Number	-	numeric order

Ordering Physician
When you define a copy to use the ordering physician sort, the system sorts the reports according to the following hierarchy:

Physician Name	-	alphabetic based on LAST,FIRST M; if free-text doctor, then sort based on semi-colon (;) with free-text name; for a physician group, then sort based on asterisk (*) with group name

Physician Code   -   if have multiple physicians with the same name,
                                    numeric order of code

Patient Name   -   alphabetic based on LAST,FIRST M

Account #   -   if have multiple patients with the same name, then
                                    numeric order

Test Code   -   numeric order

Accession Number   -   numeric order

NOTE: If you need copies of the long report for each physician of record, use the
           Physician Summary Report to generate multiple copies for the physicians.

Patient Name
When you define a copy to use the patient name sort, the system sorts the reports
according to the following hierarchy:

Patient Name   -   alphabetic based on LAST,FIRST M

Account #   -   if have multiple patients with the same name, then
                                    numeric order

Test Code   -   numeric order

Accession Number   -   numeric order

Terminal Digit
When you define a copy to use the terminal digit of the unit number, the system sorts
the reports according to the following hierarchy:

Terminal Digit of Unit Number-   numeric order using the same terminal digit
                                        calculation as the other Outpatient and
                                        Discharge Summary reports.

NOTE: There terminal digit is calculated in STAR Laboratory as follows:

- take the last 2 digits of the unit number

- take the next last 2 digits of the unit number

- take the rest of the digits of the unit number

For example:

Unit Number1234567

Terminal Digit67-45-123

Impact

The following processing occurs when the system compiles and prints a Long Report batch:

- The batch number is incremented for the section. When the maximum number of batches, based on the Long Report Parameters Batches Active for Reprint field, is reached as the system creates a new batch, the old batch is automatically deleted.

- Each test in the uncompiled (current - unprinted) batch is evaluated and then processed if it meets the criteria defined at report generation for the Long Report batch to be printed.

- Mini-batches for each copy are created based on the parameters defined during report generation and the Copy Index and individual Long Reports are printed, once the batch is compiled.

- The Long Report batch is compiled and prints based on the default section of the performing test code in the performing department. The printing of the Long Report in the performing department is necessary because of the assignment of case number pools in the performing department.

- None of the report statuses (Draft, Draft-C, Final, Final-C, Addendum, Adden-C) print on the Long Report when printed in the batch. The batch status, Batch Print for the current batch or Batch Reprint for a previously printed batch, replaces the report status on the Long Report.

- The first time a Long Report is printed in the batch for a selected test, the system files the date and time and this information displays in the Long Rpt D/T field on the Patient Inquiry Tracking Information screen.

- A test in a Done status is filed to the current Long Report batch and subsequently corrected prior to the batch printing. When the batch is printed, the Long Report contains all test information (including the corrected results) available at the time of printing. The corrected results is flagged on the Long Report.

- A test in a Done status is filed and printed in the Long Report batch. If this test is subsequently corrected, the test is filed to the current Long Report batch. When the batch is printed, the Long Report contains all test information (including the corrected results) available at the time of printing. The corrected results is flagged on the Long Report.

- A test in a Done status is filed to the current Long Report batch and an addendum result is added prior to the batch printing. When the batch is printed, the Long Report contains all test information (including the addendum result) available at the time of printing. The addendum results is flagged on the Long Report. Addendum Only reports are not supported in the batch print process.

- A test in a Done status is filed and printed in the Long Report batch. If an addendum result is subsequently added to this test, the test is filed to the current Long Report batch. When the batch is printed, the Long Report contains all test information (including the addendum results) available at the time of printing. The addendum results is flagged on the Long Report. Addendum Only reports are not supported in the batch print process.

- When a test status is updated to Cancel, Reject or the test is edited and the status changes to Partial, if a Long Report was previously filed for the selected test, it is deleted from the appropriate batch. As a result, no hardcopy is printed in the current or previous batch.

- All tests within the Long Report Batch print a separate report and the *End of Report* message prints on the last page of each report with the printed date and time.

CURRENT BATCH REPORTS

This processor enables you to review the Long Reports for a designated section which are ready to be printed in the next batch. This processor can be used to verify that a patient's report will print in the next batch and as a QA tool to verify the report filing when implementing this enhancement.

When you access the Current Batch Report option from the Long Reports Batch menu, the system displays the following prompt:

> *Enter '[' case number, accession #, or '-' to display XXXXX reports*

When you select the Current Batch Reports option from the Long Reports Batch menu and a current Long Report does not exist in the designated section, the system displays the following error message:

> *No pending reports for SECTION!*

The name of the section selected replaces the SECTION in this message. Following this message, the system redisplays the Long Reports Batch menu.

If you enter an accession number that is not contained in the uncompiled (current-unprinted) batch, the system displays the following error message:

> *Accession # NNNNNNNNN not in current batch!*

After this message displays, the system redisplays the initial prompt.

If you enter a case number that is not contained in the uncompiled (current-unprinted) batch, the system displays the following error message:

> *Case number NNNNNNNNN not in current batch!*

After this message displays, the system redisplays the initial prompt.

If you enter a case number or accession that is contained in the uncompiled (current-unprinted) batch, the system displays a scrolling screen listing only the tests with Long Reports filed to the current batch for the selected case/accession number.

If you enter a hyphen (**-**) to display all the reports in the uncompiled (current-unprinted) batch, the system displays the following scrolling screen:

```
          General Hospital Pathology Current Batch Reports Processor
                                         Mon Sep 16, 1999 01:19 pm
   Pathology

   Case #      Patient Name            Unit #        Ordering Physician
      Accn #       Test Name                 Account #      Location
   S95-135    GREEN,NATHAN            A9209777521    KILDARE,JAMES
      1234568      GROSS & MICROSCOPIC         A22233454     2N-201-02
   S95-136    JOHNSON,ANGELA          A9209777520    WELBY,JAMES
      1234569      GROSS & MICROSCOPIC         A22233456     3E-302-01




                  F1Prev Page F2Next Page F7  Exit
```

Screen Layout

The header information in the first two lines is standard. On the fourth line, the name of the selected section displays. The primary sort is case number and the secondary sort is accession number.

For each report, the following information is provided:

• patient name

• accession number

• case number

• if defined, test name

• unit number

• account number

• ordering physician

• location

NOTE: If a test is filed to the current batch and the test status is updated to *Cancel*, *Reject* or the test is edited and the test status changes to *Partial*, it is deleted from the batch and no longer display on this screen.

Field Explanations

CASE #
This field contains the case number if the test is defined as an Anatomic Pathology type test. Up to 9 characters display left justified. If the test does not have a case number assigned, this field is blank.

PATIENT NAME
This field contains the patient's name in LAST,FIRST format. Up to 25 characters display left justified.

UNIT #
This field contains the patient's unit number. Up to 12 characters display left justified.

ORDERING PHYSICIAN
This field contains the name of the ordering physician for the test in LAST,FIRST format. Up to 16 characters display left justified.

ACCN #
This field contains the accession number for the test. Up to 10 characters display left justified.

TEST NAME
This field contains the test name. Up to 23 characters display left justified.

ACCOUNT #
This field contains the patient's account number. Up to 12 characters display left justified.

LOCATION
This field contains the current location of the patient.

If the patient is...	the system displays...
an inpatient	STA-ROOM-BD information.
an outpatient	the patient type.
discharged	*DIS* along with the previous patient type.

When you access the scrolling screen, the system displays the following at the bottom of the screen:

F1Prev Page F2Next Page F7Exit ?

For more information on these function keys and how scrolling screens function, refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

Special Considerations

MULTIDEPARTMENT CONSIDERATIONS

In a multidepartment environment, when a test is accessioned in the ordering department, the case number assigned will be from the case number pool assigned to the performing test codes. In other words, the case number is from the performing department, but is automatically assigned the next available unreserved case number when the test is accessioned in the ordering department. For example, if case numbers S93-47 to S93-60 have been reserved by a histotech in the performing department, when the ordering department accessions an interdepartmental anatomic pathology test, the case number assigned to the test is S93-61.

CANCELLED TEST PROCESSING

When a test with a case number assigned either through routine accessioning or through the Case Number Management processor is cancelled, the case number is returned to the unassigned pool.

If the test is cancelled or the specimen rejected and the test was defined for Cytology Workload/QC, the following events occur:

- The test is automatically deleted from the Repeat Queue or the Discrepancy Queue and an entry is made to the QC Process Deletion Audit.

- All workload and QC data captured on the case, including QC results, are deleted from the system.

- Management Reports will reflect the deletion of workload and QC information.

- The status of the test is changed to *Cancelled* or *Specimen Rejected*.

- If the test is in a QCC status, the original results cannot be viewed.

- If the test is in a Partial or Done status, the original results are retained and can be viewed.

CASE ASSIGNMENT PROCESSING

General laboratory number pools are not used for generating the case numbers for Anatomic Pathology type tests. A special type of number pool, called Case Number Pools, is used for Anatomic Path test types.

INTERDEPARTMENTAL TESTS

Special considerations exist for interdepartmental Anatomic Pathology tests. STAR Laboratory assumes the following when assigning case numbers:

- Case numbers for Anatomic Pathology tests will be assigned at login.

- Case numbers for interdepartmental Anatomic Pathology type tests will be assigned at login based on the primary performing department.

- Force Assign and Override options are not available for interdepartmental tests that are ordered through Case Login.

- If Manual Assignment, Force Assign, or Override options are required on interdepartmental tests, the tests should be ordered from STAR Patient Care or through Order Entry and logged into the system through the Case Login processor.

- The ordering department and the performing department are considered the same unless the test is an interdepartmental test.

- If Anatomic Pathology interdepartmental tests are defined, all case number pools used for these tests must be defined for both the ordering and the primary performing department.

- The primary performing department for interdepartmental tests is based on the default department defined in the Interdepartment Test Codes processor.   For information on this processor, refer to Chapter 6: Supporting Test Files in the *Maintenance Functions Volume I* of the STAR *Laboratory Reference Guide.*

A table of information related to the Case Login processor and how STAR Laboratory processes interdepartmental tests follows. Three different processes, (login-order through Order Entry, add-on ordered through Case Login, and order through Case Login) are presented in the table along with the four different scenarios (Auto Assign, Force Assign, Override, and Manual) for assigning case numbers.

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
Auto Assign	Auto displays in the Case	If you attempt to add on tests, the system displays the following message when selecting the case: **No test(s) to login! Add-on orders only allowed!**	*Auto* displays in the Case Number field. If this is not changed, tests from different case number pools and different performing departments can be ordered.
	The system assigns case number from assigned case number pool for the primary performing department.	The system allows adding on of tests that have the same case number pool assigned and have the same primary performing department.	The system splits accessions (tests must have same case number pool and the same primary performing department).
	The system splits accessions (tests must have the same case number pool and the primary performing department to be on the same case number).	If you attempt to add on tests that have a different case number pool, the system displays the following message: **Case number pool mismatch!**	Case numbers assigned display after the screen is accepted.
	Case numbers assigned display after the screen is accepted.	If you attempt to add on an interdepartmental test to a test that is not defined as an interdepartmental test or an interdepartmental test with a different primary performing department, the system displays the following message: **Interdept test #### not performed in [ordering or same performing department as exiting tests on the accession]!**	

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
Force Assign	The system assigns next available case number from reserved case number pool of the primary performing department for the test ordered.	If you attempt to add on tests, the system displays the following message when selecting the case: **No test(s) to login! Add-On orders only allowed!**	OPTION NOT AVAILABLE IN THIS SCENARIO FOR INTERDEPARTMENTAL TESTS!
	The case number displays in the Case Number field.	The system allows adding on of tests that have the same case number pool assigned and have the same primary performing department.	*Auto* displays in the Case Number Field. If you access the field the system displays the following prompt: **Enter override case #, '-' for table or force(F) assign next case #--**
	If you enter a period (.) to exit the screen, the unused case number is sent to the unassigned (reserved) case number pool in the primary performing department for the tests.	If you attempt to add on tests that have a different case number pool, the system displays the following message: **Case number pool mismatch!**	If you enter the Case Number field and enter **F**, the system displays the following prompt: **Enter case number pool for force assignment or '-' for table--** (The table displayed is a list of case number pools from the current ordering department).
		If you attempt to add on an interdepartmental test to a test that is not defined as an interdepartmental test **or** an interdepartmental test with a different primary performing department, the system displays the following message: **Interdept test #### not performed in [ordering or same performing department as exiting tests on the accession]!**	Once a case number displays in the case number pool, only tests that have that case number pool defined and are performed in the ordering department (not interdepartmental tests) are allowed in the ordering screen.

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
			If you enter test codes and then change the case number field to force assign, the system displays the following message: ***Test(s) defined - Force/ Override not allowed!*** At this point, the tests ordered must be deleted, if you want to use the force assign function. If a test with a different case number pool assignment or different primary performing department is entered, the system displays the following message: ***Case number pool mismatch!*** If an interdepartmental test is entered the system displays the following message: ***Test code is interdepartment!***
Override Auto Assignment	*Auto* is displayed in the Case Number field. If you access the field at this point, the system displays the following prompt: ***System defined to auto-assign case number! Enter override case number, '-' for table or force(F) assign next case number--***	If you attempt to add on tests, the system displays the following message when selecting the case: ***No test(s) to login! Add-On orders only allowed!***	OPTION NOT AVAILABLE IN THIS SCENARIO FOR INTERDEPARTMENTAL TESTS!

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
	The case number entered should be checked against the case number pool defined for the test and the existence of the case number in the reserve case number pool of the primary performing department of the ordered test. Entering a hyphen (-) will display the list of unassigned (reserved) case numbers from the primary performing department.	The system allows adding on of tests that have the same case number pool assigned and have the same primary performing department.	*Auto* is displayed in the Case Number field. If you access the field at this point the system displays the following prompt: ***Enter override case #, '-' for table or force(F) assign next case #--***
	If you enter a case number with a case number pool that is not the same as the ordered test, the system displays the following message: ***Case number pool mismatch!***	If you attempt to add on tests that have a different case number pool, the system displays the following message: ***Case number pool mismatch!***	A case number can be entered. The case number is checked against the reserve case number pool for the ordering department. If the case number entered is not found in the reserve case number pool for the ordering department, then the system displays the following message: ***Case # #### not reserved!***
	NOTE: The case number pool is based on the tests that have been ordered.	If you attempt to add on an interdepartmental test to a test that is not defined as an interdepartmental test **or** an interdepartmental test with a different primary performing department, the system displays the following message: ***Interdept test #### not performed in [ordering or same performing department as exiting tests on the accession]!***	If you enter a hyphen (-), the system displays a list of case number pools available for the ordering department.

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
			Once you select a case number pool, the system displays the list of reserved case numbers for the selected case number pool for the ordering department.
			Once a case number is selected, it displays in the case number field. You can only order tests with the same case number pool and the same performing department.
			If you enter tests and enter a case number in the Case Number field using the override option, the system displays the follow message: ***Test(s) defined - Force/ Override not allowed!***
			At this point, the tests ordered must be deleted, if you want to use the override function. Override option is not available for interdepartmental tests.
			If an interdepartmental test is entered, the system displays the following message: ***Test code is interdepartment!***

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
			If you enter a test that does not have the same case number pool assigned as the case number in field 5, the system displays the following message: ***Case number pool mismatch!***
Manual Assign	If you access the Case Number field the system displays the following prompt: ***Enter case number or '-' for table--*** The case number entered should be checked against the case number pool defined for the test and the existence of the case number in the reserve case number pool of the primary performing department of the ordered test.	If you attempt to add on tests, the system displays the following message when selecting the case: ***No test(s) to login! Add-On orders only allowed!*** The system allows adding on of tests that have the same case number pool assigned and have the same primary performing department.	OPTION NOT AVAILABLE IN THIS SCENARIO FOR INTERDEPARTMENTAL TESTS! If you access the Case Number field, the system displays the following prompt: ***Enter reserved case number or '-' for table--***
	If you enter a hyphen (**-**), the system displays the list of reserved case numbers from the primary performing department.	If you attempt to add on tests that have a different case number pool, the system displays the following message: ***Case number pool mismatch!***	If a hyphen (**-**) is entered, a list of case number pools available for the ordering department displays

Case Number Assignment Options	Login (Order Through Order Entry)	Login (Add On Orders in Case Login)	Order Through Case Login
	NOTE: The case number pool is based on the tests that have been ordered.	If you attempt to add on an interdepartmental test to a test that is not defined as an interdepartmental test **or** an interdepartmental test with a different primary performing department, the system displays the following message: ***Interdept test #### not performed in [ordering or same performing department as exiting tests on the accession]!***	Once a case number pool is selected, a table of the unassigned case numbers for the ordering department displays.
	If you enter a case number that has a different case number pool than that of the ordered tests, the system displays the following message: ***Case number pool mismatch!***		The case number entered should be checked against the reserve case number pool for the ordering department.
			Once a case number is entered in the field, only tests with the same case number pool and the same primary performing department are allowed.
			If you attempt to add other tests, the system displays the following message: ***Case number pool mismatch!***
			Interdepartmental tests cannot be entered through this process. If an interdepartmental test is entered the system displays the following message: ***Test code is interdepartment!***

CMS COMPLIANCE CHECKING (OPCD)

Tools are needed to assist providers in complying with various CMS billing requirements for the Outpatient Medicare population. These tools facilitate documentation needs at the time of order/charge entry. If the diagnosis entered for the order is not an acceptable diagnosis for the HCPCS code attached to the FIM of the orderable SIM code, then CMS processing is invoked.

When you complete the fields on the Case Login screen, the system prompts you to enter data on the Outpatient Medicare Diagnosis/Modifier Entry screen:

• If the ordering diagnosis (ICD CM code) entered is not a CMS-approved diagnosis, ABN logic is invoked, but ABN frequency logic and Duplicate/Conflict HCPCS logic are not invoked.

• If the ordering diagnosis entered is a CMS-approved diagnosis and a frequency limitation is defined, ABN logic is passed and ABN frequency logic is invoked. Duplicate/Conflict HCPCS checking is also invoked.

• If the test is determined to be a duplicate, you may proceed with the Duplicate/ Conflict HCPCS processing.

• If the test is not a duplicate, no further processing is required, and the test(s) is ordered.

The following is an example of Outpatient Medicare Diagnosis/Modifier Entry screen:

```
                General Hospital Pathology Case Login Processor
                                           Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician     Srv ICD Status
A000003485 COMPLIANCE,CMS   F  04/02/1965            AKER,TOM      ERS 10  O/P
Outpatient Medicare Diagnosis/Modifier Entry
Seq Item                            Diagnosis                   Modifier
1   PROFESSIONAL FEE - AP - CHRG












Enter ICD-10-CM diagnosis code--
            `U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list
```

Subfield Explanations

SEQ (DISPLAY ONLY)
This field numbers the service items ordered or charged.

ITEM (DISPLAY ONLY)
This field contains the Service Item descriptions ordered or charged.

DIAGNOSIS (10-C-R)
This field is for entry of the diagnosis that indicates the reason this test/procedure is being performed, and accesses the ICD CM table. The following prompt is displayed:

> *Enter ICD-[9 or 10]-CM diagnosis code--*
> *`U-`ser Dx, `A-`pproved Dx, `Dx` Admit, `-` for list,*

Enter the code in one of the following ways:

- Enter the ICD-9-CM (for example, 486.0) or ICD-10-CM code (for example, D72.829).

- Enter a portion of the code followed by a hyphen (**-**). This displays all the codes that begin with these numbers or letters. Select the code.

- Enter a hyphen (**-**) to display the entire ICD diagnosis table. Select the code.

- Enter **U-** to display the ICD Diagnosis Pointer Table and user-defined descriptions. Select the code. If no entries are defined for the ICD indicator, the system displays the following message: *No entries defined*.

  If the ICD indicator is a B and the pointer table does not have any entries with both an ICD-9 and an ICD-10 code defined, the system displays the following warning message:

  Collecting ICD-10 and 9! No entries defined with both!

- Enter **A-** to display the approved diagnosis list. (Displays if the SIM Department flag is defined.)

- Enter **Dx** to display the list of multiple diagnoses entered in the Admission process. These include the Admitting Diagnosis, Working Diagnosis, Principal Diagnosis, and multiple Secondary Diagnoses. This option is available only if the Multiple Diagnosis List parameter in the SIM Departments table is turned on. An example of a patient's ICD-10 diagnosis listing is shown on the screen below:

```
                  General Hospital Pathology Case Login Processor
                                            Thu Jan 15, 2009 09:04 am
Unit #       Name             Sex Birthdate  Room    Physician     Srv ICD Status
A000003485 COMPLIANCE,CMS   F  04/02/1965            AKER,TOM      ERS 10  O/P
Outpatient Medicare Diagnosis/Modifier Entry
Seq Item                              Diagnosis                  Modifier
1    PROFESSIONAL FEE - AP - CHRG
Page:01                       Admitting Diagnosis List
( 1) PRINCIPAL     A41.52   Sepsis due to Pseudomonas
( 2) SECONDARY     B59      Pneumocystosis




Enter choice--
```

NOTE: The Admitting Diagnosis list displays all diagnoses entered at admission.
If a patient's ICD indicator is B and an ICD-9 diagnosis is on the Admitting
Diagnosis list, the diagnosis is displayed in dim video without an option
number so it cannot be selected. If the ICD indicator is 9, there are only
ICD-9 codes available at admission, so the Admitting Diagnosis list
contains only ICD-9 codes. If the ICD indicator is 10, there are only ICD-
10 codes available at admission, so the Admitting Diagnosis list contains
only ICD-10 codes.

Choose the ordering diagnosis and press ENTER to file your choice. If an inactive ICD
CM code is entered, the following warning message is displayed:

   ICD-[9 or 10]-CM Code is Inactive as of mm/dd/yyyy.

The date reference (mm/dd/yyyy) corresponds to the date the ICD CM code was
inactivated.

At the prompt *Enter choice -,* you may choose one of the listed diagnoses as the
ordering diagnosis. Once a diagnosis is chosen and ENTER is pressed, you are
returned to the previous screen to continue with the order.

If you do not wish to use any listed diagnosis, pressing period (.) ENTER takes you
back to the original prompt and another method of choosing a diagnosis may be used
or you may period (.) ENTER again to get out of the field completely.

Once a diagnosis is chosen, a list of modifiers may be displayed. The following screen
provides an example of the table display for a miscellaneous charge that does not have
HCPCS modifiers defined at the SIM level.

```
                 General Hospital Pathology Case Login Processor
                                              Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room   Physician    Srv ICD Status
A000003485 COMPLIANCE,CMS   F  04/02/1965         AKER,TOM     ERS 10  O/P
Outpatient Medicare Diagnosis/Modifier Entry
Seq Item                          Diagnosis               Modifier
1   PROFESSIONAL FEE - AP - CHRG  001.0-CHOLERA D/T VIB CHO
Page:01                           HCPCS Modifiers         ##=Current Choices
( 1) 32-MANDATED SERVICES
( 2) 26-PROFESSIONAL COMPONENT
( 3) 77-REPEAT PROC ANOTHER PHYSI
( 4) 76-REPEAT PROC BY SAME PHYSI




 Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                            end select(NL)
```

MODIFIERS (TABLE LOOKUP)
This field enables entry of a HCPCS Level I or Level II modifier. When this field is
accessed, the list of available modifiers is automatically displayed. Determination of
which modifiers display is made in the HCPCS Modifiers code table (maintained
through the Medical Records and UM Table Maintenance processor). Not all modifiers
from this table are available for selection, only those that have been designated as
applicable for this particular Service Item. Also, the HCPCS Modifiers code table
indicates whether the modifier is applicable for Pro Fees, Non Pro Fees, or both. A Pro
Fee modifier cannot be selected for a non Pro Fee item and vice versa.

After accepting the screen, ABN, ABN Frequency and Duplicate/Conflict HCPCS logic
begins. If the ordering diagnosis ICD CM code is approved for the Service Item, the
HCPCS code does not have a frequency limitation defined and the HCPCS code
(associated with the Service Item) is not a duplicate, no further processing occurs. The
following message is displayed:

   <<Building Accession(s) please wait!>>

ABN logic results in *App* being displayed in the ABN Signed field that crosses to the
Charge record on Patient Care.

NOTE: *App* is automatically assigned by STAR if the patient is an outpatient, the
            diagnosis is an approved diagnosis and one of the insurance plans
            associated with the patient is identified as CMS-compliant.

If the ordering diagnosis is not approved for any of the Service Items, ABN processing is invoked. The following is an example of the screen that displays when a not approved diagnosis has been entered for any of the Service Items.

```
                   General Hospital Pathology Case Login Processor
                                          Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room   Physician     Srv ICD Status
A000003485 COMPLIANCE,CMS   F  04/02/1965        AKER,TOM      ERS 10  O/P
                             ABN Processing
Page:01        Following Items have invalid diagnoses for HCPCS code
( 1) LAB 5050-GROSS AND MICROSCOPIC - TISSUE
( 2) LAB 5051-PROFESSIONAL FEE - AP - CHRG ONLY




















 Print ABN (Y/N)--
```

The following prompt is displayed:

Print ABN (Y/N) --

Enter **Y** for Yes to print the ABN form. Enter **N** for No to not print the ABN form.

If you enter **Y** for Yes, the following prompt is displayed:

Enter printer name to print to, or `-` [XXXXXXXX]--

The XXXXXXXX is the default printer setup for the ABN report code.

The following prompt is displayed regardless of whether **N** or **Y** is entered at the prompt to print the ABN.

Has the ABN been signed (Y/N)--

If you enter **Y,** the following screen is displayed:

```
           General Hospital Central Processing Specimen Order Processor
                                              Thu Jan 15, 2009 09:04 am
 Unit #      Name            Sex Birthdate  Room    Physician      Srv ICD Status
 A100007256 CMS,PATIENT       F  04/04/1940 2194-01 JEKYL,JONAS J SUR 10  OPS 1
                                 ABN Processing
 Page:01      Following Items have invalid diagnoses for HCPCS code
 ( 1) LAB 4999-MICRO SENSITIVITY - CHRG ONLY




 Page:01
          Code      ABN Modifier and Reason         Modifier
 ( 1) ALSP ACCEPTS LIABILITY/SP/PATIENT SIGN
 ( 2) FQY  FREQ CHECK/PT SIGNED                           GA
 ( 3) GAPS INVALID DX/PT SIGNED                           GA

 Enter choice--
                        next pg(/ or PG DN)  Search(TAB)
```

The list of reasons from the user-defined ABN Modifier and Reason Table defined with the GA modifier or self pay ABN signed indicator is displayed. Enter your choice.

If you enter N, the list of reasons from the user-defined ABN Modifier and Reason Table defined with the GZ modifier or self pay ABN not signed indicator is displayed. Enter your choice.

After the reason is selected, the following message is displayed:

   <<Building accession, please wait!>>

When the HCPCS code assigned to a SIM item has a frequency limitation requirement assigned, the item is ordered, and the item has passed initial ABN processing with an approved diagnosis, the user sees the following message:

   Following Items have a frequency limitation requirement

```
              General Hospital Front Office Specimen Order Processor
                                               Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate Room     Physician     Srv ICD Status
A000002138 COMPLIANCE,HCFA  F  02/15/1938 4101-02 ADAIR,FRANK    MED 10  OPO 656
                                 ABN Processing
Page:01      Following Items have a frequency limitation requirement
( 1) LAB 5051-PROFESSIONAL FEE - AP - CHRG ONLY ONCE/24 HOURS




         Print ABN (Y/N)--
```

The item is displayed with the user-defined frequency text from the HCPCS table. The user is prompted to print an ABN. Whether the ABN is signed or not, items flagged with frequency requirements should be submitted to insurance companies for reimbursement as they pass to STAR Financials as an insurance covered item. ABN frequency processing assures the facility of having documentation showing that the patient was informed that Medicare might deny the item in question. If initial ABN processing fails, then neither the ABN frequency limitation check nor subsequent Duplicate/Conflict HCPCS processing is performed.

If an initial ABN or frequency ABN is generated and the user chooses to print an ABN, then the printer option screen shows either LBF printers or LBN printers for printing.

If the system determines that the HCPCS code for the ordered item has been previously ordered on the same calendar day, the following screen is displayed:

```
                  General Hospital Pathology Case Login Processor
                                           Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician    Srv ICD Status
A000003485 COMPLIANCE,CMS   F  04/02/1965          AKER,TOM     ERS 10  O/P HOM
Medicare Duplicate HCPCS Processing
Seq Item                         Necessity    Medical Necessity Reason
1   GROSS AND MICROSCOPIC - TISS
2   PROFESSIONAL FEE - AP - CHRG




Duplicate order/charge-same date of service, is it Medically Necessary (Y/N)--
                      GROSS AND MICROSCOPIC - TISS
```

Subfield Explanations

SEQ ITEM (DISPLAY ONLY)
This field displays the items identified as being a duplicate order/charge for the same date of service for the same patient. This field is display only, and cannot be edited.

NECESSITY (1-A-R)
This field is used to indicate whether the duplicate test is medically necessary and completion is required. When this field is entered, the following prompt is displayed:

Duplicate order/charge-same date of service, is it Medically Necessary (Y/N)--
XXXXXXXXXXXX

The XXXXXXXXXX is the description of duplicate item in question.

Enter **Y** for Yes to indicate this duplicate test is medically necessary. When **Y** is entered, you must enter a reason that explains why the test is medically necessary. If a HCPCS modifier has been defined in the Duplicate/Conflict HCPCS Modifier field of the SIM Department code table (maintained on Patient Care), that modifier is automatically attached to the HCPCS code associated with this Service Item.

Enter **N** for No to indicate there is no documentation present to justify the duplicate test. When **N** is entered, no further processing occurs and the test is ordered upon acceptance of this screen.

MEDICAL NECESSITY REASON (28-AN-O)
This field is used to identify the reason the duplicate test is deemed to be necessary. When Y has been entered at the previous prompt, the following prompt is displayed and completion is required:

Enter Medical Necessity Reason, `-` to list--
or `-`reason for free text

Enter one of the following:

- Enter the Duplicate/Conflict HCPCS Override Reason code.

- Enter a hyphen (**-**) to display the Duplicate/Conflict HCPCS Override Reason code table for selection.

- Enter a hyphen (**-**) followed by up to 28 characters to enter a free-form reason.

If an **N** was entered at the previous prompt, the Medical Necessity Reason is not required although the cursor rests in that field. To exit the processor, press the F7 key.

In addition to Duplicate HCPCS checking, the system allows Medicare XREF HCPCS Conflict Checking.

The Medicare XREF HCPCS Conflict Checking screen displays when all of the following are true:

- The patient's patient type is defined as being outpatient

- One of the insurance plans associated with the patient is defined as being CMS-compliant

- The Service Item has an associated HCPCS code (in the FIM), and that HCPCS code has approved ICD CM diagnosis codes defined in the HCPCS Table (located in Medical Records Maintenance on Patient Care) or no approved ICD CM codes per LMRP

- The Service Item entered has an associated price

- This SIM department is set up as CMS-Compliant for ABN and/or Dup/XREF HCPCS Checking

- No ABN processing is invoked (ABN frequency processing may or may not be invoked.)

The following is an example of the Medicare XREF HCPCS Conflict Checking screen:

```
                    General Hospital Pathology Case Login Processor
Acc# 4848                                        Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room     Physician     Srv ICD Status
A000002138 COMPLIANCE,HCFA  F  02/15/1938 4101-02 ADAIR,FRANK C MED 10  OPO 656

Medicare XREF HCPCS Conflict Checking                    CCE Modifier Allowed
Seq Item                           Conflict Category         for Code Combination

1   MISC PATH CHARGE - CHRG 0      Comprehensive                  Yes







Item has HCPCS Code Conflict!  Continue (Y/N)--
                      REPLICATE CHARGE - CHRG ONLY
```

Field Explanations

SEQ (DISPLAY ONLY)
This field is display only and contains the numeric sequence of the Service Item(s)
ordered or charged.

ITEM (DISPLAY ONLY)
This field is populated by an item ordered during this order session or an item ordered
on the same date of service, but during another order session, for which a HCPCS
combination code conflict has been detected. The HCPCS code in the FIM of the
current item being ordered is evaluated for user defined cross-reference code conflicts
in the HCPCS Processor table. If a conflict is detected, based on the user-defined
cross-reference, the description of the item is displayed.

CONFLICT CATEGORY (DISPLAY ONLY)
The Conflict Category is populated from the definition in the HCPCS Processor Table
within the XREF HCPCS / CPT® option. The definition in the Conflict Category will
apply to the relation of the item listed and the current item being ordered. The relations
entered in the table are Comprehensive, Component, or Mutually Exclusive.

CCE MODIFIER ALLOWED FOR COMBINATION CODE (DISPLAY ONLY)
This field is populated from the definition entered by the user in the HCPCS Processor
Table within the XREF HCPCS/CPT option. Within the XREF HCPCS/CPT option, the
user indicates for each HCPCS added if CMS documentation states that a CCE
Modifier is allowed to override the combination code conflict by adding further
specificity about the service being ordered.

Item has *HCPCS CODE CONFLICTS!* (DISPLAY ONLY)
This warning message is displayed if a XREF HCPCS conflict is detected by the
system. The system evaluates the HCPCS code in the FIM of the current item being
ordered to determine if there is a cross-reference HCPCS code defined in the XREF
HCPCS/CPT field that conflicts in this order session or within the same date of service.
The item displaying below the prompt is the item currently being ordered or charged.
The HCPCS in the FIM of ordered or charged item is where the system looks to
evaluate possible XREF HCPCS/CPT code conflicts.

CONTINUE (Y/N) (1-A-R)
The user is prompted to enter **Y** or **N** to order the item listed with the prompt or to step
back to the appropriate screen(s) to delete the item in conflict from the order or charge.

In Anatomic Pathology for CMS-compliant outpatients, what the system is processing
dictates how conflict items may be deleted. If the user is in Case Login and histotech
processes are defined for automatic processing, the following screen displays when
the user presses period (.) ENTER or answers negatively to the *Continue (Y/N)* conflict
prompt.

```
                    General Hospital Pathology Case Login Processor
                                      Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician     Srv ICD Status
A000001851 XREF,TEST 3       M  06/09/1967 NSY-04   GHARIB,MAHNAZ MED 10  OPO 104

 Medicare XREF HCPCS Conflict Checking                      CCE Modifier Allowed
 Seq  Item                            Conflict Category     for Code Combination

 1    MISC PATH CHARGE - CHRG O       Comprehensive                  Yes












 Delete CRY histotech auto process on accn 2129 to credit misc charge (5555)!
   Press NL--
```

In the example prompt, CRY is the histotech process, 2129 is the accession number
and 5555 is the charge associated with histotech process CRY. Pressing period (.)
ENTER returns the user to the Case Login processor. Manual intervention is required
to delete the CRY charge (TC 5555), either by deletion of the histotech process or by
accessing Miscellaneous Charge/Credit and crediting the conflicting charge.

If the user is in Histo/Cytotech Processing, adds on a process with a conflicting charge
(using any option) and enters period (.) ENTER or answers negatively to the *Continue
(Y/N)* conflict prompt, the following screen displays.

```
                    General Hospital Pathology Case Login Processor
                                                Thu Jan 15, 2009 09:04 am
 Unit #       Name              Sex Birthdate Room    Physician       Srv ICD Status
 A000001851 XREF,TEST 3          M  06/09/1967 NSY-04  GHARIB,MAHNAZ MED 10  OPO 104

 Medicare XREF HCPCS Conflict Checking                      CCE Modifier Allowed
 Seq  Item                            Conflict Category      for Code Combination

 1    MISC PATH CHARGE - CHRG O       Comprehensive                 Yes











 Error: The CRY histotech process and misc charge item 5555 will not file!
```

In the example prompt, CRY is the histotech process and 5555 is the charge
associated with histotech process CRY. The system does not file the histotech process
or the conflicting charge associated with the histotech process. No manual user
intervention is required for charge deletion. If, however, the histotech process is
needed, conflict processing should be accepted and any conflicting charges be
charged or credited as per laboratory or facility procedure.

NOTE: Conflicts may exist between professional fees attached to SIM items. If a
conflict exists and the user does not wish to continue with conflict processing,
the only way the professional fees may be deleted is via deletion of the SIM
item from the order set.

If the SIM item in conflict was ordered or charged earlier in a different order session,
but on the same date of service, the previous item must be cancelled and credited
using the appropriate cancellation reasons. Each facility should develop policies and
procedures for the proper process to cancel and credit items from prior order/charge
entry sessions.

If **Y,** at the *Continue (Y/N)* prompt, is entered a check to the CCE Modifier Allowed field
within the HCPCS XREF/CPT function is performed to see if the item can be billed as
covered if a modifier is added.

If a check in the HCPCS XREF function detects a *No* in the CCE Modifier Allowed field,
the system does not prompt the user for an override reason. As defined by CMS
documentation, *No* in the CCE Modifier Allowed field indicates no modifier would be
appropriate for that HCPCS cross-reference code combination. The item is stored in
the same manner as a *not medically necessary duplicate* and is sent to STAR Patient
Accounting as non-covered. Non-covered items print on the STAR Patient Accounting

Conflicting HCPCS Report as a HCPCS conflict for the user to evaluate the order for cancellation and/or crediting for removal from billing and claims.

If a check within the HCPCS XREF function detects a *Yes* in the CCE Modifier Allowed field, the system prompts the user to enter a conflict override reason from the user-defined Duplicate/Conflict HCPCS Override Reason table. As defined by CMS documentation, *Yes* in the CCE Modifier Allowed field indicates that an appropriate modifier is allowed to differentiate between the services. The override reason and modifier from the user-defined Duplicate/Conflict HCPCS Override table are stored and the modifier is attached to the HCPCS from the FIM of the current item being ordered and sent to STAR Patient Accounting to be submitted as covered on the claim.

After the user enters **Y** to continue the order, if a modifier is allowed, the user is prompted to enter an override reason from the Duplicate/Conflict HCPCS Override Table or to enter a free text reason as shown below.

> *Enter Cross-reference Conflict Reason, ' - ' to list --*
> *or ' - ' reason for free text*

```
                    General Hospital Pathology Case Login Processor
Acc# 4848                                        Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician      Srv ICD Status
A000002138 COMPLIANCE,HCFA  F  02/15/1938 4101-02 ADAIR,FRANK C MED 10  OPO 656

Medicare XREF HCPCS Conflict Checking                     CCE Modifier Allowed
Seq Item                            Conflict Category        for Code Combination

1    MISC PATH CHARGE - CHRG 0     Comprehensive                  Yes









Enter Cross Reference Conflict Reason, '-' to list--
                         or '-'reason for free text
```

Only the override reasons defined as Conflict in the Reason Type field of the Duplicate/ Conflict HCPCS Override Table are displayed for selection.

```
            General Hospital Pathology Case Login Processor
Acc# 4848                                   Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000002138 COMPLIANCE,HCFA  F  02/15/1938 4101-02 ADAIR,FRANK C MED 10  OPO 656


Medicare XREF HCPCS Conflict Checking                CCE Modifier Allowed
Seq  Item                           Conflict Category   for Code Combination


1    MISC PATH CHARGE - CHRG -0     Comprehensive            Yes
Page:01
     Code     Conflict Override Reason Description       Modifier
( 1) 9     DIFFERENT BODY SITE                          59
( 2) 59    DISTINCT PROCEDURAL SERVICE/                 59
( 3) 91    REPEAT CLIN DIAG LAB/SAME DAY/SEP SP         91
( 4) 78    RET TO OR/RELATED PROCED/DUR POSTOP          78
( 5) 100   TESTING EDIT                                 47
( 6) 79    UNREL PROCEDUR/SAME DR/DURING POSTOP         79




 Enter choice--
```

If the user chooses to enter a dash, the table of conflict codes is displayed for selection. The user selects the appropriate override reason/modifier for the conflict identified. The override reason and modifier are stored in the system for review and the modifier is attached to the FIM of the current item being ordered to send to STAR Patient Accounting as covered for billing.

If the user chooses **Y** to continue the order, but the code combination of the current item being ordered and the item detected as the conflict does not allow a modifier based on the definition in the Cross-reference function, the user is not prompted to select an override reason. The CCE Modifier Allowed for Code Combination is populated with *No* which indicates that no modifier is allowed and that the item is passed to STAR Patient Accounting as non-covered. This item displays on the STAR Patient Accounting report, Conflicting HCPCS within Same Date of Service without Documentation of Medical Necessity for notification to the SIM department.

The user receives the message *CCE Modifier Indicator - No modifier allowed!* and the prompt to press ENTER. After pressing ENTER, the option to accept the screen is displayed.

The user enters F7 to accept and assign the order and accession numbers.

Conflicts may exist between professional fees attached to SIM items. If a conflict exists and the user does not want to continue with conflict processing, the only way the professional fees may be deleted is via deletion of the SIM item from the order set.

Once all the duplicate tests have been processed, the ordering process is complete.

When a credit is issued for a CMS-compliant patient either via the Miscellaneous Charge processor or deleting a process or block in Histo/Cytotech processing, the Outpatient Medicare Diagnosis/Modifier Entry screen is displayed for you to enter the

diagnosis. You need to enter the appropriate diagnosis to match that of the charge. The ordering diagnosis is available as the default because the ordered test is available in Histo/Cytotech Processing. In addition, the ABN and ABN Reason fields are updated as follows for the credit:

- If the diagnosis is valid, in Credit Inquiry, the ABN field defaults to *APP*.

- If the diagnosis is invalid, in Credit Inquiry, the ABN defaults to *No* and ABN reason defaults to *Credit - ABN not printed!*

- If the SIM item has a frequency limitation, the ABN defaults to *FQ/N* and the ABN reason defaults to *Credit - ABN not printed!*

NOTE: ABN processing and frequency limits that take place for the credit are complimentary to those for the charge. This processing results in default values for the ABN and ABN Reason fields. No duplicate HCPCS/medical necessity processing takes place for the credit.

When the screen is accepted, the diagnosis is sent with the credit in the network transaction to Patient Care and Patient Accounting.

NOTE: If your facility has implemented service time processing, when a process or block is deleted and a credit is issued, the service date/time of the charge is sent to STAR Patient Care in the network transaction.

HISTOTECH PROCESSING

The Histotech Processing processor enables you to assign an unlimited number of histotech processes per block for both default and alternate histotech numbering schemes. Using the Histotech Block Processing edit, add, batch, and view functions, you can manage label generation, workload capture, and miscellaneous charging for all surgical cases including those involving multiple specimens.

Histotech Numbering Schemes

Two types of numbering schemes exist for histotech processing: the specimen letter-block number (default) and the block letter (alternate). The numbering schemes are controlled by the Histotech Number field within the Anatomic Path Parameters processor. Please check with your System Manager to determine how your laboratory department is defined.

SPECIMEN LETTER-BLOCK NUMBER (DEFAULT)

In the specimen letter-block number histotech numbering scheme, a specimen type designation is required for each block. If the selected specimen is different from the one already defined, a new specimen letter is defined and the block number is reset to one. For example, number A1 indicates block 1 for specimen type A, number A2 indicates block 2 for specimen type A, number B1 indicates block 1 for specimen type B, and number Z1 indicates block 1 for the last specimen type Z, before changing the alpha character to lower case. The new specimen type is assigned to a case after "Z" is presented as a1, b1, c1, and so forth. The use of lower case letters increases the number of specimen types that can be processed with the default numbering scheme to 52.

```
Opt Case #   Block  Specimen/Process DescriptionTest  Processed Page:01
 1) S94-8   A1  Tissue Biopsy            TISSUE - GROSS EXAM
          1A) Cyto smr, from fluid -  @1              Yes
 2) S94-8   A2   Tissue Biopsy
          2A) H & E Stain -                    No
          2B) ON EDGE AT LEVELS - 2 slds x 3      No
          2C) Reticulum Stain -  @001            No
```

BLOCK LETTER (ALTERNATE)

The block letter numbering scheme provides a block letter regardless of specimen type. The same process can be used within a block more than once.

```
Opt Case #  Block  Specimen/Process Description      Test  Processed Page:01
 1) S94-9  A   Liver Biopsy                      TISSUE - GROSS EXAM
          1a) Cyto smr, from fluid -  @1          Yes
          1b) Silver Stain - @001                 No
 2) S94-9  B   Liver Biopsy                      GROSS & MICROSCOPIC
          2a) H & E Stain - @3.0                  No
          2b) Cyto smr - @2.0                     Yes
          2c) Mason's Trichrome slds @2 x 2       Yes
          2d) H & E Stain - @3.0                  No
```

Block numbering is independent of the specimen. While the specimen type designation is still required for each block, block numbering is not reset to one for each specimen type. For example, block A indicates the first block for the case, block B indicates the second block for case, block C indicates the third block for the case, block Z indicates the 26th block for the case, block AA indicates the 27th block for the case, block BB indicates the 28th block for the case, and block ZZ indicates the 52nd and last definable block for the case.

The histotech block letter (for example, A, B...AA, BB...ZZ) is assigned automatically as each new block is defined. If only one block is defined, no block letter is defined. However, if additional blocks are defined for this accession, the original unlabeled block becomes block A and subsequent blocks are defined beginning with B and so forth.

Histotech Processing Processor

The Histotech Processing processor provides the following functions:

Edit   Edit the information related to each existing block and the attached histotech processes as follows:

- Attach a new histotech process to a block

- Process a HT process by entering the applicable date of service, # of replicates, thickness, and # of slides/block

- Reactivate a HT process filed as deleted

- Delete histotech processes from a block

- Delete the entire block from a case

- Print/Reprint HT process labels

Add   Add one or multiple blocks to a case at the same time. Currently defined histotech processes are added to all blocks for the add episode.

Batch Entry   Perform a batch entry of multiple blocks with the same histotech processes. Assign a date of service to miscellaneous HT charges. Histotech processes available for Batch Entry must not require input for number of replicates, thickness, or number of slides per block at Add time.

Batch Process   Batch process histotech processes previously attached to multiple blocks.

View   Look at blocks and their associated histotech processes. For the selected case, all histotech processing information is available.

The Histotech Processing processor is usually an option on the Anatomic Pathology section menu.

```
                    General Hospital Pathology Processor
                                          Wed Sep 04, 2002 04:52 pm
 Pathology Input Options

          Option No.  Option
          --------------------------------------
             1        Order Entry
             2        Patient Inquiry
             3        Case Login
             4        Anatomic Path Order Management
             5        Histo/Cytotech Processing
             6        Histo/Cytotech Processing Report & Audit
             7        Recall Management
             8        Anatomic Path Result Reporting
             9        Review Queue Reporting
            10        History Cardfile - Network
            11        Miscellaneous Charge/Credit
            12        Professional Billing Input
            13        Cytology QA
            14        Long Reports Batch
            15        Miscellaneous Charge Report
            16        Incomplete Work Report
 Enter option number--
```

Upon selecting HistoCytotech Processing, the following prompt displays:

    Enter `&`unit,`*`account #,accession # or `[`case # --
                 patient name (Last,First M), `-`SS# or `=` for current

Identify the patient using one of the patient lookup routines described under Accessing Patient Information in the Information Entry Techniques chapter in the General Information Volume of the STAR Laboratory Reference Guide. Or, enter the Anatomic Path case number preceded by an open bracket ([), for example, ([S94-100). The system displays only that accession (functions the same as entering the accession number).

At all application entry points that accept the case number as a valid entry, you also have the ability to key in part of the information that is actually accepted by the screen.

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At case number entry points, case numbers that are defined for the current calendar year would be ([S94-100). The system now accepts the ([S100) and makes the appropriate interpretation. This eliminates the need for three keystrokes each time you enter a current year case number in the system. The system continues to accept the complete entry of number and year. When the entry does not include a dash (-), the system interprets it as the current year.

NOTE: If the test entered has not been logged in before entering this processor, when you select the test for resulting, the following prompt displays:

> *Login now? [Y]--Accn# #### has not been logged in!*

Select **Y** to login.

Once the patient and the test are selected, the Histotech Processing Processor Block Index screen displays.

NOTE: If the case has more than one test with histotech processes assigned, regardless of the test selected, all blocks for all the tests on the case display.

```
      General Hospital Anatomic Pathology Histotech Processing Processor
Accn #: 5282                                    Thu Jan 15, 2009 09:04 am
Unit #      Name         Sex Birthdate  Room    Physician     Srv ICD Status
A000000010 TESTWHITE,ONE   F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 961
   Case Number:  S95-426
Opt  Block Number  Specimen/Specimen Modifier        Test           Page:01
( 1) S95-426-A1    Liver-left lobe                   GROSS AND MICROSCOPIC
( 2) S95-426-A2    Liver-left lobe
( 3) S95-426-A3    Liver-left lobe
( 4) S95-426-A4    Liver-left lobe
( 5) S95-426-A5    Liver-left lobe
( 6) S95-426-B1    Liver-right lobe
( 7) S95-426-B2    Liver-right lobe
( 8) S95-426-B3    Liver-right lobe
( 9) S95-426-B4    Liver-right lobe




 Enter option to edit, add(A), batch entry(B), batch process(P) or view(V)--
```

Field Explanations

OPT
The process option number. Each block is numbered for selection when editing histotech process information associated with the block.

BLOCK NUMBER
The case number and block indicator for each defined block.

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SPECIMEN/SPECIMEN MODIFIER
The description of each specimen and modifier (if defined) for each defined block.

TEST
The test name appears in the right column of the screen. Test name to which blocks have been attached. The test description displays with the first block assigned and only displays again if there are additional tests defined with blocks.

If no blocks exist for the case, the following message and prompt display on the Histotech Processing Block Index screen.

No blocks exist!   Add(A) a new block or batch entry(B)? [A]--

If blocks exist for this case, the following prompt displays:

Enter option to edit, add(A), batch entry(B), batch process(P) or view(V)--

Selecting the batch processing option P initiates a check by the system to determine if there are blocks on the case that have only histotech processes eligible for batch processing. Refer to for the criteria. If no blocks exist that are eligible for batch processing, entering a **P** displays the following message and returns you to the previously described prompt:

No blocks available for batch processing!

EDIT

When blocks exist on a case,you have the option to edit the information related to each block and the attached histotech processes. The Histotech Processing Block Index screen edit option provides the following functions:

• Attach a new histotech process to a block

• Process histotech processes by entering the applicable date of service, # of replicates, thickness, and # of slides/block

• Reactivate a HT process filed as deleted

• Delete histotech processes from a block

• Delete the entire block from a case

• Print/Reprint HT process labels

NOTE: Once edits to existing HT processes have occurred, the system evaluates the settings in the Maintenance Processor/Histotech Processes for replicates, thickness, and slides/block, regardless of how the HT process was attached to the case. HT processes can be attached automatically based on the build

in Histotech Processes/Test or added through the add option in the Histotech Processing processor.

From the Histotech Processing Processor Block Index screen, to edit the selected block, enter the selected option number. The HT Edit Block screen displays.

```
         General Hospital Anatomic Pathology Histotech Processing Processor
Accn #: 5282                                        Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician      Srv ICD Status
A000000010 TESTWHITE,ONE     F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 961
                      GROSS AND MICROSCOPIC - TISSUE
Block Number: S95-426-A1              Specimen: Liver - left lobe
 1 HT Processes    Defined
 2 HT Processes              I    Processed   DOS      Rep  Thick   Slds/Bl
BLOCK W/2 H&E                     Yes       08/15/95   1            1
Additional H & E                 Yes       08/15/95   2    1        1
Cell Block                       No




         F1Prev Page   F2Next Page   F4Delete F5Delete Block   F6Reset   F7Exit

```

Field Explanations

1. HT PROCESSES (TABLE LOOKUP-R)
This field is used to select the histotech processes that are attached to the block. The following prompt displays:

Enter Histo code or `-` for table--

To attach a new process to the block, enter the histotech process code. Enter a dash for a table display of the histotech processes in alphabetical order by description. To perform a partial lookup, enter the first few characters of the histotech description. Histotech processes, previously selected for the block, display in the table with the option number highlighted.

The number of histotech processes you can attach to a block is unlimited. However, the number of histotech processes you can select from the table at one time is dependent on the limitations of the table display. The length of the histotech process codes has an impact on the table selection limits. The more characters, the fewer selections you can make at a time.

To de-select an entry from this table, first enter a minus sign in front of the option number that was previously assigned to the block. Then, you must initiate the delete

function field 2 (on this screen) to complete the process for filing the histotech process as filed as deleted.

When you complete the selection of HT processes for this block, the following message displays for all HT processes previously filed as deleted:

[Histotech Process description] filed as deleted! Reactivate? (Y/N)--

If you choose not to reactivate, enter **N**. You are prompted to add a new entry of the histotech process that was previously filed as deleted for the block:

[Histotech Process description] process previously defined and deleted, add again? (Y/N) [N]--

To add the HT process to the block, enter **Y**. At this point, you can no longer reactivate the previously defined episode of the HT process back to the block.

Once an HT code is entered or the table selection process is complete, Defined displays in the field.

NOTE: Reactivation occurs once the screen is accepted with HT processes that were previously deleted. Reactivated HT processes that were processed before being filed as deleted generate a new miscellaneous charge with the same date of service as previously defined. If the HT process that is reactivated had not been processed, no miscellaneous charges are posted until the HT process is processed.

2. HT PROCESSES/PROCESSED/DOS/REP/THICK/SLDS/BLK
This field uses scrolling screen processing.

Scrolling Screen

The fields in this scrolling screen are used to update processing information for the histotech processes attached to the selected block.

The following function keys are used for the scrolling screen:

F1 Prev Page   F2 Next Page   F4 Delete   F5 Delete Blk   F6 Reset   F7 Exit

For more information, see "Histotech Processing Scrolling Screen Edit Functions" on page 3-123. For information on scrolling screens, refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

HT PROCESSES (TABLE LOOKUP-R)
This column is a display-only column. The information that displays is determined by the entries in Field 1.

PROCESSED (1-A-R)
This column indicates the status of the histotech process. A Yes in this column means the histotech processes have been previously processed. A No means the HT processes are ordered, but not previously processed.

If the entry is set to No, the following prompt displays:

Process? (Y/N)--

Enter **Y** to move the cursor to the next field in the scrolling screen.

If the entry is set to Yes, the HT process was already processed. The following prompt displays:

[HT description] already processed, reprint labels? (Y/N) [N]--
Block [block number]

To move to the next available field and not reprint labels, enter **N**. To reprint labels once the screen is accepted, enter **Y**. The response *Yes* displays followed by an asterisk (Yes*) indicating your request to reprint labels. Once you accept the screen, *Yes* again displays upon re-entry to the screen.

To address the workload requirements, the following prompt displays:

Capture standard Workload(W), Repeat(R) workload or No(N) workload? [N]--
Block [block number]

For more information, see Histotech Processing Workload Recording subsection.

NOTE: Until you accept the Histotech Process screen using the F7 key, labels do not print. Once the Processed field is set to Yes and you accept the screen, it can not be changed back to No. You must print the additional labels (where Yes* is displayed), or delete the histotech process.

DOS (DATE FORMAT-O)
The function of this column is to enter a date of service or display the date of service associated with the histotech process. The date of service is attached to the miscellaneous charges associated with the histotech process. Entering the column, displays the following prompt:

Enter date of service [mm/dd/yy]--

The default for the prompt is the collection date for the case. A future date is not allowed. A previous date can be entered. A displayed date cannot be edited.

For any Anatomic Pathology tests, if Histotech Processing is not defined as *Automatic,* then the Date of Service for histotech processes is defined via the Histotech Processing Processor using the Date of Service column as the following screen displays:

```
          General Hospital Histology Histo/Cytotech Processing Processor
 Accn #: 2899                                   Thu Jan 15, 2009 09:04 am
 Unit #      Name              Sex Birthdate  Room    Physician     Srv ICD Status
 A000002109 TEST,AUNT          F  03/03/1943 117-1   ADAIR,FRANK C MED 10  I/P 87
                               CYTOLOGY SMEAR, GYN
   Block Number: C02-1034                      Specimen: Tissue

  1 HT Processes
    Defined
  2 HT Processes                           Processed   DOS     Rep  Thick  Slds/Blk
    Cytology Direct Smear                    No



                   Enter date of service [03/08/02]--
 F1Prev Page F2Next Page F4 Delete  F5Delete Blk F6 Reset  F7  Exit   ?
```

The Date of Service can be manually edited and is filed when the process is executed.

NOTE: When histotech processes are auto processed, the collection date displays for the date of service.

For those histotech processes that were defined as processed for a case prior to having access to this column, the date of service is set to display the collection date of the case.

If your facility has implemented service time processing, this field is displayed as D/T of Serv.

The function of this column is to enter a date and time of service or display the date and time of service associated with the histotech process. The date of service is attached to the miscellaneous charges associated with the histotech process. When you access the column, the following prompt is displayed:

Enter date/time of service [mm/dd/yy xxxx]--

The default for the prompt is the collection date/time for the case. A future date is not allowed. If the date/time entered is a future date/time, the system displays the following message:

Error: Date/time of service can not be in the future!

After a date/time is entered and filed, it cannot be edited. If you try to edit a filed date/time, the system displays the following message:

Field cannot be edited!

REP (3-N-R)

The column defines the number of replicates associated with the selected histotech process. The replicate is part of the information used to determine the miscellaneous charges and workload associated with the histotech processes/blocks.

The options available depend on the setting in the Maintenance - Anatomic Path -> Histotech Processes processor as follows:

- If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path -> Histotech Processes), the entry is required regardless of the setting in the Processed column of the screen.

- If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path -> Histotech Processes), the entry is required if the Processed column is set to Yes. If the Processed column is set to No, the information can not be entered.

- If the histotech process is defined with a replicate value (Maintenance - Anatomic Path - > Histotech Processes), the value displays and is eligible to edit prior to accepting the screen. Once the information is filed, it is not eligible for edit.

- If the histotech processes is added to the case automatically as a by-product of Case Login, the setting defined in Maintenance - Anatomic Path -> Histotech Processes/Test overrides the definition of Maintenance - Anatomic Path -> Histotech Processes.

The following prompt displays:

Enter number of replicates [1]--

The default is one. Once the entry for this field is filed, the information can not be edited.

THICK (3-AN-O)

This column indicates the thickness to be included in the histotech process definition. The options available are dependent on the setting in the Maintenance - Anatomic Path -> Histotech Processes processor, as follows:

- If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path - > Histotech Processes), the entry is available regardless of the setting in the Processed column, but is not required.

- If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path - > Histotech Processes), the entry is eligible for entry, but is not required if the Processed column is set to Yes. If the Processed column is set to N, the information can not be entered.

- If the histotech process is defined with a thickness value (Maintenance - Anatomic Path - > Histotech Processes), the value displays and is eligible for edit.

The following prompt displays:

Enter thickness--

The default entry for the column is one. A valid entry consists of 1 to 3 alphanumeric values. To accept the screen, no value is required in this field.

NOTE: If the histotech processes is added to the case automatically as a by-product of Case Login, the setting defined in Maintenance - Anatomic Path -> Histotech Processes/Test overrides the definition of Maintenance - Anatomic Path -> Histotech Processes.

SLD/BLK (3-N-O)
This column determines the number of slides per block that should be associated with the selected histotech process. The value entered is used in the determination of the slide workload and the number of labels that print for the Histotech Process. The options available for this column are dependent on the setting in the Maintenance - Anatomic Path - > Histotech Processes processor as follows:

- If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path - > Histotech Processes), the entry is required regardless of the setting in the Processed column.

- If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path - > Histotech Processes), the entry is required if the Processed column is set to Yes. If the Processed column is set to No, the information can not be entered.

- If the histotech process is defined with a slide per block value (Maintenance - Anatomic Path - > Histotech Processes), the value displays and is eligible to edit prior to accepting the screen. Once the information is filed, it is not eligible for edit.

- If the histotech processes is added to the case automatically as a by-product of Case Login, the setting defined in Maintenance - Anatomic Path - > Histotech Processes/Test overrides the definition of Maintenance - Anatomic Path - > Histotech Processes.

The following prompt displays:

Enter number of slides per block [1]--

The default is one. Enter 1 to 3 numeric values.

Histotech Processing Overview

The following table presents the information that is available or is required at different points in the processing of histotech processes for number of replicates, thickness, and number of slides based on the definitions of the fields in the Maintenance processor for Histotech Processes.

Processed Column	Date of Service	Maintenance Definition	Number of Replicates	Thickness	Number of Slides per Block
No	Not available	Add time	Required	Available for entry (not required)	Required
No	Not available	Process time	Not available	Not available	Not available
No	Not available	Value defined	Displays not available for edit after initial data is filed.	Displays available for edit (not required).	Displays not available for edit after initial data is filed.
Yes	Required (display only after initial entry accepted)	Add time	Displays not available for edit after initial data is filed.	Displays available for entry (not required).	Displays not available for edit after initial data is filed.
Yes	Required (display only after initial entry accepted)	Process time	Required	Available for entry (not required).	Required
Yes	Required (display only after initial entry accepted)	Value defined	Displays not available for edit after initial data is filed.	Displays available for entry (not required).	Displays not available for edit after initial data is filed.

The first column of the table represents the setting in the process column when a HT process is added to a block. HT processes can be added to a block either by the Add process and batch entry, or predefined in the Histotech Processes/Test maintenance processor. The method of attaching the HT processes to a block is not relevant when interpreting the information in the table.

The information related to number of replicates, thickness and number of slides per block can be entered into the system at three different steps of processing a histotech process based on the information defined in the Histotech Processes maintenance processor. These are represented in the Maintenance Definition column. The three methods include:

- A numeric value can be defined in the Maintenance processor (Value Defined).

- The information can be entered when a HT process is added to a block (Add Time).

- The information can be entered when a HT process is processed once it has been assigned to a block (Process Time).

Histotech Processing Scrolling Screen Edit Functions

F4 Key
Deleting Histotech Processes from a Block

Use the F4 key to delete selected histotech processes from a block. The deletion can be initiated for the histotech process where the cursor is located. Once the F4 key is selected, double asterisks display after the HT process description in column one. Once the screen is accepted, the HT processes are deleted from the block. If the HT process(es) deleted was previously processed, the system generates a credit of the miscellaneous charges associated with the HT process.

When you delete an HT process from a block and the process has a miscellaneous charge attached to it, the system creates a miscellaneous credit. If the patient is CMS compliant, the system displays the Outpatient Medicare Diagnosis/Modifier Entry screen for you to enter the diagnosis and modifier. For more information on this screen, refer to Chapter 12: Billing/Charging in the *General Applications Volume* II of the *STAR Laboratory Reference Guide*.

If there is only one histotech attached to the block, you cannot delete it using the F4 key. The following message displays:

Only one histotech process defined! Select F5 to delete entire block!

NOTE: Workload does not automatically update. When an HT process is deleted, you need to make any changes to workload capture manually.

F5 Key
Deleting a Block from a Case

Use the F5 (Delete Blk) key to delete a block from a case. Once you select the F5 key, the following prompt displays:

Delete entire block - [block number]? (Y/N)--

If you enter **Y**, the following message displays:

Block [block number] filed as deleted!

Double asterisks display next to the HT descriptions in the scrolling screen. Until you accept the screen, the block is not actually filed as deleted.

When you delete a block from a case and the process has a miscellaneous charge attached to it, the system creates a miscellaneous credit. If the patient is CMS compliant, the system displays the Outpatient Medicare Diagnosis/Modifier Entry screen for you to enter the diagnosis and modifier. For more information on this screen, refer to Chapter 12: Billing/Charging in the *General Applications Volume* II of the *STAR Laboratory Reference Guide.*

F6 Key
Resetting the Last Edit

Use the F6 key to reset the last edit made to the histotech process where the cursor is located before moving the cursor to another line. Once the cursor is moved to another line, no changes can be made. If the F4 key was selected to delete the histotech where the cursor is located, use the F6 key to delete the double asterisk (before the cursor is moved to another line).

F7 Key
Exiting and Accepting the Screen

When you complete all necessary fields, use the F7 key to exit the screen. The following prompt displays:

Accept this screen? (Y/N) [Y]--

To return to the screen, enter **N**. To accept the screen and exit, enter **Y**.

If you selected to process a histotech process or reprint labels for a histotech process that was previously processed, and no alternate printers are defined, the labels print. If you have alternate histotech process label printers defined, a printer is required to accept the screen and the following prompt displays:

Print labels on [default printer description] (Port #xxx)? (Y/N) [Y]-
Block [block number]

To initiate printing from the default printer, enter **Y**. Enter **N** to display a list of the alternate printers. If a list of alternate printers does not exist the following prompt displays:

Press NL

If you period (.) ENTER out of the alternate printer table display, you are returned to the scrolling screen. Once a printer is selected, the following message displays:

Printing!

If you accepted the scrolling screen and no histotech processes are defined to be processed and/or no reprint labels are requested, the following message displays:

Filed!

Impact

•   If the HT process(es) filed as deleted were previously processed, the system generates a credit of the miscellaneous charges associated with the HT process.

•   Workload is not automatically updated. When a HT process is deleted, any changes needed to workload capture must be made manually.

•   When histotech processes are deleted individually or when an entire block is deleted, credits are generated for the miscellaneous charges associated with the histotech processes as well as replicates. The date of service associated with these credits reflects the date of service previously displayed with the histotech process.

•   The numbering scheme reflects that a block has been filed as deleted when other than the last block is deleted. For example, on a case that has three blocks (A1, B1, C1) if you delete the second block, the information on Histotech Processing screens displays A1, C1. The next block added to the case with a different specimen type (default numbering scheme) is labeled D1.

•   There is no impact on the numbering of additional blocks added when the last block is deleted from a case. For example, on a case that has three blocks (A1, B1, C1) and you delete the third block, the information on Histotech Processing screens will display A1, B1. The next block added to the case with a different specimen type (default numbering scheme) is labeled C1.

•   When a case has a test in a status of partial or higher and the test has a SNOMED code component defined to evaluate specimens in Case Login or Histotech Processing, the following message displays when a block is deleted using the F5 key:

SNOMED Code results may exists of [Specimen type description]! Must be manually updated through result entry! Press NL--

ADD

The Add option on the Histotech Processing Block Index screen is used to add new blocks to a case. Multiple blocks can be added at the same time. The histotech processes that are defined are added to all blocks added for the add episode. The number of histotech processes that can be assigned to the added blocks is unlimited.

NOTE: During Histotech/Cytotech processing, outpatient charge documentation via ABN processing and/or Duplicate/Conflict HCPCS processing can be

captured for the outpatient Medicare population to comply with various CMS billing requirements. See the *CMS Compliance Checking* section of this document for further information.

At the prompt on the Histotech Processing Block Index screen, enter **A**. The Adding New Block(s) screen displays:

```
              General Hospital Histology Histo/Cytotech Processing Processor
 Accn #: 15282                                     Thu Jan 15, 2009 09:04 am
 Unit #      Name          Sex Birthdate  Room      Physician     Srv ICD Status
 A000000010 TESTWHITE,ONE   F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 961
 Case#: S99-426                   Adding New block(s)
  1 Test                                  2 Number of Blocks
  3 Specimen                              4 Specimen Modifier
  5 Histotech Processes
  6 HT Processes                 Processed   DOS      Rep  Thick  Slds/Blk




 Enter field number or '/' starting field number--
```

Field Explanations

1. TEST (TABLE LOOKUP-R)
This field is used to select the test. When there is only one test on the case number (accession) selected, that test name displays and you can not access this field. If more than one test exists on the case, a table displays. You must select a test to proceed to the next field.

2. NUMBER OF BLOCKS (2-N-R)
This field is used to enter the number of blocks to be added to the case. The following prompt displays:

Enter number of blocks [1]--

3. SPECIMEN TYPE (TABLE LOOKUP-R)
This field is used to enter the specimen type to be associated with the blocks. The following prompt displays:

Enter specimen type or '-' for table [primary specimen type]--

Enter the specimen type code or enter a dash to display a table of specimens listed in alphabetical order by description. For a partial table display, enter the first few characters of the specimen type description followed by a dash. The specimen type

description displays 19 characters. The default for the prompt is the primary specimen type attached to the case.

4. SPECIMEN MODIFIER (25-C-O)
This field is used to enter the specimen modifier associated with the specimen and the block. The following prompt displays:

Enter specimen modifier--

5. HT PROCESSES (TABLE LOOKUP-R)
This field is used to select the histotech processes to be attached to the block. The following prompt displays:

Enter Histo code or `-` for table--

Enter a single histotech process code or enter a dash for a table display of histotech processes in alphabetical order by description. For a partial lookup, enter the first few characters of the histotech process description.

The number of histotech processes that can be attached to a block is unlimited. The number of histotech processes that can be selected from the table at one time is depends on the length of the histotech process codes. The more characters, the fewer selections you can make.

Once the table selection process is complete, the status, Defined, displays in the field.

6. HT PROCESSES/PROCESSED/DOS/REP/THICK/SLDS/BLK
This field uses scrolling screen processing.

Scrolling Screen

The fields in this scrolling screen are used to update processing information for the histotech processes being added to the case in Field 5.

The following function keys are used for the scrolling screen:

F1Prev Page F2Next Page F4 Delete F6 Reset F7 Exit

For information on scrolling screen processing, refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*. For information on the specific HT function keys, see "Histotech Processing Scrolling Screen Edit Functions" on page 3-123.

HT PROCESSES (TABLE LOOKUP-R)
This column is a display-only column. The entries in Field 5 determine the information displayed.

PROCESSED (1-A-R)
Indicate if the histotech processes is to be processed. Once the information in this column is accepted (that is, the screen is accepted), it can not be edited.

There are multiple scenarios that can occur related to the definitions of the Histotech Processes in the Maintenance Functions. See the table display in Edit. Upon entry to this column in the add function, N displays.

When the cursor is located on this column, the following prompt displays:

Process? (Y/N)--

NOTE: For CMS Compliance Checking processing, the Processed field must contain a Y for Yes.

DOS (DATE FORMAT-O)
Enter the date of service associated with the histotech process. The column can not be entered unless the Processed column is set to Yes. The prompt for this column is:

Enter date of service [mm/dd/yy]--

The default for this column is the case's collection date. Once the information in this column is accepted (information on the screen is accepted), it cannot be edited.

If your facility has implemented service time processing, this field is displayed as D/T of Serv.

The function of this field is to enter a date and time of service or display the date and time of service associated with the histotech process. The date of service is attached to the miscellaneous charges associated with the histotech process. When you access the field, the following prompt is displayed:

Enter date/time of service [mm/dd/yy xxxx]--

The default for the prompt is the collection date/time for the case. A future date is not allowed. If the date/time entered is a future date/time, the system displays the following message:

Error: Date/time of service can not be in the future!

After a date/time is entered and filed, it cannot be edited. If you try to edit a filed date/time, the system displays the following message:

Field cannot be edited!

REP (3-N-R)
Enter/view the number of replicates associated with the selected histotech process. The replicate information is used in determining the miscellaneous charges and

workload associated with the histotech processes/blocks. Moving the cursor to this column displays the following prompt:

Enter number of replicates [1]--

The default is one. Once the entry for this column has been filed, the information can not be edited.

The options available for this column depend, as follows, on the setting in the Maintenance - Anatomic Path -> Histotech Processes processor:

• If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path -> Histotech Processes), the entry is required regardless of the setting in the Processed column of the screen.

• If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path - > Histotech Processes), the entry is required if the Processed column is set to Yes. If the Processed column is set to No, the information can not be entered.

• If the histotech process is defined with a replicate value (Maintenance - Anatomic Path - > Histotech Processes), the value displays and is eligible for edit until the entry is filed.

THICK (3-AN-O)
Specify a thickness as part of the histotech process definition. The following prompt displays:

Enter thickness--

The default entry for the column is one. Enter from 1 to 3 alphanumeric characters. No value is required in this column to accept the screen.

The options available for this column depend on the setting in the Maintenance - Anatomic Path - > Histotech Processes processor, as follows:

• If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path - > Histotech Processes), the entry is of thickness is available regardless of the setting in the Processed column but is not required.

• If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path - > Histotech Processes), the entry is eligible for entry but is not required if the Processed column is set to Yes. If the Processed column is set to 'No', the information can not be entered.

• If the histotech process is defined with a thickness value (Maintenance - Anatomic Path - > Histotech Processes) the value will display and is eligible for edit.

SLDS/BLK (3-N-O)
Enter the number of slides per block that should be associated with the selected histotech process. This value is used in the determination of the slide workload and the number of labels that print for the Histotech Process. The following prompt displays:

Enter number of slides per block [1]--

The default is one. Enter from 1 to 3 numeric values.

The options available for this column depend on the setting in the Maintenance - Anatomic Path - > Histotech Processes processor, as follows:

- If the histotech process is defined to be required at Add time (Maintenance - Anatomic Path - > Histotech Processes), the entry is required regardless of the setting in the Processed column.

- If the histotech process is defined to be required at Process time (Maintenance - Anatomic Path - > Histotech Processes), the entry is required if the Processed column is set to Yes. If the Processed column is set to No, the information can not be entered.

- If the histotech process is defined with a slide per block value (Maintenance - Anatomic Path - > Histotech Processes), the value displays and is eligible for edit until the entry is filed.

When you complete all necessary fields, use the F7 key to exit the screen. The following prompt displays:

Accept this screen? (Y/N) [Y]--

To return to the screen, enter **N**. To accept the screen and exit, enter **Y**.

If you selected to process a histotech process or reprint labels for a histotech process that was previously processed, and no alternate printers are defined, the labels print. If you have alternate histotech process label printers defined, a printer is required to accept the screen and the following prompt displays:

Print labels on [default printer description] (Port #xxx)? (Y/N) [Y]--

To initiate printing from the default printer, enter **Y**. Enter **N** to display a list of the alternate printers. If you period (.) ENTER out of the printer table display, you are returned to the scrolling screen. Once a printer is selected, the following message displays:

Printing!

If you have accepted the scrolling screen and no histotech processes have been defined to be processed and/or no reprint labels are requested, the following message:

Filed!

Impact

The system captures workload and miscellaneous charges for any histotech processes that are defined as processed through the Add option. The amount of workload and miscellaneous charges that are filed depend on the definitions in the Histotech Processes Maintenance Function processor and the values entered through the Add function.

When the screen is accepted, the service date and time is networked to STAR Patient Care (and ultimately to STAR Patient Accounting) along with the charge or credit.

BATCH ENTRY

The Histotech processor supports batch entry of histotech processes on multiple blocks. A date of service can be assigned to miscellaneous charges.

NOTE: During Histotech/Cytotech processing, outpatient charge documentation via ABN processing and/or Duplicate/Conflict HCPCS processing can be captured for the outpatient Medicare population to comply with various CMS billing requirements. See the *CMS Compliance Checking* section of this document for further information.

The following assumptions apply to this function:

- If you define multiple blocks in the block field, the histotech processes defined are attached to all the blocks.

- After you accept the batch order screen, all deletes are done on individual blocks.

- Blocks are grouped by specimen type/modifier (with the default number scheme).

- This function is designed to work with the single add function for those histotech processes unique to an individual block.

- Histotech processes selected through this function must have the following information predefined and/or not require input at the time of order or process:

  - Number of replicates

  - Thickness

  - Number of slides

At the Histotech Processing Block Index screen, enter **B**. The following Batch Entry screen displays. This screen uses scrolling screen processing to allow you to batch enter information related to histotech processes.

NOTE: If multiple tests exist on the case, a screen displays for you to select the test for which new blocks are to be added (as with the single Add option).

```
              General Hospital Histology Histo/Cytotech Processing Processor
Accn #: 5282                                  Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room     Physician     Srv ICD Status
A000000010 TESTWHITE,ONE   F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 968
Case#: S95-426                      Batch Entry
                     GROSS AND MICROSCOPIC - TISSUE
1 Labels     2 Date of Service        3 Default Printer
    Yes          08/22/95                 301-3 Printer Area (Port #246)


4 Blocks    Specimens          Modifier         HT Processes      Process
    2        Liver              left









              Enter histotech code or `-` for table--
     F1Prev Page F2Next Page F3 Insert   F4 Delete  F6 Reset  F7  Exit
```

Field Explanations

1. LABELS (1-A-R)
This field determines whether labels print for all the processes entered through the batch processor. The following prompt displays:

Print Labels? (Y/N) [Y]--

2. DATE OF SERVICE (DATE FORMAT-R)
The field is used to enter the date of service that needs to be attached to the miscellaneous charges associated with the histotech processes to be processed. The following prompt displays:

Enter date of service [mm/dd/yy]--

The Default date in the Date of Service prompt is the Collection Date for the case as seen in the following screen. The Date of Service is entered manually, files when the batch is processed, and is applied to all histotech processes in the batch.

```
          General Hospital  Histology Histo/Cytotech Processing Processor
Accn #: 3647                                    Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000002289 TEST,MICRO      F  04/24/1984  LD-01  KING,KIMDONOT PSY 10  OB 540
Case#: S02-1262                       Batch Entry
                       GROSS AND MICROSCOPIC - TISSUE

 1 Labels   2 Date of Service      3 Default Printer
   Yes      ->                       EPL@WINDWARD 4TH FL (Port #244)

 4 Blocks  Specimens             Modifier               HT Processes Process




Enter date of service [04/01/02]--
```

If your facility has implemented service time processing, this field is called Date/Time of Service and is used to enter the date/time of service that needs to be attached to the miscellaneous charges associated with the histotech processes to be processed. If your facility has implemented service time processing, this field is displayed as D/T of Serv.

The function of this field is to enter a date and time of service or display the date and time of service associated with the histotech process. The date of service is attached to the miscellaneous charges associated with the histotech process. When you access the field, the following prompt is displayed:

Enter date/time of service [mm/dd/yy xxxx]--

The default for the prompt is the collection date/time for the case. A future date is not allowed. If the date/time entered is a future date/time, the system displays the following message:

Error: Date/time of service can not be in the future!

After a date/time is entered and filed, it cannot be edited. If you try to edit a filed date/time, the system displays the following message:

Field cannot be edited!

3. DEFAULT PRINTER (TABLE LOOKUP-R)
The default printer displays in this field. You have the option to select alternate printers (if defined) from a table display. When you enter this field, the system displays the following prompt:

Enter option number of alternate printer [default printer]--

4. BLOCKS/SPECIMENS/MODIFIER/HT PROCESSES/PROCESSED
This column uses scrolling screen processing.

Scrolling Screen

The columns in this scrolling screen are used to batch enter information related to histotech processes.

The following function keys are used for the scrolling screen:

F1Prev Page F2Next Page F3 Insert F4 Delete F6 Reset F7 Exit

For information on scrolling screen processing, refer to Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*. For information on the specific HT function keys, see "Histotech Processing Scrolling Screen Edit Functions" on page 3-123.

BLOCKS (2-N-R)
This column uses scrolling screen processing. The field contains the number of blocks that need to be defined for a specific specimen. The following prompt displays:

Enter number of blocks--

The numbering convention follows that in the individual Add processor.

SPECIMEN (3-NC-R)
This column contains the specimen. A code or table selection is available. Only one specimen can be selected from the table. The following prompt displays:

Enter specimen type or `-` for table--

MODIFIER (25-AN-O)
A free text modifier can be entered in this column. The following prompt displays:

Enter specimen modifier--

HT PROCESSES (TABLE LOOKUP-R)
This column contains the histotech processes to be associated with each block defined for this episode. An unlimited number of processes are allowed per block. The only histotech processes that display are those that meet the criteria of no input required at order or at process time for the following information:

- Number of replicates

- Thickness

- Number of slides

This is a required column. The following prompt displays:

Enter histotech code or `-` for table--

Enter a single histotech process code or enter a dash for a table display of histotech processes in alphabetical order by description. For a partial lookup, enter the first few characters of the histotech process description.

The number of histotech processes that can be attached to a block is unlimited. The number of histotech processes that can be selected from the table at one time is depends on the length of the histotech process codes. The more characters, the fewer selections you can make.

Once the table selection process is complete, the status, Defined, displays in the field.

PROCESS (1-A-R)
This column contains the status of the processes. A Yes in this field means the histotech processes are being processed at the time they are ordered. A No in this field means the histotech processes are ordered, but not processed at the time of order.

The system displays the following prompts. The flow of the prompts depends on the answer entered for the first prompt for this field:

Process histotech processes now? (Y/N)--

If all the above information has been defined in the histotech builder, you can accept the entire batch of processes by pressing the F7 key to exit the scrolling screen. The following prompt displays:

Accept this screen? (Y/N) [Y]--

If you accept the screen and histotech processes are defined to be processed, the following message displays:

Blocks/Processes filed - labels printing!

If you accept the screen, and histotech processes are defined not to be processed, the following message displays:

Blocks/Processes filed!

The labels print in order of the options listed in the scrolling screen.

The system returns to the screen from which you selected the Batch option. The system updates that screen with the information accepted in the Batch Entry screen.

If you exit the screen without accepting it, you are returned to the screen from which the Batch option was selected for the patient.

BATCH PROCESS

The Batch Process option enables you to batch process histotech processes
previously attached to multiple blocks. The blocks eligible for batch processing must
meet the following criteria:

- Histotech processes that have are defined to have number of replicates, thickness,
  and/or slides per block information entered at process time must already be
  processed.

- Histotech processes that have the number of replicates, thickness, and/or slides
  per block information entered at add time or as defined numeric values from the
  Maintenance processor.

NOTE: During Histotech/Cytotech processing, outpatient charge documentation via
ABN processing and/or Duplicate/Conflict HCPCS processing can be
captured for the outpatient Medicare population to comply with various CMS
billing requirements. See the *CMS Compliance Checking* section of this
document for further information.

At the prompt on the Histotech Processing Block Index screen, enter **P**. The Batch
Processing screen displays for the selection of the blocks eligible for batch processing.

```
          General Hospital Histology Histo/Cytotech Processing Processor
Accn #: 5282                                    Thu Jan 15, 2009 09:04 am
Unit #     Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000000010 TESTWHITE,ONE   F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 961
  Case Number: S95-426
                           Batch Processing

 1 Labels         2 Date of Service       3 Default Printer
   Process                                  301-3 Printer Area (Port #246)
 4 Blocks


Page:01    Blocks available for batch processing        ##=Current Choices
 1) S95-426-A1   Liver-left lobe                 GROSS AND MICROSCOPIC
 2) S95-426-A2   Liver-left lobe
 3) S95-426-A3   Liver-left lobe
 4) S95-426-A4   Liver-left lobe
 5) S95-426-A5   Liver-left lobe
 6) S95-426-B1   Liver-right lobe
 7) S95-426-B2   Liver-right lobe
 8) S95-426-B3   Liver-right lobe
 9) S95-426-B4   Liver-right lobe

Enter choices (e.g. 1,7,5-9), all(A) or '-'choices to remove--
                        end selection(NL)
```

NOTE: Blocks that have been completely processed display in dim video in the table.
Blocks containing processes that have not been completed display in bright
video.

Field Explanations

1. LABELS/WKLD (1-A-R)
This field is used to select which histotech process labels print when the blocks are
batch processed. The workload for the blocks can also be determined on those
processes that are being reprocessed. The following prompt displays:

Print HT process labels(P), reprint labels(R), all(A) or none(N) [P]--

Options available include:

P   Process   The system prints HT process labels for all HT processes that have
                 not previously been processed. This is the default.

R   Reprint   The system prints HT processes labels for all HT processes that
                 were previously processed.

A   All   The system prints HT processes for all HT processes included in the
                 batch process.

N   None   No HT labels are printed.

2. DATE OF SERVICE (DATE FORMAT-R)
This field is used to enter the date of service for the miscellaneous charges associated
with the histotech processes to be processed. The following prompt displays:

Enter date of service [mm/dd/yy]--

The default date in the Date of Service prompt is the Collection Date for the case as
seen in the following screen. The Date of Service is entered manually, files when the
batch is processed, and is applied to all histotech processes in the batch.

```
         General Hospital   Histology Histo/Cytotech Processing Processor
Accn #: 3647                                  Thu Jan 15, 2009 09:04 am
Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000002289 TEST,MICRO      F  04/24/1984 LD-01   KING,KIMDONOT PSY 10  OB 540
Case Number: S02-1262
                          Batch Processing

 1 Labels/Wkld   2 Date of Service  3 Default Printer
   Process       ->                 EPL@WINDWARD 4TH FL (Port #244)

 4 Blocks







Enter date of service [04/01/02]--
```

The histotech processes that reflect this date and post miscellaneous charges are those processes that have not been previously processed.

NOTE: Upon accepting the screen, the DOS does not change for those HT processes that have previously been processed through the Add Block screen or the Histotech Process screen. Batch Processing does not generate additional miscellaneous charges for previously processed HT processes.

If your facility has implemented service time processing, this field is called Date/Time of Service and is used to enter the date/time of service that needs to be attached to the miscellaneous charges associated with the histotech processes to be processed. If your facility has implemented service time processing, this field is displayed as D/T of Serv.

The function of this field is to enter a date and time of service or display the date and time of service associated with the histotech process. The date of service is attached to the miscellaneous charges associated with the histotech process. When you access the field, the following prompt is displayed:

    Enter date/time of service [mm/dd/yy xxxx]--

The default for the prompt is the collection date/time for the case. A future date is not allowed. If the date/time entered is a future date/time, the system displays the following message:

    Error: Date/time of service can not be in the future!

After a date/time is entered and filed, it cannot be edited. If you try to edit a filed date/time, the system displays the following message:

    Field cannot be edited!

3. DEFAULT PRINTER (TABLE LOOKUP-R)
This field displays the default histotech process label printer. You have the option to select an alternate printer, if defined, with a table lookup.

4. BLOCKS (TABLE LOOKUP-R)
This field is used to select multiple blocks to be processed. Entering this field displays a table of blocks eligible for batch processing. The information displayed for each block includes the following:

- Option number for selection

- Block number consisting of case number with block indicator

- Specimen/Specimen Modifier descriptions for the block

- Test name to which the blocks have been attached

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Only blocks eligible for batch processing display for the case. You can select one block or multiple blocks. To deselect an option, enter a dash (-) in front of the option number.

To be selected, all HT processes attached to the block must currently have all information related to number of replicates, thickness and number of slides per block previously defined. Thickness is optional. This definition could have occurred through previous processing, at add time or as predefined entries in the Maintenance Function Histotech Processes builder.

Once you have completed all the fields on the batch processing screen, the following message displays:

Accept this screen? (Y/N) [Y]--

To make edits to the selected field, enter **N**. Enter **Y** to display the following message:

Batch processing complete!

If **R** or **A** was entered in the Labels/Wkld field, you are prompted for additional information about the workload to be captured for HT processes that have previously been processed with the following prompt prior to the message that batch processing is completed:

Reprocessing capture standard wkld(W), Repeat(R) wkld or No(N) wkld? [N]--

When the screen is accepted, all workload associated with the batch processing occurs. Workload is automatically captured for HT processes being processed for the first time through Batch Processing (those HT processes that have block and/or slide workload defined).

NOTE: Reactivation occurs once the screen is accepted with Histotech processes that were previously deleted. Reactivated Histotech processes that were executed before being filed as deleted generate a new miscellaneous charge with the same Date of Service as previously defined. The Date of Service is the Collection Date. If the Histotech process that was reactivated had not been processed, no miscellaneous charges were posted until the Histotech process is executed.

No matter how the histotech process was attached to a block, if the histotech process is deleted the associated charge is credited. The credit date is the Date of Service or Collection Date

VIEW

The View option enables you to look at blocks and associated histotech processes. All histotech processing information for the selected case displays.

At the prompt on the Histotech Processing Block Index screen, enter **V** to view the blocks and attached HT processes for the selected case. The Histotech Processing View screen displays.

NOTE: If the case has more than one test with histotech processes defined, regardless of the test selected, all blocks for all tests on the case display.

```
                General Hospital Histotech Processing Processor
 Accn #: 1886                               Thu Jan 15, 2009 09:04 am
 Unit #      Name          Sex Birthdate  Room    Physician     Srv ICD Status
 A000000010 TESTWHITE,ONE   F  02/18/1967 2103-02 DOCTOR,ATTEND MED 10  I/P 964
 Case Number:  S95-426                                     Blocks: 5
 Test/Block         Specimen/Specimen Modifier/Process       Processed
 Gross and Microscopic
 S95-426-A1         Liver-left lobe
                      BLOCK W/2 H&E -  @1                          Yes
                      Additional H & E -  @1                       Yes
                      Calcium -  @4                                Yes
                      Cell Block -  @4                             Yes
                      Crystal Violet -  @4                         Yes
                      Cytology Direct Smear -  @P                  No
                      Darkfield Exam -  @3                         No
                      Decalcification -  @4                        Yes
 S95-426-A2         Liver-left lobe
                    BLOCK W/2 H&E -  @1                            Yes
 S95-426-A3         Liver-left lobe
                    3A) BLOCK W/2 H&E -  @1                        Yes


              F1 Prev Page  F2 Next Page  F7 Exit
```

The screen is a display-only scrolling screen. The header line of the scrolling screen includes: Test/Block, Specimen/Specimen Modifier/Process and Processed.

The first line of the data is the test code description. The test code displays before the first block that is defined for the test.

The next line of data in the scrolling screen includes the block number (case number and block indicator) and the specimen with a specimen modifier (if defined).

The next lines of data included are the histotech processes with slides/block, thickness indicator, (if defined), and number of replicates. If the value is greater than one, the information related to slides/block and replicates displays a value.

The last column of data for the line indicates that the histotech process has been processed. If the HT process has been processed, Yes displays in the processed column. If the HT process has not been processed, No displays in the processed column.

The F1 and F2 function keys are used to page back and forward through the block/HT information. F7 is used to exit the screen.

Histotech Labels

Histotech labels can be produced as base labels or as bar code labels. Examples of how to produce each type of labels are presented.

BASE LABELS

The following histotech labels represent those produced on a Data General TP2 dot matrix printer. The label stock should measure at least 7/8 inch x 1 3/16 inch (the same as collection and accession label stock).

The fields printed are:

First Line: Histotech Number (case and block ID)
The histotech number includes the case number character, case number and block ID for the test and is cross-referenced to the accession number. The format of the case number is:

- First character of case number pool code

- Two-digit year

- A hyphen (-)

- Sequence number

For example:

S94-100 = Anatomic Path sequence number, year 1994,

number 100

C94-189 = Cytology sequence number, year 1994,

number 189

Second Line: Label Identifier (patient unit #, number pool number or specimen type)

Third Line: Patient's Name

Fourth Line: Collection Date/Time

Fifth Line: Process Name/Label Text Thickness Slide Designator

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```
                    S94-3-A2
                    001042811=Pat
                    JOHNSON,THOMAS H
                    08/23/94 1543
                    Cyto st @1 1/4
```

```
                    S94-3-A2
                    001042811=Pat
                    JOHNSON,THOMAS H
                    08/23/94 1543
                    Cyto st @1 2/4
```

```
                    S94-3-A2
                    001042811=Pat
                    JOHNSON,THOMAS H
                    08/23/94 1543
                    Cyto st @1 3/4
```

BAR CODE LABELS

If you choose to use bar code labels for your histotech labels, several features are
available including:

- The option to label the second of two identical processes ordered on the same
  block as a RECUT or any other designation.

- The option to print the slide designator on the histotech slides. The slide
  designator indicates the number of slides out of the defined total number of slides
  for a given process (for example, 1/3, 2/3 or 3/3).

- The option to print the process name on the histotech slides. The process name
  is the label text defined for a given process (for example, H & E Stain or Cyto Smr).

These features are defined per process through the Histotech Process table and the
Histotech Processes/Test processor. They can be defined differently for the same
histotech process. The parameters defined in the Histotech Process/Test processor
controls what prints on the label(s) which are generated at the time of accessioning.
The parameters defined in the histotech process controls what prints on the label(s)
generated from the Histotech Processor. See Chapter 1: Worksheet Instructions for
detailed information on bar coding.

When label(s) for histotech processes are reprinted, the label(s) generated are a copy of the label(s) that were originally printed. For example, the label(s) that print at accessioning can be defined to print the histotech process name and no slide designator, and the label(s) that print when the process is selected in the Histotech Processor can be defined to print neither the process name nor the slide designator. If you then ask for a reprint of a process that was originally generated at the time of accession, the label prints only the process name.

The following histotech labels represent those produced on a bar code printer. They are called bar code since they are printed on a bar code printer and require a bar code format. The label format is completely user definable. You have several options at this prompt. Refer to Bar Code Functions in Chapter 1: Functional Overview in the *General Information Volume* of the *STAR Laboratory Reference Guide*. The label stock should measure at least 7/8 inch x 1 3/16 inch (the same as collection and accession label stock).

The fields printed are:

First Line: Histotech Number (case and block ID)
The histotech number includes the case number character, case number and block ID for the test and is cross-referenced to the accession number. The format of the case number is:

- First character of case number pool code

- Two-digit year

- A hyphen (-)

- Sequence number

For example:

S94-100 = Anatomic Path sequence number, year 1994,

number 100

C94-189 = Cytology sequence number, year 1994,

number 189

Second Line: Slide Designator

Third Line: Process Name/Label Text

Fourth Line: Recut Designator

Fifth Line: Hospital ID

Sixth Line: Hospital Location

```
                              S94-3-A2
                              1/3
                              Cyto st
                              RECUT2
                              GENHOSP
                              City,USA
```

```
                              S94-3-A2
                              2/3
                              Cyto st
                              RECUT2
                              GENHOSP
                              City,USA
```

```
                              S94-3-A2
                              3/3
                              Cyto st
                              RECUT2
                              GENHOSP
                              City,USA
```

HISTOTECH PROCESSING REPORT AND AUDIT

The Histotech Processing Report and Audit lists all histotech processes that have not been processed and allows you to track any actions taken against a histotec/cytotech process. It serves as a worklist. This processor is usually located on the Anatomic Pathology section menu.

```
                      General Hospital Pathology Processor
                                            Thu Aug 19, 2004 12:54 pm
Pathology Input Options


             Option No.  Option
             ---------------------------------------
                 1       Patient Inquiry
                 2       Order Entry
                 3       Case Login
                 4       Anatomic Path Order Management
                 5       Histo/Cytotech Processing
                 6       Histo/Cytotech Processing Report & Audit
                 7       Recall Management
                 8       Anatomic Path Result Reporting
                 9       Review Queue Reporting
                10       History Cardfile - Network
                11       Miscellaneous Charge/Credit
                12       Professional Billing Input
                13       Cytology QA
                14       Long Reports Batch
                15       Incomplete Work Report
                16       Histo/Cyto Process Audit & Rpt
Enter option number--
```

Select the Histo/Cyto Process Audit and Rpt processor. The following Pathology Input Options screen displays.

```
                      General Hospital Pathology Processor
                                            Fri Aug 06, 1993 10:15 am
Pathology Input Options




             Option No.  Option
             ---------------------------------------
                       1. Histo/Cytotech Processing Report
                       2. Histo/Cytotech Processing Audit









Enter option number--

```

Histo/Cytotech Processing Report

If you enter **1** at the prompt on the Pathology Input Options screen, the following screen displays.

```
      General Hospital Anatomic Pathology Histotech Processing Report Processor
                                             Fri Aug 06, 1993 10:15 am
                     Histotech Process Report (Wide)

 1 Sort by                      2 Default Printer
->                                3rd floor (Port #19)













 Sort by Accession number(A), Patient Account Number(N) or Process(P) [P]   |
```

Field Explanations

1. SORT BY (1-A-R)
To sort the report by accession number, enter **A**. Enter **N** to sort by patient account number or **P** to sort by histotech process. The default is to sort by process.

2. DEFAULT PRINTER
This field displays the default printer for this report. You may access this field by entering **/2** (slash 2) and selecting from the display of alternate printers. The screen displays a list of alternate printers available for this report. Select a printer or press ENTER for the default.

NOTE: This is a wide report and should only be printed on 132 column paper.

Upon completion of all required fields, the following prompt displays:

Accept this screen?(Y/N) [Y]--

Accept the screen by entering **Y** or pressing ENTER. Enter **N** to edit.

Output

The Histotech Processing Report prints according to the selected sort method and at the printer designated. The example of the Histotech Processing Report shows the report sorted by individual histotech processes. The heading of the report includes the

department name, sort option, date/time printed and the page number. The fields on the report are the same for all sort options. They only differ in the order in which they appear on each report. The following describes each field:

PROCESS
This is the Histotech Process description stored in the histotech process table.

ACCN #
This is the accession number.

ACCOUNT #
This is the patient's account number.

PATIENT'S NAME
This is the patient's name.

TEST
This is the name of the test for which the process is defined.

SPECIMEN
This is the specimen type defined for the process.

Block
This is the Case-Block to which the process belongs.

REPLICATE
The far right column of the report is the number of replicates to be performed for this process.

The message *End of Report* prints in the center of the line at the end of the report.

Figure 3.7 Community Lab Histotech Processing Report (ALHRLHR0)

```
                                Community Lab - Histo/Cytotech Processing Audit
                                           Printed: 04/10/02 1709
Sort: Name                            Start: 03/11/02 1709 End: 04/10/02 1708
Patient Name                        Acct          Histotech#    Accn    Accn D/T         Test Code
Process          Act   Action D/T   Process Tech        Specimen      Specimen Modifier  Date of Service

COMPLIANCE,HCFA                     A0115200008  S02-1279-A1   2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
AFB          PROC  04/08/02 1233  HBOC EMPLOYEE      Tissue                            04/08/02

COMPLIANCE,HCFA                     A0115200008  S02-1279-A1   2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
TRI          PROC  04/08/02 1233  HBOC EMPLOYEE      Tissue                            04/08/02

COMPLIANCE,HCFA                     A0115200008  S02-1279-A1   2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
CRY          PROC  04/08/02 1233  HBOC EMPLOYEE      Tissue                            04/08/02


                                              End of Report
```

Histo/Cytotech Processing Audit

If you enter **2** on the Pathology Input Options screen, the following screen displays.

```
        General Hospital Histo/Cytotech Processing Audit Processor
                                      Wed Oct 21, 1992 01:03 pm

    1 Start Date                2 End Date            3 Sort
      07/09/97 1535               07/11/97 1535          Name

    4 Hardcopy              5 Default Printer
      Yes                      LDM-800 PRINTER IN CLOS






 Accept this screen? (Y/N) [Y]--
```

Field Explanations

1. START DATE (DATE-R)
This field is based on accession date. The field will default to the appropriate date as defined for report retention. To change the date, the following prompt displays:

   Enter start date--

Indicate the date the system should begin the search for Histo/Cytotech processes. For more information on date entry in this field, refer to the date/time entry techniques describe in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

2. END DATE (DATE-R)
This field is based on accession date. The default date, the current date, displays automatically. To change the date, the following prompt displays:

   Enter end date--

Indicate the date the system should stop searching for Histo/Cytotech processes. For more information on date entry in this field, refer to the date/time entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

If the date you enter is not greater than the date in the Start Date field, the system displays the following error message:

   End Date BEFORE Start Date!

3. SORT (6-A-R)

This field allows you to define how the report should display or print. When you access this field, the following prompt displays:

> *Sort (D)ate, (H)isto#, (I)Proc Tech, Proc (C)ode, Patient (N)ame,*
> *Patien(T) Acct, or (S)ingle patient ? [N]--*

The default is patient name. For all options except (S), each patient's information in the audit will display or print.

The following describes each sort in detail:

D - Date

If this option is chosen the user will see the following prompt:

> *Sort by (P)rocessing date or (A)ccession date? [P]--*

The default is processing date. The field displays *Processing Date* for a processing date sort and *Accession Date* for an accession date sort.

(H) Histotech Number

The report sorts in chronological order based on case numbers. The field displays *Histo#* for a case number sort.

(I) Processing Technologist

The report sorts in ACSII sequence based on the ID codes of the processing technologists. The field displays *Process Tech* for a processing tech sort.

(C) Process Code

The report sorts in ASCII sequence based on the histotech process codes. The field displays *Process Code* for a histotech process sort.

(N) Patient Name

The report sorts in alphabetical order based on patient last name. The field displays *Name* for a patient name sort or if the default option is chosen.

(T) Patient Account

The report sorts in ASCII sequence based on patient account numbers. The field displays *Patient Acct* for a patient account sort.

(S) Single Patient

If this option is chosen the user will see the following prompt:

> *Enter `&`unit #,`*`account #,accession # or `[`case #--*
> *patient name (Last,First M), `-`SS# or `=` for current*

Only one account number can be chosen. Once the patient is accessed, the report will sort with only the selected patient's audit information. The field will display *Single Patient* for a single patient sort. This is the only option to limit the size of the report.

NOTE: If the start date is greater than the processing date or if no processing date exists for the selected patient the system will display "*No entries defined*!"

4. HARDCOPY (1-A-R)
This field enables you to indicate whether you want a hard copy. Enter **Y** or **N**. The default is No. Also, the default option does not automatically display.

5. DEFAULT PRINTER (TABLE LOOKUP - O)
This field displays the description of the printer set up during system installation. The most common printer is for the wide reports.

The printer location can be changed by selecting this field's option number. The field automatically displays the default printer. The screen then displays alternate printers defined for wide reports. Select another printer from the displayed choices. If the parameters are acceptable, initiate the search by entering **Y** at the following prompt.

Accept this screen? (Y/N) [Y]--

To edit parameters or exit this processor, enter **N**.

Output

If you enter **N** in the Hardcopy field, the system displays the following screen with all histo/cytotech processes falling within the chosen parameters:

```
              General Hospital Histo/Cytotech Processing  Audit  Processor
                                             Mon Jun 12, 1995 08:25 am
                      Histo/Cytotech Processing Audit
Name/Acct        Case#     Date      HP Code      Act    Act D/T      P/T
 JONES,JOHN A    S95-1574 06/10/95   H & E x5    CANC 06/11/95 1000   S838
WHITE,THOMAS M S95-1546 06/10/95   GIEMSA      EDIT 06/12/95 0718   RT250










                  F1Prev Page   F2Next Page   F7Exit

```

This screen uses scrolling screen processing for display only.

Screen Description

Headings used in the report display:

- Name/Acct - the information displayed will be the patient's name or account number. The account number will display only if the report was sorted by account (T).

- Case # - the case number will display. The cases will display in chronological order if the report was sorted by case number (C).

- Date - the date displayed is the processing date or the accession date. The processing date will always display unless the report is sorted by accession date (A).

- HP Code - the Histo/Cytotech process code will display.

- Act - displays the action taken on the block or histo/cytotech process. Actions will be

  - Proc - processed

  - Proc-Bt - processed via batch processing

  - Del-P - deleted process

  - Del-B - deleted block

  - Add-P - added on process

  - Add-B - added on block

  - Add-E - added on via batch entry

  - Edit-P - edited process

  - Edit-B - edited block

- Act D/T - the date/time the action was taken will display.

- P/T - the ID code of the Processing Tech performing the action will display.

Pressing F7 to exit takes you back to the Histo/Cytotech Audit Processor.

If you entered **Y** in the Hardcopy field, the system prints the report on the designated printer with all histo/cytotech processes falling within the chosen parameters. An example of the printed report follows.

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Figure 3.8 Histo/Cytotech Audit Report (ALGWLGR0)

```
                        Community Lab - Histo/Cytotech Processing Audit
                                     Printed: 04/10/02 1709
Sort: Name                       Start: 03/11/02 1709 End: 04/10/02 1708
Patient Name                         Acct          Histotech#   Accn    Accn D/T           Test Code
Process          Act   Action D/T    Process Tech        Specimen      Specimen Modifier  Date of Service

COMPLIANCE,HCFA                      A0115200008  S02-1279-A1  2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
AFB              PROC  04/08/02 1233  HBOC EMPLOYEE       Tissue                          04/08/02

COMPLIANCE,HCFA                      A0115200008  S02-1279-A1  2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
TRI              PROC  04/08/02 1233  HBOC EMPLOYEE       Tissue                          04/08/02

COMPLIANCE,HCFA                      A0115200008  S02-1279-A1  2948   04/08/02 1222      5050 GROSS AND MICROSCOPIC - TISSUE
CRY              PROC  04/08/02 1233  HBOC EMPLOYEE       Tissue                          04/08/02



                                          End of Report
```

Figure 3.9 Histo/Cytotech Audit Report (ALGWLGR0) (service time processing)

```
                        Laboratory - Histo/Cytotech Processing Audit
                                     Printed: 08/14/07 1545
                           Start: 07/15/07 0000 End:08/14/07 0000
Sort: Name                                                                         Page 1

Patient Name                         Acct          Histotech#   Accn    Accn D/T          Test Code
Process          Act   Action D/T    Process Tech        Specimen      Specimen Modifier  Date/Time of Service

LORENTZ,ROLLAND                      A0635400001  S07-1503-A3  1167   08/01/07 0918      5050 GROSS AND MICROSCOPIC - TISSUE
AFB              ADD-B 08/14/07 1545  HRVV EMPLOYEE       Tissue                          07/29/07 0800

                                          End Of Report
```

Report Layout

Header Information

LINE 1
The name of the department that generated the report

LINE 2
The date and time the report was printed.

LINE 3
The user-defined start date/time and end date/time for the report.

LINE 4
The user-defined sort for the report and the page number.

Body of Report

PATIENT NAME
The name of each patient found in the audit meeting the user's criteria prints.

ACCT
The account number of each patient in the audit meeting the user's criteria prints.

HISTOTECH#
The histotech number for each patient in the audit meeting the user's criteria prints. The histotech number consists of the case number and block indicator.

ACCN
The accession number for each patient in the audit meeting the user's criteria prints.

ACCN D/T
The accession date for each patient in the audit meeting the user's criteria prints.

TEST CODE
The test code and test description for each patient in the audit meeting the user's criteria prints.

PROCESS
Each histotech process description for each patient in the audit meeting the user's criteria prints.

ACT
Each action taken against a histotech process for each patient in the audit meeting the user's criteria prints.

ACTION D/T
The action date and time for each patient in the audit meeting the user's criteria prints.

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PROCESS TECH
The name of the processing tech for each histotech process for each patient in the audit meeting the user's criteria prints. Items are filed in ASCII sequence by ID code.

SPECIMEN
The specimen type for each patient in the audit meeting the user's criteria prints.

SPECIMEN MODIFIER
Any specimen modifier attached to any specimen for each patient in the audit meeting the user's criteria prints.

DATE/TIME OF SERVICE
The date and time of service for each patient in the audit.

If the report is greater than one page, the appropriate page breaks must be included with the following displaying at the end of the page:

(Continued)

The comment *End of Report* will print when all items meeting the user's criteria have printed on the report.

NOTE: If the start date is greater than the processing date or if no processing date exists for the selected patient the system will print "*No entries defined*!"

RESULT REPORTING

Two paths are available for accessing Result Entry processors within Anatomic Pathology. The first path involves the Anatomic Pathology Bay where the test is selected prior to accessing the patient. Patients are accessed using standard patient look-up routines. This path is identical to other STAR Laboratory Result Entry routines.

The second path involves the Anatomic Path Result Reporting processor where direct access to the Result Entry processors occurs. The test selection step is bypassed. The Anatomic Path Result Reporting processor is usually located on the Anatomic Pathology section menu.

```
                       General Hospital Pathology Processor
                                           Thu Aug 19, 2004 02:31 pm
   Pathology Input Options


            Option No.  Option
            --------------------------------------
               1        Patient Inquiry
               2        Order Entry
               3        Case Login
               4        Anatomic Path Order Management
               5        Histo/Cytotech Processing
               6        Histo/Cytotech Processing Report & Audit
               7        Recall Management
               8        Anatomic Path Result Reporting
               9        Review Queue Reporting
              10        History Cardfile - Network
              11        Miscellaneous Charge/Credit
              12        Professional Billing Input
              13        Cytology QA
              14        Long Reports Batch
              15        Incomplete Work Report
              16        Histo/Cyto Process Audit & Rpt
   Enter option number--
```

Cytology QC Results

You can use Anatomic Pathology Result Reporting (APRR) to capture Cytology Workload/QC information. The system enables you to enter Workload/QC information while resulting a test through the Result Entry process.

When you enter the Anatomic Path Result Reporting function, the following prompt displays:

> *Enter accession #, '[' case #, '*' account # or '&' unit #--*
> *patient name (Last,First M), `-`SS# or `=` for current*

Identify the patient, using one of the Patient Look-Up routines described under Accessing Patient Information in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

If more than one Anatomic Path test is associated with the case number you enter, the system lists the tests for selection. If the test you select is in either the Repeat Queue

or the Discrepancy Queue, the following message displays and the system returns you to the initial transaction for result reporting:

Test in quality control check process!

The system performs the following checks to determine whether the case is eligible for Cytology Workload/QC capture:

- Cytology Workload/QC must be activated.

- The CNP (Case Number Pool) Workload/QC indicator must be set to *Yes*.

If the case is eligible for Cytology Workload/QC, the system performs two additional checks to determine whether to prompt for screener ID:

- It determines whether the user is defined as a cytology screener (active or inactive) in the Cytology Personnel maintenance processor. If the user is defined as a screener, the Result Reporting processor displays.

- If the user is not defined as a cytology screener, the system checks the Workload/QC Prompt field in the Workload/QC Parameters maintenance processor. If the field is Yes, non-cytology personnel are prompted for QC and workload information when entering patient results. If the field is No, non-cytology personnel cannot enter QC and workload information when entering patient results.

If the case meets the necessary conditions to prompt for screener ID, the following screen displays. Two additional fields display for Anatomic Path tests, compared to General Lab tests. The *Case #* displays on the left on the screen and *Blocks* displays on the right. Both fields appear on the fifth line under the patient demographics. Display of the specimen type is controlled by the test.

```
        General Hospital Anatomic Pathology Result Reporting Processor
AC#:4038                      CYTOLOGY SMEAR, GYN     Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician     Srv ICD Status
A000000027 BROWN,CINDY         F  02/18/1970 2104-02 GARDNER,JANE   ERS 10  I/P 694
Case#: C95-425                                                      Blocks: 1
                                      Specimen: PAP Smear









    Enter screener code or '-' for table [444]--
```

If the entry of a screener ID is not indicated, the system displays the standard Result Reporting screen.

If entry of workload/QC is indicated, the system displays the following prompt:

Enter screener code or '-' for table [signed-on user's code] --

If you are defined in the Cytology Personnel maintenance processor as an active screener, the prompt includes your code as the default. If you enter an invalid code, the following message displays:

Invalid code!

If you enter a valid screener code or press ENTER to accept the default, the system displays the Result Reporting screen.

If you enter a hyphen (**-**) at the prompt, a table of eligible screeners displays. These screeners are defined in the Cytology Personnel maintenance processor.

```
         General Hospital Anatomic Pathology Result Reporting Processor
AC#:4038                     CYTOLOGY SMEAR, GYN     Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room    Physician     Srv ICD Status
A000000027 BROWN,CINDY        F  02/18/1970 2104-02 GARDNER,JANE  ERS 10  I/P 694
Case#: C95-425                                                    Blocks: 1
                                        Specimen: PAP Smear

           Screener                      Max Sld Count     QC N/A      Page:01
( 1) Brown,Charlie [197]                      40
( 2) Curtins,John [C322]                      80
( 3) Custer,Mary [444]                        90
( 4) Davis,Ann [C311]                         80
( 5) Dunne,Harry [C111]                       50.5
( 6) Edwards,Dave [B222]                      12
( 7) Everly,Jane [C555]                       999
( 8) Gordon,Gwen [B444]                       43.5
( 9) Hurley,Mike [A123]                       40
(10) Mason,Pam [B555]                         60.0          X
(11) Moonan,Margaret [B333]                   12
(12) Stewart,Steve [180]                      50            X


Enter choice--
                          next page(/)
```

The system continues to prompt for a valid entry. You must enter a valid screener before you can access the Result Reporting screen.

```
         General Hospital Anatomic Pathology Result Reporting Processor
AC#:4038                    CYTOLOGY SMEAR, GYN      Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician      Srv ICD Status
A000000027 BROWN,CINDY       F  02/18/1970 2104-02 GARDNER,JANE   ERS 10  I/P 694
Case#: C95-425                                                    Blocks: 1
                                  Specimen: PAP Smear

( 1)*Clinical Data ?
( 2) Specimen Adeq :
( 3)*Explanation   :
( 4) Diagnosis     :
( 5)*Categorizatio :
( 6)*Hormonal Eval :
( 7) Maturation In :
( 8) Recommendatio :
( 9) Estrogen Regi :
(10)*SNOMED Code 1 :
(11)#Review Queue  :
(12) Reviewed by   :
```

You can enter the test results on the Result Reporting screen. The system displays the following prompt as the main prompt for entering results:

> *Enter number to edit, fill(F), print(P), or accept(A) --*
> **=options, draft(D), fax(X), Queue(Q)*

These options depend on the flag settings for the section and test. If you select *, a list of / (slash) options display. You do not need to enter **/** before the alpha characters when you select from this list. If you select these options on the main prompt, you must include the /.

Once you accept the results, the system determines what additional workload/QC information is required for this case. If you press period (.) ENTER at the prompt, the system returns you to the Result Reporting patient identifier prompt.

WORKLOAD/QC PROCESSING

The system performs the following checks before prompting for Workload/QC capture:

- The CNP Workload/QC indicator must be set to *Yes*.

- A valid screener ID was entered prior to result entry.

- No workload can exist on this case for the screener through result reporting.

If multiple tests on the same case are resulted by the same screener, the screener is prompted the first time only through result reporting to enter workload/QC information on the case.

If all criteria is met, the system checks whether the workload maximum for the screener has been met or exceeded. It performs an 8-hour workload check only if the flag in the Workload/QC Parameters maintenance processor is set to *Yes* and only for the first 8 hours of the screener's current 24-hour window. If the 8-hour workload limit has been reached, the following prompt displays:

> *[Screener name] has screened the maximum number of slides for the 8-hour check! Continue? (Y/N) [N]--*

If you enter **N** or period (.) ENTER you are returned to the patient ID prompt in result reporting. No results are recorded and workload/QC information is not captured.

If you enter **Y**, the system continues with the display of the Workload/QC screen. The case is flagged as having exceeded the screener's maximum workload on the Management Reports.

If the flag for the 8-hour workload check in the Workload/QC Parameters maintenance processor is set to No, or if the screener is beyond the first 8 hours in the current 24-hour window, the system checks to determine whether the maximum for 24 hours has been reached. The following prompt displays if the screener has reached or exceeded the maximum workload for the 24-hour period:

> *[Screener name] has screened the maximum number of slides for the 24-hour period! Continue? (Y/N) [N]--*

If you enter **N** or period (.) ENTER, you are returned to the patient ID prompt in result reporting. No results are recorded and no workload/QC information is captured.

If you enter **Y**, the system makes the next check in the Workload flow processing. The test is sent to the Repeat Queue when all information is entered. The system stores an indicator showing that the case was resulted by a screener who had exceeded the 24-hour maximum slide count.

Use the Workload/QC entry screen for entering workload/QC information after you enter results on the Result Reporting screen. Workload and QC information is stored at the case level and at the screener level. Fields on the following screen may contain previously entered data, based on prior result reporting or activity on the case and/or the screener.

```
        General Hospital Histology Surg Path Result Reporting Processor
AC#:4038                    CYTOLOGY SMEAR, GYN    Thu Jan 15, 2009 09:04 am
Unit #     Name             Sex Birthdate  Room    Physician      Srv ICD Status
A000000027 BROWN,CINDY       F  02/18/1970 2104-02 GARDNER,JANE   ERS 10  I/P 694
Case#: C95-425                                                    Blocks: 1
                                    Specimen: PAP Smear

 1 Screener ID
   Custer,Mary [444]

   Current 24-Hour Window
 2 Slide Count    3 Maximum Count    4 Total Time       5 Most Recent Workload
   20.0                90.0            03:43              06/12/95 1517

   Current Case Information
 6 # of Slides  7 Exempt Slides  8 Slide Count  9 High Risk  10 Diag Category
->               N/A

   Additional Information
11 24-Hour Start Time      12 Other Slide Count    13 Other Duties
   06/12/95 1200                 0.0                      0

Enter number of slides [2]--
```

Field Explanations

1. SCREENER ID (DISPLAY ONLY)
This field contains the name and ID code of the selected screener.

Current 24-Hour Window

This section of the screen displays information about the screener's current 24-hour window. The information is reset each 24 hours and gives an accurate picture of the screener's workload status with regard to the defined limits.

2. SLIDE COUNT (DISPLAY ONLY)
This field contains the total slide count for the current 24-hour window for the screener. It represents the sum of all slide counts filed by the system for this screener for the amount of time from the 24-Hour Start Time (Field 11) to the current system time. The first time a screener enters data to begin a new 24-hour window, *0.0* displays in this field.

3. MAXIMUM COUNT (DISPLAY ONLY)
This field contains the maximum number of slide counts allowed by the screener in a given 24-hour time frame. This value is defined in the Cytology Personnel maintenance processor.

4. TOTAL TIME (DISPLAY ONLY)
This field contains the total time consumed within the screener's current 24-hour window. Two different times are included:

- The first value is the total time spent screening slides during the screener's current 24-hour window.

- The second value (in parenthesis) is the total time spent on other duties during the screener's current 24-hour window.

- The total of these two times (in military time) represents the number of hours between the 24-hour start time and the current system time.

The first time a screener enters data to begin a new 24-hour window, *00:00* displays in this field.

5. MOST RECENT WORKLOAD (DISPLAY ONLY)

This field contains the date and time of the most recent workload for the screener. This information indicates how long it has been since workload was captured by the system and helps determine whether additional information is entered in Field 13 (Other Duties). No data appears in this field the first time through in the current 24 hours.

Current Case Information

This section of the screen is used to enter workload and quality control information related to the current case.

6. # OF SLIDES (2-N-R)

This field contains the number of physical slides examined when determining the results for the case. You can define a default for this field in the Workload/Quality Control Parameters maintenance processor and enter up to two digits, using *1* to *99*. When you access this field, the system displays the following prompt:

Enter number of slides [user defined default]--

7. EXEMPT SLIDES (DISPLAY ONLY)

This field displays *NA* for this processor. If the screener examines slides with this case that should be exempt from the 24-hour maximum count, the slides can be added through the Update Workload Information processor.

8. SLIDE COUNT (4-NC-R)

This field contains the slide count for this case and this screener. This count is totalled and then checked against the individual's 24-hour maximum slide count. You can enter *0.5* to *99*. The only valid decimal value is in increments of *0.5*.

The entry of one or one-half counts depends on the method of slide preparation. Preparations that disperse cells on less than half the slide (cytospin prep) should count as *0.5* for each slide. If cells are dispensed over the entire slide (PAP smear), a count of *1.0* should be entered for each slide examined.

When you access this field, the system displays the following prompt:

Enter slide count for case workload [user defined default]--

You can define a default for this prompt in the Workload/Quality Control Parameters maintenance processor.

NOTE: If you try to enter data in this field without entering data in Field 6 (# of Slides), the system displays the following message and returns you to Field 6:

> *# of slides required!*

The system also checks that the number entered in Field 6 and the number in Field 8 are valid. The value entered in Field 8 must be less than or equal to the entry in Field 6. If you enter a value that does not meet this criteria, the system displays the following message:

> *Slide count cannot exceed number of slides!*

The # of Slides and the Slide Count fields must be greater than zero (0). If you enter a zero in either of these fields, the following message displays:

> *Zero slide count not allowed!*

9. HIGH RISK (1-A-R)
This field contains information designating the patient as high risk. The system displays the following prompt:

> *Is patient considered high risk? (Y/N) [user defined default]--*

If you enter **Y**, the system checks the flag in the Workload/Quality Control Parameters maintenance processor and determines whether the test should automatically go to the Repeat Queue. You can define the default. Once the initial entry is filed, this field is Display Only.

If the High Risk indicator is entered during Case Login, the setting automatically displays and the field is Display only.

NOTE: High Risk tracking occurs at the case level.

10. DIAG CATEGORY (TABLE LOOKUP-R)
This field contains the original diagnosis category for this case. The system checks the flag in the Workload/Quality Control Parameters maintenance processor to determine whether the test should be considered for random selection to the Repeat Queue for quality control of negative GYN cases. The following prompt displays at the initial entry:

> *Enter diagnosis code or '-' for table--*

If you enter a hyphen (**-**), a table of active diagnosis categories defined in the Diagnosis Categories maintenance processor displays. After the initial entry is filed, this field is Display Only. You must make updates through the Update Workload Information processor.

Additional Information

The information in this section of the screen is related to the screener rather than to the current case. You can use this section to enter data related to the starting time of your current 24-hour window. You can also enter information related to work performed in another laboratory, as well as the time spent performing duties other than screening of cytology cases.

11. 24-HOUR START TIME (DATE FORMAT-C)
This field contains the 24-hour start time for the screener. The time entered must be within 24 hours of the current system time. If you have worked in this 24-hour window at another laboratory, you should enter the time you started working at the other laboratory.

The system checks the 24-hour maximum slide count for each screener against the current 24-hour window. The maximum is calculated for work performed in a 24-hour period and is not specific to an individual location. The following prompt displays with a default of current system date and time when you access this field:

Enter date/time first case screened [current date/time]--

The system makes multiple checks on the data entered in this field. Various error messages display when an invalid date/time is entered.

- Date/time entered overlaps a previous 24-hour window:
  Date/time overlaps previous 24-hour window!

- Date/time entered exceeds 24 hours back from current system time:
  Date/time not in previous 24-hour window!

- Date/time entered is in the future:
  Date/time in future!

After the start time has been filed the first time for the screener in the current 24-hour window, this field is Display Only. You must make any updates through the Update Workload Information processor.

12. OTHER SLIDE COUNT (4-NC-O)
This field contains the slide count the screener has performed during the current 24-hour window at another location. You can enter digits with a decimal in increments of 0.5. The count entered here is added to the 24-hour maximum for the screener, but is not counted against department workload.

You must enter the 24-Hour Start Time field before this field can be accessed. Otherwise, the following message displays:

24-hour start time required!

When you access this field, the system displays the following prompt with a default of zero (0):

Enter total slide count from other location [0]--

After the initial entry is filed, this field is Display Only. Any updates to the information must be made through the Update Workload Information processor.

13. OTHER DUTIES (4-NC-O)
This field enables you to enter time during the current 24-hour window not spent screening slides. You must have data in the 24-Hour Start Time field (Field 11) before you can access this field. Otherwise, the following message displays and the cursor moves to Field 11:

24-hour start time required!

When you access this field, the system displays the following prompt with a default of zero (0):

Enter hours spent on other duties than screening (for example: 0.25, 1.5) [0]--

You can enter time in this field in increments of 0.25 hours (15-minute increments). When the system files the entry, the information in Field 4 (Total Time) is updated to reflect the addition. If the entry in this field is greater than the time defined in Field 4 (Total Time), the following message displays:

Cannot exceed total screening time!

NOTE: The amount of time you enter depends on the scenario:

(1) If this is the first workload capture for the current 24-hour window (Most Recent Workload field is blank), enter the amount of time spent on activities other than screening slides *since the 24-hour start time.*

(2) If this is the second or any subsequent workload capture for the current 24-hour window (a value displays in Most Recent Workload field), enter the amount of time spent on activities other than screening slides *since the most recent workload.*

When you complete the Workload/QC screen, the following prompt displays:

Accept this screen? (Y/N) [Y] --

If you press period (.) ENTER out of the Workload/QC screen at any time, the system returns you to the patient ID prompt in result reporting. The results you entered are not filed and workload/QC information is not captured.

FILING RESULTS

When you accept the Workload/QC screen, the system determines how and where the results should be filed. The system checks whether QC processing is required for the test and whether the test should automatically go to the Repeat Queue.

If you accept the results by any option other than Repeat Queue (RQ), the system performs the following checks to determine whether the test should be selected for quality control processing through the Repeat Queue:

- The test must be defined in the Repeat Queue Results maintenance processor.

- QC must be activated for the screener.

- High risk processing requirements must be met.

- QC % processing requirements must be met.

- The system must determine whether the screener has exceeded the maximum number of counts for the 8 hours or 24 hours.

NOTE: Using the RQ option to accept results always sends the test to the Repeat Queue. The system still checks to determine the status of the test when it enters the Repeat Queue. For more information refer to the "Repeat Queue Option Processing" on page 3-168.

Repeat Queue Results

A test can be processed through the Repeat Queue only if it has been defined in the Repeat Queue Results maintenance processor and has at least one component defined for discrepancy checking.

Screener QC Status

If the screener is not activated for QC, the system does not automatically send tests accepted by the individual to the Repeat Queue for processing. This criteria is defined in the Cytology Personnel maintenance processor. Only pathologists defined as technical supervisors should be exempt from the QC process.

High Risk Processing

The following criteria determines whether the test is sent to the Repeat Queue because of High Risk processing:

- The case must be defined as High Risk.

- The High Risk flag in the Workload/Quality Control maintenance processor must be set to send all High Risk cases to the Repeat Queue.

- The test must be in a status of less than QCC when the screener enters result reporting.

If the screener is activated for QC and the test meets the High Risk criteria, the test is sent to the Repeat Queue in a status of QCC. The system displays the following message:

Logged!

The following message also displays.

Test selected for QC! Must be processed through repeat queue! Press NL--

If the test does not meet all the High Risk criteria, the system checks whether the test meets the QC% processing criteria.

Automatic Quality Control (QC) Processing

The system selects random tests to be QC'd prior to the results being available for reporting if the Workload/Quality Control Parameter maintenance processor has the %QC flag set. The following criteria defines %QC processing:

- The test must be in a status of less than QCC.

- The Primary Specimen type must be defined in the GYN Specimen maintenance processor.

- The Diagnosis Category entered must be the same as the Negative Diagnosis Category defined in the Workload/Quality Control Parameters maintenance processor.

If the screener is activated for QC and the test meets the QC% processing criteria and is selected at random, the results are filed and the status of the test is QCC. The system displays the following message:

Logged!

The following message also displays:

Test selected for QC! Must be processed through repeat queue! Press NL--

Maximum Number of Slides Processing

If the test does not meet any of the previous criteria for QC processing, the system checks whether the maximum number of counts for the 8 hours or 24 hours has been exceeded. The following criteria defines Maximum Number of Slides screened:

- The screener has reached the maximum number of slides for the first 8 hours of screening.

- The screener has reached the maximum number of slides for the current 24-hour window.

If the screener is activated for QC, the results are filed in a Done or Partial status based on the result components entered. The system displays the following message:

Logged!

The following message also displays:

Test selected for QC! Screener max slide count exceeded! Press NL--

NOTE: If the screener is not activated for QC, the test is not sent to the Repeat Queue. An indicator displays on the Management Reports showing that the case was examined *after* the screener exceeded the maximum limit.

REPEAT QUEUE OPTION PROCESSING

You can accept results and manually send a test to the Repeat Queue for processing by selecting the Repeat Queue (RQ) option for any test that has the Case Number Pool Workload/QC indicator set to Yes. The system performs additional checking on the status of the test when the test goes to the Repeat Queue.

- The status of the test may not change if the test was in a Partial or Done status upon entry to result reporting. Results do not have to be entered or changed to move the test to the Repeat Queue with the RQ option.

- The status of the test will be QCC if the test was in Specimen Received status in result reporting and High Risk Patient processing occurs.

- The status of the test will be QCC if the test was in Specimen Received status in result reporting and Automatic QC processing occurs.

- The status of the test will be Partial or Done based on the components resulted, if results were entered and accepted in result reporting and High Risk or Automatic QC processing did not occur.

Once the Repeat Queue option has been selected, the Workload/QC information has been accepted, and the High Risk, Automatic QC process, and Maximum Number checks have been passed, the system displays the following messages:

Logged!
Test selected for QC! Now available in repeat queue!

Additional Cytology QC Results Processing

Results on tests not selected by the system for QC processing and not sent manually to the Repeat Queue using the RQ option are logged and available in Patient Inquiry and for patient reports. The system displays the following message:

Logged!

The system continues processing as follows for all tests updated to a Partial or Done status, whether the tests are sent to the Repeat Queue or not:

- The system prompts the user for History Cardfile entry or logs results to the Cardfile, as indicated by maintenance processor settings.

- It prompts for Professional Fee Billing, as indicated by maintenance processor settings.

- It sends the test to the Review Queue for processing, if indicated.

- It returns the user to Case Login, if indicated.

Word Processing Results

Result entry processors for Anatomic Pathology are identical to those within STAR Laboratory except for word processing for auto T-coding and SNOMED (diagnostic coding) results. These result types are discussed in this section. For further details on routine Result Entry processors, refer in the *General Applications Volume I* of the *STAR Laboratory Reference Guide*.

Certain result types involve a large amount of textual reporting and require word processing functionality for result entry.

If your workstation and ID are set up to enable Microsoft Word, then the Word Processing Interface is invoked. Refer to Chapter 4: Word Processing Interface in the *STAR Navigator User's Guide*.

If your hospital purchased McKesson's STAR Navigator and your workstation and ID are set up to enable its use with a Windows-based word processor, the STAR Navigator Windows-based Word Processing Interface is invoked. Refer to Chapter 4: Word Processing Interface in the *STAR Navigator User's Guide* for further details.

Otherwise, Softkey Editor is accessed. Refer to Chapter 10: Softkey Editor in the *General Information Volume* of the *STAR Laboratory Reference Guide* for detailed information.

Word processing results enable you to create textual results or edit standard result text, which are commonly used textual results specified during installation within the system files. To demonstrate word processing results, the Diagnosis field was

selected on the Result Reporting screen. For an example of this screen, see the
Result Reporting screen in the Cytology QC Results subsection.

```
                General Hospital Pathology Result Reporting Processor
AC#:1465          SUPT - ANATOMIC PATH GROSS/MICRO Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A001042621 JOHNS,ALLAN        M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Case#: S90-8                                                      Blocks: 2
Result: Diagnosis                     Specimen: Liver Biopsy








Enter Std Result Text code, first letters '-' for table -- -
                         Create new(N) document
```

To access standard result text, use one of the table entry techniques described in
Chapter 4: Information Entry Techniques in the *General Information Volume* of the
STAR Laboratory Reference Guide.

If a subgroup was assigned to this result component, the system displays only the
standard result text documents assigned to the subgroup upon entry of '-' for table
display. To create a new document and go directly into word processing, enter **N**.

In this example, a hyphen (**-**) was entered to select a standard result text.

```
            General Hospital Anatomic Pathology Result Reporting Processor
AC#: 1465              ANATOMIC PATH GROSS/MICRO  Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A001042621 JOHNS,ALLAN        M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Case#: S90-8                                                      Blocks: 2
Result:  Diagnosis                    Specimen: Liver Biopsy

Page:01                    Standard Result Text            #=Current Choices
( 1) NL    - Normal Liver
( 2) PRMIC - Prostate Microscopic Description
( 3) PROS  - Prostate Gross Description








Enter choices(e.g. 1,7,5-9) or '-' choices to remove --
                         end selection(NL)
```

The standard result text defined during system installation display for selection. Select standard result text options from the list. End selection by pressing ENTER.

```
          General Hospital Anatomic Pathology Result Reporting Processor
AC#: 1465              ANATOMIC PATH GROSS/MICRO   Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A001042621 JOHNS,ALLAN        M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Case#: S90-8                                                     Blocks: 2
Result:  Diagnosis                            Specimen: Liver Biopsy


        Selected Standard Result Text
        Code      Description
        NL        Normal Liver









Correct(Y/N), or edit text(E)? [Y] --
```

The screen displays the code and summary description. Verify your selection by entering **Y** to accept the Standard Result Text report as is. Enter **N** to select another standard result text. If multiple text are selected, they will be combined into one document for this result field. Enter **E** to edit the summary.

If you have a word processing interface, the system displays the following:

   Copying document!

If you are using the Softkey editor, the system displays *Compiling Standard Result Text Documents!* before displaying the following screen:

```
          General Hospital Anatomic Pathology Result Reporting Processor
AC#:1465          SUPT - ANATOMIC PATH GROSS/MICRO   Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A001042621 JOHNS,ALLAN        M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 1
Case#: S90-8                                                     Blocks: 2
Result:  Diagnosis                            Specimen: Liver Biopsy

  │The liver appears normal in color.  It measures   cm by   cm and      │
  │weighs     grams.                                                      │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
  │                                                                       │
 1In- 2Ln  3Ins 4Scn 5Scn  6Ins 7Ins 8Ctr 9Del 1Del   1Mrk 1Mrk 1Fmt 1Pat 1End
   Srt Fct  Doc  Fwd  Bck    Txt  Ln   Ln   Ln  0Wrd   1Ln  2Pge 3Scn 4Inq 5Edt
```

The summary then displays within Softkey Editor. At the top of the screen, the system displays the patient demographics, the result name, and the specimen type. The system displays the case number and blocks for Anatomic Pathology tests only. For detailed instructions on using Softkey Editor, refer to Chapter 10: Softkey Editor in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

WARNING: If you select an unfiled textual result field and no changes are made, the field is not filled and no textual result data is retained for that field.

For example, if you select one or more precanned text files for a textual result field, but make no changes to the text, the selected text fields are not retained for the result field.

In order for any changes to textual results to be retained, no matter which type of STAR word processing is used, you must make a change to the text.

WORD PROCESSING FOR AUTO T-CODING

For auto T-coding Anatomic Pathology tests, enter the defined character before and after the text that is checked for coding purposes (in the following example, @bone marrow@).

The text defined between the characters must match the specimen description defined in the specimen type table.

```
          General Hospital Anatomic Pathology Result Reporting Processor
AC#: 4759         ANATOMIC PATH TEST WP-HX CARDFILE Thu Jan 15, 2009 09:04 am
Unit #       Name            Sex Birthdate  Room    Physician     Srv ICD Status
A0000105428TESTWHITE,ROBERT M  12/23/1962          JOHNSON, JILL MED 10  DIS AMA
Case#: S92-126                                                      Blocks: 3
Result:  Gross Description           Specimen: TISSUE

    | Specimen consists of cylindrical tissue measuring  cm in total      |
    | length. ES                                                          |
    |                                                                     |
    |      Specimen consists of a cylindrical firm                        |
    |      @bone marrow@ biopsy -- x -- mm.  ES                           |
    |                                                                     |




 1Ins 2Ln  3Ins 4Scn 5Scn   6Ins 7Ins 8Ctr 9Del 1Del   1Mrk 1Mrk 1Fmt 1Pat 1End
  ert Fct  Doc  Fwd  Bck     Txt  Ln   Ln   Ln   0Wrd   1Ln  2Pge 3Scn 4Inq 5Edt
```

These characters do not display when you access word processing from any inquiry function (for example Patient Inquiry, History Cardfile, or Patient Care). The characters only display when you access the component through result reporting.

EDITING A WORD PROCESSING RESULT

If a word-processing result field is selected for editing, the screen displays the first ten lines of the result text. If more than ten lines of text exist for this result, Continued displays in blinking reverse video and the system prompts:

Enter Std Result Text code first letters '-' for table or edit (E) --
Create new(N) document or view(V)

Enter the first letters of standard result text code followed by a hyphen (**-**) to display a table of codes starting with those letters. Enter just the hyphen (**-**) to display the entire table.

NOTE: If the sum of the length of the codes you select is greater than 110, the system displays the following message and returns you to the table display:

Too many SRT's selected!

You can enter and edit a new summary code using Softkey Editor or you can create a new summary by entering **N**. With either method, the system overwrites the original text with the new entry.

Enter **E** to display the existing text to be edited through the Softkey Editor processor. Enter **V** to view a single word processing component or all resulted word processing components.

NOTE: If you select an unfilled textual result field and no changes are made, the field is not filled and no textual result data is retained for that field. For example, if you select one or more precanned text files for a textual result field, but make no changes to the text, the selected text fields are not retained for the result field. In order for any changes to textual results to be retained, no matter which type of STAR word processing is used, you must make a change to the text.

INTERPRETIVE REPORTING USING WORD PROCESSING ON COMPONENT

When a test has a component that is designated as using interpretive reporting word processing and has interpretive reporting parameters set up, that component displays *Interp* in the field when you access the test in result reporting.

```
              General Hospital SEROTONIN URINE QUANT (5HIAA) Processor
AC#:1523          SEROTONIN URINE QUANT (5HIAA)       Thu Jan 15, 2009 09:04 am
Unit #       Name              Sex Birthdate  Room     Physician     Srv ICD Status
A0000900685JOHNSON,DEB J   F  06/06/1966 2104-1  BAAB,GARY H   MED 10  I/P 51


                                    Specimen: 24 Hr Urine

( 1) Serotonin[5HI :15
( 2)*Comment       :
( 3)^Comment Inter :
( 4) Interpretatio :Interp






Enter number to edit, accept(A), print(P), fill(F)--
                    * = options, replicate(R), repeat(RR)
```

When you access the component defined as having interpretive word processing, the
system evaluates all results entered up to this point to find a match to the resulting
criteria defined in the Interpretive Parameters processor. The system finds the first
matching criteria and displays the appropriate standard result text.

If you access a component that is used in the interpretive reporting parameters and the
result changes, the system displays tildes (~~) for the interpretive component. When
you access the interpretive component, the system displays the new standard result
text based on the updated criteria information.

If a field is designated as an interpretive component and the component does not meet
the criteria to automatically display a standard result text, the system displays the
following message:

> *Enter Std Result Text code, first letters`-` for list --*
>   *`N` to create document*

From this prompt you can access all Standard Result Text documents for your
laboratory department.

If the component meets the interpretive criteria to result in a standard result text
document to fill in the interpretive component, the following screen displays for
information purposes.

```
              General Hospital SEROTONIN URINE QUANT (5HIAA) Process
AC#:1523          SEROTONIN URINE QUANT (5HIAA)     Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room      Physician      Srv ICD Status
A0000900685JOHNSON,DEB J    F  06/06/1966 2104-1  BAAB,GARY H    MED 10  I/P 51


Result:  Interpretation                   Specimen: 24 Hr Urine

    A result of greater than 50 mg of 5-hydroxy indole acetic acid ( 5-HIAA)
    in 24 hours is indicative of carcinoid syndrome.  Phenothiazine drugs
    interfere with this analysis and can cause false positive reactions.
    Patients who take reserpine or use guiacolate-containing cough medicine
    excrete moderate amounts of 5-HIAA, and massive ingestion of bananas,
    pineapples, avocados, mushrooms or walnuts causes mild excess urinary
    excretion.






     F1=Prev Pg  F2=Next Pg  F3=Edit  ~ to clear  F7=Exit
```

This is a view only screen. Interpretive results are typically viewed without the need for editing. Use the F1 key to display the previous page of information and the F3 key to go into the edit mode. Edit text using either the Softkey editor or a PC-based word processing package. Enter a tilde (~) to clear the result. Press F7 to exit the result field. For more information on the Softkey editor, refer to Chapter 10: Softkey Editor in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

The Interpretatio(n) field on the following screen now contains the standard result text *(04/30 1035 SER*)*:

```
              General Hospital SEROTONIN URINE QUANT (5HIAA) Processor
AC#: 1523              SEROTONIN URINE QUANT (5HIAA) Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room      Physician      Srv ICD Status
A0000900685JOHNSON,DEB J    F  06/06/1966 2104-1  BAAB,GARY H    MED 10  I/P 51


                              Specimen: 24 Hr Urine

( 1) Serotonin[5HI : 15
( 2)*Comment       :
( 3)^Comment Inter :
( 4) Interpretatio : 04/30 1035  SER*








Enter number to edit, accept(A), print(P), fill(F)--
                   * = options, replicate(R), repeat(RR)
```

NOTE: If a resulting criterion has been linked to standard result text that has been deleted in the Standard Result Text maintenance processor, the system displays the following message prior to accessing word processing when the resulting criterion is activated:

> *Std Result Text code not on file!*

Example of Result Criteria for Interpretive Reporting a CK Interpretive Component

This example describes how you might set up result criteria for triggering an interpretive report on a CK test. The following table contains criteria for reporting a standard result text in the CK Interpretive component field.

In this example, the following components have criteria defined that can trigger a standard result text to fill in the CK Interpretive component field:

- CK(U/L)

- CK-MB(U/L)

- CK-MB(%).

There are five possible standard result text documents that would be reported in the CK Interpretive component field following the evaluation of the result criteria for the three results:

- CK Normal 45-235

- CK Abnormal >235

- CK-MB High >10

- CK-MB Borderline (5-10)

- CK-MB Normal (0-4).

You would build the criteria outlined in the following table in an hierarchical order in the Interpretive Reporting Parameters maintenance processor. If the firstoption is true - if CK(U/L) is greater than 235 - then the CK Abnormal >235 standard result text document displays when you access the CK Interpretive component field. The evaluation of criteria takes place when you access the component with the interpretive word processing special processing.

If the first option is not true, STAR Laboratory evaluates the next option in the table. The system evaluates these options sequentially until a true value is found. If all options are evaluated and none of them are true, then when you access the CK Interpretive component, the system invokes word processing.

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Example of Result Criteria for Interpretive Reporting a CK Interpretive Component

Option Number	Component	Result Criteria	Standard Result Text Document
1	CK (U/L)	>235	CK Abnormal >235
2	CK-MB (U/L)	>10	CK-MB High >10
3	CK-MB (U/L)	=5	CK-MB Borderline (5-10)
4	CK-MB (U/L)	=6	CK-MB Borderline (5-10)
5	CK-MB (U/L)	=7	CK-MB Borderline (5-10)
6	CK-MB (U/L)	=8	CK-MB Borderline (5-10)
7	CK-MB (U/L)	=9	CK-MB Borderline (5-10)
8	CK-MB (U/L)	=10	CK-MB Borderline (5-10)
9	CK-MB (%)	<4	CK-MB Normal (0-4)
10	CK-MB (%)	<10	CK-MB Borderline (5-10)
11	CK-MB (%)	>10	CK-MB High >10
12	CK (U/L)	>44	CK Normal 45-235

The following table displays how each of the options could be invoked. For the first option to be invoked, the CK must be over 235 and the other two results could be any result or no result at all. If the CK is under 235, then any of the remaining 11 options could be invoked depending upon how the CK-MB(U/L) and/or CK-MB(%) are resulted.

Example of Results to Trigger the Standard Result Text in the CK Interpretive Component Field

Option Number Invoked	CK (UL)	Results For: CK-MB (U/L)	CK-MB (%)	CK Interpretation
1	>235	Any Result	Any Result	CK Abnormal
2	<235	>10	Any Result	K-MB High
3	<235	5	Any Result	CK-MB Borderline
4	<235	6	Any Result	CK-MB Borderline
5	<235	7	Any Result	CK-MB Borderline
6	<235	8	Any Result	CK-MB Borderline
7	<235	9	Any Result	CK-MB Borderline
8	<235	10	Any Result	CK-MB Borderline
9	<235	0-4	0-4	CK-MB Normal
10	<235	0-4	5-10	CK-MB Borderline
11	<235	0-4	>10	CK-MB High (>10)
12	45-235	0-4	0-4	CK Normal 45-235

Whenever a result for one of the trigger components, such as (CK (U/L), CK-MB(U/L) or CK-MB(%) are changed or added after you access the interpretive component, a tilde (~) displays for the interpretive component and you must re-access the field to evaluate the new information. For example, if only the CK was entered as 300, and you then accessed the CK Interpretation component, the CK Abnormal >235 document would display in the CK Interpretation field. If you then entered the CK-MB(U/L) as **20**, the CK Interpretation field would display a tilde. When you access the CK Interpretation field, the system would evaluate the criteria (CK=300, CK-MB(U/L)=20), and then fill in the CK Abnormal >235 document. Note that even though the standard result document that was selected had been in the field previously, the system must evaluate the new information in case there is a change in the interpretation.

SPECIAL CONSIDERATIONS

Panic Processing

When a trigger component for interpretive reporting has a panic value and you answer yes to reject all results, the components with the interpretive word processing special processing attached displays two tildes (~~) rather than ~~Panic Reject. This is true of all word processing, date/time, and SNOMED components. Upon re-entry to the Result Reporting processor, the interpretive component displays interp in the field.

Cleared Results

When you clear a trigger component for interpretive reporting using two tildes (~~), the system also clears the result component that had interpretive processing attached. This component displays two tildes rather than the previous standard result text information. Upon re-entry to the Result Reporting processor, the interpretive component displays interp in the field.

Delta Check Processing

When you clear a trigger component for interpretive reporting by answering yes to delete failed delta check results, the system also clears the result component that had interpretive processing attached. This component displays two tildes (~~) rather than the previous standard result text information. Upon re-entry to the Result Reporting processor, the interpretive component displays interp in the field.

Faxing Long Report

When the long report is faxed from Patient Inquiry or Result Reporting, you must use the default form for Print/Print set up for each section. When the fax is initiated, the default section for the ordered test is the one used to access the appropriate header form.

SNOMED II Code Result Reporting

NOTE: When using SNOMED II Code Result Reporting, the SNOMED CT parameter is set to *No* and is not active.

When a SNOMED code result field is selected, the screen displays the name of that result field in reverse video at the top left. Up to 50 diagnoses can be entered per result. The descriptions associated with these diagnoses can be up to 240 characters.

If the test level flag is set to show the specimen/modifier in result reporting, the system continues to display the Primary specimen/modifier on the result entry screen. If you did not login the test before entering this processor, the system displays the following prompt when you select the test for resulting:

Login now? [Y]--

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Accn#XXXX not logged in for test XXXX - GROSS & MICROSCOPIC

The following screen flow represents resulting a SNOMED code component without auto T-coding being activated.

```
              General Hospital Pathology Result Reporting Processor
AC#: 1465                    GROSS/MICRO         Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
A001042621 JOHNS,ALLAN       M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Result:  Dx. Coding                                            Blocks: 2















Enter group code or `-` for table --
                                `NL` to skip
```

The first requirement is category selection. To select from the table, use one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*. Press ENTER to skip this result component.

```
              General Hospital Pathology Result Reporting Processor
AC#: 1465                    GROSS/MICRO         Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
A001042621 JOHNS,ALLAN       M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Result:  Dx. Coding                                            Blocks: 2
Group: GENERAL
Page:01                            T CODES (1)
( 1) T-61300  Adenoid, NOS
( 2) T-53001  Anterior tongue
( 3) T-69000  Anus, NOS
( 4) T-69000      M-26000 Aberrant tissue, NOS
( 5) T-69000      M-41740 Abscess, NOS
( 6) T-69000      M-93100 Adamantinoma, NOS
( 7) T-69000      M-81403 Adenocarcinoma, NOS
( 8) T-66000  Appendix, NOS
( 9) T-66000      M-46400 Appendicitis,obstructive
(10) T-X9840  Auerbach's plexus
(11) T-53130  Base of tongue
(12) P-1140   Biopsy, NOS
(13) P-1140       M-46300 Appendicitis w/ perforation

Enter choice--
                                next page(/)
```

The category selected determines which set of T-codes displays for selection. If the flag for auto-display of the T-code table is set to YES, the table displays automatically. Otherwise, you must use one of the table entry techniques described in Chapter 4:

Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide* to display the table and/or select a T-code.

M-codes assigned to T-codes display in dim video beneath the master T-code. The M-codes are listed in alphabetical order indented from the corresponding T-code. See the preceding screen. Select the T-code or a T/M code combination from this list.

If a T-code is selected, the following prompt displays for entry of the M-code:

> *Enter `M` code, first letters `-` or `-` for table --*

Enter the M-code using one of the table entry techniques described in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide*.

If a non-existent T or M-code is entered, the following prompt displays:

> *T-CODE T-##### not found! Add? (Y/N)--*

Enter **Y** to add a new code. See Chapter 2: Maintenance Functions, for detailed instructions on adding a new code. Enter **N** to select another code.

Additional selects are allowed. The maximum number of SNOMED prompts is 50. The following prompt displays:

> *Enter group code or `-` for table [GENERAL] --*
> *`/E` to end selection*

The general category originally selected is the default and displays within brackets ([]).
Enter a general category code using table selection. Or, enter **/E** to end SNOMED
code selection.

```
                    General Hospital Pathology Result Reporting Processor
AC#: 1465                                 GROSS/MICRO  Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room    Physician     Srv ICD Status
A001042621 JOHNS,ALLAN        M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 4
Result:  Dx. Coding                                             Blocks: 2
Descriptions                                          Codes:
1) Liver, NOS - Aberrant tissue, NOS                  T-56000,M-26000
2) Liver, NOS - Aberrant tissue, NOS                  T-69000,M-26000*







Enter option to edit, opt`C`, opt`D`, add(A), delete(D), accept (Y/N)? [Y] --
```

Once the desired number of SNOMED codes are entered, the final edit screen displays
the descriptions and codes selected. At the following prompt you can edit a selection,
add another selection, delete a SNOMED code, accept the entries or modify the code
or description of a selection.

The asterisk (*) after the T/M-codes indicates that a miscellaneous code is also
present. All codes can be displayed with the opt `C` selection.

- Enter **A** to add another code.

- Enter **D** to delete a selection.

- Enter **Y** to accept the entry and return to the result entry screen.

- To edit a SNOMED entry, enter the option number. The following prompt
  displays:

    Modify code(C) or description(D) [D] ? --

    Enter **C** to edit the code. Enter **D** or press ENTER to edit the description.

Enter an option number immediately followed by **C** to edit a code. The following
prompt displays:

    *Enter **N**EW code -- T-69000,M-41740*

Enter the new code. Use the arrow keys to move back and forth within the codes displayed in the prompt. Separate each T, M and miscellaneous code with a comma (,).

Enter the option number immediately followed by **D** to edit a description. The following prompt displays:

> *Enter NEW description -- Anus, NOS - Abscess, NOS*

Enter the new description up to 240 characters. Use the left and right arrow keys to move back and forth within the codes displayed in the prompt. Use the up arrow key to insert characters and the down arrow keys to delete characters. When the description includes more characters than can display on one line, the system displays "..." at the end of the field. The entire description can be viewed if selected for edit.

NOTE: Edits to the code and/or descriptions within this screen only affects the current patient record. The existing SNOMED table is not altered as a result of this process. You must update the SNOMED table with the new code for future use if appropriate.

SNOMED CODE AUTO T-CODE RESULTS

The following screen flow represents a system that has activated auto T-coding for component option 9 and no auto T-coding for component option 10.

```
          General Hospital Anatomic Pathology Result Reporting Processor
AC#:4759      ANATOMIC PATH TEST WP-HX CARDFILE    Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room     Physician    Srv ICD Status
N0000105428TESTDOE,JANE     F  11/25/1974 2204-2  SMITH, SUE    MED 10  IPI 141
Case#: S92-126                                                  Blocks: 2
                                   Specimen: BREAST


( 1)*Operative Pro :
( 2) Date of Opera :
( 3)*Clinical Hist :
( 4) Gross Descrip :
( 5) Grossed by    :
( 6) Microscopic D :
( 7)#Read by       :
( 8) Diagnosis     :
( 9) SNOMED CODE   :
(10)*SNOMED Cont'  :
(11)*Comment       :
(12)#Reviewed by   :
(13)^Review Queue  :
(14) Released By    :

Enter number to edit, accept(A), print(P), fill(F)--
                    * = options, replicate(R), repeat(RR)
```

Entering a SNOMED Code result type component with auto T-coding defined accesses the following screen, which displays all the specimens found to be auto T-coded by the system. This screen displays in the same format regardless of the method chosen to select the specimen types (order entry, histotech or result entry).

The processing of automatically assigned specimens requires a new method of filing information. The maximum number of T/M code combinations per result component is 50.

NOTE: When you edit previous results, and the results are filing (or being used in a display or report), the following message displays:

Results for this accession being utilized! Please wait!

This message displays as many as five times. If data can not be accessed, the display returns to the prompt (to enter accession for resulting).

Auto T-Coding Index Screen

The test level flag for this test is set to prompt for the specimens to be used for auto T-coding.

```
                 General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO   Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room     Physician    Srv ICD Status
A0000105428TEST DOE,JANE    F  11/25/1974 2204-2  SMITH, SUE    MED 10  IP1 141
Result:  SNOMED CODE                                           Blocks: 2
                             Specimen: Breast

                     Specimens Eligible for SNOMED CODING

 ( 1) Breast
 ( 2) Bone Marrow




Select specimen, add(A), delete(D), auto T-Code(T) [T]--
```

On the initial auto T-coding index screen, the specimen type displayed reflects the specimen that was entered at login, histotech processing, or result reporting (based on the test level flag). Once a specimen is selected for T-coding, the following screens reflect that specimen (currently being T-coded).

If the component level flag is set to initiate auto T-coding automatically, the previous screen does not display. The system automatically initiates the T-coding process with the first defined specimen.

If you select an individual specimen for T-coding, the process follows the same flow as auto T-coding, but returns to the auto T-code index screen once the SNOMED coding is complete for the selected specimen.

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Auto T-Coding

Auto T-Code (T) is the default for the previous prompt. This selection allows processing automatically from one specimen to the next without you having to select the next specimen. Depending on the setup of the T-codes and groups, the number of key strokes is greatly reduced.

Adding A Specimen

Adding a specimen (A) allows you to enter a specimen code or select a specimen(s) from the specimen table.

The following prompts display for adding specimens:

Enter specimen type or '-' for possible specimens--

If a specimen code is entered that has not been assigned to a T-code, the following message displays:

No T-Codes associated with selected specimen!

If you enter a hyphen (**-**), a table display contains the following prompt:

Enter option(s) to be added--
                    end selection(NL)

The table displays only specimens that have been attached to T-codes. After you make selections, the following prompt displays:

Accept? (Y/N)--

If you accept (**Y**) the screen, the specimen or specimens are added.

Deleting A Specimen

Deleting (**D**) a specimen or specimens allows you to delete specimens that have been automatically assigned for this component. Once the specimen(s) have been deleted, the screen displays the updated list of specimens.

The following prompts display for this option (and operate as do the same prompts used for Adding A Specimen):

Enter option(s) to be deleted--
                        end selection(NL)

Accept? (Y/N)--

Edit *Specimen

The second time you enter the auto T-coding index screen, the prompt changes to make it easier for you to make edits.

*Select specimen, add(A), delete(D), auto T-coding(T), edit *specimen(N) [T]--*

You have the option to select another individual specimen for auto T-coding. An asterisk (*) preceding the specimen indicates the coding for the specimen has already taken place. The specimen marked by an asterisk cannot be selected for auto T-coding or deleting.

Edits to specimens marked with an asterisk are performed by selecting the **N** option. This option displays the final edit screen on which you can make any necessary changes. Do not select the **N** option until you are ready to move to the Final Edit screen. Selecting **N** allows you to edit all specimens that have been T-Coded.

Multiple T-Codes

If an automatically-assigned specimen is associated with multiple T codes, a screen such as the following example displays:

```
                 General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO   Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room     Physician     Srv ICD Status
A0000105428TEST DOE,JANE    F  11/25/1974 2204-2   SMITH, SUE    MED 10  IP1 141
Result: *SNOMED CODE                                            Blocks: 2
                                     Specimen: Breast

                                     T-Codes
( 1) T-04000  Breast  (9)
( 2) T-04010  Female Breast, NOS  (10)
( 3) T-04100  Nipple  (3)




 Enter option or new group(G) [Next Specimen]--

```

The specimens are followed by a number in parentheses indicating the default group for the T-code.

NOTE: If there is only one group associated with the specimen, the previous screen does not display; the next screen displays the T-codes and T/M code combinations associated with the selected group.

Selecting a new group (G) accesses the screen which displays different groups for selection. If you press period (.) ENTER for the default (Next Specimen), a screen displays with the next specimen to be T-coded, if auto T-coding has been invoked. If individual specimens have been selected, the default returns the display to the auto T-coding index screen to select the next specimen.

If this screen displays the last specimen to be auto T-coded, the default is to access the Final Edit screen. The following prompt displays:

Enter option or new group(G) [Final Edit Screen]-

```
                  General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO    Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room    Physician     Srv ICD Status
A0000105428TEST DOE,JANE    F  11/25/1974 2204-2  SMITH, SUE    MED 10  IP1 141
Result: *SNOMED CODE
                                       Specimen: Breast

Page:01                               T-Codes (1)
( 1) T-04000  Breast
( 2) T-04000      M-41740 Abscess
( 3) T-04000      M-22300 Accessory, supernumerary struc
( 4) T-04000      M-81403 Adenocarcinoma
( 5) T-04000      M-74220 Adenosis, sclerosing
( 6) T-04000      M-85002 Carcinoma, intraductal, non-infil, NOS
( 7) T-04000      M-55400 Calcification
( 8) T-04000      M-82003 Carcinoma, adenoid cystic
( 9) T-04000      M-85003 Carcinoma, infiltrating duct
(10) T-04000      M-85303 Carcinoma, inflammatory
(11) T-04000      M-85202 Carcinoma, lobular, in situ
(12) T-04000      M-85103 Carcinoma, medullary
(13) T-04000      M-84803 Carcinoma, mucinous

Enter option, search(S), `/E` end selection [New Group]--
                              next page(/)
```

The T-codes and T/M combinations displayed are defined for the default group. Selection from the default group is available as well as new search criteria.

The number in parentheses next to T-codes represents a counter to identify which T/M combination is being selected. The number increments by one each time a T/M combination is completed.

If a T-code is selected without an M-code, the following prompt displays:

Enter M-code, first letters `-` or `-` for table--

Pressing period (.) ENTER for the default [New Group] allows you to select a different group of T-Codes to select.

For both the M-codes and the T-codes, you have access to alternate names only when you use the Search option. If you enter **S** at the previous prompt to select the Search option, the system displays the following screen:

```
                    General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO     Thu Jan 15, 2009 09:04 am
Unit #      Name               Sex Birthdate  Room     Physician     Srv ICD Status
A0000105428TEST DOE,JANE        F  11/25/1974 2204-2  SMITH, SUE     MED 10  IP1 141
Result: *SNOMED CODE
                                          Specimen: Breast
















 Enter T-code first letters '-' or '-' table--
```

The T-code or the first letters of the T-code description can be entered at this prompt.
If the first letters of the T-code fdlowed by a hyphen (-) are entered, the system checks
the primary name and any alternate names defined for the T-codes. A table display of
all T-codes allows you to select the appropriate T-code.

If alternate names have been defined, an asterisk (*) displays preceding the alternate
named entry.

```
                    General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO     Thu Jan 15, 2009 09:04 am
Unit #      Name               Sex Birthdate  Room     Physician     Srv ICD Status
A0000105428TEST DOE,JANE        F  11/25/1974 2204-2  SMITH, SUE     MED 10  IP1 141
Result: *SNOMED CODE                                              Blocks: 1
                                          Specimen: Breast

Page:01                    T-Codes (* denotes alternate names)
( 1)  T-Y4100  Abdomen, NOS
( 2)  T-Y4300  Abdominal wall, NOS
( 3)  T-Y9160  Above knee region
( 4)  T-11390  Acetabulum, NOS
( 5)  T-X8500  Acoustic nerve, NOS
( 6)  T-61300  Adenoid, NOS
( 7)  T-93100  Adrenal cortex, NOS
( 8)  T-93020  Adrenal gland, left
( 9)  T-93000  Adrenal gland, NOS
(10)  T-93010  Adrenal gland, right
(11)  T-93200  Adrenal medulla
(12) *T-88300  Amnion
(13)  T-8Y310  Amniotic cytologic material

Enter choice--
                                    next page(/)
```

After you select the T-code, the following screen displays:

```
              General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO   Thu Jan 15, 2009 09:04 am
Unit #       Name             Sex Birthdate  Room     Physician      Srv ICD Status
A0000105428TEST DOE,JANE       F  11/25/1974 2204-2   SMITH, SUE     MED 10  IP1 141
Result:  SNOMED CODE
                                            Specimen: Breast

T-Code: T-04300 Mammary duct








Enter M-Code, first letters `-`or `-` for table--

```

You can enter the M-code at the prompt. A hyphen or the first letters of the M-code
followed by a hyphen accesses a table of all available M-codes for selection. The table
displays codes in alphabetical order of description. The table includes alternate
names. An asterisk (*) displays preceding an alternate name entry.

After you select a corresponding M code, the system begins processing the next
defined specimen. In this example, the next specimen is Bone Marrow.

For the Bone Marrow specimen example, the specimen type has been assigned to one
group that contains one T code, and no T/M code combinations have been defined.
The next screen in the flow is displays as follows:

```
              General Hospital Pathology Result Reporting Processor
AC#:4759                              GROSS/MICRO     Thu Jan 15, 2009 09:04 am
Unit #       Name             Sex Birthdate  Room      Physician      Srv ICD Status
A0000105428TEST DOE,JANE       F  11/25/1974 2204-2   SMITH, SUE     MED 10  IP1 141
Result:  SNOMED CODE                                  Specimen:  Bone Marrow

T code:  T-06000 Bone Marrow










Enter M-Code, first letters `-`or `-` for table--

```

Entering an M-code on the previous screen results in all auto-assigned specimens have been assigned to T/M code combinations. Processing continues with the Final Edit screen that is described in the next section.

Final Edit Screen

Processing for the Final Edit screen, as it pertains to auto T-coding, follows the standard screen flow.

```
                  General Hospital Pathology Result Reporting Processor
AC#:4759                        GROSS/MICRO    Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room    Physician     Srv ICD Status
A0000105428TEST DOE,JANE    F  11/25/1974 2204-2  SMITH, SUE    MED 10  IP1 141
Result: SNOMED CODE
Descriptions                                              Codes:
1) Mammary duct - Surgical margins free of tumor ...      T-04000,M-41740*
2) Bone Marrow - Normal tissue, NOS                       T-06000,M-00100




 Enter option to edit, opt`C`, opt`D`, add(A), delete(D), accept(Y/N) [Y]--
```

When the Description includes more characters than can display on one line, the system displays ellipses (...) at the end of the field. The entire description can be viewed if you select it for editing.

The asterisk (*) following the T/M codes indicates that a miscellaneous code is also present. All codes can be displayed if you select *opt`C`*.

NOTE: After you have entered all results for this test and entered **A** to accept the results, the system checks to see if the previous results are being accessed; if the previous results are not being accessed, the new results are filed.

If the previous results are being accessed, the following message displays:

> *Results for this accession being utilized! Please wait!*

This message continues to display until the result is filed.

SNOMED CT Code Result Reporting

NOTE: To perform SNOMED CT coding, you must have access to the SNOMED CT database.

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When using SNOMED CT Code Result Reporting, the SNOMED CT parameter is set to *Yes* and is active.

When the SNOMED Code component is accessed, the following screen is displayed:

```
            General Hospital Histology Surg Path Result Reporting Processor
AC#:9064      ROUTINE             SNOMED        Thu Jan 15, 2009 09:04 am
Unit #     Name            Sex Birthdate  Room    Physician    Srv ICD Status
A100006300 TEST,ALT         F  04/04/1980          ABEL,JODI A  MED 10  DIS HOM
Case#: S04-19
                                     Specimen: Cyst

( 1)^CT PROTOCOL   : HODGKINS (273037,2)
( 2) Specimen Type : CYST
( 3) Gross Descrip : 03/16 0834 HODGKINS (273037,2)
( 4) Microscopic E : 03/16 0840 HODGKINS (273037,2)
( 5) Comment       : NONE
( 6) SNOMED Code   :?




     Enter SNOMED CT code, partial code`*` or single word`-`--
                   @word-word@ for double word search
```

The prompt, *Enter SNOMED CT code, partial code`*` or single word`-`-- @word-word@ for double word search*, allows you to search the SNOMED CT database in several ways:

- SNOMED Code

- Partial SNOMED Code

- Word Search Not Using SNOMED CT Hierarchies

  - Single Word Search

  - Double Word Search

- Word Search with Active SNOMED Hierarchies

SNOMED Code

If a SNOMED CT code is entered, the system automatically fills the code number and fully specified name into the component. For example, 373176000 was entered as a response to the previous prompt and the following screen is displayed:

```
              General Hospital Histology Surg Path Result Reporting Processor
AC#:8720       ROUTINE AM              SNOMED          Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician      Srv ICD Status
A100004451 TEST,BARRY         M  01/01/1979          ABEL,JODI A    MED 10  DIS HOM
Result:   SNOMED Code
Page:01                               SNOMED CT Information
( 1) 373176000-pTis  Ductal carcinoma in situ (breast) (finding)




Add (A), Delete(D) or Accept(Y/N) [Y]--
```

NOTE: You can add up to 50 additional codes, delete codes, or accept/reject the code that was entered.

If you enter **A**, you are taken to the search prompt as follows in order to add additional SNOMED codes.

> *Enter SNOMED CT code, partial code`*` or single word`-`--*
> *@word-word@ for double word search*

If you enter **D**, the following prompt is displayed:

> *Enter option(s) to be deleted--*
> *end select(NL)*

Single or multiple options can be entered to remove the selection from the screen. When the selection is finished, the following prompt is displayed:

> *Add (A), Delete(D) or Accept(Y/N) [Y]--*

If you enter **Y**, the selections are accepted and the screen returns to the main resulting screen. The SNOMED field can be selected again prior to accepting the accession for additional edits.

Partial SNOMED Code

If you enter a partial SNOMED CT code followed by an asterisk (*), the system searches the database for numeric matches and the matches are displayed in table format. The partial code must include at least four digits. If fewer than four digits are entered, the following message is displayed:

> *Invalid format for this field!*

For example, 3714* was entered as a response to the prompt and the following screen is displayed:

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:9064      ROUTINE              SNOMED       Thu Jan 15, 2009 09:04 am
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A100006300 TEST,ALT         F  04/04/1980         ABEL,JODI A   MED 10  DIS HOM
Case#: S04-19
SNOMED CT Information

( 1) 371484003|Patient name (observable entity)
( 2) 371482004|Surgical pathology identifier (observable entity)
( 3) 371439000|Specimen type (observable entity)
( 4) 371475003|Specimen size (observable entity)
( 5) 371480007|Tumor site (observable entity)
( 6) 371441004|Histologic type (observable entity)
( 7) 371469007|Histologic grade (observable entity)
( 8) 371470008|Tubule formation score (observable entity)
( 9) 371471007|Nuclear pleomorphism score (observable entity)




Enter choices(e.g. 1,7,5-9) or '-'choices to remove-
                              end select (NL)
```

You can select up to 50 codes as required and continue to enter SNOMED CT codes up to 50 per component. Once the selection is made, the following prompt is displayed:

Add (A), Delete(D) or Accept(Y/N) [Y]--

Word Search Not Using SNOMED CT Hierarchies

When the system functions use single or double word searches, it differs from entering the code or using partial code search because the screens are different if SNOMED CT Hierarchy functionality is active.

Single Word Search
If a single word followed by a hyphen (**-**) is entered, the system searches the database for alphabetic matches and the matches are displayed in table format for selection. The SNOMED CT code and fully specified name are displayed on the table.

If a SNOMED CT code is entered, the system automatically fills the code number and fully specified name into the component. For example, *Liver-* was entered as a response to the prompt and the following screen is displayed. If more than one page of information is displayed, you can navigate using the PAGE DOWN and PAGE UP keys.

```
        General Hospital Histology Surg Path Result Reporting Processor
AC#:9064        ROUTINE              SNOMED       Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician      Srv ICD Status
A100006300 TEST,ALT          F  04/04/1980         ABEL,JODI A   MED 10  DIS HOM
Case#: S04-19
SNOMED CT Information

( 1) 256002-Kupffer cell (cell)
( 2) 318001-Structure of cardiac impression of liver (body structure)
( 3) 790007-Structure of visceral aspect of liver (body structure)
( 4) 1059007-Opisthorchiasis (disorder)
( 5) 1684009-Structure of ligamentum teres of liver (body structure)
( 6) 1846000-Opisthorchis felineus (organism)
( 7) 2644002-Cauterization of liver (procedure)
( 8) 2909002-Structure of posterior portion of diaphragmatic aspect of liver (bo
( 9) 3319006-Artificial liver, device (physical object)
(10) 3650004-Congenital absence of liver (disorder)
(11) 3860006-Structure of transplanted liver (body structure)
(12) 3873005-Failed attempted abortion with acute yellow atrophy of liver (disor
(13) 4549001-Entire vagus nerve parasympathetic fibers to liver, gallbladder, bi
(14) 4974007-Operation on liver (procedure)
(15) 5415002-Destruction of lesion of liver (procedure)


Enter choices (e.g. 1,7,5-9) or '-'choices to remove
                end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

You can select up to 50 codes as required. When your selection is complete, the following prompt is displayed.

Add (A), Delete(D) or Accept(Y/N) [Y]--

Double Word Search
If you use the double word search option, the format *@word-word@* is used and the system searches for the word combination.

For example, Congenital heart was entered as *@congenital-heart@* in the following example.

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:8720      ROUTINE AM            SNOMED        Thu Jan 15, 2009 09:04 am
Unit #     Name              Sex Birthdate  Room    Physician     Srv ICD Status
A100004451 TEST,BARRY         M  01/01/1979           ABEL,JODI A  MED 10  DIS HOM
Result:  SNOMED Code
Page:01                           SNOMED CT Information         ##=Current Choices
( 1) 1131009-Congenital valvular insufficiency (disorder)
( 2) 2061000-Conductive hearing loss of combined sites (finding)
( 3) 3820005-Inner ear conductive hearing loss (finding)
( 4) 5148006-Hypertensive heart disease with congestive heart failure (disorder)
( 5) 5375005-Chronic left-sided congestive heart failure (disorder)
( 6) 5947002-Consultation for hearing and/or speech problem (procedure)
( 7) 9634000-Congenital dislocation of radial head (disorder)
( 8) 10633002-Acute congestive heart failure (disorder)
( 9) 10818008-Congenital malposition of heart (disorder)
(10) 12770006-Cyanotic congenital heart disease (disorder)
(11) 13213009-Congenital heart disease (disorder)
(12) 15190000-Tympanic membrane conductive hearing loss (finding)
(13) 17414004-Contusion to heart (disorder)
(14) 36315003-Malignant hypertensive heart disease without congestive heart fail
(15) 38439000-Cranial duplication (disorder)

Enter choices (e.g. 1,7,5-9) or '-'choices to remove
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

You can select up to 50 codes as required. Once your selection of SNOMED codes is complete, the following prompt is displayed:

Add (A), Delete(D) or Accept(Y/N) [Y]--

Word Search with Active SNOMED Hierarchies

If you perform a word search when SNOMED hierarchies are active, the following screen is displayed. This screen is the same whether a single word search is performed using the format, *Liver-* or if a double word search is performed using the format *@congenital-heart@.*

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:9064     STAT            SURGICAL PATHOLOGY  Thu Jan 15, 2009 09:04 am
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A100006300 Test,Alt         M  04/04/1980 4101-02 ABEL,JODI A   MED 10   I/P 1197
Case#: S04-19


Result: *SNOMED Code                   Specimen: Tissue
Page:01                          SNOMED CT Hierarchies         ##=Current Choices
( 1) Attribute
( 2) Body Structure
( 3) Clinical finding
( 4) Observable Entity
( 5) Procedure/intervention
( 6) Specimen




Enter choices (e.g. 1,7,5-9) or '-'choices to remove
                           end select(NL)
```

Once the search word(s) is entered, a list of active SNOMED hierarchies for selection is displayed. The hierarchies that display are determined by using the *Assign SNOMED CT Hierarchies for Resulting* processor, which is located in Maintenance - Anatomic Path>SNOMED CT Hierarchy. If the hierarchy is active, it is displayed for selection and is available for search. You are now able to narrow the scope of the search and reduce the responses returned by the search.

If the hierarchies selected contain sub-hierarchies, the following prompt is displayed:

Include all sub-hierarchies? (Y/N) [Y]-

If you enter **Y**, the search continues and the list of SNOMED codes meeting the criteria is displayed.

If you enter **N**, a list of sub-hierarchies for the hierarchy(s) previously selected is displayed on the screen as follows:

```
( 1) body structure
( 2) cell
( 3) cell structure
( 4) morphologic abnormality




    Enter choices (e.g. 1,7,5-9) or '-'choices to remove
                        end select(NL)
```

Single or multiple sub-hierarchies can be entered, narrowing the scope of the search. After you make your selection, the search proceeds and the list of SNOMED codes meeting the criteria is displayed.

SNOMED CAP Cancer Protocols Result Reporting

Once Template Processing is created, the processing must follow through to Result Entry. The component defined with Template Processing must be resulted first in order for the other components to fulfill the defined protocol template requirements.

When the component with Template Processing is chosen, the following screen is displayed with a list of active protocol templates.

```
        General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT            SURGICAL PATHOLOGY Thu Jan 15, 2009 09:04 am
Unit #     Name           Sex Birthdate  Room     Physician     Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1    ADAIR,FRANKIE SUR 10  I/P 2
Result: *Cancer Checklist              Specimen: Appendix

Page:01                          Select Protocol
( 1) COLON RECTUM EXC BIOPSY (14,29)
( 2) ADRENAL GLAND RESECTION (2,16)
( 3) AMP OF VATER-AMPULLECTOMY (3,17)
( 4) THYROID RESECTION (31,81)
( 5) LUNG BIOPSY (49,64)
( 6) OVARY-OOPHORECTOMY (52,67)
( 7) RHABDOMYOSARCOMA (60,75)
( 8) APPENDIX-RESECTION (68,85)




Enter number of protocol
```

You are prompted to choose a protocol. Only one protocol can be chosen from the list.
The numbers to the right of the protocol indicate the checklist ID and version number
respectively. These values are filed as part of the component result.

PROTOCOL COMPONENT RESULTS

The following screen is displayed when a protocol is chosen. In this example,
Appendix-Resection was chosen..

```
        General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT            SURGICAL PATHOLOGY   Thu Jan 15, 2009 09:04 am
Unit #     Name           Sex Birthdate  Room     Physician     Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1    ADAIR,FRANKIE SUR 10  I/P 2
Result: *Cancer Protocol Report        Specimen: Appendix

College of American Pathologists Cancer Checklist; Appendix: Resection
Appendix: Resection, 7/1/2006, 85.1000043
Note: Check 1 response unless otherwise indicated
MACROSCOPIC
SPECIMEN TYPE
___ Appendectomy
Length of appendix (cm): ___
___ Appendectomy and right colectomy
Length of appendix (cm): ___
Length of colonic segment (cm): ___
___ Other (specify): ___
Peritoneal Implant(s)
___ Peritoneal implant specimen(s) submitted
TUMOR SITE
___ Proximal half of appendix
___ Distal half of appendix
```

You can make choices by entering an *X* at the line.

NOTE: The *X* you enter is not displayed when you enter V for View in AP Result Reporting and is not is printed with the selected text of the protocol.

Additionally, line items requiring related input can be resulted.

You can delete the data entered by the user for a line in the cancer checklist designated as "P" (to display the line in the report and prompt for related input) by one of the following methods:

*   Overwrite the data defined for the fill-in line with new text.

*   Press Delete.

*   Enter **D**.

*   Press Backspace.

If the first character does not need to be edited or removed, you can use either Backspace or Delete to delete all other characters that had been entered before ENTER was pressed.

Before the first character can be deleted, the user input process must be terminated by pressing ENTER or NEW LINE to remove all characters from the fill-in line.

To remove the first character of text, move the cursor to the first character and press the up or down arrow to access the fill-in line to edit or delete.

Some prompt lines designated with a "P" have a check-off line (enter **X**) and a fill-in line for data after pressing ENTER. For example: ___ Other (specify): ___

To remove all text from the fill-in line, do one of the following at the check-off line:

*   Press Delete.

*   Enter **D**.

*   Press Backspace.

The following screen is an example of selected, resulted items. Once all items have been resulted or if you enter a period (**.**) in any field within the template, the following prompt is displayed in the screen:

Generate (T)ext, (S)ave incomplete, (V)iew, (Q)uit with no changes-

```
            General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT            SURGICAL PATHOLOGY   Thu Jan 15, 2009 09:04 am
Unit #    Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1   ADAIR,FRANKIE SUR 10  I/P 2
Result: *Cancer Protocol Report       Specimen: Appendix

College of American Pathologists Cancer Checklist; Appendix: Resection
Appendix: Resection, 7/1/2006, 85.1000043
Note: Check 1 response unless otherwise indicated
MACROSCOPIC
SPECIMEN TYPE
X    Appendectomy
Length of appendix (cm): 4
___  Appendectomy and right colectomy
Length of appendix (cm): ___
Length of colonic segment (cm): ___
___  Other (specify): ___
Peritoneal Implant(s)
X    Peritoneal implant specimen(s) submitted
TUMOR SITE
X    Proximal half of appendix
 __  Distal half of appendix

Generate (T)ext, (S)ave incomplete, (V)iew, (Q)uit with no changes--
```

The options from the prompt function as follows:

- **T (Generate Text)** - With this option, data is filed as word processing and no edits are necessary. If future edits are required, it must be done by Softkey Editor or the defined word-processing interface.

  The following screen shows the result Cancer Protoc, where results have filed to text using the T option.

```
General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT            SURGICAL PATHOLOGY   Thu Jan 15, 2009 09:04 am
Unit #    Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1   ADAIR,FRANKIE SUR 10  I/P 2
Case#: S08-1571
                                  Specimen: Appendix

( 1) Physician    : Brown
( 2) Date of Surge : Dec 16, 2008
( 3) Specimen Type : Appendix
( 4) << DIAGNOSIS  :
( 5)*Cancer Checkl : APPENDIX-RESECTION (68,85)
( 6)*Cancer Protoc : 12/17 1031 APPENDIX-RESECTION (68,85)
( 7) Gross Descrip :
( 8) Microscopic E : 12/17 0931 (1) Incomplete Data
( 9)*SNOMED Code   : 12/17 1031 <18>
(10)*Addendum      :
(11)#Transcription :
(12)#Review Queue  :
(13) Reviewed by   : Bill Rush,


Enter number to edit, accept(A), fax(X), print(P), fill(F)--
                  * = options, replicate(R), repeat(RR)
```

- **S (Save incomplete)** - With this option, data is filed in template format. You can make additional edits to the template at a later time. In the above screen, the result *Microscopic E* is displayed in the field using the *S* option.

- **Q (Quit with no changes)** - This option allows you to exit from the template without making any changes. This is similar to pressing period (.) ENTER to exit a function. New edits are not saved. However, previously filed data is retained.

  You can use this option if you want to correct an error for text that has not been filed. You can exit the result, select it again, and key the correct response.

- **V (View)** - With this option you can view the data entered to verify results entered prior to generating text. The following screen is displayed with the entered results using the View option.

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:1555      STAT            SURGICAL PATHOLOGY    Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician      Srv ICD Status
A000006059 TEST,PATIENT     M  05/05/1955 404-1    ADAIR,FRANKIE SUR 10  I/P 2
Result: *Cancer Protocol Report       Specimen: Tissue

College of American Pathologists Cancer Checklist; Appendix: Resection
MACROSCOPIC
SPECIMEN TYPE
   Appendectomy
Length of appendix (cm): 4
   Peritoneal implant specimen(s) submitted
TUMOR SITE
   Proximal half of appendix
TUMOR SIZE
Greatest dimension (cm): 4
Additional dimension (cm): 2
Additional dimension (cm): 2
TUMOR CONFIGURATION
   Ulcerative
MICROSCOPIC

Press NL--
```

The SNOMED CT code for each line selected is displayed by the SNOMED component where auto-coding is turned on.   In this manner, SNOMED coding is automatically done based on the results selected for the protocol.

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT            SURGICAL PATHOLOGY    Thu Jan 15, 2009 09:04 am
Unit #     Name           Sex Birthdate  Room     Physician      Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1    ADAIR,FRANKIE SUR 10  I/P 2
Case#: S08-1571
Result: *SNOMED Code                     Specimen: Appendix
Page:01                         SNOMED CT Information
( 1) 395526000-Macroscopic specimen observable (observable entity)
( 2) 371439000-Specimen type (observable entity)
( 3) 421615004-Specimen from appendix obtained by appendectomy (specimen)
( 4) 423173005-Length of appendix specimen (observable entity)
( 5) 371480007-Tumor site (observable entity)
( 6) 422488004-Proximal half of appendix structure (body structure)
( 7) 263605001-Tumor size (observable entity)
( 8) 371479009-Tumor size, largest dimension (observable entity)
( 9) 395512009-Tumor size, additional dimension (observable entity)
(10) 371500007-Tumor configuration (observable entity)
(11) 369760009-Ulcerated tumor configuration (finding)
(12) 395527009-Microscopic specimen observable (observable entity)
(13) 371441004-Histologic type (observable entity)
(14) 35917007-Adenocarcinoma, no subtype (morphologic abnormality)

Add (A), Delete(D) or Accept(Y/N) [Y]--
                       next pg(/ or PG DN)  Search(TAB)
```

You can add, delete or accept the existing SNOMED codes. If more than 14 codes are listed, you are able to page up and/or down.

When all required fields are resulted, the final resulting screen is displayed:

```
          General Hospital Histology Surg Path Result Reporting Processor
AC#:1556      STAT             SURGICAL PATHOLOGY  Thu Jan 15, 2009 09:04 am
Unit #     Name           Sex Birthdate  Room     Physician      Srv ICD Status
A000006059 TEST,PATIENT    M  05/05/1955 404-1    ADAIR,FRANKIE SUR 10  I/P 2
Case#: S08-1571
                                  Specimen: Appendix

( 1) Physician     : Brown
( 2) Date of Surge : Dec 16, 2008
( 3) Specimen Type : Appendix
( 4) << DIAGNOSIS  :
( 5)*Cancer Checkl : APPENDIX-RESECTION (68,85)
( 6)*Cancer Protoc : 12/17 1031 APPENDIX- (68,85)
( 7) Gross Descrip :
( 8) Microscopic E :
( 9)*SNOMED Code   : 12/17 1031 <18>
(10)*Addendum      :
(11)#Transcription :
(12)#Review Queue  :
(13) Reviewed by   : Bill Rush,


Enter number to edit, accept(A), fax(X), print(P), fill(F)--
                   * = options, replicate(R), repeat(RR)
```

Result Verification

Result verification prompts, such as the following one, are the same as in other areas of STAR Laboratory with the exception of viewing word processing results and printing a draft copy of the Anatomic Path Long Report.

```
                General Hospital Pathology Result Reporting Processor
AC#:1465                           GROSS/MICRO Thu Jan 15, 2009 09:04 am
Unit #      Name           Sex Birthdate  Room    Physician      Srv ICD Status
A001042621 JOHNS,ALLAN      M  02/02/1902 3101-2  ADAIR,FRANK C EMR 10  PER 1
Case#: S93-8                                                     Blocks: 2
                                 Specimen: Liver Biopsy

( 1) Date of Surge ? May 17, 1993      (14)^Review Queue  : Dr. Smith
( 2) Physician     : Dr. Smith         (15) Released by    :
( 3)*Clinical Hist : Pain upper right quadrant
( 4) Specimen Sour :
( 5)*Frozen Sectio : 05/17 1557 ABS
( 6) Gross Descrip : 05/17 1557 APP
( 7) Grossed by    : Dr. Smith
( 8)*Microscopic E : 05/17 1557 BIO
( 9)*Read by       : Dr. Smith
(10) Diagnosis     : 05/17 1557 BMB
(11) Dx Coding     : T-56000,M-26000
(12)*Comment       : 11
(13)#Transcription : K S White

Enter number to edit, accept(A), fax(X), print(P), fill(F)--
                    * = options, replicate(R), repeat(RR)
```

The options available from the prompt in result verification are as follows:

A (ACCEPT)

If you select the Accept (A) option, the system files the results.

If the test is in a partial status and the test is set to report partials, a partial Long Report prints.

If the test reaches a done status for the first time, a final Long Report prints.

If the test is resulted (already in a done status), and an external component is added or changed, a supplemental Long Report prints.

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```
                    General Hospital Pathology Result Reporting Processor
AC#:4148                         CYTOLOGY,*GYN SMEAR  Thu Jan 15, 2009 09:04 am
Unit #      Name               Sex Birthdate  Room     Physician      Srv ICD Status
A000000027 WHITTLE,SHERRY   F  02/18/1970 2104-02 BELL,THOMAS J ERS 10  I/P 723
Case#: C95-527
                                      Specimen: PAP Smear


              /A  - Add-On Order          /II - Another Pat Inquiry
              /OO - Another Pat Order     /R  - Check Five by Result
              /F  - Check Five by Test    /C  - Check Previous
              /Q  - Clinical Questions    /K  - Comment Review
              D   - Draft Report          /H  - History Cardfile
              /M  - MD Copy To            /MS - Multiple Specimens
              /O  - Order                 /I  - Patient Inquiry
              /PB - Professional Billing  Q   - Queue Accession
              /RM - Recall Management     RQ  - Repeat Queue
              /RT - Resulting Techs       /VV - Valid Value List
              V   - View Report


Enter option--
                        NL for main options
```

V (VIEW)

Enter **V** to view all word processing results. If there is more than one word processing result, you can view each individually by pressing ALT-F5 key.

D (DRAFT)

Enter **D** to print a draft copy of the Long Report. See your System Manager for the location of the draftcopy long report printer. Thisoption works the same as if the report were accepted, in other words, all results entered up to that point are filed. When you enter **D**, the results are filed and the following message displays:

  Logged!

A Partial Long Report (labelled Draft in the lower left corner) prints at the printer designated for the Anatomic Pathology Long Report.

Based on the flag setting in the Anatomic Path Parameters, you can print history cardfile information when you accept your test results with the Draft option through result reporting. You are prompted to print previous history information regardless of the test status (partial or done).

As a part of the Anatomic Pathology Result Reporting process, selecting **D,** for the draft option, results in printing previous case information in the Anatomic Pathology Draft Past History Report along with the Anatomic Pathology Draft Long Report.

When you enter **D**, the following prompt displays:

Print previous case history with draft report? (Y/N) [N]--

This prompt allows you to determine if previous case information should automatically print with the Anatomic Pathology Draft Long Report.

The system retrieves previous case information as stored in the History Cardfile for a date range determined by the previous case search flag setting. The History Cardfile search crosses all patient accounts and is limited to anatomic pathology type tests only. This information prints the Anatomic Pathology Draft Past History Report in a modified Cardfile Detail format immediately following the printed Anatomic Pathology Draft Long Report.

If no previous case information is found, the Anatomic Pathology Draft Past History Report prints in modified Cardfile detail format with the current accession information and a message indicating the Cardfile search is complete and no information was found.

If the Cardfile Search flag is set for a specific number of days the following message prints:

Cardfile search from LAST SEARCH DATE until CURRENT DATE completed.No previous case information found.

If the Cardfile Search flag is set for ALL the following message prints:

Cardfile search completed, no previous case information found.

NOTE: The Draft option is also available when releasing reports from Review Queues.

RQ (REPEAT QUEUE)

You can accept results and manually send a test to the Repeat Queue for processing by selecting the Repeat Queue (RQ) option forany test that has the Case Number Pool Workload/QC indicator set to Yes and is defined in the Repeat Queue Results maintenance processor.

For more information on the RQ option and Repeat Queue processing refer to the .

Batch Print Long Report

This section of the document outlines the system actions when you accept results for a test defined to print a long report using the Accept, Print, Draft, Fax, or Queue options and the test is defined to print the long report in batch.

Accept

The system files a long report to the batch rather than printing the defined number of copies immediately when A is used to accept the test results and the following criteria are met:

- default performing section for test is active for long reports

- test is defined to print a long report in the batch

- test is in a Done status

Batch long reports are not the only reports that can print on the system when the above criteria are met. The following matrix presents scenarios where additional system processing occurs. Both long reports and primary reports may print depending on ordering category, flag settings, and status of the test.

When test results are filed to the batch, the results are available for viewing and printing in Patient Inquiry. If you need a good copy of the long report prior to printing the batch of long reports, a duplicate copy can be printed from Patient Inquiry. The copy printed will have a report status of Duplicate.

If you need a throw away copy of the long report prior to printing the batch of long reports, you can print a draft copy from result reporting.

NOTE: Printing an Anatomic Pathology long report from Result Reporting now includes the *End of Report* message with the printed date and time.

Accept Processing				
Ordering Category	**STAT/ASAP Flag**	**Partial Test Status**	**Done Test Status**	**Done Status and Correct Addendum**
STAT	Print	1 copy of long report prints immediately	Long report is filed to Batch	Long report is filed to Batch
		1 copy of primary prints immediately	Defined number of primary copies print immediately	Defined number of primary copies print immediately
		If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately

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Accept Processing				
Ordering Category	**STAT/ASAP Flag**	**Partial Test Status**	**Done Test Status**	**Done Status and Correct Addendum**
STAT	Suppress	No system processing occurs	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately
Routine	N/A	No system processing occurs	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately

Print

The system files a long report to the batch rather than printing the defined number of copies immediately when P is used to accept the test results (and force print a copy of the results) and the following criteria are met:

- default performing section for test is active for long reports

- test is defined to print a long report in the batch

- test is in a Done status

Batch long reports are not the only reports that can print on the system when the above criteria are met. The following matrix presents scenarios where additional system processing occurs. Both long reports and primary reports may print depending on ordering category, flag settings and status of the test.

When test results are filed to the batch, the results are available for viewing and printing in Patient Inquiry. If you need a good copy of the long report prior to printing the batch of long reports, a duplicate copy can be printed from Patient Inquiry. The copy printed will have a report status of Duplicate.

If you need a throw away copy of the long report prior to printing the batch of long reports, you can print a draft copy from result reporting.

NOTE: Printing an Anatomic Pathology long report from Result Reporting now includes the *End of Report* message with the printed date and time.

Print Processing				
Ordering Category	**STAT/ASAP Flag**	**Partial Test Status**	**Done Test Status**	**Done Status and Corrected/ Addendum**
STAT	Print	1 copy of long report prints immediately on the defined default long report printer 1 copy of primary prints immediately If Force Prints STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints STATS/ASAP are defined to print across the network 1 copy of primary prints immediately
STAT	Suppress	1 copy of long report prints immediately on the defined default long report printer 1 copy of primary prints immediately I If Force Prints are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately
Routine	N/A	1 copy of long report prints immediately on the defined default long report printer 1 copy of primary prints immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately

Draft

The system files a long report to the batch rather than printing the defined number of copies immediately when D is used to accept the test results and the following criteria are met:

- default performing section for test is active for long reports

- test is defined to print a long report in the batch

- test is in a Done status

Batch long reports are not the only reports that can print on the system when the above criteria are met. The following matrix presents scenarios where additional system processing occurs. Long reports, Draft Long reports and Primary reports may print depending on ordering category, flag settings and status of the test.

The use of the Draft option to accept results will always prints a Draft Long Report. In addition, the Previous Cardfile History Report, if defined, prints following the Draft Long Report. The printing of the Draft Long Report and the Previous Cardfile History Report are not supported through the Batch Long Report processor. These reports will continue to follow current system functionality by immediately printing to the printer defined default Draft Long Report printer (LRP).

When test results are filed to the batch, the results are available for viewing and printing in Patient Inquiry. If you need a good copy of the long report prior to printing the batch of long reports, a duplicate copy can be printed from Patient Inquiry. The copy printed will have a report status of Duplicate.

If you need a throw away copy of the long report prior to printing the batch of long reports, you can print a draft copy from result reporting.

NOTE: Printing an Anatomic Pathology draft report from Result Reporting now includes the *End of Report* message with the printed date and time.

Draft Processing				
Ordering Category	STAT/ASAP Flag	Partial Test Status	Done Test Status	Done Status and Corrected/ Addendum
STAT	Print	1 copy of primary prints immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer	Long Report is filed to batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer	Long Report is filed to batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer
STAT	Suppress	1 draft copy prints on the default draft printer	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer
Routine	N/A	1 draft copy prints on the default draft printer	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately 1 draft copy prints on the default draft printer

Fax

The system files a long report to the batch rather than printing the defined number of copies immediately when X is used to accept the test results and the following criteria are met:

- default performing section for test is active for long reports

- test is defined to print a long report in the batch

- test is in a Done status

Batch long reports are not the only reports that can print on the system when the above criteria are met. The following matrix presents scenarios where additional system processing occurs. Both long reports and primary reports may print depending on ordering category, flag settings and status of the test:

When test results are filed to the batch, the results are available for viewing and printing in Patient Inquiry. If you need a good copy of the long report prior to printing the batch of long reports, a duplicate copy can be printed from Patient Inquiry. The copy printed will have a report status of Duplicate.

If you need a throw away copy of the long report prior to printing the batch of long reports, you can print a draft copy from result reporting.

Fax Processing				
Ordering Category	**STAT/ASAP Flag**	**Partial Test Status**	**Done Test Status**	**Done Status and Corrected/ Addendum**
STAT	Print	1 copy of long report prints immediately on the defined default long report printer	Long report is filed to Batch	Long report is filed to Batch
		1 copy of primary prints immediately	Defined number of primary copies print immediately	Defined number of primary copies print immediately
		If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately
		A copy of the test results is faxed	A copy of the test results is faxed	A copy of the test results is faxed

Fax Processing				
Ordering Category	STAT/ASAP Flag	Partial Test Status	Done Test Status	Done Status and Corrected/ Addendum
STAT	Suppress	1 copy of long report prints immediately on the defined default long report printer 1 copy of primary prints immediately If STAT/ASAP are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed	Long report is filed to Batch Defined number of primary copies print immediately If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed
Routine	N/A	1 copy of long report prints immediately on the defined default long report printer 1 copy of primary prints immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed	Long report is filed to Batch Defined number of primary copies print immediately If Force Prints are defined to print across the network 1 copy of primary prints immediately A copy of the test results is faxed

Queue

This option displays only when a review queue is set up for the selected test. Queue placement is normally part of the acceptance process and is based on the information set up in the master test file. The queue placement option can be used when a report which has been queued is reentered and a result is overwritten. Entering **Q** after changing a result causes the report to be placed in the queue once again and the test status changes to Partial. When these results display within Patient Inquiry, they are flagged as Pending Review. When the test is not set up to display results if in a review queue, these results are not available in Patient Inquiry until the report is released from the queue.

The system files a long report to the batch rather than printing the defined number of copies immediately when Q is used to accept test results and the following criteria are met:

- default performing section for test is active for long reports

- test is defined to print a long report in the batch

- test is in a Done status

Batch long reports are not the only reports that can print on the system when the above criteria are met. The following matrix presents scenarios where additional system processing occurs. Both long reports and primary reports may print depending on ordering category, flag setting, and status of the test.

When test results are filed to the batch, the results are available for viewing and printing in Patient Inquiry. If you need a good copy of the long report prior to printing the batch of long reports, a duplicate copy can be printed from Patient Inquiry. The copy printed will have a report status of Duplicate.

If you need a throw away copy of the long report prior to printing the batch of long reports, you can print a draft copy from result reporting.

Queue Processing				
Ordering Category	STAT/ASAP Flag	Partial Test Status	Done Test Status	Done Status and Corrected/ Addendum
STAT	Print	1 copy of long report prints immediately	Long report is filed to Batch	Long report is filed to Batch
		1 copy of primary prints immediately	Defined number of primary copies print immediately	Defined number of primary copies print immediately
		If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately
STAT	Suppress	No system processing occurs	Long report is filed to Batch	Long report is filed to Batch
			Defined number of primary copies print immediately	Defined number of primary copies print immediately
			If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately	If STATS/ASAP are defined to print across the network 1 copy of primary prints immediately

Queue Processing				
Ordering Category	STAT/ASAP Flag	Partial Test Status	Done Test Status	Done Status and Corrected/ Addendum
Routine	N/A	No system processing occurs	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately	Long report is filed to Batch Defined number of primary copies print immediately If Routines are defined to print across the network 1 copy of primary prints immediately

REVIEW QUEUE REPORTING

In the Review Queue Reporting processor, a test is released from a review queue using the batch or sequential release. If the selected test is defined to print a Long Report in a batch and the test status is Done, the system files the report to the long report batch for the designated section. The Accept, Print, Draft, Fax and Queue options are available during the Review Queue Reporting process. The system processing is the same as that performed in Result Reporting processor documented in the previous section.

REPEAT QUEUE REPORTING

In the Repeat Queue Reporting processor, a test is resulted and released from the queue. If the selected test is defined to print a Long Report in a batch and the test status is Done, the system files the report to the long report batch for the designated section. The Accept, Print, Draft, Fax and Queue options are available during the Repeat Queue Reporting process. The system processing is the same as that performed in Result Reporting processor documented in the previous section.

DISCREPANCY QUEUE REPORTING

In the Discrepancy Queue Reporting processor, a test is resulted and released from the queue. If the selected test is defined to print a Long Report in a batch and the test status is Done, the system files the report to the long report batch for the designated section. The Accept, Print, Draft, Fax and Queue options are available during the Discrepancy Queue Reporting process. The system processing is the same as that performed in Result Reporting processor documented in the previous section.

VIEW MULTIPLE SPECIMENS

If the test has multiple specimens attached, and the test flag is set to display the specimen/modifier in result reporting, you may also view all specimens associated with a test. The system displays the specimens in the same format as in Patient Inquiry.

```
                General Hospital Pathology Result Reporting Processor
AC#:1465                          GROSS/MICRO Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician     Srv ICD Status
A001042621 WHITTLE,SHERRY    F  02/18/1970 2104-02 BELL,THOMAS J EMR 10  PER 1
Case#: S95-88                                                     Blocks: 3
                              Specimen: Gross and Microscopic


( 1) Date of Surge : May 17, 1993     (15)#Review Queue  : Dr. Smith
( 2) Physician     : Dr. Smith
( 3)*Clinical Hist : clinical inform|
( 4) Specimen Sour : spec
( 5)*Frozen Sectio : 05/17 1557 ABS
( 6) Gross Descrip : 05/17 1557 APP
( 7) Grossed by    : Dr. Smith
( 8)*Microscopic E : 05/17 1557 BIO
( 9)*Read by       : Dr. Smith
(10) Diagnosis     : 05/17 1557 BMB
(11)*SNOMED Code 1 : 05/17 1558 <1>
(12)*SNOMED Code 2 :
(13)*Comment       : 11
(14)#Transcription : K S White,Produ|


Enter number to edit, accept(A), fax(X), print(P), fill(F)--
                      * = options, replicate(R), repeat(RR)
```

The option from the prompt in result reporting is /MS. The /MS option is also available through Review Queue Result Reporting. To view this refer to .

```
                General Hospital Pathology Result Reporting Processor
AC#:4148              CYTOLOGY,*GYN SMEAR    Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room     Physician      Srv ICD Status
A000000027 WHITTLE,SHERRY    F  02/18/1970 2104-02 BELL,THOMAS J ERS 10  I/P 723
Case#: S95-88

                              Specimen: Gross and Microscopic


          /A  - Add-On Order         /II - Another Pat Inquiry
          /OO - Another Pat Order    /R  - Check Five by Result
          /F  - Check Five by Test   /C  - Check Previous
          /Q  - Clinical Questions   /K  - Comment Review
          D   - Draft Report         /H  - History Cardfile
          /M  - MD Copy To           /MS - Multiple Specimens
          /O  - Order                /I  - Patient Inquiry
          /PB - Professional Billing  Q  - Queue Accession
          /RM - Recall Management     RQ - Repeat Queue
          /RT - Resulting Techs      /VV - Valid Value List
          V   - View Report



Enter option--
                      NL for main options
```

After you select /MS for Multiple Specimens, the system displays the following screen:

```
                  General Hospital Pathology Result Reporting Processor
AC#:1465                      CYTOLOGY, *GYN SMEAR  Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000000027 WHITTLE,SHERRY   F  02/18/1970 2104-02 BELL,THOMAS J ERS 10  1/P 723
Case#: S95-88                                                       Blocks: 3
                                      Specimen: Gross and Microscopic


                                      Multiple Specimens

    Specimen                Modifier                     Receive Date/Time
     Tissue                                              09/28/94 1345
     Ovary                      Left                     09/28/94 1345
     Fallopian Tubes                                     09/28/94 1345







                    F1Page Prev F2 Next Rage F7Exit
```

CHECK FIVE BY RESULT

When you enter **R** for Check Five by Result for a component-based laboratory test, the system displays a list of reportable components for the test code. This list is the externally reportable results for the test that are not excluded at the component level. You can select the result for the Check Five by Result option. The system displays the last five occurrences of the result along with the accession number, date, and time of collection and the test name in which the result was contained. If there are more than five occurrences in the patient's record, you can display the next five occurrences.

```
                  General Hospital Patient Inquiry Processor
                                          Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room    Physician     Srv ICD Status
A0000000866JOHNSON,CHARLES   M  09/07/1962 2304-1  DERAUF,DONALD MED 10  I/P 160
                         Acct #: A9121400002
                  Accession # 2630 ELECTROLYTES
Specimen: Blood                                    Collected: 01/08/92 0812
Result Name               Results                  Normal Range
Sodium(mM/L):             158                       125-155
Potassium(mM/L):          5.8          H            3.6-5.1
Chloride(mM/L):           108                       98-109
HCO3(mM/L):               38           DH           22-30
Anion Gap:                17.80                     12-20
Glucose(gm/dl):           100                       Neg







Enter option-- R
                              * = Options
```

Enter **R** for Check Five by Result. The system displays the following screen:

```
                    General Hospital Patient Inquiry Processor
                                            Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate Room     Physician    Srv ICD Status
A0000000866JOHNSON,CHARLES  M  09/07/1962 2304-1  DERAUF,DONALD MED 10  I/P 160


Page:01                          Available Components
( 1)  Sodium(mM/L)
( 2)  Potassium(mM/L)
( 3)  Chloride(mM/L)
( 4)  HCO3(mM/L)
( 5)  Anion Gap
( 6) *Comment
( 7) *Date/Time Resulted
( 8)  Glucose(gm/dl)
( 9) *Accn Comment
(10) *Fasting?




 Enter choice--

```

Select one component for Check Five. This screen display excludes:

- Components that cannot be reported externally

- Components defined to be excluded from excluded from Test Lookup and
  Check Five

- Word processing components

NOTE: All occurrences of this component in the patient's record are eligible for
display in Check Five by Result.

WARNING: If you select a component that may be in every teston the patient (such
as a comment component), then every test on that patient will display
in Check Five by Result.

For more information on the Check Five by Result option, refer to Chapter 1: Inquiry
Processor in the *General Applications Volume I* of the *STAR Laboratory Reference
Guide.*

ANATOMIC PATH DRAFT PAST HISTORY REPORT

The Anatomic Pathology Draft Past History Report prints after the Draft Long Report in a modified cardfile detail format. An example of this report is provided following the report layout, demographic data, accession data, and result components.

Report Layout

PAGE COUNTER
This is the page number for the report in the upper right corner.

REPORT DATE/TIME
This is the date/time the report is printed. It is centered on the second line.

REPORT NAME
This report is entitled *History Cardfile Report.* This field is centered on the third line.

DEMOGRAPHIC DATA

The following section prints for each patient in the history cardfile.

DEMOGRAPHIC HEADER
The header line is repeated on each page above the columns of report data. It contains the following data columns:

- Name

- Date of Birth

- Sex

- Room

- Status

- Number of Inpatient Days

NAME
The report contains the patient's name in the first demographic data column.

BIRTHDATE
The report contains the patient's date of birth to the right of the patient name.

SEX
The report prints *F* for a female patient or *M* for a male patient. This field prints to the right of the patient's date of birth.

ROOM
The report contains the patient's room number to the right of the sex code.

STATUS
The report contains the patient's status code to the right of the room number.

NUMBER OF INPATIENT DAYS
The report contains the number of days the patient has been in the hospital as an inpatient.

ACCESSION DATA

The following section prints for each accession in the patient's history cardfile. The report prints a horizontal line of hyphens before each set of accession data and after the Account Number and Last Edited fields.

ACCESSION NUMBER
The report prints the accession number in the first accession data field. This field is left justified.

ORDERED TEST NAME
The report prints the name of the test that was ordered for this accession below the accession number. This field contains a maximum of 20 characters and the report truncates the characters in the test name beyond the 20th character.

ORDERED DEPT
The report prints the department in which the order was originated below the ordered test name.

COLLECT DATE/TIME
The report prints the date and time the specimen was collected for the test below the ordered department.

ACCESSION DATE/TIME
The report prints the date and time the specimen was accessioned below the collection date and time.

UNIT NUMBER
The report prints the unit number below the accession date and time.

CASE NUMBER
The report prints the case number for this accession on the same line with the accession number on the right side of the report.

SPECIMEN TYPE
The report prints the specimen type below the case number.

--MODIFIER
The report prints the specimen modifier below the specimen type.

ORDER DIAGNOSIS
The report prints the order diagnosis below the modifier.

ORDER PHYSICIAN
The report prints the ordering physician below the order diagnosis.

FILE DATE/TIME
The report prints the date the history cardfile was created below the ordering physician.

RESULT COMPONENTS

The following fields represent result components for a test code. You can define different components to print on the report for each accession number and each test. Please refer to Chapter 15: History Cardfile in the *General Applications Volume I* of the *STAR Laboratory Reference Guide* for further information.

DATE OF SURGERY
The report prints the date the operation was performed for this accession below the horizontal line of hyphens. This field is left justified.

PHYSICIAN
The report prints the physician's name below the date of surgery.

SPECIMEN SOURCE
The report prints the specimen source information below the physician name.

DIAGNOSIS
The report prints the textual results of the diagnosis for this accession below the Specimen Source.

SNOMED CODES
The report prints the SNOMED codes for this accession below the Diagnosis.

Figure 3.10 Anatomic Pathology - Draft Past History Rpt (1 of 3)
(ALGRLGR0)

```
                                                        Page 1
                              Thu Aug 19, 1993 12:32 pm
                               History Cardfile Report

Name                    Birthdate:        Sex        Room         Status
SMITH,JANE G            01/01/59          F          LAA-105-02   I/P 1
-------------------------------------------------------------------------------
Accession Number :      1848                   Case Number    :   S93-112
Ordered Test Name:      5050-GROSS AND MICRO   Specimen Type  :   Appendix
Ordered Dept     :      LAB                    --Modifier      :   LIVER
Collect Date/Time:      08/19/93 1125          Order Diagnosis:
Acen Date/Time   :      08/19/93 1125          Order Physician:   RYAN, GEORGE S
Unit Number      :      A000000144            File Date/Time  :   08/19/93 1129
-------------------------------------------------------------------------------


Date of Surgery            08/19/93 0000


Physician                  Adams, Harold


Specimen Source            Appendix


-------------------------------------------------------------------------------
Accession Number :      9000000006             Case Number    :   S91-205
Ordered Test Name:      5050-GROSS AND MICRO   Specimen Type  :   Tissue
Ordered Dept     :      LAB                    --Modifier      :   Cervical
Collect Date/Time:      08/20/91 0800          Order Diagnosis:   OVARIAN CYST NE
Acen Date/Time   :      08/21/91 0900          Order Physician:   RYAN, GEORGE S
Unit Number      :      A000000144            File Date/Time  :   08/19/93 1123
-------------------------------------------------------------------------------

Diagnosis
Specimen labeled "left tube and ovary" and received fresh for frozen
section interpretation is an adnexal mass weighing 1270 grams.  The
fallopian tube is identified having a length of 6 cm and a greatest
diameter of 4 mm.  Underlying ovary is enlarged with a greatest diameter
of 14 cm. Capsular surface is for the most part intact;  however, areas
of apparent rupture of the capsular surface area seen with a diameter
of 5 cm.  Sectioning reveals a solid and cystic adenocarcinoma with
abundant mucus production.

Ovary shows a mucinous cystadenocarcinoma with individual cells and
nuclei showing abundant mucin production.  Grade I architecture is
identified;  however, indivimoderate nuclear pleomorphism present.

SNOMED CODET-83000,M-81403
     Cervix, uterine - Adenocarcinoma, NOS



(cont'd)
```

Figure 3.11 Anatomic Pathology - Draft Past History Rpt (2 of 3)
(ALGRLGR0)

```
                                                             Page 2
                              Thu Aug 19, 1993 12:32 pm
                               History Cardfile Report

Name                     Birthdate:         Sex        Room          Status
SMITH,JANE G             01/01/59           F          LAA-105-02    I/P 1
-------------------------------------------------------------------------------
Accession Number :       9000000006             Case Number   :     S91-205
Ordered Test Name:       5050-GROSS AND MICRO   Specimen Type :     Tissue
Ordered Dept     :       LAB                    --Modifier    :     Cervical
Collect Date/Time:       08/20/91 0800          Order Diagnosis:    OVARIAN CYST NE
Acen Date/Time   :       08/21/91 0900          Order Physician:    RYAN, GEORGE S
Unit Number      :       A000000144             File Date/Time :    08/19/93 1123
-------------------------------------------------------------------------------

SNOMED Code 1            T-87020, M-84703
(cont'd)                    Ovary, left - Cystadenocarcinoma, mucin, NOS

                        T-86120, M-84703
                          Fallopian tube, left - Cystadenocarcinoma, mjcin,
                          NOS

Date of Surgery         08/19/91 0000

Physician               Jones, Arnold K

Specimen Source         Cervical Biopsy
-------------------------------------------------------------------------------
Accession Number :       9000000005             Case Number   :     C89-555
Ordered Test Name:       5010-CYTOLOGY SMEAR,   Specimen Type :     PAP Smear
Ordered Dept     :       LAB                    --Modifier    :     N/A
Collect Date/Time:       04/01/89 0800          Order Diagnosis:    FEM GENITAL SYM
Acen Date/Time   :       04/01/89 0800          Order Physician:    RYAN, GEORGE S
Unit Number      :       A000000144             File Date/Time :    08/19/93 1105
-------------------------------------------------------------------------------

Diagnosis               Infection Suggestive Chlamydia species
                        Inflammatory/reactive Inflammatory - now specific
                        etiology Epithelial Cell Abnormalities Atypical
                        squamous cells of undetermined significance

SNOMED Code 1           T-83000,M-41740
                           Cervix, uterine - Abscess, NOS




                                  (cont'd)
```

Figure 3.12 Anatomic Pathology - Draft Past History Rpt (3 of 3)
(ALGRLGR0)

```
                                                      Page 3
                         Thu Aug 19, 1993 12:32 pm
                          History Cardfile Report

Name                 Birthdate:        Sex          Room          Status
SMITH,JANE G         01/01/59          F            LAA-105-02    I/P 1
--------------------------------------------------------------------------------
Accession Number :   9000000005             Case Number    :   C89-555
Ordered Test Name:   5010-CYTOLOGY SMEAR,    Specimen Type   :   PAP Smear
Ordered Dept    :    LAB                      --Modifier     :   N/A
Collect Date/Time:   04/01/89 0800           Order Diagnosis:   FEM GENITAL SYM
Acen Date/Time  :    04/01/89 0800           Order Physician:   RYAN, GEORGE S
Unit Number     :    A000000144              File Date/Time :   08/19/93 1105
--------------------------------------------------------------------------------

SNOMED Code 1        T-83000,M-41740
                       Cervix, uterine - Endometriosis, NOS

Maturation Index     Normal Estrogen Activity, > 85% superficial
                     keratinized cells

Estrogen Regimen     Normal















                          ** End of Report
```

REVIEW QUEUES

Review Queues function as a holding area of the system for tests which require review prior to release. Tests can be added manually to a queue or placed automatically in a queue, based on criteria defined in the test file.

The Review Queue is a process of result reporting. Workload can be captured through the Review Queue in much the same way as it is through the Repeat Queue. The information entered can be # of slides, exempt slides, or a combination of both.

NOTE: The Workload/QC screen that displays in the Review Queue contains the same fields as those on the Workload/QC screen in the Repeat Queue. For a description of these fields refer to the "Field Explanations" on page 3-161.

Screener identification for the Review Queue follows the same guidelines as it does in the Discrepancy Queue when the system defaults to the user signed on as the screener. For a description of this field and other information refer to the "Field Explanations" on page 3-161.

When you accept results through Review Queue reporting, you can be prompted to perform a GYN comparison and go directly to the GYN Comparison processor. To use this feature, you must have GYN Comparison - Review Queue Reporting activated with the Anatomic Path Parameters maintenance processor Review Queue Comparison setting.

The Perform GYN Comparison prompt only displays for tests in the review queue that meet the standard GYN comparison criteria:

- The test must be an AP type test.

- The case number pool must be defined as either histology or cytology.

- The case must have a GYN specimen type (primary or additional).

- The test code must have comparison components defined.

- The test must be in a partial or higher status (done, backloaded, cardfile or archived).

In the event a search is performed, the test must have been collected within the comparison search window time frame.

```
             General Hospital Histology Review Queue Reporting Processor
AC#:2359        GROSS AND MICROSCOPIC - TISSUE Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician     Srv ICD Status
A000000027 TESTWHITE,SHERRY F  02/18/1970             DOCTOR,ATTEND ERS 10  DIS EXP
Case#: S95-224                                                      Blocks: 3
                                    Specimen: Cervix

( 1) Date of Surge : Feb 19, 1995     (15)#Review Queue  : Dr. Smith
( 2) Physician     : SMITH            (16)*Released by    : Dr. Smith
( 3)*Clinical Hist : NONE PROVIDED
( 4) Specimen Sour : Cervix
( 5)*Frozen Sectio : 10/21 1604 BIOP|
( 6) Gross Descrip : 10/21 1605 NEG
( 7) Grossed by    : Dr. Smith
( 8)*Microscopic E : 10/21 1605 APP
( 9)*Read by       : Dr. Smith
(10) Diagnosis     : 10/21 1607 APP
(11)*SNOMED Code 1 : 10/21 1605 <1>
(12)*SNOMED Code 2 : 10/21 1606 <2>
(13)*Comment       :
(14)#Transcription : Janis Chastain,|

Perform GYN comparison? (Y/N) [Y]--
```

Once the *Logged!* message displays and prior to the *Continue with next report? (Y/N) [Y]--* prompt, the following prompt displays:

> *Perform GYN comparison? (Y/N) [Y]--*

The default, if any, is also determined by the Anatomic Path Parameters maintenance processor Review Queue Comparison setting.

If you enter **N**, the following prompt displays when additional entries are in the review queue to be processed:

> *Continue with next report? (Y/N) [Y]--*

If you enter **Y**, the system automatically takes you into the GYN Comparison processor. The case number just resulted through the review queue reporting processor is automatically selected as the first case for comparison. Comparison options are dependent on the case number pool assignment for this test:

If the case resulted is a cytology case, the options available are:

- Cytology to Histology

- Cytology to Cytology

If the case resulted is a histology case, the options available are:

- Histology to Cytology

• Histology to Histology

Once a valid option is selected, the Second Entry screen displays and the comparison process proceeds as described in the GYN Comparison part of this section.

When additional entries are in the review queue to be processed, once the comparison process is complete, or if the comparison process is interrupted at any point, the following prompt displays:

Continue with next report? (Y/N) [Y]--

For further details on Review Queues, see Chapter 6: Test Processing in the *General Applications Volume I* of the *STAR Laboratory Reference Guide.*

PATIENT INQUIRY

Patient Inquiry can be used as described in the *General Applications Volume I* of the *STAR Laboratory Reference Guide* with the exception of an additional method of accessing the patient through the case number.

> *Enter `&`unit,`*`account #,accession # or `[`case # --*
> *patient name (Last,First M), `-`SS# or `=` for current*

Identify the patient using one of the Patient Look-Up routines described under Accessing Patient Information in Chapter 4: Information Entry Techniques in the *General Information Volume* of the *STAR Laboratory Reference Guide.*

If you select a test through an Inquiry processor and the status of the test is QCC, the following message displays:

> *This test has a status of QCC!*

This message displays in the same location as the message when a test is in Specimen Received status and results are not available.

Viewing Word Processing Results

You can also enter the Anatomic Path case number preceded by an open bracket ([), for example, [S95-100. The system displays only that accession (functions the same as entering the accession number).

At all application entry points of the system that accept the case number as a valid entry, you now have the ability to key in part of the information that is actually accepted by the screen.

At case number entry points, case numbers that are defined for the current calendar year would be S95-111. The system now accepts the S111 and makes the appropriate interpretation. This eliminates the need for three keystrokes each time you enter a current year case number. The system continues to accept the complete entry of number and year. When the entry does not include a -, the system interprets it as current year.

Additional validity checks remain unchanged.

```
                 General Hospital Patient Inquiry Processor
                                         Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A0000105428SMITH, JANE         F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
 Case#: S95-111          Acct #: A9232800003                        Blocks: 1
            Accession # 5132 GROSS AND MICRO
Specimen: Tissue                                     Collected: 09/28/94 1407

Date of Surgery:        Sep 28, 1993
Physician:              GOLDEN
Clinical History:       Not available
Specimen Source:        Tissue
Frozen Section:         09/28 1049 APP
Gross Description:      09/28 1049 BIO
Grossed by:             Dr. Smith
Microscopic Exam:       09/28 1049 APP
Read by:                Dr. Smith
Diagnosis:              09/28 1050 VAS
SNOMED Code 1:          09/28 1050 <1>



Enter option--
                          * = options, / = next page
```

When you enter the asterisk (*) to view the options for selection, the system displays
the following screen:

```
                 General Hospital Patient Inquiry Processor
                                         Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room     Physician      Srv ICD Status
A100006298 TEST,AUDIT          F  01/02/1934 100-02  ADAIR,FRANK M MIC 10  OPR 144
 Case#: S04-44          Acct #: A0402300003
                 Accession # 9391 SNOMED
Specimen: Cyst                                       Collected: 06/07/04 1450


         D - Admit Dx List          B - Blood Product Avail
         R - Check Five by Result   F - Check Five by Test
         K - Comments               X - Fax
         G - General Information     H - History Cardfile
         M - MD Copy Audit          P - Print Primary
         S - Print Summary          RT- Resulting Techs
         C - SNOMED Codes           L - Test Lookup
         T - Tracking               V - View Report




Enter option--
                          * = Options
```

If you enter **V** to select the View Report option, the system displays the following
screen with the long textual results through the Softkey Editor processor. This option
appears in the prompt only when there are results to view.

If the test contains multiple word processing components, the system prompts you to
select the individual component or all word processing components.

```
                  General Hospital Patient Inquiry Processor
                                           Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician      Srv ICD Status
A0000105428SMITH, JANE         F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
 Case#: S93-111         Acct #: A9232800003                        Blocks: 1
          Accession # 5132 GROSS AND MICRO
Specimen: Tissue                                     Collected: 09/28/94 1407


Viewing Result:  Gross Description


   | Specimen consists of fragments of whitish fibrocartilaginous tissue in  |
   | aggregate measuring 2.5 cm.                                              |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |
   |                                                                         |

 1     2     3     4Scn 5Scn  6     7     8     9     1     1     1     1     1     1End
                   Fwd  Bck                          0     1     2     3     4     5Vw
```

The screen contains the patient demographics at the top, the case number, the result
name, and the specimen type. Press ALT-F5 key to return to the previous screen.

Long Report
If you enter **A** to select the Print Long Report option, the system displays the following
screen, enabling you to select the printer for the report:

```
                  General Hospital Patient Inquiry Processor
                                            Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician      Srv ICD Status
A0000105428SMITH, JANE         F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
 Case#: S93-111         Acct #: A9232800003                        Blocks: 1
          Accession # 5132      GROSS AND MICRO
Specimen: Tissue                                     Collected: 09/28/94 1407
                   Default S/P LONG REPORT printer
                  3RD FL MIDDLE PRTR RM (port # 116)

                        Alternate Printers
( 1) Port # 105 - OUTSIDE OF LABORATORY (Kyocera Laser
( 2) Port #  24 - IN PRINTER ROOM (*DG 6215
( 3) Port #  44 - LDM-800 PRINTER (B/600
( 4) Port #  71 - 3RD COPY ROOM (LIPS-10 Laser
( 5) Port # 115 - IN DATA CENTER (B/600
( 6) Port # 116 - 3RD FL MIDDLE PRTR RM (Kyocera Laser
( 7) Port # 122 - 3RD FL MIDDLE PRTR RM (Kyocera Laser



Enter option number of alternate printer [Port #116]--
                    next page(/)
```

When you access the preceding screen, the system displays the printers defined for
LRP - Partial Long Report (if the test has a status of *partial*) or LPS - S/P Long Report
(if the test has a status of *done* or greater). These printers are available to the Patient

Inquiry processor in STAR Laboratory only (not in STAR Patient Care). The Long
Reports generated by this processor use the forms defined as the main patient
Anatomic Path Long Report.

Fax Duplicate Copies
If you enter **X** to select the Fax option, the system displays the following screen:

```
                 General Hospital Patient Inquiry Processor
                                           Thu Jan 15, 2009 09:04 am
 Unit #      Name              Sex Birthdate  Room    Physician     Srv ICD Status
 A0000105428SMITH, JANE         F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
  Case#: S93-111              Acct #: A9232800003                     Blocks: 1
            Accession # 5132 GROSS AND MICRO
 Selected Locations:
 DEFAULT,PHYSICIAN           HMO   (404)668-5496








 Fax Long Report(L), Primary(P) or Summary(S)--
```

Select a report for faxing. The prompt does not include the long report option unless
there is a long report defined for the test and the test has a status of *partial* or higher.
You must print the long report once before you can issue a duplicate copy of the report
either by fax or local print. To exit this processor without faxing reports, press ENTER
(there is no default for this prompt).

STAR Laboratory enables you to display SNOMED Codes if a SNOMED Code
component is defined for the test regardless of the number of defined T/M
combinations (1 to 50). SNOMED Code components display with the date and time of
the last edit to the component. The number in brackets <1> refers to the number of T/
M combinations you have defined. Any time you edit the field, the system updates the
date/time and counter to indicate the current information.

SNOMED Code
If you enter **C** to select SNOMED Codes, the system displays all SNOMED Codes
defined for the test.

NOTE: If results for the test are being filed or used to generate a report, the following
message displays:

>   *Result for this accession being utilized! Try again later!*

The system displays the following screen, which contains the SNOMED Codes that
you have defined for the test:

```
                    General Hospital Patient Inquiry Processor
                                               Thu Jan 15, 2009 09:04 am
Unit #      Name                Sex Birthdate  Room     Physician      Srv ICD Status
A0000105428SMITH, JANE          F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
 Case#: S93-111                 Acct #: A9232800003                     Blocks: 1
           Accession # 5132 GROSS AND MICRO
Specimen: Tissue                                      Collected: 09/28/94 1407

                                   SNOMED Codes
SNOMED Code:
   Fallopian tube, NOS - Calcification (T-86100, M-55400)
   Ovary, left - Adenocarcinoma (T-87000, M-81403)




Press NL to continue--
```

Multiple Specimens

If you enter **MS** for Multiple Specimens at the Patient Inquiry processor, the system displays all the specimens defined for the case on the AnatomicPath Specimen Inquiry screen.

NOTE: The system does not display the MS option unless this is an Anatomic Path test type with a test status of specimen received or higher and multiple specimens for the case exist.

```
                    General Hospital Patient Inquiry Processor
                                               Thu Jan 15, 2009 09:04 am
Unit #      Name                Sex Birthdate  Room     Physician      Srv ICD Status
A0000105428SMITH, JANE          F  11/25/1974 1117-1  GOLDEN,SAMUEL ANS 10  I/P 15
 Case#: S93-111                 Acct #: A9232800003                     Blocks: 1
           Accession # 5132 GROSS AND MICRO
Specimen: Ovary-Left                                 Collected: 09/28/94 1407

                               Multiple Specimens

    Specimen               Modifier                   Receive Date/Time
     Tissue                                             09/28/94 1345
     Ovary                 Left                         09/28/94 1345
     Fallopian Tubes                                    09/28/94 1345




                    F1Page Prev F2 Next Rage F7Exit
```

The columns of information on this screen include the information entered in the case login order screen.

If more than one page of specimens is present, the system allows you to page forward and back to view all of the specimens with a scrolling screen. The following function keys are available in this processor.

F1 Prev Page F2 Next Page F7 Exit

MISCELLANEOUS CHARGE/CREDIT

The Miscellaneous Charge/Credit processor is used to apply charges/credits to patient accounts. Charges may be automatically captured for a histotech procedure if a Miscellaneous Charge code is assigned to both the single process and to the replicate. The code, description and price (assigned to this item) are captured. Replicate charges are captured when this procedure is performed multiple times per block. For further details on Miscellaneous Charge/Credit processing and other Billing information, please refer in the *General Applications Volume II* of the *STAR Laboratory Reference Guide*.

PROFESSIONAL BILLING

The Professional Billing processor is used to assign or edit the rendering physician and coding for a test, when you do not perform these tasks at the time of resulting. For further details on Professional Fee Billing and other Billing information, please refer in the *General Applications Volume II* of the *STAR Laboratory Reference Guide.*

HISTORY CARDFILE

History Cardfile is an online database used to store and retrieve specific patient results across all visits or accounts. Following is a brief overview of how Cardfile processors function. For further details, refer to Chapter 15: History Cardfile in the *General Applications Volume II* of the *STAR Laboratory Reference Guide.*

Overview

User-selected result components are stored in the cardfile upon result acceptance in STAR Laboratory. As many as 84 result components may be added to the cardfile for each test code. All result component types can be stored in History Cardfile. Any General Lab, Anatomic Pathology, or Advanced Blood Bank test type may be activated to file result components in the cardfile. Results are filed automatically or by prompting the user after accepting the values in the Results Entry processor.

Cardfile results are stored separately from other results allowing selective review of a patient's filed result values. This allows archiving of all results without sacrificing on-line inquiry of specific result components. The cardfile may be viewed through Cardfile Inquiry, Patient Inquiry, or an option in Results Entry and Review Queue processing. The cardfile displays essential demographic and user-selected result fields for each accessioned test. Demographic information includes:

- File Creation Date/Time

- Medical Record Number

- Account Number

- Anatomic Pathology Case/Cytology Number

- Accession Number

- Ordering Department

- Ordering Test Code

- Collect Date/Time

- Multiple Specimens and Modifiers

- Ordering Physician

- Ordering Diagnosis

- Most Recent File Edit Date/Time

The most common application of the History Cardfile is in Anatomic Pathology/ Cytology sections. One "card" is assigned to each test of the case number. Typically these tests have diagnostic summary, interpretation, or SNOMED code result components which are clinically relevant in subsequent cases. When stored in the cardfile, previous results are accessible through Cardfile Inquiry. SNOMED code results, accessible through a Cardfile Search, allow similar case review based upon topographical and morphological code. Other applications for the History Cardfile include Blood Bank and Special Chemistry. Cardfile results, such as ABO/Rh Type, Antibody Identification, and Chromosome Analysis, are stored for each accessioned test and accessible through Cardfile Inquiry.

Results are added to the cardfile once they are accepted in Results Entry processing. If a result is designated to be filed in the cardfile but has no value, no cardfile entry is made for that result. If a result value is changed after being accepted, the cardfile is updated with the most recent entry.

NOTE: Results on tests in a QCC status are not stored in the cardfile.

Backloading Previous Cases

Results not currently stored in the STAR Laboratory database (those entered prior to system LIVE and those archived from the system) can be backloaded into the cardfile. Since backloaded cases must have valid medical record and account numbers, an admission processor is provided to enter any missing patients. (Although patient admission on STAR Laboratory is allowed in stand-alone and interfaced environments such as CLINIPAC, when STAR Laboratory is networked to STAR Patient Care, patients must be admitted on Patient Care.)

An accession range from 9000000001 to 9999999999 indicates a backloaded accession. These accessions can have user-assigned case numbers and backdated collection, accession and completion dates. When resulting backloaded accessions, only those results filed in the cardfile display. Backloaded accessions are assigned a status of Backload when accessioned and keep this status after all results are entered. As long as the accession status remains Backload, results may be edited. Backloaded accession are accessible in Patient Inquiry only through the accession number.

Accessions already in STAR Laboratory can be added to the cardfile by re-resulting the accession (for example, adding an internal result to the test code) after indicating which result component is to be stored in the cardfile.

History Cardfile Functions

CARDFILE INQUIRY
This processor allows viewing of results stored in the cardfile for a selected patient. Cardfiles display in reverse chronological order with the most recent card displaying first. You can page backward (to previous cards) and forward (to more recent cards) and can print or queue each card individually.

Multiple Specimens: The History Cardfile processor displays multiple specimens in the same format as the Patient Inquiry processor. The multi-specimen (MS) option has been added to the prompt in History Cardfile for an Anatomic Path type test.

The multi-specimen option displays only if multiple specimens are defined. If you select the MS option, the system displays a screen containing all specimens.

 NOTE: Cardfile inquiry is also possible through the following:

Patient Inquiry - Cardfile inquiry can be accessed from the result display screen within Patient Inquiry by entering **H** at the prompt.

Results Entry - Cardfile inquiry can be accessed from the results entry by entering **/H** (slash H) at a specific result field or at the prompt.

Review Queue - Cardfile inquiry can be accessed from the review queue by entering **/H** (slash H) at a specific result field or at the prompt.

CARDFILE SEARCH
This function allows review of all SNOMED type results stored in the cardfile. The search retrieves all similar cards/cases (based upon SNOMED coding) as specified in the search criteria. The search may be displayed or printed. If displayed, the search produces a listing of all similar cards/cases, which may be reviewed in more detail from the search listing screen (see Cardfile Inquiry). If printed, the search produces a list of all similar cards/cases.

CARDFILE QUEUE PRINT
This function allows printing of all cards placed in the cardfile queue. Either a Cardfile Summary or Detail Report may be produced. The Cardfile Summary Report lists all cards in the queue. The Cardfile Detail Report prints a separate page for each card in the cardfile queue and deletes the card from the queue.

PREVIOUS CASE ADMISSION
This function allows patient admission on STAR Laboratory and is restricted to stand-alone and interfaced environments. If your STAR Laboratory system is networked to STAR Patient Care, patients must be admitted on Patient Care. This processor is only intended for patient accounts being backloaded, that is if an account already exists on the system, this step is not necessary. This option is reserved for employees with a security level greater than or equal to that defined in the History Cardfile Flags.

PREVIOUS CASE ACCESSION
This function allows previous cases (anatomic pathology/cytology related and others) to be accessioned. Accessions entered through this processor are automatically assigned sequential accession numbers from 9000000001 to 9999999999, indicating that these are backloaded accessions. The case number, an optional field, is user-assignable and the Collection, Accession, and Complete Date fields may be backdated as necessary. All accessions which are entered through this processor have a status of Backload. This option is reserved for employees with a security level greater than or equal to the one defined in the History Cardfile Flags.

NOTE: For CMS-Compliant outpatients refer to "CMS COMPLIANCE CHECKING (OPCD)" on page 3-96.

PREVIOUS CASE RESULT
This function allows you to enter results on previous cases (anatomic pathology/cytology related and others). Only backloaded accessions can be resulted through this processor; however, these accessions can be resulted through either the Previous Case Result or Results Entry processor. The Previous Case Result processor is located in the History Cardfile menu for convenience. Only those results filed in history cardfile display for resulting. Backloaded accessions which have been resulted maintain a status of Backload.

PREVIOUS CASE LISTING
This function prints a list of all cases which have been backloaded and accessioned as well as those which have been resulted. It provides a current listing of those cases with a status of Backload and flags those which have results in the cardfile. It may also be used to list all backloaded cases which have only been accessioned.

Midnight Processing

Two cardfile functions are performed by midnight processing:

Cardfile Status Change

Each backloaded accession is given a status of Backload at accessioning remains that throughout resulting. The status automatically changes to Cardfile by midnight processing based on the status retention criteria. The status retention defines the maximum number of days to allow resulting after the first cardfile result has been entered. Once an accession's status changes to Cardfile, no edits are allowed.

Print Queue Deletion

The print queue is automatically deleted each time a Detail Report is printed. However, if a Detail Report is not printed, midnight processing deletes all entries in the print queue which have exceeded the Queue Retention Days.

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HISTOTECH PROCESSING WORKLOAD RECORDING

Workload capture of Anatomic Pathology can occur upon completion of a histotech process. Unlike other sections within STAR Laboratory, many of the procedures are completed prior to test completion and apart from results entry. Workload units, captured automatically wherever possible, can also be captured through the Manual Workload Capture processor for miscellaneous and additional histotech procedures. For further details on Workload processing, refer to Chapter 11: Workload Processing in the *General Applications Volume II* of the *STAR Laboratory Reference Guide*.

```
        General Hospital Anatomic Pathology Histotech Processing Processor
Accn #: 1465                               Thu Jan 15, 2009 09:04 am
Unit #     Name          Sex Birthdate  Room    Physician     Srv ICD Status
A001042621 JOHNS,ALLAN    M  02/02/1922 3101-2  ADAIR,FRANK C EMR 10  PER 1
Opt Case #    Block  Specimen/Process Description        Test  ProcessedPage:01
 1) S93-8       A    Liver Biopsy                    TISSUE - GROSS EXAM
                        1a) Cyto smr, from fluid -  @1               Yes
                        1b) Silver Stain - @001                      No
 2) S93-8       B    Liver Biopsy                    GROSS & MICROSCOPIC
                        2a) H & E Stain - @3.0                       No
                        2b) Cyto smr - @2.0                          Yes
                        2c) Mason's Trichrome slds @2 x 2            Yes




Capture standard (W)orkload, (R)epeat workload or (N)o workload? [N] --
                Cyto smr, from fluid of Block S93-18-A
```

Additional workload can be captured if an existing block is processed again, as in the case of reprinting labels. You are given the option of capturing standard workload defined for the histotech process displayed in the line below the prompt (enter **W**), repeat workload (enter **R**) or no workload (enter **N** or press ENTER).

CYTOLOGY QA

This section-level function accesses a submenu that includes options related to cytology workload, quality control, and quality assurance. These options include the following:

- Repeat Queue

- Discrepancy Queue

- Print Repeat/Discrepancy Queue

- Update Workload Information

- Management Reports

To access this function, select Cytology QA on the section menu.

```
                    General Hospital Pathology Processor
                                              Thu Aug 19, 2004 12:54 pm
 Pathology Input Options


         Option No.  Option
         --------------------------------------
             1       Patient Inquiry
             2       Order Entry
             3       Case Login
             4       Anatomic Path Order Management
             5       Histo/Cytotech Processing
             6       Histo/Cytotech Processing Report & Audit
             7       Recall Management
             8       Anatomic Path Result Reporting
             9       Review Queue Reporting
            10       History Cardfile - Network
            11       Miscellaneous Charge/Credit
            12       Professional Billing Input
            13       Cytology QA
            14       Long Reports Batch
            15       Incomplete Work Report
            16       Histo/Cyto Process Audit & Rpt
 Enter option number--
```

The following screen displays:

```
                         General Hospital Pathology Processor
                                            Mon Jun 12 1995 11:07 am
Pathology Cytology QA Input Options

            Option No.  Option
            ----------------------------------------
               1        Repeat Queue
               2        Discrepancy Queue
               3        Print Repeat/Discrepancy Queue

               4        Update Workload Information

               5        Management Reports




Enter option number--
```

Repeat Queue

The Repeat Queue provides additional quality control for tests previously resulted in
result reporting. The system conducts a *blind* review in the Repeat Queue, without
knowledge of previously entered results. The Repeat Queue also captures screener
and case workload when appropriate.

NOTE: Once a test is in the Repeat Queue, it is not eligible for processing through
results reporting. If the test is in a QCC status, the previously entered results
cannot be viewed through the Inquiry processors. If a test is sent to the
Repeat Queue using the RQ options and is in a Done status, the previously
entered results can be viewed through the Inquiry processors. If a test is sent
to the Repeat Queue using the RQ option and is in a Partial status, the results
may or may not be viewable through the Inquiry processors, depending on
how your facility has set your partial results flag.

To access this option, select Repeat Queue on the Cytology QA Input Options menu.
If Cytology Workload/QC is not active, the following message displays and the system
returns you to the submenu for another selection:

Cytology quality control not activated!

If no tests exist in the Repeat Queue, the system displays the following message and
returns you to the submenu for another selection.

No entries available!

If tests exist in the Repeat Queue, the Repeat Queue index screen displays a table of available tests to be processed. The tests appear in order of case number (oldest case number first) by case number pool. Other information includes the test number and name, original screener ID code, and status of the test.

```
                    General Hospital Repeat Queue Processor
                                        Mon Jun 12, 1995 12:50 pm

                         Repeat Queue              ##=Current Choices
Opt#    Case #           Test Name                 Screener    Status
( 1)    C94-416    5014-CYTOLOGY,*GYN SMEAR        7141        Partial
( 2)    C94-423    5014-CYTOLOGY,*GYN SMEAR        7989        QCC














 Enter option(s) to process or delete(D)--
                            end selection(NL)
```

The following prompt displays for table selection if you do not have adequate security level to use the Delete option:

> *Enter option(s) to process--*
> *end selection(NL)*

You can select one or more entries from the screen. If you select more than one entry, the system completes processing the first selection before it displays information for the next one.

If you have adequate security to use the Delete option, the following prompt displays:

> *Enter option(s) to process or delete(D)--*
> *end selection(NL)*

DELETING A TEST

If you enter **D**, the system displays the following prompt:

> *Enter option to delete--*

The test will not be processed through the QC process if you delete it from the Repeat Queue. An audit of the deletion will appear on the QC Process Deletion Audit Management Report. For an example of this report refer to Figure 3.22 QC Process Deletion Audit (ALGRLGR0) 3-306 in this chapter.

One of two scenarios can occur when you delete a test in the Repeat Queue.

SCENARIO 1 - TEST IS IN A QCC STATUS
If you select a test in a QCC status for deletion, the following prompt displays:

Test in a QCC status! Original results will be accepted! Are you sure? (Yes/N)--

If you enter **N**, you can select another option to delete. If you enter **Yes**, the system displays the following message:

Logged!

Impact

- The system updates the status of the test to Partial or Done, based on the result components that were resulted through result reporting.

- The system prompts you to enter information for cardfile entry and/or professional fee billing processing, based on flag settings.

- The system maintains the Workload/QC information (case level and screener level) entered through result reporting with the test.

- You can use the Inquiry functions to view the test results entered through result reporting, based on flag settings.

- You can process the test again through result reporting.

- You can process the test through the Review Queue if the status indicates and Review Queue processing is defined for the test.

NOTE: The prompt to print previous history results (when the test is in a Done status) is not an option when the test is deleted from the Repeat Queue.

SCENARIO 2 - TEST IS IN A PARTIAL OR DONE STATUS
If you select a test in a Partial or Done status for deletion, the system displays the following message:

Deleted!

Impact

- The status of the test is not changed.

- You can use the Inquiry functions to view the test results entered through result reporting, based on flag settings.

- You can process the test again through result reporting.

• The system maintains the Workload/QC information (case level and screener level) entered through result reporting with the test.

• You can process the test through the Review Queue if the status indicates and Review Queue processing is defined for the test.

PROCESSING A TEST

When you select a test to process on the Repeat Queue screen, the following screen displays and prompts you to enter the screener code.

```
                    General Hospital Repeat Queue Processor
AC#:1136        GROSS AND MICROSCOPIC - TISSUE  Thu Jan 15, 2009 09:04 am
Unit #     Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000000140 SMITH,JAN        F  04/11/1959 2111-02 9999          MED 10  I/P 33
Case#: C94-423                                                  Blocks: 1
                              Specimen: Pap Smear








 Enter screener code or '-' for table--
```

The prompting of the screener code enables the transcriptionist to enter results, while capturing Workload/QC information for the screener who performed the microscopic exam at the same time.

If you are not defined in the Cytology Personnel maintenance processor, the system displays the following prompt:

Enter screener code or '-' for table--

If you are defined in the Cytology Personnel maintenance processor as an active Cytology screener, the system displays a default of your screener code. If you are the screener who performed the microscopic examination for the test, you can press ENTER at the following prompt:

Enter screener code or '-' for table [signed on user's code]--

If you enter an invalid code, the system displays the following message:

Invalid code!

If you enter a hyphen (**-**) at the prompt, the following screen displays:

```
                General Hospital Repeat Queue Processor
AC#:1136        CYTOLOGY, *GYN SMEAR              Thu Jan 15, 2009 09:04 am
Unit #     Name              Sex Birthdate  Room    Physician    Srv ICD Status
A000000140 SMITH,JAN          F  04/11/1959 2111-02 9999         MED 10  I/P 33
Case#: C94-423                                                   Blocks: 1
                                  Specimen: Pap Smear


          Screener                        Max Sld Count    QC N/A      Page:01
( 1) Martin,Walter [4454]                     90
( 2) Jones,William M.D. [5544]               100
( 3) Smith,Cindy [6692]                       90
( 4) Walker,John [5545]                       90
( 5) White,Marty [66985]                      90
( 5) Williamson,Martha [5598]                 80
( 6) Wilson,Sally [6564]                      95




Enter choice--

```

This screen displays a table of active screeners from the Cytology Personnel maintenance processor. You must enter a valid screener to proceed through the Repeat Queue process. When you do so, a modified Result Reporting screen displays.

```
                General Hospital Repeat Queue Processor
AC#:1136        CYTOLOGY, *GYN SMEAR              Thu Jan 15, 2009 09:04 am
Unit #     Name              Sex Birthdate  Room    Physician    Srv ICD Status
A000000140 SMITH,JAN          F  04/11/1959 2111-02 9999         MED 10  I/P 33
Case#: C94-423                                                   Blocks: 1
                                  Specimen: Pap Smear

( 1) Clinical Data : ****
( 2) Specimen Adeq : Unacceptable
( 3)*Explanation   : ****
( 4) Diagnosis     :
( 5) Categorizatio :
( 6) Recommendatio :
( 7) SNOMED Code 1 :
( 8)#Review Queue  : Dr. Smith
( 9)#Transcription :
(10)SReleased by   :



Enter number to edit, fill(F), print(P) or accept(A)--
                    * = options, draft(D), fax(X), Queue(Q)
```

The system displays the following prompt as the main prompt for entering results:

Enter number to edit, fill(F), print(P), or accept(A)--
*   *=options, draft(D), fax(X), Queue(Q)*

The options on the previous prompt are dependent on flag settings for the section and test. If you enter period (.) ENTER at the prompt, the system returns you to the Repeat Queue index screen to select another entry for processing or continues with your next selection, if you made more than one.

If you select *, a list of / (slash) options display. You do not have to enter **/** before the alpha characters when you select from the list. If you select these additional options on the main prompt, you must include the /.

ENTERING RESULTS

Based on the settings in the Repeat Queue Results maintenance processor, the components that display on the resulting screen have different result entry criteria.

Auto - Autofill

Certain results from the original resulting processor display in dim video in the Result fields for those components defined in Repeat Queue Results maintenance processor as Auto. If a component is defined to autofill and no results are entered on the original result reporting, asterisks (****) display in the Component Result field. If you select an autofill component, the following message displays:

Result is autofill - No edits allowed!

Disc - Discrepancy Check

Components defined in the Repeat Queue Results maintenance processor as Disc are eligible for entering results. These results are entered through result reporting and checked against the results entered through the Repeat Queue. The system interprets any differences between the original results entered through results reporting and the results entered through the Repeat Queue as a discrepancy. If a discrepancy exists, the test is sent to the Discrepancy Queue for processing.

None

Components defined in the Repeat Queue Results maintenance processor as None are eligible for entering results. Discrepancy checking is not performed on these components.

WORKLOAD/QC PROCESSING

When you accept the Result Entry screen, the Workload/QC screen displays if the screener code entered has not had workload captured for this case through the Repeat Queue. If multiple tests on the same case are processed through the Repeat Queue by the same screener, the screener will only be prompted the first time to enter workload/QC information.

The system checks the screener code to evaluate the slide count for the previous 24 hours and/or 8-hour period, depending on flag settings, and does the 8-hour check prior to the 24-hour check if the setting indicates that the 8-hour check is activated. A message displays prior to the Workload/QC screen, when indicated:

[SCREENER NAME] has screened the maximum number of slides

for the [24 or 8]-hour period!

You can continue the process by responding to the following prompt:

Continue? (Y/N) [N]--

If you enter **N**, the system returns you to the Repeat Queue index screen. No results are recorded and no workload/QC information is captured.

If you enter **Y**, the system continues the Repeat Queue process with the display of the Workload/QC screen. The case is flagged as having exceeded the screener's maximum workload on Management Reports.

Workload and QC information is stored at the case level and at the screener level. Fields on the Workload/QC screen may contain previously entered data, based on prior result reporting activity on the case, prior workload activity for the screener, and/ or prior QC processing on the case.

```
                    General Hospital Repeat Queue Processor
AC#:1136        CYTOLOGY, *GYN SMEAR              Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician    Srv ICD Status
A000000140 SMITH,JAN         F  04/11/1959 2111-02 9999         MED 10  I/P 33
Case#: C95-423                                               Blocks: 1
                              Specimen: Pap Smear

 1 Screener ID
   Martin,Walter [5564]


   Current 24-Hour Window
 2 Slide Count   3 Maximum Count    4 Total Time        5 Most Recent Workload
   25.0             80.0              06:00  (00:30)       06/12/95 1510

   Current Case Information
 6 # of Slides  7 Exempt Slides  8 Slide Count  9 High Risk  10 Diag Category
->                                              Yes


   Additional Information
11 24-Hour Start Time      12 Other Slide Count     13 Other Duties
   06/12/95 1004            0.0                      0

Enter number of slides [2]--
```

Field Explanations

1. SCREENER ID (DISPLAY ONLY)
This field contains the name and ID code of the screener entered at the beginning of the Repeat Queue processor.

Current 24-Hour Window

This section of the screen displays information about the screener's current 24-hour window. The information is reset each 24 hours and gives an accurate picture of the screener's status with regard to the defined limits.

2. SLIDE COUNT (DISPLAY ONLY)
This field contains the total slide count for the current 24-hour window for the screener. It represents the sum of all slide counts filed by the system for this screener for the amount of time from the 24-Hour Start Time (Field 11) to the current system time. The first time a screener enters data to begin a new 24-hour window, *0.0* displays in this field.

3. MAXIMUM COUNT (DISPLAY ONLY)
This field contains the maximum number of slide counts allowed by the screener in a given 24-hour time frame. This value is defined in the Cytology Personnel maintenance processor.

4. TOTAL TIME (DISPLAY ONLY)
This field contains the total time consumed within the screener's current 24-hour window. Two different times are included:

- The first value is the total time spent screening slides during the screener's current 24-hour window.

- The second value (in parenthesis) is the total time spent on other duties during the screener's current 24-hour window.

- The total of these two times (in military time) represents the number of hours between the 24-hour start time and the current system time.

The first time a screener enters data to begin a new 24-hour window, *00:00* displays in this field.

5. MOST RECENT WORKLOAD (DISPLAY ONLY)
This field contains the date and time of the most recent workload for the screener. This information provides an indicator of how long it has been since workload was captured by the system and helps determine whether additional information will be entered in Field 13 (Other Duties). No data appears in this field for the first time through in the current 24 hours.

Current Case Information

This section of the screen is used to enter workload and quality control information related to the current case.

6. # OF SLIDES (2-N-C)
This field contains the number of physical slides examined when determining the results for the case. A default can be defined for this field in the Workload/Quality Control Parameters maintenance processor. You can enter up to two digits, using *0* to *99.* When you access this field, the system displays the following prompt:

> *Enter number of slides [user defined default]--*

7. EXEMPT SLIDES (2-N-C)
This field contains the number of exempt slides allowed on this case for this screener. This number will not be counted against the screener's 24-hour maximum slide count.

The following scenarios describe the criteria that can be used to determine whether data should be entered in this field rather than in Field 6 and Field 8.

Scenario 1. An individual qualified as a technical supervisor is examining tissue slides associated with the case or is using the Repeat Queue processor to review previously examined slides for the case. These slides are not counted against the screener's 24-hour maximum. The system stores this information and prints the number on management reports, separated out from the slide counts that are included in the screener's maximum.

Scenario 2. An individual *not* qualified as a technical supervisor is using the Repeat Queue for an interim review before sending the cases to the technical supervisor. The slides for that individual will not be entered in this field. Slides are not considered exempt except for individuals qualified as technical supervisors.

When you access this field, the system displays the following prompt with a default of zero (0):

> *Enter number of exempt slides [0]--*

You can enter **0** to **99**. This field enables you to follow regulations and to have flexibility when regulations change and impact which slides will be counted against the screener's maximum workload value. The system does not determine when data must be entered in this field in order to accept the screen. You make that decision, according to the policies of your institution.

NOTE: Either the # of Slides field or the Exempt Slides field is required. One of the two fields must have a value greater than zero (0). Both fields can have values entered. If you try to enter **0** in both fields, the following prompt displays:

> *# of slides required!*

If you enter data in the # of Slides field, the Slide Count field is also required.

8. SLIDE COUNT (4-NC-R)
This field contains the slide count for this case and this screener. This is the count that
is totalled and then checked against the individual's 24-hour maximum slide count.

You can enter **0.5** to **99**. The only valid decimal value is in increments of *0.5*. The entry
of one or one-half counts depends on the method of slide preparation. Preparations
that disperse cells on less that half the slide (cytospin prep) should count as *0.5* for
each slide. If cells are dispersed over the entire slide (pap smear), a count of *1.0*
should be entered for each slide examined.

When you access this field, the system displays the following prompt:

> *Enter slide count for case workload [user defined default]--*

You can define a default for this prompt in the Workload/Quality Control Parameters
maintenance processor.

NOTE: If you try to enter data in this field without entering data in Field 6, the system
displays the following message and returns you to Field 6:

> *# of slides required!*

The system makes an additional check. The number entered in Field 6 and
the number in Field 8 must be valid. The value entered in this field must be
less than or equal to the entry in Field 6. If you enter a value that does not
meet this criteria, the system displays the following message:

> *Slide count cannot exceed number of slides!*

If you change Field 6, you must update this field. Field 7 does not impact the
value in this field.

9. HIGH RISK (DISPLAY ONLY)
This field contains information designating the patient as high risk. This information is
entered through result reporting the first time Workload/QC information is captured for
the case. If the information in this field is incorrect, you must change it through the
Update Cytology Workload Information processor.

10. DIAG CATEGORY (TABLE LOOKUP-R)
This field contains the QC diagnosis category for this case. The field is required the
first time Workload/QC information is entered on the case through the Repeat Queue.
For subsequent entries for this case, the field is Display Only.

When you can access this field, the system displays the following prompt:

> *Enter diagnosis code or '-' for table--*

Entering a hyphen (**-**) displays a table of active diagnosis categories defined in the Diagnosis Categories maintenance processor. If the information in this field is incorrect, you must change it through the Update Cytology Workload Information processor.

Additional Information

The information in this section of the screen is related to the screener rather than to the current case. You can use this section of the screen to enter data related to the starting time of your current 24-hour window. You can also enter information related to work performed in another laboratory, as well as the time spent performing duties other than screening of cytology cases.

11. 24-HOUR START TIME (DATE FORMAT-C)
This field contains the 24-hour start time for this screener. The time entered must be within 24 hours of the current system time. If you have worked in this 24-hour window at another laboratory, you should enter the time you started working at the other laboratory.

The 24-hour maximum slide count for each screener is checked against the current 24-hour window. The maximum is calculated for work performed in a 24-hour period and is not specific to an individual location. The following prompt displays with a default of current system date and time when you access this field:

> *Enter date/time first case screened [current date/time]--*

The system makes multiple checks on the data entered in this field. Various error messages display when an invalid date/time is entered.

- Date/time entered overlaps a previous 24-hour window:*Date/time overlaps previous 24-hour window!*

- Date/time entered exceeds 24 hours back from current system time:*Date/time not in previous 24-hour window!*

- Date/time entered is in the future:*Date/time in future!*

After the start time has been filed the first time for the screener in the current 24-hour window, the field is Display Only. You must make any updates through the Update Workload Information processor.

12. OTHER SLIDE COUNT (4-NC-O)
This field contains the slide count the screener has performed during the current 24-hour window at another location. The slide count entered in this field will not be counted as department workload. It will be counted only against the 24-hour maximum for the screener. You can enter digits with decimals in increments of 0.5.

You must enter the 24-Hour Start Time field before this field can be accessed. Otherwise, the following message displays:

> *24-hour state time required!*

When you access this field, the system displays the following prompt with a default of zero (0):

Enter total slide count from other location [0]--

13. OTHER DUTIES (4-NC-O)
This field enables you to enter time during the current 24-hour window not spent screening slides. You must enter the 24-Hour Start Time field before you can access this field. Otherwise, the following message displays:

24-hour state time required!

When you access this field, the system displays the following prompt with a default of zero (0):

Enter hours spent on other duties than screening (i.e. 0.25, 1.5) [0]--

You can enter time in this field in increments of 0.25 hours (15-minute increments). When the system files the entry, the information in Field 4 (Total Time) is updated to reflect the addition. If the entry is greater than the time defined in Field 4 (Total Time), the following message displays:

Cannot exceed total screening time!

NOTE: The amount of time you enter depends on the scenario:

(1) If this is the first workload capture for the current 24-hour window (Most Recent Workload field is blank), enter the amount of time spent on activities other than screening slides *since the 24-hour start time*.

(2) If this is the second or any subsequent workload capture for the current 24-hour window (a value displays in Most Recent Workload field), enter the amount of time spent on activities other than screening slides *since the most recent workload*.

The following prompt displays upon completion of the Workload/QC screen:

Accept this screen? (Y/N) [Y]--

If you press period (.) ENTER out of the Workload/QC screen, the system returns you to the previous index screen for another selection. The results you entered are not filed, and the test remains in the Repeat Queue in its original status.

Viewing Original/QC Results

Once you accept the Workload/QC screen, the system performs a discrepancy check between the results just entered and those previously entered through result reporting. The following prompt displays:

View original results (Y/N) [Y]?--

If you enter **Y**, the following screen displays with both the original and the QC results.

```
                    General Hospital Repeat Queue Processor
AC#:1039                    CYTOLOGY,*GYN SMEAR     Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000000125 BROWN, CINDY      F  09/08/1989         GARDNER, JANE MED 10  DIS
Case#: C94-485                         Specimen: PAP Smear         Blocks: 1
Orig Diag: Unsatisfactory              QC Diag: Negative
  Component                    Original Results
   Clinical Data            : Not available
   Specimen Adeq            : Unacceptable
   Explanation              : Bloody smear
   Diagnosis                : Unable to report
   Recommendations          : Submit new specimen
F1=Prev Pg    F2=Next Pg     QC Results         F5=Change Window    F7=Exit
   Clinical Data            : Not available
   Specimen Adeq            : Acceptable
   Explanation              :
   Diagnosis                : Normal PAP Smear
   Recommendations          : Follow-up in one year
```

The format of the screen is as follows:

- The original and QC diagnosis categories display below the Patient Demographics information.

- The original results display in the top window of the screen.

- The QC results display in the bottom window.

- F5 toggles between windows. F1 and F2 view additional results in both windows.

- F7 exits the display of results.

Components with a discrepancy display both the component name and result in bright video. All other component names and results display in dim video.

NOTE: Valid Value and Delta Check flags do not display with results on this screen.

Filing Results

When you exit the Result View screen or enter **N** at the preceding prompt, the system takes you to the next step in the QC process. If a discrepancy occurred between the original results and the QC results on the components flagged to check for discrepancies, the following message displays:

Test sent to discrepancy queue!

If no discrepancies were found, the following message displays:

Logged!

(1) When no discrepancies exist, the process completes as follows:

- The original results entered through result reporting are filed and available for inquiry and patient reporting.

- Results entered through the Repeat Queue for components that were left blank through result reporting and were defined as *None* in the Repeat Queue Results maintenance processor are filed to the patient report and become available for inquiry.

- This processing accommodates components with Autofill ID/required special processing and security crosslinks needed to have the test reach a Done status. The pathologist can then complete the test through the Repeat Queue without having to send the test to the Review Queue (when no discrepancies are defined).

- The original diagnosis category entered through result reporting is filed as the final diagnosis category on the case for Management Reports.

- The QC results and diagnosis category entered through the Repeat Queue are logged for Cytology QA Management Reports.

- Tests in a QCC status are updated to Partial or Done, based on the results entered through result reporting and those logged through the Repeat Queue.

- Tests in a Partial status are sent to the Review Queue for processing, if indicated by maintenance processor settings and resulted components.

- The system prompts for History Cardfile or files results automatically to the Cardfile, as indicated by maintenance processor settings.

(2) When discrepancies exist, the process completes as follows:

- The test is sent to the Discrepancy Queue for processing.

- If the test was in a QCC status when it was placed in the Repeat Queue, the status is not changed. The test cannot be processed through result reporting, nor can the results be viewed through the Inquiry processors.

- If the test was in a Done status when it was placed in the Repeat Queue, the status is not changed. The test cannot be processed through result reporting, but the original results can be viewed through the Inquiry processors.

- If the test was in a Partial status when it was placed in the Repeat Queue, the status is not changed. The test cannot be processed through result reporting and the original results may or may not be viewable through the Inquiry processors, depending on how your facility has set you view partial results flag.

When processing is complete for the selected test, the system returns to the Cytology QA submenu. If you selected more than one test, the next test is processed when you respond **Y** to the following prompt.

Continue with next selection? (Y/N) [Y]--

If you press ENTER, the next selection appears for processing. If you enter **N**, you return to the submenu.

SPECIAL CONSIDERATIONS

RT Option

The information available through the Resulting Tech (RT) option in Patient Inquiry and results reporting display the name of the person signed on when results were entered either in result reporting or the Repeat Queue, as indicated for each component.

Professional Fee Billing

The prompt for Professional Fee Billing does not occur when results are logged out of the Repeat Queue in a Done status. The following applies if your system is configured to prompt for Professional Fee Billing when results are accepted:

• If the test enters the Repeat Queue in a QCC status and you complete the test through the Repeat Queue, the Professional Billing processor must be used to enter professional fee billing information.

Discrepancy Queue

The Discrepancy Queue is used to process tests with discrepancies between the original results entered in result reporting and the QC results entered in the Repeat Queue. Information entered through this processor can be used as documentation for monitoring screener accuracy. Once a test is in the Discrepancy Queue, it is not eligible for processing through results reporting or the Repeat Queue. If the test is in a QCC status, the previously entered results cannot be viewed through the Inquiry functions.

If the test is in a Done status, the previously entered results can be viewed through the Inquiry functions. If the test is in a Partial status, the previously entered results may or may not be viewed through the Inquiry functions depending on how your facility has set your view partial results flag.

To access this option, select Discrepancy Queue on the Pathology Cytology QA Input Options menu. If Cytology Workload/QC is not active, the following message displays:

Cytology quality control/workload not activated!

The system also checks for a valid level of security. The security level needed to access this processor is defined in the Workload/Quality Control Parameters maintenance processor. The following prompt displays:

> *Enter ID code--*

If the security code is not high enough, the following message displays:

> *NOT authorized for this function!*

When no tests are in the Discrepancy Queue, the following message displays:

> *No entries available!*

If tests exist in the Discrepancy Queue, the Discrepancy Queue Index screen displays a table of available tests to be processed. Information on the screen includes the case number, test code, test name, test status, and names of original and QC screeners.

```
                  General Hospital Discrepancy Queue Processor
                                             Mon Jun 12, 1995 11:07 am

                              Discrepancy Queue                    Page:01
 Opt#  Case #            Test Name
 ( 1)  C95-465           5014-CYTOLOGY,*GYN SMEAR
         Orig: Martin,Walter           QC: Smith,Jane
 ( 2)  C95-482           5014-CYTOLOGY,*GYN SMEAR
         Orig: Williamson,Martha       QC: Mason,Charles








 Enter option to process or delete(D)--
```

The tests appear in order of case number (oldest case number first). If several test exist on the same case, the tests display inASCII sequence. The system displays the following prompt:

> *Enter option to process or delete(D) --*

DELETING A TEST

If you enter **D**, the system displays the following prompt:

> *Enter option to delete--*

The test will be removed from the QC process if you delete it from the Discrepancy Queue. An audit of the deletion will appear on the Cytology Workload/QC

Management Report, QC Process Deletion Audit. For an example of this report refer to Figure 3.22 QC Process Deletion Audit (ALGRLGR0) 3-306.

One of two scenarios can occur when you delete a test in the Discrepancy Queue.

SCENARIO 1 - TEST IS IN A QCC STATUS
If you select a test in a QCC status for deletion, the following prompt displays:

Test in a QCC status! Original results will be accepted! Are you sure? (Yes/N)--

If you enter **N**, you can select another option to delete. If you enter **Yes**, the system displays the following message:

Logged!

Impact

- The system updates the status of the test to Partial or Done, based on the result components that were resulted through result reporting.

- You can process the test again through result reporting.

- The system prompts you to enter information for cardfile entry and/or professional fee billing processing, based on flag settings.

- The system maintains the Workload/QC information (case level and screener level) that was entered through result reporting and the Repeat Queue with the test.

- The QC results entered through the Repeat Queue are available on the Repeat QC Management Report.

- The original results entered through result reporting are filed to the patient's record. No results entered from the Repeat Queue will be available for reporting on the patient reports or viewable through Inquiry processors.

- You can process the test through the Review Queue if status indicates and Review Queue processing is defined for the test.

NOTE: The prompt to print previous history results (when the test is in a Done status) is not an option when the test is deleted from the Discrepancy Queue.

SCENARIO 2 - TEST IS IN A PARTIAL OR DONE STATUS
If you select a test in a Partial or Done status for deletion, the system displays the following message:

Deleted!

Impact

- The status of the test is not changed.

- No QC results entered from the Repeat Queue will be available for reporting on the patient reports or viewable through the Inquiry processors.

- The original test results entered through result reporting will be available through the Inquiry processors, based on flag settings.

- You can process the test again through result reporting.

- The system maintains the Workload/QC information (case level and screener level) that was entered through result reporting and the Repeat Queue with the test.

- You can process the test through the Review Queue if status indicates and Review Queue processing is defined for the test.

- The results entered through the Repeat Queue are available on the Repeat QC Management Report.

WORKLOAD/QC PROCESSING

When you select an option from the Discrepancy Queue to process, the system checks your sign-on code. If you are an active screener in the Cytology Personnel maintenance processor and you have no workload associated with the selected case, the Workload/QC screen appears. You are assumed to be the screener and the system automatically enters your ID into the Screener ID field.

The system considers all workload captured through this processor to be exempt from counting against the 24-hour maximum count for the screener. These cases have already been reviewed at least twice (once through result reporting and once through Repeat Queue).

NOTE: You do not have to be defined in the Cytology Personnel maintenance processor to process tests through the Discrepancy Queue. The system will not prompt you for entry of workload/QC information. It takes you directly to view original/QC results.

NOTE: This feature enables rotating pathologists who might not routinely deal with cytology cases to review, interpret and complete the Cytology QA process without workload tracking.

```
                        General Hospital Discrepancy Queue Processor
AC#:1014        GROSS AND MICROSCOPIC - TISSUE     Thu Jan 15, 2009 09:04 am
Unit #      Name              Sex Birthdate  Room    Physician      Srv ICD Status
A000000086 BROWN, CINDY    M  05/15/1995 CCU-05  SMITH, JOHN    ERS 10  I/P 561
Case#: S95-452                                                   Blocks: 1
                                  Specimen: Pap Smear

 1 Screener ID
   Williamson, Martha [197]


   Current 24-Hour Window
 2 Slide Count   3 Maximum Count    4 Total Time       5 Most Recent Workload
   0.0             80.0               00:00

   Current Case Information
 6 # of Slides  7 Exempt Slides  8 Slide Count  9 High Risk  10 Diag Category
->                                               No

   Additional Information
11 24-Hour Start Time      12 Other Slide Count    13 Other Duties
                                                      0

Enter number of slides [2]--
```

Field Explanations

1. SCREENER ID (DISPLAY ONLY)
This field contains the name and ID of the screener entered at the beginning of the
Discrepancy Queue processor.

Current 24-Hour Window

This section of the screen displays information relating to the screener's current 24-
hour window. The information is reset each 24 hours and gives an accurate picture of
the screener's status with regard to the defined limits.

2. SLIDE COUNT (DISPLAY ONLY)
This field contains the total slide count for the current 24-hour window for the screener.
It represents the sum of all slide counts filed by the system for this screener for the
amount of time from the 24-Hour Start Time (Field 11) to the current system time. The
first time a screener enters data to begin a new 24-hour window, *0.0* displays in this
field.

3. MAXIMUM COUNT (DISPLAY ONLY)
This field contains the maximum number of slide counts allowed by the screener in a
given 24-hour time frame. This value is defined in the Cytology Personnel
maintenance processor.

4. TOTAL TIME (DISPLAY ONLY)
This field contains the total time consumed within the screener's current 24-hour
window. Two different times are included:

- The first value is the total time spent screening slides during the screener's current 24-hour window.

- The second value (in parenthesis) is the total time spent on other duties during the screener's current 24-hour window.

- The total of these two times (in military time) represents the number of hours between the 24-hour start time and the current system time.

The first time a screener enters data to begin a new 24-hour window, *00:00* displays in this field.

5. MOST RECENT WORKLOAD (DISPLAY ONLY)
This field contains the date and time of the most recent workload episode for the screener. This information provides an indicator of how long it has been since workload was captured by the system and helps determine whether additional information will be entered in Field 13 (Other Duties). No data appears in this field for the first time through in the current 24 hours.

Current Case Information

This section of the screen is used to enter workload and quality control information related to the current case.

6. # OF SLIDES (DISPLAY ONLY)
This field cannot be accessed through the Discrepancy Queue. It is used in result reporting and the Repeat Queue to enter data about the number of physical slides that were examined for the case and counted against the screener's 24-hour maximum. All slides examined as a result of this processor are considered exempt and are not counted against the 24-hour screener maximum. This field displays *0*.

7. EXEMPT SLIDES (2-N-C)
This field contains the number of exempt slides examined for this case by this screener. All slides examined as a result of the Discrepancy process are considered exempt and are entered in this field. This number is not counted against the screener's 24-hour maximum.

When you access this field, the system displays the following prompt:

Enter number of slides--

You can enter **1** to **99** in this field.

NOTE: This data appears on Cytology Workload/QC Management Reports. It is evaluated separately from the data counted for the 24-hour maximum for the screener.

8. SLIDE COUNT (DISPLAY ONLY)
This field cannot be accessed through the Discrepancy Queue. It is used in result reporting and the Repeat Queue to enter data about the number of counts that are examined for the case and counted against the screener's 24-hour maximum.

All slides examined as a result of this processor are exempt and will not be counted against the 24-hour screener maximum. This field displays *0*.

9. HIGH RISK (DISPLAY ONLY)
This field contains information designating the patient as high risk. This information is entered through result reporting the first time Workload/QC information is captured for the case. If the information in this field is incorrect, you must change it through the Update Cytology Workload Information processor.

10. DIAG CATEGORY (DISPLAY ONLY)
This field contains the most current diagnosis category for this case. The field can be accessed the first time through result reporting for the case and the first time through the Repeat Queue. If the information in this field is incorrect, you must change it through the Update Cytology Workload Information processor.

Additional Information

The information in this section of the screen is related to the screener rather than to the current case. This section of the screen enables you to enter data related to the starting time of your current 24-hour window. You can also enter information related to work performed in another laboratory, as well as the time spent performing duties other than screening of cytology cases.

11. 24-HOUR START TIME (DATE FORMAT-C)
This field contains the 24-hour start time for this screener. The time entered must be within 24 hours of the current system time. If you have worked in this 24-hour window at another laboratory, you should enter the time you started working at the other laboratory.

The 24-hour maximum slide count for each screener is checked against the current 24-hour window. The maximum is calculated for work performed in a 24-hour period and is not specific to an individual location. When you access this field, the following prompt displays with a default of current system date and time:

> *Enter date/time first case screened [current date/time]--*

The system makes multiple checks on the data that is entered in this field. Various error messages display when an invalid date/time is entered.

- Date/time entered overlaps a previous 24-hour window:*Date/time overlaps previous 24-hour window!*

- Date/time entered exceeds 24 hours back from current system time:*Date/time not in previous 24-hour window!*

- Date/time entered is in the future:*Date/time in future!*

After the start time has been filed the first time for the screener in the current 24-hour window, the field is Display Only. Any updates must be made through the Update Workload Information processor.

12. OTHER SLIDE COUNT (4-NC-O)
This field contains the slide count the screener has performed during the current 24-hour window at another location. You can enter digits with a decimal in increments of *0.5*. The slide count entered in this field is not counted as department workload. It is counted only against the 24-hour maximum for the screener.

You must enter the 24-Hour Start Time field before this field can be accessed. Otherwise, the following message displays:

24-hour state time required!

When you access this field, the system displays the following prompt with a default of zero (0):

Enter total slide count from other location [0]--

Once you accept the data in this field, any updates to the information must be made through the Update Workload Information processor.

13. OTHER DUTIES (4-NC-O)
This field enables you to enter time during the current 24-hour window not spent screening slides. You must enter the 24-Hour Start Time field before you can access this field. Otherwise, the following message displays:

24-hour state time required!

When you access this field, the system displays the following prompt with a default of zero (0):

Enter hours spent on other duties than screening (i.e. .25, 1.5) [0]--

You can enter time in this field in increments of 0.25 hours (15 minute increments). When the system files the entry, the information in Field 4 (Total Time) is updated to reflect the addition. If the entry is greater than the time defined in Field 4 (Total Time), the system displays the following message:

Cannot exceed total screening time!

NOTE: The amount of time you enter depends on the scenario:

(1) If this is the first workload capture for the current 24-hour window (Most Recent Workload field is blank), enter the amount of time spent on activities other than screening slides *since the 24-hour start time*.

(2) If this is the second or any subsequent workload capture for the current 24-hour window (a value displays in Most Recent Workload field), enter the amount of time spent on activities other than screening slides *since the most recent workload*.

If you press period (.) ENTER out of the Workload/QC screen, the system returns you to the previous index screen for another selection. The workload and QC information is not captured. The test remains in the Discrepancy Queue in its original status.

When you complete the information on the Workload/QC screen, the following prompt displays:

Accept this screen? (Y/N) [Y]--

If you enter **Y**, the system displays the following screen with both the original and the QC results.

```
                 General Hospital Discrepancy Queue Processor
AC#:4011                    CYTOLOGY,*GYN SMEAR    Thu Jan 15, 2009 09:04 am
Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000000430 BUCKLEY,JOANN    F  01/05/1951 106-01  BABB,GARY H   MED 10  I/P 36
Case#: C95-399                          Specimen: PAP Smear
Orig Diag: NORMAL                       QC Diag: POSITIVE
  Component                 Original Results
   Clinical Data          : NORMAL HISTORY
   Specimen Adequacy      : Satisfactory
   Explanation            :
   Diagnosis              : Infection
   Categorization         : CLASS I - Within Normal Limits
   Recommendations        : Follow-up with collection of genital specimen for
                          : routine
F1=Prev Pg    F2=Next Pg   QC Results           F5=Change Window     F7=Exit
   Clinical Data          : NORMAL HISTORY
   Specimen Adequacy      : Satisfactory
   Explanation            :
   Diagnosis              : Nonspecific fungal organism
   Categorization         : CLASS III - Atypical cells with pre-malignant
                          : features
   Recommendations        : Follow-up with collection of genital specimen for
```

The format of the screen is as follows:

• The original and QC diagnosis categories display below the Patient Demographics information.

• The original results display in the top window of the screen.

• The QC results display in the bottom window.

• F5 toggles between windows.

• F1 and F2 view additional results in both windows.

• F7 exits the display of results.

Components with a discrepancy display both the component name and results in bright video. All other component names and results display in dim video.

NOTE: Valid Value and Delta Check flags do not display with results on this screen.

When you press **F7** from the display of results, the following screen displays. You can select options and record comments to process the discrepancy.

```
                    General Hospital Discrepancy Queue Processor
AC#:4011                    CYTOLOGY,*GYN SMEAR      Thu Jan 15, 2009 09:04 am
Unit #     Name         Sex Birthdate  Room    Physician     Srv ICD Status
A000000430 BUCKLEY,JOANN   F  01/05/1951 106-01  BABB,GARY H   MED 10  I/P 36
Case#: C95-399                         Specimen: PAP Smear
Orig Diag: NORMAL                      QC Diag: POSITIVE

 1 Clinical      2 Discrepancy Category               3 View Results
->
 4 Corrective Action Comment



 5 Report/Validate              6 Diagnosis Category




Is this a clinical discrepancy? (Y/N)--
```

Field Explanations

1. CLINICAL (1-A-R)
This field enables you to indicate whether the discrepancy is of clinical importance or can be disregarded. When you enter the field, the following prompt displays:

Is this a clinical discrepancy? (Y/N)--

If you enter **N**, Fields 2, 5, and 6 display N/A. You can still view the results (Field 3), or enter a comment (Field 4). No miss is filed against either screener, original or QC.

If you enter **Y**, you indicate that the discrepancy is of clinical importance. You can access Fields 2, 5, and 6.

2. DISCREPANCY CATEGORY (TABLE LOOKUP-R)
This field enables you to enter the code of up to six characters or a hyphen (**-**) for a table display of all active discrepancy categories defined in the Discrepancy Category maintenance processor. The system displays the following prompt:

Enter the discrepancy code or '-' for table--

3. VIEW RESULTS (1-A-O)
This field enables you to return to the split screen format of the original and QC results and once again review the results. Any information entered on this screen is retained when you return to the Result Viewing screen and then return to the Discrepancy Entry screen.

4. CORRECTIVE ACTION COMMENT (220-C-O)
This field enables you to enter 220 characters of free text. You can use the field to document the corrective action taken for the screener who made the error, or to justify why the discrepancy found by the system was not considered to be of clinical significance. The following prompt displays:

Enter comment--

The information entered in this field appears on the Discrepancy Report in the Management Reports section.

5. REPORT/VALIDATE (1-A-C)
The field provides access only if Field 1 is set to *Yes*. The system does a check on the status of the test.

(1) If the test is in a Partial or Done status, the following prompt displays:

Validate original(O), qc(Q) or neither(N) screener's results--

Processing through the Discrepancy Queue when the test is not in QCC does not affect the results that will be filed to the patient record. The original results will be filed to the patient record. The system performs a validation of the screeners and documents it for use on Management Reports.

When you accept the screen, the system interprets your entry for this field as follows:

- If you entered **O**, the original screener on the case is validated as *Correct*. The system files the miss for the QC screener who entered QC results through the Repeat Queue. Only the results entered through result reporting will be available in the patient record.

- If you entered **Q**, the QC screener on the case is validated as *Correct*. The system files the miss for the original screener who resulted the test through result reporting. Only the results entered through result reporting will be available in the patient record. After accepting the screen, the following message is displayed:

Miss(es) filed! Additional followup may be required! Press NL--

If you want the QC screener results to be reported, you must make those changes in result reporting.

• If you entered **N**, the system files misses for both the original and the QC screeners. The original results entered through result reporting will be available in the patient record. After accepting the screen, the following message is displayed:

Miss(es) filed! Additional followup may be required! Press NL--

If you don't want either of the results to be reported, you must make those changes in result reporting.

(2) If the test is in a QCC status, the system displays the following prompt:

Report original(O), qc(Q) or no(N) results--

When the test is in a QCC status, processing though the Discrepancy Queue determines which set of results will be filed to the patient record and files misses to the appropriate screeners.

When you accept the screen, the system interprets your entry for this field as follows:

• If you entered **O**, the system files the original results as the reportable results. These results were entered through result reporting and the miss will automatically be filed to the screener who resulted the test from the Repeat Queue (QC screener).

• If you entered **Q**, the system files the QC results entered through the Repeat Queue as the reportable results. The screener who entered results through results reporting will be given the miss (original screener).

• If you entered **N**, the system logs a miss to both the original and the QC screeners. The test is returned to a Specimen Received status. The Workload/ QC information for the case and for the screeners (both original and QC) is retained for Management Reports.

6. DIAGNOSIS CATEGORY (TABLE LOOKUP-C)
This field enables you to enter a final diagnosis category for the case for Management Reports. The system automatically fills this field based on selections for Field 1, Clinical, and Field 5, Report/Validate:

• If Field 1 is *N*, the original diagnosis category displays.

• If Field 1 is *Y* and you chose to report or validate the *original* screener or results (you selected O in Field 5), the original diagnosis category displays.

- If Field 1 is *Y* and you chose to report or validate the *QC* screener or results (you selected Q in Field 5), the QC diagnosis category displays.

- If Field 1 is *Y* and you chose to report or validate *neither* screener or results (you selected N in Field 5), *N/A* displays.

You can also manually update this field. The following prompt displays:

Enter diagnosis category or '-' for table--

NOTE: If the original Diagnosis Category needs to be updated, you must use the Update Workload Information processor.

Impact

Use the following tables to validate the processing that occurs through the Discrepancy Queue. You must first determine whether the discrepancy has clinical significance. If it does not, the outcome is the same for all tests. If the discrepancy is clinical, the outcome depends on the status of the test and the validation of the screener's results (original results, QC results, no results).

Non-Clinical Discrepancy Interpretation

Test Status	Miss(es) Assigned	System Messages	Outcome
All Statuses	None	Logged!	-System files results that were entered in result reporting and any additional results entered from the Repeat Queue (those defined as None in the Repeat Queue Results builder and not resulted through result reporting) to patient record.
			-System prompts for History Cardfile entry (if applicable).
			-Updates can be made through result reporting.
			-Review Queue processing is now available (if applicable).
			-All results entered through the Repeat Queue will be available on the Repeat QC Management Report.
			-Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.

Clinical Discrepancy Interpretation

Test Status	Report/Validate	System Messages	Outcome
QCC	Original results reported	Logged!	-Original results filed to patient record.
			-A miss is filed for the QC screener.
			-System prompts for History Cardfile entry (if applicable).
			-Updates can be made through result reporting.
			-Review Queue processing is now available (if applicable).

Test Status	Report/Validate	System Messages	Outcome
			-All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.
QCC	QC results reported	Logged!	-Repeat Queue results filed to patient record. -A miss is filed for the original screener. -System prompts for History Cardfile entry (if applicable). -Updates can be made through result reporting. -Review Queue processing is now available (if applicable). -All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.

Test Status	Report/Validate	System Messages	Outcome
QCC	Neither Original nor QC results reported	Test returned to Spec Recd status! Add. followup may be required! Press NL--	-No results are filed to the patient record. -Status of test is returned to Specimen Received. -A miss is filed for both the original and QC screeners. -All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.
Partial or Done	Original screener input validated	Miss(es) filed! Add. followup may be required! Press NL--	-No change to status of test. -System files a miss for the QC screener. -Updates can be made to the test through result reporting. -Only results entered through result reporting will be available in the patient record. -Review Queue processing is now available (if applicable). -All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.

Test Status	Report/Validate	System Messages	Outcome
Partial or Done	QC screener input validated	Miss(es) filed! Add. followup may be required! Press NL--	-No changes to status of test. -System files a miss for the original screener. -Updates can be made to the test through result reporting. -Only results entered through result reporting will be available in the patient record. -Review Queue processing is now available (if applicable). -All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.
Partial or Done	Neither screener's input validated	Miss(es) filed! Add. followup may be required! Press NL--	-No change to status of test. -System files misses to the original and the QC screener. -Updates can be made to the test through result reporting. -Only results entered through result reporting will be available in the patient record. -Review Queue processing is now available (if applicable). -All results entered through the Repeat Queue will be available on the Repeat QC Management Report. -Results entered through result reporting and flagged as having a discrepancy with Repeat Queue results will be available on the Repeat QC Management Report.

SPECIAL CONSIDERATIONS

RT Option

The information available through the Resulting Tech (RT) option in Patient Inquiry and results reporting display the name of the person signed on when results were entered either in result reporting or the Repeat Queue, as indicated for each component.

Professional Fee Billing

The prompt for Professional Fee Billing does not occur when results are logged out of the Discrepancy Queue in a Done status. The following applies if your system is configured to prompt for Professional Fee Billing when results are accepted:

- If the test enters the Repeat Queue in a QCC status and you complete the test through the Discrepancy Queue, the Professional Billing processor must be used to enter professional fee billing information.

Print Repeat/Discrepancy Queue

The Print Repeat/Discrepancy Queue prints lists of entries currently in the Repeat Queue or the Discrepancy Queue. It can be used when more than one screener is assigned to review different groups of tests or screeners in the Repeat Queue or the Discrepancy Queue.

To access this option, select Print Repeat/Discrepancy Queue on the Pathology Cytology QA Input Options menu. The Repeat Queue Report can be sorted by screener or test code for the Repeat Queue. The secondary sort is by date with the oldest date first. The Discrepancy Queue Report sorts by the original screener or the QC screener.

When the sort is by screener, the screener name prints once for each individual. When the sort is by test code, the test code/description prints once for each test.

```
 General Hospital Print Repeat/Discrepancy Queue Processor
                                             Fri Apr 16, 1993 10:09 am
 Print Repeat/Discrepancy Queue

 1 Queue              2 Sort                  3 Number of Copies
 ->                                           1
 4 Default Printer
   Closet (Port #55)




 Print repeat(R) or discrepancy(D) queue--
```

Field Explanations

1. QUEUE (1-A-R)
This field determines which queue will print a list of entries. The system displays the following prompt:

Print repeat(R) or discrepancy(D) queue--

2. SORT (1-A-R)
This field contains the options you can select to sort. If you select Repeat Queue, the system displays the following prompt:

Sort by screener(S) or test code(T)--

If you select Discrepancy Queue, the system displays the following prompt:

Sort by original(O) or qc(Q) screener--

3. NUMBER OF COPIES (2-N-O)
This field enables you to select the number of copies to print. The default is one copy. The following prompt displays:

Enter number of copies to print (1-99) [1]--

4. DEFAULT PRINTER (TABLE LOOKUP-R)
This field contains a table of available printers. The default printer displays in the field. If you want to select an alternate printer, enter the field and respond to the following prompt:

Enter option number of alternate printer [Default Printer]--

Update Workload Information

The Update Workload Information option updates workload and quality control information for an individual case or screener workload episode. To access this option, select Update Workload Information on the Pathology Cytology QA Input Options menu.

You must have adequate security to access this function, as defined in the Quality Control/Workload maintenance processor. If the level is not high enough, the system displays the following message and enables you to enter an additional security level:

Enter ID code--

If the security level is still not high enough, the following message displays:

NOT authorized for this function!

Once your security is validated, you can update a specific case or screener. The following screen displays.

```
                  General Hospital Update Workload Information Processor
                                                   Mon Jun 12 1995 10:09 am












  Update case(C) or screener(S) workload--
```

The system prompts you to select a case or screener for the update with the following message:

Update case(C) or screener(S) workload--

UPDATING CASE LEVEL INFORMATION

If you select a case workload update by entering **C**, the following prompt displays:

Enter case number--

You can enter a complete format of the case number or a partial entry of the case number pool and number. If you enter a case number that does not have a workload indicator defined in the Case Number Pool maintenance processor, the following message displays:

No workload captured for case number [case number entered at prompt]!

If you press ENTER or press period (.) ENTER, you return to the previous prompt to select a case or screener for update. When you enter a valid case number, the following screen displays.

```
           General Hospital Update Workload Information Processor
                                            Thu Jan 15, 2009 09:04 am
   Unit #      Name          Sex Birthdate  Room    Physician    Srv ICD Status
   A000000641 LEVINE,ANN      F  03/04/1956 104-02  GARDNER, JANE MED 10  I/P 26

   Case: C95-44
                          Case Level Information
    1 Number of Slides                 2 High Risk
      1                                  Yes

    3 Original Diagnosis Category       4 QC Diagnosis Category
      Negative                           N/A




   Enter field number or '/' starting field number--
```

Field Explanations

1. NUMBER OF SLIDES (2-N-R)
This field enables you to enter the number of slides to be updated. The number in this field is the number of slides entered the first time workload and QC information is captured on the case through results reporting. The system uses this number to compile data for the Department Workload Report. The default is the previously entered value filed for the case.

The system displays the following prompt:

Enter number of slides [current value]--

2. HIGH RISK (1-A-R)
This field enables you to determine whether the patient case is classified as a high risk. The default is the previously entered value filed for the case. The system displays the following prompt:

Is patient high risk? (Y/N) [Y]--

3. ORIGINAL DIAGNOSIS CATEGORY (3-A-R)
This field contains the diagnosis category entered through result reporting. The system displays the following prompt:

Enter diagnosis category or '-' for table [current value]--

4. QC DIAGNOSIS CATEGORY (3-A-R)
This field contains the QC Diagnosis category entered through the Repeat Queue. The system displays the following prompt:

Enter diagnosis category or '-' for table [current value]--

If a QC value does not exist for this field, N/A displays and the field cannot be edited. When you complete all the fields, the system displays the following prompt:

Accept this screen? (Y/N) [Y]--

If you enter **N**, you can continue to edit the fields on the screen. If you enter **Y** or press ENTER, the following message displays:

Update(s) Filed!

UPDATING SCREENER LEVEL INFORMATION

You can update workload information for active screeners for a limited period of time. If you selected a screener workload update by entering **S** for screener at the initial processor prompt, a table of active entries from the Cytology Personnel maintenance processor displays with the following prompt:

Enter choice--

```
      General Hospital Update Workload Information Processor
                                          Mon Jun 12, 1995 01:32 pm
 Update Workload Information

        Screener                    Max Sld Count     QC N/A      Page:01
( 1) Walker,Cindy [197]                  80
( 2) Martin,Walter [444]                 90










 Enter choice--

```

When you select a valid screener, the following table of workload episodes for the screener displays. Workload episodes are sorted by date and time of workload capture.

A screener can have multiple workload episodes for a case, if the case has been processed through several processors (results reporting, Repeat Queue, Discrepancy Queue, Review Queue). Cases can be listed more than once.

```
                General Hospital Update Workload Information Processor
                                                Mon Jun 12, 1995 10:35 am
  Update Workload Information

                      Workload Episodes for Walker,Cindy          Page:01
 ( 1) C95-44       06/12/95 0901
 ( 2) C95-38       06/12/95 0930
 ( 3) C95-45       06/12/95 1015








 Enter choice--
```

Two categories of workload episodes are available for update: (1) The screener's current active 24-hour window; (2) The screener's previous 24-hour window.

- A screener's 24-hour window is considered current or active only when the 24-hour start time is within 24 hours of the current system date and time. Episodes included in the current active 24-hour window display in bright video.

- A screener's 24-hour window is considered *not* active when the most recent 24-hour start time precedes 24 hours of the current system date and time. Episodes included in the previous or mostrecent 24-hour window display in dim video.

- Episodes from only one previous 24-hour window are available for updates.

When you select an entry from the current 24-hour window (bright video), the following screen displays.

```
                 General Hospital Update Workload Information Processor
                                               Mon Jun 12, 1995 10:35 am
 Update Workload Information
                                               Episode:C95-44
                                                     06/12/95 0901


 1 Screener ID
   Walker,Cindy [197]


 2 Slide Count    3 Maximum Count     4 Total Time       5 Most Recent Workload
   1.0                80.0              01:35               06/12/95 1015


   Episode Information
 6 Number of Slides        7 Exempt Slides          8 Slide Count
   2                       0                         1.0

   Current 24-Hour Information
 9 24-Hour Start Time     10 Other Slide Count    11 Other Duties
   06/12/95 0900           0.0                       0



 Enter field number or '/' starting field number--

```

Field Explanations

EPISODE (DISPLAY ONLY)
This field displays the case number and date/time of workload capture.

1. SCREENER ID (DISPLAY ONLY)
This field contains the name and ID code of the selected screener.

2. SLIDE COUNT (DISPLAY ONLY)
This field contains the total slide count for the current 24-hour window for the screener.
It represents the sum of all slide counts filed by the system for this screener for the
amount of time from the 24-Hour Start Time (Field 9) to the current system time.

3. MAXIMUM COUNT (DISPLAY ONLY)
This field contains the maximum number of slide counts allowed by the screener in a
given 24-hour time frame. This value is defined in the Cytology Personnel
maintenance processor.

4. TOTAL TIME (DISPLAY ONLY)
This field contains the total time consumed within the screener's current 24-hour
window. Two different times are included:

- The first value is the total time spent screening slides during the screener's
  current 24-hour window.

• The second value (in parenthesis) is the total time spent on other duties during the screener's current 24-hour window.

• The total of these two times (in military time) represents the number of hours between the 24-hour start time and the current system time.

5. MOST RECENT WORKLOAD (DISPLAY ONLY)
This field contains the date and time of the most recent workload for the screener. The workload is filed when the results are accepted through result reporting.

Episode Information

This section of the screen is used to modify workload information related to the current episode.

6. NUMBER OF SLIDES (2-N-C)
This field contains the number of physical slides examined by the screener in resulting the test. You can enter up to two digits, using *0* to *99*. Once you enter a value in this field, you must enter data in the Slide Count field. When you access this field, the system displays the following prompt:

Enter number of slides [current value]--

7. EXEMPT SLIDES (2-N-C)
This field contains the number of exempt slides allowed on this case for the screener. This number will not be counted against the screener's 24-hour maximum slide count. The current value is the default for the prompt that displays when you access this field:

Enter number of exempt slides [current value]--

8. SLIDE COUNT (4-NC-R)
This field contains the screener's slide count for this episode on the case. When you access this field, the system displays the following prompt:

Enter slide count for case workload [current value]--

If you try to enter data in this field without entering data in the Number of Slides field, the system displays the following message and returns you to Field 6:

# of slides required!

The system makes an additional check. The numbers entered in Field 6 and Field 8 must be valid. The value entered in this field must be less than or equal to the entry in Field 6. If you enter a value that does not meet this criteria, the system displays the following message:

Slide count cannot exceed number of slides!

If the Number of Slides field is greater than zero (0), entering a zero in this field displays the following message:

Zero slide count not allowed!

Current 24-Hour Information

This section of the screen displays information relevant to the screener's current 24-hour window. This information is reset each 24 hours and gives an accurate picture of the screener's status with regard to the defined limits.

9. 24-HOUR START TIME (DATE FORMAT-C)
This field contains the 24-hour start time for this screener. The time entered should be within 24 hours of the current system time. If you have worked in this 24-hour window at another laboratory, you should enter the time you started working at the other laboratory.

The system displays the following prompt:

Enter date/time first case screened [current date/time]--

The system makes multiple checks on the data entered in this field. Various error messages display when the wrong date/time is entered.

- Date/time entered overlaps a previous 24-hour window:*Date/time overlaps previous 24-hour window!*

- Date/time entered exceeds 24 hours back from current system time:*Date/time not in previous 24-hour window!*

- Date/time entered is in the future:*Date/time in future!*

10. OTHER SLIDE COUNT (4-NC-O)
This field contains the slide count the screener has performed in the past 24 hours at another location. The slide count entered in this field will not be counted as department workload. It will be counted only against the current 24-hour maximum for the screener.

When you access this field, the system displays the following prompt:

Enter total slide count from other location [current value]--

11. OTHER DUTIES (4-NC-O)
This field enables you to enter time during the current 24-hour window not spent screening slides. When you access this field, the system displays the following prompt:

Enter hours spent on other duties than screening (i.e. 0.25, 1.5) [current value]--

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NOTE: The current value is the total of all Other Duties erties made by the screener during the current 24-hour window.

When you accept this screen, the system displays the following prompt and returns you to the submenu for another selection:

Update(s) Filed!

When you select an episode outside the current 24-hour window (dim video), a modified workload screen displays.

```
                   General Hospital Update Workload Information Processor
                                               Mon Jun 12, 1995 07:55 am
 Update Workload Information

                                               Episode: C95-30
                                                        06/09/95 0857


 1 Screener ID
   Walker,Cindy [197]

   Episode Information
 2 Number of Slides        3 Exempt Slides           4 Slide Count
   2                         0                         2.0







 Enter field number or '/' starting field number--
```

For an explanation of the field descriptions on this screen refer to the "Field Explanations" on page 3-276.

Management Reports

Select Management Reports on the Pathology Cytology QA Input Options menu. This processor displays a table of reports available for selection. These reports include the following:

- Department Workload Report

- Diagnosis Categories Report

- Discrepancy Report

- GYN Comparison Report

- QC Process Deletion Audit

- Repeat QC Report

- Screener GYN QC Report

- Screener Workload Report

```
                General Hospital Management Reports Processor
                                           Mon Jun 12, 1995 12:49 pm
Laboratory

                    Cytology Workload/QC Management Reports          Page:01
( 1) Department Workload Report
( 2) Diagnosis Categories Report
( 3) Discrepancy Report
( 4) GYN Comparison Report
( 5) QC Process Deletion Audit
( 6) Repeat QC Report
( 7) Screener GYN QC Report
( 8) Screener Workload Report




 Enter choice--

```

All reports except the GYN Comparison report are related to the Cytology QA workload /QC processing. You only have access to these management reports when Cytology Workload/QC is activated.

The GYN Comparison Report provides information related to GYN comparisons only and is independent of any Cytology Workload/QC processing performed through the Repeat and Discrepancy Queues.

Unless otherwise noted, with the exception of the GYN Comparison report, the following conditions apply to all Workload/QC Management Reports:

- Data is limited to tests linked to Case Number Pools with the Workload/QC indicator set to *Yes.*

- Data is limited to tests in a QCC or higher status.

- For multi-department institutions, data is limited to Case Number Pools for the current department.

- The diagnosis category included in reports is the final or *most current* diagnosis category entered in the system for the case.

- Reports can be printed to hard copy or displayed to the screen.

- Reports can include diagnosis categories, screeners, and GYN specimen types that are both active and/or inactive as indicated by report, date range, and user-selected options.

NOTE:

- Workload/QC episodes are recorded during result reporting, Repeat Queue processing, Discrepancy Queue processing, and Review Queue processing. The multiple episodes that exist *for a case* can span multiple dates. Management Reports will include data from cases that have *any* Workload/QC activity recorded on a date included in the date range requested for the report.

- Selecting any management report other than the GYN Comparison report when Cytology Workload/QC is not active displays the following message:

  Cytology quality control/workload not activated!

DEPARTMENT WORKLOAD REPORT

This report provides data for the department's total number of Cytology cases, totals of GYN and nonGYN cases, total number of Cytology slides, and totals of GYN and nonGYN slides.

Totals are also broken down by Diagnosis Categories and Specimen Types. When you select the Department Workload Report, the following screen displays:

```
                    General Hospital Management Reports Processor
                                             Mon Jun 12, 1995 11:03 am

 Department Workload Report

 1 Start Date              2 End Date               3 Format
->
 4 Hardcopy                5 Default Printer
   Yes                       Closet (Port #55)









 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload data. The default is the first day of the current month. Thesystem displays the following prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the current date. If you enter an invalid date in either Date field, the following message displays:

Invalid date!

3. FORMAT (1-A-R)
This field enables you to select the formatto print the report. The system displays the following prompt:

Print summary(S) or detail(D) format--

The Detail format report includes specimen type data.

4. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following prompt:

Hardcopy? (Y/N) [Y]--

NOTE: If your Hardcopy field is set to *No*, the system displays the report online.
Function keys enable you to move around in the report. *F1* moves to the previous page, *F2* pages forward to the next page, and *F7* exits the screen and returns you to the list of Management Reports.

5. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in the builder. A tableof alternate printers displays for selection. The prompt for this field will be the standard for printer selection.

Output

The Department Workload Report can be printed in detail or summary format. It sorts GYN and non-GYN cases and slides. In addition to the case and diagnosis data included on the Summary report, the Detail report includes specimen type information.

NOTE: The diagnosis categories that display on this report represent the *final* or most current diagnosis entered in the system for the case.

Figure 3.13 Department Workload Report (Summary) (ALGRLGR0)

```
                                                                    Page 1
                                    Laboratory
                            Mon Jun 12, 1995 02:43 pm
                         Department Workload Report (Summary)
                         Cases Resulted: 05/01/95 thru 05/31/95
****************************************************************************

                              GYN           nonGYN          Total
             ---------------------------------------------------------
             # of cases       141             17             158
             # of slides      390             34             424

Diagnosis
Categories                    GYN           nonGYN          Total
-------------------------------------------------------------------
ABNORMAL                       65              7              72
MALIGNANT                      13              2              15
NORMAL                         31              5              36
NOT APPLICABLE                 27              3              30
POSITIVE                        5              0               5

                            End of Report
```

Figure 3.14 Department Workload Report (Detail) (ALGRLGR0)

```
                                                              Page 1
                                 Laboratory
                          Mon Jun 12, 1995 02:41 pm
                       Department Workload Report (Detail)
                       Cases Resulted: 05/01/95 thru 05/31/95
    ***********************************************************************

                              GYN            nonGYN         Total
           ----------------------------------------------------------
           # of cases         142              16             158
           # of slides        392              32             424

    Diagnosis
    Categories                GYN            nonGYN         Total
    ----------------------------------------------------------------
    ABNORMAL                    65              7              72
    MALIGNANT                   13              2              15
    NORMAL                      32              4              36
    NOT APPLICABLE              27              3              30
    POSITIVE                     5              0               5

    Specimen               Diagnosis Categories            Total
    --------------------------------------------------------------------
    Bartholin Cyst (nonGYN)  [MAL]    =     2                  2
    Body Fluid (nonGYN)      [ABN]    =     7                 14
                             [NA]     =     3
                             [NORM]   =     4
    Cervix (GYN)             [NORM]   =     1                  1
    PAP Smear (GYN)          [ABN]    =    65                141
                             [MAL]    =    13
                             [NA]     =    27
                             [NORM]   =    31
                             [POS]    =     5

                            End of Report
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Department Workload Report*. *Summary* or *Detail* is also part of the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body (Summary)

 # OF CASES/SLIDES - GYN - nonGYN - TOTAL
These fields display the number of cases and number of slides for tests resulted within a specific period of time, with subtotals for GYN and nonGYN cases and slides, and a total for both.

DIAGNOSIS CATEGORIES - GYN - nonGYN - TOTAL
These fields display the diagnosis categories for cases resulted within a specific period of time, with subtotals for GYN and nonGYN cases and a total for both. The list of diagnosis categories appear in alphabetic order.

NOTE: The diagnosis categories that display on this report represent the final or most current diagnosis category entered for the case.

Report Body (Detail)

 # OF CASES/SLIDES - GYN - nonGYN - TOTAL
These fields display the number of cases and number of slides for tests resulted within a specific period of time, with subtotals for GYN and nonGYN cases and slides, and a total for both.

DIAGNOSIS CATEGORIES - GYN - nonGYN - TOTAL
These fields display the diagnosis categories for cases resulted within a specific period of time. Subtotals for GYN and nonGYN cases and a total for both also display. The list of diagnosis categories appears in alphabetical order.

NOTE: The diagnosis categories that display are the final or *most current* for the case.

SPECIMEN - DIAGNOSIS CATEGORIES - TOTAL
These fields display the specimens associated with the cases resulted within a specific period of time, including an indicator of GYN or nonGYN for each specimen type, the diagnosis category and count for each specimen type, and the total number of cases for each specimen type. All nonGYN specimens are listed first, followed by GYN specimens. Specimens appear in alphabetical order within each group.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Department Workload Report.

DIAGNOSIS CATEGORIES REPORT

This report provides a list of cases for tests resulted in a given date range, sorted by diagnosis category or ordering physician. It includes case numbers and High Risk indicators. It can be used to evaluate the diagnosis categories of the cases submitted by the ordering physicians. When you select the Diagnosis Categories Report, the following screen displays:

```
                      General Hospital Management Reports Processor
                                                  Mon Jun 12, 1995 11:03 am

 Diagnosis Category Report

 1 Start Date              2 End Date                3 Sort
->
 4 Hardcopy                5 Default Printer
   Yes                       Closet (Port #55)










 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload information. The default date is the first day of the current month. The system displays the following prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the current date. If you enter an invalid date in either Date field, the following message displays:

Invalid date!

3. SORT (1-A-R)
This field enables you to select the sort to print the report. The system displays the following prompt:

> *Sort by diagnosis category(D) or ordering physician(O)--*

If you enter **D** for diagnosis category, a table of categories from the Diagnosis Categories maintenance processor appears with the following prompt:

> *Select categories to print or all(A)--*

4. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following prompt:

> *Hardcopy? (Y/N) [Y]--*

5. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in the builder. A table of alternate printers displays for selection. The prompt for this field will be the standard for printer selection.

Output

The Diagnosis Category Report can be sorted by diagnosis category or by ordering physician. Multiple entries for a case displays if multiple tests are ordered on a case. A hard copy report sorted by ordering physician page breaks on each ordering physician included in the report.

NOTE: The diagnosis categories that display on this report represent the *final* or *most current* diagnosis category entered in the system for the case.

Figure 3.15 Diagnosis Category Report (Diagnosis) (ALGRLGR0)

```
                                                              Page 1

                              Laboratory
                        Mon Jun 12, 1995 02:44 pm
                     Diagnosis Category Report (Diagnosis)
                     Cases Resulted  05/01/95 thru 05/31/95      * = High Risk
**************************************************************************

Diagnosis
Category  Case #       Test Code/Description         Ordering Physician
-------------------------------------------------------------------------
[ABN]     C95-398      5014-CYTOLOGY,*GYN SMEAR      BABB,GARY H
          C95-400      5014-CYTOLOGY,*GYN SMEAR      COLEMAN,MICHAEL G
          C95-401      5014-CYTOLOGY,*GYN SMEAR      PULLON,PAIGE
          C95-402      5014-CYTOLOGY,*GYN SMEAR      GARDNER,JANE
          C95-404      5014-CYTOLOGY,*GYN SMEAR      COLEMAN,MICHAEL G
          C95-416      5014-CYTOLOGY,*GYN SMEAR      BABB,GARY H
          C95-421      5014-CYTOLOGY,*GYN SMEAR      GARDNER,JANE
          C95-423      5014-CYTOLOGY,*GYN SMEAR      BABB,GARY H
         *C95-426      5010-CYTOLOGY SMEAR, GYN      GARDNER,JANE
          C95-431      5014-CYTOLOGY,*GYN SMEAR      PULLON,PAIGE
          C95-433      5014-CYTOLOGY,*GYN SMEAR      COLEMAN,MICHAEL G
          C95-434      5014-CYTOLOGY,*GYN SMEAR      BABB,GARY H
          C95-436      5014-CYTOLOGY,*GYN SMEAR      COLEMAN,MICHAEL G

                          End of Report
```

Figure 3.16 Diagnosis Category Report (Physician) (ALGRLGR0)

```
                                                              Page 1
                              Laboratory
                        Mon Jun 12, 1995 02:45 pm
                     Diagnosis Category Report (Physician)
                     Cases Resulted: 05/01/95 thru 05/31/95      * = High Risk
**************************************************************************

Ordering               Diagnosis
Physician              Category   Case #      Test Code/Description
-------------------------------------------------------------------------
ADAMS,FRANK C          [POS]       C94-387    5014-CYTOLOGY,*GYN SMEAR
BAKER,GARY H           [ABN]      *C95-452    5014-CYTOLOGY,*GYN SMEAR
                       [MAL]       C95-441    5016-CYTOLOGY,*BODY FLUID
                       [NA]       *C95-453    5014-CYTOLOGY,*GYN SMEAR
                       [NORM]      C95-457    5016-CYTOLOGY,*BODY FLUID
                       [POS]       C95-399    5014-CYTOLOGY,*GYN SMEAR
COLEMAN,STEVEN         [ABN]      *C95-447    5014-CYTOLOGY,*GYN SMEAR
                       [NA]        C95-406    5014-CYTOLOGY,*GYN SMEAR
                       [NORM]     *C95-455    5014-CYTOLOGY,*GYN SMEAR
DAVIS,MATHEW           [ABN]      *C95-449    5014-CYTOLOGY,*GYN SMEAR
                       [MAL]       C95-409    5014-CYTOLOGY,*GYN SMEAR
ELLIS,MARTHA           [ABN]      *C95-426    5010-CYTOLOGY SMEAR, GYN
                       [NORM]      C95-425    5010-CYTOLOGY SMEAR, GYN

                          End of Report
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Diagnosis Category Report*. *Diagnosis* or *Physician* is also part of the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report. An asterisk (*) denotes High Risk cases.

Report Body (Diagnosis)

DIAGNOSIS CATEGORY
This field displays the diagnosis category for the cases resulted during a specific period of time.

CASE #
This field displays the case number for the cases resulted during a specific period of time. Case numbers are listed in ascending numerical order. An asterisk (*) denotes a High Risk case.

TEST CODE/DESCRIPTION #
This field displays the test code(s) and description(s) for the cases resulted during a specific period of time.

ORDERING PHYSICIAN
This field displays the name of the ordering physician for the test resulted on the cases during a specific period of time.

NOTE: The fields for the Physician version of the Diagnosis Category Report are the same as those on the Diagnosis version. Only the placement of the fields is different. The Ordering Physician field appears first on the Physician version. The Diagnosis field appears first on the Diagnosis version.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Diagnosis
Category Report.

DISCREPANCY REPORT

This report provides information to monitor and manage result discrepancies between
individuals who examined and resulted the same case. Two formats are available.

The Summary report provides screener level statistics, by test and original screener,
on the number and percentage of cases rescreened and checked for discrepancies,
including the number and percent of screener misses.

The Detail report provides QC information, by test and screener, on each case sent to
the Discrepancy Queue for processing. This report also includes free text comments
that describe the follow-up action for the discrepancy. When you select the
Discrepancy Report, the following screen displays:

```
                        General Hospital Management Reports Processor
                                              Mon Jun 12, 1995 11:03 am

 Discrepancy Report

 1 Start Date             2 End Date             3 Format
->
 4 ID Codes               5 Non-Clinical         6 Hardcopy
                            Yes                    Yes
 7 Default Printer
   Closet (Port #55)







 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload information.
The default date is the first day of the current month. The system displays the following
prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the current date. If you enter an invalid date in either Date field, the following message displays:

Invalid date!

3. FORMAT (1-A-R)
This field enables you to select the format in which to print the report with the following prompt:

Print summary(S) or detail(D) format--

4. ID CODES (TABLE LOOKUP-R)
This field enables you to enter one, several, or all codes displayed in the table of active cytology personnel. The system automatically displays the table of ID codes when you enter the field.

5. NON-CLINICAL (1-A-C)
This field enables you to include nonclinical discrepancies on the report. The system displays the following prompt:

Include non-clinical discrepancies? (Y/N) [Y]--

You can access this field only if the format is set to detail.

6. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following prompt:

Hardcopy? (Y/N) [Y]--

7. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in the builder. A tableof alternate printers displays for selection. The prompt for this field will be the standard for printer selection.

Output

The Discrepancy Report can be printed in summary or detail format. The Summary report provides screener level statistics, sorted by test and original screener, on the number and percentage of cases rescreened and checked for discrepancies, including the number and percent of misses.

The Detail report provides QC information, by test and screener, on each case sent to the Discrepancy Queue. Information from nonclinical discrepancies can be excluded from the report. This report includes the original and repeat screeners' IDs with their assigned diagnosis codes, the Discrepancy Queue screener's ID and assigned discrepancy category, and free text comments.

Figure 3.17 Discrepancy Report (Summary) (ALGRLGR0)

```
                                                              Page 1
                              Laboratory
                       Mon Jun 12, 1995 02:47 pm
                        Discrepancy Report (Summary)
                   Cases Resulted: 05/01/95 thru 05/31/95
***************************************************************************


                Test Code: 5010-CYTOLOGY SMEAR, GYN

                         Total    Total    Total      %        %
Screener                 Orig     QC'd     Misses   Repeated  Misses
-----------------------------------------------------------------------
DAVISON,WILLIAM [3212]     2        0        0        0.0      0.00
-----------------------------------------------------------------------
Totals                     2        0        0        0.0      0.00

                Test Code: 5014-CYTOLOGY,*GYN SMEAR

                         Total    Total    Total      %        %
Screener                 Orig     QC'd     Misses   Repeated  Misses
-----------------------------------------------------------------------
WILSON,MARY [4412]        28       23        9       82.1     39.13
-----------------------------------------------------------------------
Totals                    28       23        9       82.1     39.13

                             End of Report
```

Figure 3.18 Discrepancy Report (Detail) (ALGRLGR0)

```
                                                              Page 1
                              Laboratory
                       Mon Jun 12, 1995 02:42 pm
                        Discrepancy Report (Detail)
                   Cases Resulted: 05/01/95 thru 05/31/95
***************************************************************************


                Test Code: 5014-CYTOLOGY,*GYN SMEAR

"Miss" assigned to: EDWARDS,SUSAN [7523]
------------------------------------------
Case Number:                 C95-486
Original Diag/Screener:      NORM / 7523
Repeat Diag/Screener:        UNSAT / 7989
Disc Category/Screener:      MOD / 444
Discrepancy Comment:         ORIGINAL SCREENER WILL REVIEW SLIDE WITH PATHOLOGIST
                             TO DETERMINE CRITERIA FOR SPECIMEN ADEQUACY.

Case Number:                 C95-501
Original Diag/Screener:      MODIS / 7989
Repeat Diag/Screener:        NORM / 7523
Disc Category/Screener:      MOD / 444
Discrepancy Comment:         SCREENER TO REVIEW SLIDE WITH PATHOLOGIST
                             TO DETERMINE CRITERIA FOR DISPLASIA
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Discrepancy Report. Summary* or *Detail* is also part of the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body (Summary)

TEST CODE
This field is used as a method of sorting the discrepancy information for the screeners by test code. The test code and description print before the screener discrepancy statistics for the test. The information is centered on the line.

SCREENER
This field displays the name and ID of the *original* screener who performed the examination through result reporting.

TOTAL ORIG
This field displays the total number of cases examined for the designated test code and original screener through result reporting.

TOTAL QC'D
This field displays the total number of original examinations reviewed through the Repeat Queue after results were entered through result reporting. This number represents the total number of cases QC'd for the test and original screener.

NOTE: This number represents all cases processed through the Repeat Queue for the original screener, including those processed by automatic random selection, auto high risk, and manual selection using the RQ option.

TOTAL MISSES
This field displays the total number of misses assigned to the original screener for the test. This number represents the number of original screener cases determined by the Discrepancy Queue screener to be in error.

% REPEATED
This field displays the percentage of original cases processed through the Repeat Queue, based on the total number of QC'd cases, divided by the total number of original examinations times 100.

% MISSES
This field displays the percentage of misses for the original screener, based on the total number of misses divided by the total number of QC'd cases times 100.

TOTALS #
This field displays the totals of the fields for all original screeners for the specific test.

Report Body (Detail)

TEST CODE
This field sorts the discrepancy information for the screeners by test code. The test code and description print before the screener discrepancy statistics for the test. The information is centered on the line.

"MISS" ASSIGNED TO:
This field displays the name and ID of the screener assigned a miss for the test and case. Misses are reported on either the original or the QC screener or both.

CASE NUMBER
This field displays the case number of the case screened on a specific test. The test code number and name appear above this field.

ORIGINAL DIAG/SCREENER
This field displays the original diagnosis and the screener's ID.

REPEAT DIAG/SCREENER
This field displays the QC diagnosis and the screener's ID.

DISC CATEGORY/SCREENER
This field displays the discrepancy category and the screener's ID.

DISCREPANCY COMMENT
This field displays the discrepancy comment.

NOTE: *Non-clinical* appears after this section if you selected all discrepancies and the discrepancy is non-clinical. If you selected only clinical discrepancies and a miss was assigned to one of the screeners for a clinical discrepancy, this information also displays.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Discrepancy Report.

GYN COMPARISON REPORT

The GYN Comparison Report provides information related to all GYN Comparison processing. There are three options:

- A detail report for all comparisons on a single case.

- A summary report of all comparisons for a specific date range.

- A detail report for all comparisons for a specific date range.

Any report by date range references the accession date of all cases processed through the GYN Comparison processor, not the date the comparison was actually performed. If either one or both tests in a comparison were accessioned within the date range entered, the comparison information is included in the report.

There are two format options:

- The summary format provides a list of all comparisons done on cases that fall within the requested date range.

- The detail format includes detail information at the comparison and case level including all results that were compared.

When you select the GYN Comparison Report the following screen displays:

```
                   General Hospital Management Reports Processor
                                             Mon Jan 22, 1996 03:14 pm

 GYN Comparison Report

1 Single
->
2 Start Date      3 End Date

4 Format          5 Hardcopy           6 Default Printer
                      Yes                  301-3 Printer Area (Port #246)






  Enter case number--
```

Field Explanations

1. SINGLE (12-C-O)
This field is used to generate an individual report on a single case. The report includes detail information related to all comparisons for the case number entered. Entering this field displays the following prompt:

Enter case number---

Entering a case number is limited to cases only from the current department's case number pool. Both long and short case number formats are accepted.

If you enter a case number not defined as histology or cytology in the Case Number Pool maintenance processor, the system displays the following message:

Case number pool not defined as histology or cytology!

If you enter a valid case number, but no comparison has been performed, the system displays the following message:

No comparison performed for case # [insert case number]!

Entering a valid case number in this field causes the system to autofill Fields 2 and 3 with *N/A* and a date range may not be entered. Field 4 displays *Detail*. When a valid case number is displayed in Field 1, fields 2 through 4 can not be entered or edited.

If you press period (.) ENTER for Field 1, *N/A* displays in the field and you are prompted to enter a Start Date in Field 2.

If you entered a valid case number and then decide to use a date range instead, you may re-enter Field 1 and press period (.) ENTER. The previous entry is replaced with N/A. Fields 2 through 4 are blanked and are ready for input.

2. START DATE (DATE FORMAT-C)
This field enables you to enter a start date for aGYN Comparison report. The system displays the following prompt:

Enter start date [first day current month]--

The default for the prompt is the first day of the current month. You can enter the default date or any previous date. A future date is not allowed. If you enter an invalid date in this field, the system displays the following message:

Invalid date!

If a valid case number has been entered in Field 1, this field displays *N/A* and cannot be accessed. When Field 1 displays N/A, Fields 2 and 3 are required.

NOTE: For any report that includes a date range, the date checked is the accession date for all cases processed through the comparison processor, not the date the comparison was actually performed. If either one or both tests in a comparison were accessioned within the date range entered, the comparison information is included in the report.

3. END DATE (DATE FORMAT-C)
This field enables you to enter an end date for a GYN Comparison report. The system displays the following prompt:

Enter end date [today's date]--

The default for the prompt is the current date. You can enter the default date or any previous date after the start date in Field 1 through the current date. If you enter a date outside these boundaries the system displays the following message:

Invalid date!

If a valid case number has been entered in Field 1, this field displays *N/A* and cannot be accessed. When Field 1 displays *N/A*, fields 2 and 3 are required.

4. FORMAT (1-A-C)
This field enables you to select the format for the report. If a valid case number has been entered in Field 1, the field displays *N/A* and cannot be accessed. Entering this field displays the following prompt:

Print summary(S) or detail(D) format--

The detail (D) option is available for single case and date range reports. The summary (S) option is available only for date range reports. When a valid case number is displayed in Field 1, this field displays Detail and can not be entered or edited.

5. HARDCOPY (1-A-R)
The field enables you to select a hardcopy report or display the information to the screen. Entering this field displays the following prompt:

Hardcopy (Y/N) [Y]--

The default for this field is to print a hardcopy report.

6. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hardcopy, the default printer is the General Reports printer defined in the builder. A table of alternate printers displays for selection. The prompt for this field is the standard for printer selection.

Output

The GYN Comparison report may be generated for a single case or for all cases within a specific date range. A report by date range references the accession date for all comparison cases. Date range reports may be printed in summary or detail format. Both summary and detail format entries for a date range appear in chronological order. The date that is used for the sort is the date/time the first partial was filed for the first case selected to be compared through the GYN Comparison processor. A single case report defaults to the detail format only.

Detail Report Format

The detail format of the report is available for both the individual print and the date range print of information and includes the following data for each comparison:

- Clinical Discrepancy Indicator

- Discrepancy Category (if applicable)

- Comparison Comments

- Name of Person Performing Comparison/Date/Time of Comparison

- Patient Name

- Oldest Case Selected in the Comparison Processor

    - Case Number/Accession Number

    - Oldest Test Code/Description

    - Performing Department (department where results were entered)

    - Resulting Tech (not available on history cardfile entries)

    - Date/Time Results Entered

- Results Checked for Comparison (from the oldest case)

- Newest Case Selected in the Comparison Processor

    - Case Number/Accession Number

    - Newest Test Code/Description

    - Performing Department (department where results were entered)

    - Resulting Tech (not available on history cardfile entries)

    - Date/Time Results Entered

- Results Checked for Comparison (from the oldest case)

Summary Report Format

The summary format option is only available for a report that is generated for a specified date range and includes the following information:

- Oldest Case Selected Case Number

- Newest Case Selected Case Number

- Discrepancy Category Code

- Employee ID Code of Person Performing the Comparison

- Date/Time Comparison Performed

NOTES:

- Cases from History Cardfile do not include the resulting tech (not available on history cardfile entries).

- Cancelled tests in Summary formatted reports display as *[Accn#/C]*.

- In cancelled tests in Detail formatted reports, the Case # field displays as *Cancelled*.

- If results have been corrected, the correction flag displays but no previous results print on these reports.

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Figure 3.19 GYN Comparison Report (Detail) - Single Case (ALGRLGRO)

```
                                                                     Page 1
                                    Laboratory
                           GYN Comparison Report (Detail)
                             Mon Jan 22, 1996 04:21 pm
                             Single Case Comparison
****************************************************************************
Clinical Discrepancy      :  Yes
Discrepancy Category      :  Insignificant [INS]
Comparison Comments       :
Comparison Tech/D/T       :  Smith,Alex M.D. (01/22/96 1620)
Patient Name              :  NALA,BLANCHE
----------------------------------------------------------------------------
OLDEST CASE SELECTED FOR COMPARISON
Case #/Accn#        : C96-884 / 1243
Test Code           : 5014-CYTOLOGY,GYN SMEAR
Performing Dept      : General Lab
Result Tech/D/T      : Adams,Susan (01/22/96 1609)
-------------------------------------
RESULTS CHECKED FOR COMPARISON
Clinical Data         :Normal
Specimen Adequacy     :Satisfactory
Explanation           :
Diagnosis             :Mild dysplasis
Categorization        :CLASS I - Within Normal Limits
Recommendations       :
     Follow-up with collection of genital specimen for routine
     chlamydia workup.
SNOMED Code           :Endometrium, NOS - Endometriosis, NOS
                      :(T-84000,M-76500)
Reviewed by           :Halsted,George M.D.
-------------------------------------
NEWEST CASE SELECTED FOR COMPARISON
Case #/Accn#        : S96-444 / 1244
Test Code           : 5024-HISTO CERVIX
Performing Dept      : General Lab
Result Tech/D/T      : Conner,William (01/22/96 1610)
-------------------------------------
RESULTS CHECKED FOR COMPARISON
Clinical Data         :None Available
Specimen Adequacy     :Satisfactory
Diagnosis             :Moderate dysplasia
Recommendations       :
     Follow-up with collection of genital specimen for routine
     chlamydia workup.
SNOMED Code           :Cervix, uterine - Normal Cytology, NOS
                      :(T-83000,M-00120)
Reviewed by           :Bender,Chris M.D.

                         *** End of Report ***
```

Figure 3.20 GYN Comparison Report (Detail) - Date Range (ALGRLGRO)

```
                                                                      Page 1
                                    Laboratory
                          GYN Comparison Report (Detail)
                             Mon Jan 22, 1996 04:52 pm
                              01/21/96 thru 01/22/96
**************************************************************************
Clinical Discrepancy      :  Yes
Discrepancy Category      :  Insignificant [INS]
Comparison Comments       :
Comparison Tech/D/T       :  Smith,Alex M.D. (01/22/96 1620)
Patient Name              :  NALA,BLANCHE
-------------------------------------------------------------------------
OLDEST CASE SELECTED FOR COMPARISON
Case #/Accn#        : C96-884 / 1243
Test Code           : 5014-CYTOLOGY,GYN SMEAR
Performing Dept     : General Lab
Result Tech/D/T     : Adams,Susan (01/22/96 1609)
-------------------------------------
RESULTS CHECKED FOR COMPARISON
Clinical Data         :Normal
Specimen Adequacy     :Satisfactory
Explanation           :
Diagnosis             :Mild dysplasis
Categorization        :CLASS I - Within Normal Limits
Recommendations       :
      Follow-up with collection of genital specimen for routine
      chlamydia workup.
SNOMED Code           :Endometrium, NOS - Endometriosis, NOS
                      :(T-84000,M-76500)
Reviewed by           :Halsted,George M.D.
-------------------------------------
NEWEST CASE SELECTED FOR COMPARISON
Case #/Accn#        : Cancelled / 1244
Test Code           : 5024-HISTO CERVIX
Performing Dept     : General Lab
Result Tech/D/T     : Conner,William (01/22/96 1610)
-------------------------------------
RESULTS CHECKED FOR COMPARISON
Clinical Data         :None Available
Specimen Adequacy     :Satisfactory
Diagnosis             :Moderate dysplasia
Recommendations       :
      Follow-up with collection of genital specimen for routine
      chlamydia workup.
SNOMED Code           :Cervix, uterine - Normal Cytology, NOS
                      :(T-83000,M-00120)
Reviewed by           :Bender,Chris M.D.

                             (Continued next page)
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

REPORT TITLE
The title of this report is *GYN Comparison Report (Detail)*. This field prints directly below the Department Name field on the third line of the report.

DATE/TIME PRINTED
The date and time the report was printed is centered on the fourth line of the report. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the *GYN Comparison Report (Detail)*.

Figure 3.21 GYN Comparison Report (Summary) - Date Range
(ALGRLGR0)

```
                                                           Page 1
                                Laboratory
                     GYN Comparison Report (Summary)
                         Mon Jan 22, 1996 05:15 pm
                         01/01/96 thru 01/22/96
****************************************************************************
Oldest           Newest          Discrepancy      Compared By      Comparison
Case #           Case #          Category                          Date/Time
----------------------------------------------------------------------------
C96-881          S96-481         [SIG]            [B444]           01/11/96 1553
C96-881          S96-481         [INS]            [B444]           01/11/96 1606
C96-881          S96-481         N/A              [#47141]         01/11/96 1615
C96-881          C96-879         [LB2]            [#47141]         01/12/96 1639
C96-881          C96-53          [SIG]            [#47141]         01/15/96 1151
C96-879          S96-436         [SIG]            [#47141]         01/05/96 1610
C96-879          S96-436         N/A              [#47141]         01/05/96 1626
C96-879          10217/C         N/A              [#47141]         01/09/96 1035
C96-879          S96-436         N/A              [#47141]         01/09/96 1037
S96-436          C96-880         N/A              [#47141]         01/11/96 1618
C96-880          S96-437         N/A              [#47141]         01/09/96 1237
S95-478          S96-437         N/A              [#47141]         01/22/96 1111
S95-478          S96-437         [SIG]            [#47141]         01/22/96 1152
10465/C          S96-437         N/A              [#47141]         01/22/96 1207
C95-869          C96-53          N/A              [#47141]         01/15/96 1149
C96-53           C96-882         [SIG]            [#47141]         01/15/96 1507
C96-884          S96-444         N/A              [#47141]         01/22/96 1620


                          *** End of Report ***
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This
field is centered.

REPORT TITLE
The title of this report is *GYN Comparison Report (Summary)*. This field prints directly
below the Department Name field on the third line of the report.

DATE/TIME PRINTED
The date and time the report was printed is centered on the fourth line of the report.
This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body

OLDEST CASE #
This field displays the oldest case number of the two cases selected for comparison.

NEWEST CASE #
This field displays the newest case number of the two cases selected for comparison.

DISCREPANCY CATEGORY
This field displays the discrepancy category as determined by the person performing the comparison.

COMPARED BY
This field displays the employee ID code of the person who performed the comparison.

COMPARISON DATE/TIME
This field contains the date and time the comparison was performed.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the *GYN Comparison Report (Summary)*.

QC PROCESS DELETION AUDIT

This report provides an audit of all tests manually removed from the Repeat Queue or the Discrepancy Queue. The report provides the name of the person who deleted the test, as well as the time and date the test was deleted.

Tests can be removed from the QC process in any of the following ways:

- Manual deletion from the Repeat Queue

- Manual deletion from the Discrepancy Queue

- Deletion as a result of a specimen rejection

- Deletion as a result of an order cancellation

When you select the QC Process Deletion Audit, the following screen displays:

```
                        General Hospital Management Reports Processor
                                              Mon Jun 12, 1995 11:03 am

  QC Process Deletion Audit

 1 Start Date              2 End Date
->
 3 Hardcopy                4 Default Printer
   Yes                       Closet (Port #55)










  Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload data. The
default date is the first day of the current month. The system displays the following
prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's
date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the
current date. If you enter an invalid date in either Date field, the following message
displays:

Invalid date!

3. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following
prompt:

Print hardcopy of report? (Y/N) [Y]--

4. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer will be the General Reports printer defined
in the builder. A table of alternate printers will display for selection. The prompt for this
field will be the standard for printer selection.

Output

The QC Process Deletion Audit lists tests removed from the Cytology QA process and
includes information about the deleted test.

NOTE: In multi-department institutions, QC Process Deletion Audit reports generated
in the ordering department can include tests referenced with Case Number
Pools from the performing department.

Figure 3.22 QC Process Deletion Audit (ALGRLGR0)

```
                                                             Page 1
                               Laboratory
                       Mon Jun 12, 1995 10:37 am
                       QC Process Deletion Audit
                        05/01/95 thru 05/31/95

Date/time        Delete ID       Queue   Case #      Accn #      Test Code
-------------------------------------------------------------------------
05/10/95 1629    WILSON,MARY      Repeat  C95-402     4014        5014
05/11/95 1408    WILSON,MARY      Repeat  C95-402     4014        5014
05/12/95 1302    WILSON,MARY      Repeat  C95-411     4023        5014
05/12/95 1324    WILSON,MARY      Repeat  C95-409     4021        5014
05/12/95 1330    WILSON,MARY      Repeat  C95-409     4021        5014
05/12/95 1357    MILLER,BARRY     Disc    C95-404     4016        5014
05/16/95 1057    WILSON,MARY      Repeat  C95-409     4021        5014
05/16/95 1437    WILSON,MARY      Repeat  S95-406     4024        5050
05/17/95 1117    MILLER,BARRY     Repeat  C95-416     4029        5014
05/19/95 0921    DAVIS,CINDY      Repeat  C95-437     4054        5016
05/19/95 0926    DAVIS,CINDY      Repeat  C95-437     4054        5016
05/19/95 0945    MILLER,BARRY     Disc    C95-438     4055        5016
05/19/95 1620    WILSON,MARY      Disc    C95-442     4059        5016
05/23/95 1056    WILSON,MARY      Repeat  C95-439     4056        5016
05/24/95 0754    WILSON,MARY      Cancel  C95-441     4058        5016

                        End of Report
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This
field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *QC Process Deletion Audit.* This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body

DATE/TIME
This field contains the date and time the test was deleted from the QC process.

DELETE ID
This field displays the name of the person who deleted the test from the QC process. If the test was deleted because of cancellation (order cancellation or specimen rejection) the name of the person who performed the cancellation displays.

QUEUE
This field displays the Queue (Repeat or Discrepancy) from which the test was removed. If the test was removed from the Repeat Queue, the word *Repeat* displays. If the test was removed from the Discrepancy Queue, the word *Disc* displays. If the test was deleted from the QC process as a by-product of cancellation (either order cancel or specimen reject), the word *Cancel* displays.

CASE NUMBER #
This field displays the case number assigned to the test.

ACCN #
This field displays the accession number associated with the test.

TEST CODE
This field displays the test code of the deleted test.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the QC Process Deletion Audit.

REPEAT QC REPORT

This report prints a list of cases processed through the Repeat Queue and includes all QC and discrepancy results. When a discrepancy exists, both original and QC results appear for review. An asterisk (*) displays next to the results reported for the patient for components with discrepancies, regardless of any screener "miss" assignment.

The report can be sorted by case or screener (original or QC). A report sorted by case includes cases for a specific period of time. In a sort by screener, you can select one, several, or all screeners for the report.

When you select the Repeat QC Report, the following screen displays. If your institution is multifacility, a screen appears first, enabling you to select the facility.

```
                     General Hospital Management Reports Processor
                                          Mon Jun 12, 1995 11:03 am

 Repeat QC Report

 1 Start Date             2 End Date              3 Sort
->
 4 ID Codes               5 Hardcopy         6 Default Printer
                            Yes                Closet (Port #55)











 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload data. The default date is the first day of the current month. The system displays the following prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the current date. If you enter an invalid date in either Date field, the following message displays:

Invalid date!

3. SORT (1-A-R)
This field enables you to select the format in which to print the report. The system displays the following prompt:

Sort by case(C), original(O) or repeat(R) screener--

4. ID CODES (TABLE LOOKUP-R)
This field enables you to enter one, several, or all codes displayed in the table of cytology personnel. The system automatically displays a table of active and inactive screener ID codes when you enter the field.

NOTE: This field is active only when the sort is by screener. If you select the case(C) option for the Sort field, this field becomes inactive and displays *N/A*.

5. HARDCOPY (1-A-R)
This field enables you to select a hard copy report. The system displays the following prompt:

Hardcopy? (Y/N) [Y]--

6. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in the builder. A table of alternate printers displays for selection. The prompt for this field will be the standard for printer selection.

Output

The Repeat QC Report can be sorted by case, original screener, or repeat screener. This report includes all QC results entered through the Repeat Queue. When a discrepancy is identified, the results entered through result reporting for this episode are also included. An asterisk (*) displays next to the results reported.

Figure 3.23 Repeat QC Report (Case) (ALGRLGR0)

```
                                                                Page 1
                                Laboratory
                          Mon Jun 12, 1995 04:25 pm
                            Repeat QC Report (Case)
                       Cases Resulted: 05/01/95 thru 05/31/95
***************************************************************************

Case #          : C95-471
Test Code       : 5017-CYTOLOGY-PAP SMEAR
Repeat Screener : LEWIS,STEVE [7989]
Original Screener: ADAMS,MATHEW [7141]


                       RESULTS CHECKED FOR DISCREPANCIES
NO DISCREPANCIES
---------------
Recommendations    : Follow-up with collection of genital specimen for routine
                     chlamydia workup.

SNOMED Code 1      : Endometrium, NOS - Endometriosis, NOS (T-84000,M-76500)

DISCREPANCIES
---------------
Diagnosis

   Orig result     : Infection

  *QC result       : Nonspecific fungal organism

                     RESULTS NOT CHECKED FOR DISCREPANCIES

Lab Comment        : The specimen submitted was labelled correctly
Specimen Adequacy  : Satisfactory
Review Queue       : Dr. Fitz
Transcriptionist   : WILLIAMS,MARK
-----------------------------------------------------------------------------
```

Figure 3.24 Repeat QC Report (Original Screener) (ALGRLGR0)

```
                                                              Page 1
                              Laboratory
                         Mon Jun 12, 1995 04:36 pm
                     Repeat QC Report (Original Screener)
                     Cases Resulted: 05/01/95 thru 05/31/95
**************************************************************************

Original Screener: WILSON,MARY [7141]
Case #           : C95-486
Test Code        : 5014-CYTOLOGY,*GYN SMEAR
Repeat Screener  : DAVIS,CINDY [7989]


                      RESULTS CHECKED FOR DISCREPANCIES
NO DISCREPANCIES
---------------
Diagnosis          : Infection
Categorization     : CLASS I - Within Normal Limits
Recommendations    : Follow-up with collection of genital specimen for routine
                     chlamydia workup.

DISCREPANCIES
---------------
SNOMED Code 1
  *Orig result     : Cervix-Normal tissue, NOS(T-83000,M-00100)
   QC result       : Endocervix-Atpia,mild (T-83300,M-69710)

                      RESULTS NOT CHECKED FOR DISCREPANCIES

Clinical Data      : None available
Specimen Adequacy  : Satisfactory
Explanation        : ADDED IN RQ
Review Queue       : Dr. Fitz
Transcriptionist   : SMITH,MARTHA
-----------------------------------------------------------------------------
```

Figure 3.25 Repeat QC Report (Repeat Screener) (ALGRLGR0)

```
                                                                       Page 1
                                       Laboratory
                                 Mon Jun 12, 1995 04:47 pm
                               Repeat QC Report (Repeat Screener)
                               Cases Resulted: 05/01/95 thru 05/31/95
         ***************************************************************************

         Repeat Screener  : LEWIS,SUE [7931]
         Case #           : C95-474
         Test Code        : 5010-CYTOLOGY-PAP SMEAR
         Original Screener: WILLIAMSON,SHERRY [8523]


                             RESULTS CHECKED FOR DISCREPANCIES
         NO DISCREPANCIES
         ---------------
         Diagnosis          : Infection
         SNOMED Code 1      : Endometrium, NOS - Endometriosis, NOS (T-84000,M-76500)

         DISCREPANCIES
         ---------------
         Recommendations
           *Orig result    : Follow-up with new specimen in one month.
            QC result      : No follow-up required.
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Repeat QC Report. Case*, *Original Screener*, or *Repeat Screener* also appears in the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body (Case)

CASE #
This field displays the case number of the resulted case.

TEST CODE
This field displays the test code and a description of the resulted case.

REPEAT SCREENER
This field displays the name and ID of the QC screener.

ORIGINAL SCREENER
This field displays the name and ID of the original screener.

NOTE: These fields also appear on the Repeat QC Report (Original Screener) and the Repeat QC Report (Repeat Screener) in a different order.

RESULTS CHECKED FOR DISCREPANCIES
This section of the report includes the results of components defined as *DISC* in the Repeat Queue Results maintenance processor. Two subsections display: NO DISCREPANCIES and DISCREPANCIES.

NO DISCREPANCIES
This subsection displays the QC results entered through the Repeat Queue for the components defined as *DISC* when no discrepancies were found between the original results entered through result reporting and those entered through the Repeat Queue. If all components defined as *DISC* have discrepancies, the phrase *No data to print!* appears under this heading.

DISCREPANCIES
When result discrepancies exist, this subsection displays both the results entered through result reporting (original results) and those entered in the Repeat Queue (QC results). If no discrepancies exist, *No data to print!* prints under this heading.

RESULTS NOT CHECKED FOR DISCREPANCIES
This section includes all other QC test results entered through the Repeat Queue for those components not defined as *DISC*.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Repeat QC Report.

SCREENER GYN QC REPORT

This report can be used to review the total number and percent of negative GYN cases for an original screener that are rescreened through the Repeat Queue. The statistics included in this report are limited to those GYN cases defined in result reporting with a negative diagnosis category. The Detail report also includes the case numbers for those tests processed through the Repeat Queue.

When you select the Screener GYN QC Report, the following screen displays:

```
                     General Hospital Management Reports Processor
                                          Mon Jun 12, 1995 11:03 am

 Screener GYN QC Report

 1 Start Date              2 End Date              3 Format
->
 4 ID Codes                5 Hardcopy         6 Default Printer
                             Yes                  Closet (Port #55)








 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload data. The
default date is the first day of the current month. The system displays the following
prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's
date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the
current date. If you enter an invalid date in either Date field, the following message
displays:

Invalid date!

3. FORMAT
This field enables you to select the format in which to print the report. The system
displays the following prompt:

Print summary(S) or detail(D) format--

4. ID CODES (TABLE LOOKUP-R)
This field enables you to enter one, several, or all codes displayed in the table of
cytology personnel. The system automatically displays the table of active and inactive
screener ID codes when you enter the field.

5. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following
prompt:

Hardcopy? (Y/N) [Y]--

6. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in
the builder. A tableof alternate printers displays for selection. The prompt for this field
will be the standard for printer selection.

Output

The Screener GYN QC Report can be printed in a summary or a detail format. The
summary format includes department totals. The detail format includes the case
numbers of the tests rescreened through the Repeat Queue.

Figure 3.26 Screener GYN QC Report (Summary) (ALGRLGR0)

```
                                                            Page 1
                              Community Laboratory
                         Mon June 12, 1995  1:00 pm
                          Screener GYN QC Report (Summary)
                         Cases Resulted: 06/05/95 thru 06/08/95


*****************************************************************************
Screener                                # NEG GYN    # Rescreened    %QC'd
---------------------------------------------------------------------------
Martin,Walter [4454]                         200              20     10.0%
White,Randy [447754]                         300              35     11.7%
----------------                         ---------       ---------   ------
Department Total                             500              55     11.0%

                              End of Report
```

Figure 3.27 Screener GYN QC Report (Detail) (ALGRLGR0)

```
                                                            Page 1
                                 Community Laboratory
                              Mon June 12, 1995  1:00 pm
                              Screener GYN QC Report (Detail)
                              Cases Resulted: 06/05/95 thru 06/08/95
                                                            *=High Risk
****************************************************************************
Screener                              # NEG GYN    # Rescreened    %QC
--------------------------------------------------------------------------
Smith,John [3550]                        100            10         10.0%

        *C94-586     C94-602     C94-622     C94-633     C94-636
         C94-659     C94-670     C94-685    *C94-696     C94-702

Martin,Walter [4454]                     200            20         10.0%

         C94-587     C94-605     C94-628    *C94-635     C94-638
         C94-661     C94-672    *C94-686     C94-688     C94-712
         C94-713    *C94-719     C94-730     C94-742     C94-749
         C94-753     C94-770     C94-785    *C94-793     C94-802

                              End of Report
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Screener GYN QC Report. Summary* or *Detail* also appears in the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

NOTE: An asterisk (*) denotes High Risk cases.

Report Body (Summary)

SCREENER - # NEG GYN - # RESCREENED - %QC'D
These fields display the name and ID of the original screener, the number of negative GYN cases reported through result reporting, the number of those cases rescreened through the Repeat Queue, and the percentage of rescreened cases.

DEPARTMENT TOTAL
This field displays the department total for all negative GYN cases resulted within a specific period of time.

NOTE: The Department Total statistics include data for *all* original screeners, active and inactive, for a specific time period, not just those screeners selected for the report.

Report Body (Detail)

SCREENER - # NEG GYN - # RESCREENED - %QC'D
These fields display the name and ID of the original screener, the number of negative GYN cases reported through result reporting, the number of those cases rescreened through the Repeat Queue, and the percentage of rescreened cases.

The report provides detail for each screener by listing the case number for each case rescreened and displaying an asterisk (*) if the case was High Risk.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Screener GYN QC Report.

SCREENER WORKLOAD REPORT

This report displays workload information for one, several, or all screeners within a selected date range. Screener workload includes all workload captured in result reporting, the Repeat Queue, the Discrepancy Queue, and the Review Queue. When you select the Screener Workload Report, the following screen displays:

```
                    General Hospital Management Reports Processor
                                              Mon Jun 12, 1995 11:03 am

 Screener Workload Report

 1 Start Date          2 End Date              3 Format
->
 4 ID Codes            5 Hardcopy           6 Default Printer
                         Yes                   Closet (Port #55)










 Enter start date [06/01/95]--
```

Field Explanations

1. START DATE (DATE FORMAT-R)
This field enables you to enter the beginning date to compile workload data. The default date is the first day of the current month. The system displays the following prompt:

Enter start date [first day current month]--

2. END DATE (DATE FORMAT-R)
This field enables you to enter the ending date to compile data. The default is today's date. The system displays the following prompt:

Enter end date [today's date]--

You can enter any date beginning with the start date or after the start date through the current date. If you enter an invalid date in either Date field, the following message displays:

Invalid date!

3. FORMAT
This field enables you to select the format in which to print the report. The system displays the following prompt:

Print summary(S) specimen(N) or case(C) format--

4. ID CODES (TABLE LOOKUP-R)
This field enables you to enter one, several, or all codes displayed in the table of cytology personnel. The system displays the table of active and inactive screener ID codes when you enter the field.

5. HARDCOPY (1-A-R)
This field enables you to select a hardcopy report. The system displays the following prompt:

Hardcopy? (Y/N) [Y]--

6. DEFAULT PRINTER (TABLE LOOKUP-O)
If you select a hard copy, the default printer is the General Reports printer defined in the builder. A tableof alternate printers displays for selection. The prompt for this field will be the standard for printer selection.

Output

The Screener Workload Report can be printed showing summary data, specimen type detail, or case detail. Case, slide count, and diagnosis category information is sorted by GYN and nonGYN counts.

Figure 3.28 Screener Workload Report (Summary (ALGRLGR0))

```
                                                            Page 1
                                Community Laboratory
                             Mon June 12, 1995  1:00 pm
                           Screener Workload Report (Summary)
                         Cases Resulted: 06/05/95 thru 06/08/95
  *************************************************************************

WILSON,MARY [8541]
                                    GYN            nonGYN         Total
                    -------------------------------------------------------
                    # of cases      51             8              59
                    # of slides     145 (35)       16             161 (35)

                    Diagnosis
                    Categories      GYN            nonGYN         Total
                    -------------------------------------------------------
                    ABNORMAL        21             2              23
                    MALIGNANT       3              2              5
                    NORMAL          11             3              14
                    NOT APPLICABLE  16             1              17


                              End of Report
```

Figure 3.29 Screener Workload Report (Specimen) (ALGRLGR0)

```
                                                            Page 1
                                Community Laboratory
                             Mon June 12, 1995  1:00 pm
                          Screener Workload Report (Specimen)
                         Cases Resulted: 06/05/95 thru 06/08/95
  *************************************************************************

WILSON,MARY [8541]
                                    GYN            nonGYN         Total
                    -------------------------------------------------------
                    # of cases      51             8              59
                    # of slides     145 (35)       16             161 (35)

                    Diagnosis
                    Categories      GYN            nonGYN         Total
                    -------------------------------------------------------
                    ABNORMAL        21             2              23
                    MALIGNANT       3              2              5
                    NORMAL          11             3              14
                    NOT APPLICABLE  16             1              17


                    Specimen            Diag Categories          Total
                    -------------------------------------------------------
                    Body Fluid (nonGYN)  [ABN]    = 2            7
                                         [MAL]    = 1
                                         [NA]     = 1
                                         [NORM]   = 3
                    Bone (nonGYN)        [MAL]    = 1            1
                    PAP Smear (GYN)      [ABN]    = 21           51
                                         [MAL]    = 3
                                         [NA]     = 16
                                         [NORM]   = 11

                              End of Report
```

Figure 3.30 Screener Workload Report (Case) (ALGRLGR0)

```
                                                              Page 1
                                   Community Laboratory
                                Mon June 12, 1995  1:00 pm
                                Screener Workload Report (Case)
                             Cases Resulted: 06/05/95 thru 06/08/95
    ****************************************************************************

  WILSON,MARY [8541]
                                        GYN            nonGYN          Total
                  ---------------------------------------------------------------
                  # of cases             51             8               59
                  # of slides            145 (35)       16              161 (35)

                  Diagnosis
                  Categories             GYN            nonGYN          Total
                  ---------------------------------------------------------------
                  ABNORMAL               21             2               23
                  MALIGNANT              3              2               5
                  NORMAL                 11             3               14
                  NOT APPLICABLE         16             1               17


                  Specimen               Diag Categories                Total
                  ---------------------------------------------------------------
                  Body Fluid (nonGYN)    [ABN]    = 2                    7
                                         [MAL]    = 1
                                         [NA]     = 1
                                         [NORM]   = 3
                  Bone (nonGYN)          [MAL]    = 1                    1
                  PAP Smear (GYN)        [ABN]    = 21                   51
                                         [MAL]    = 3
                                         [NA]     = 16
                                         [NORM]   = 11

          Case        Type     Diag       Specimen         Sld  HR   Over Max
          --------------------------------------------------------------------
          C95-398     GYN      [ABN]      PAP Smear         2
          C95-400     GYN      [ABN]      PAP Smear         1
          C95-403     GYN      [NORM]     PAP Smear         3
          C95-404     GYN      [ABN]      PAP Smear         2
          C95-404     GYN      [ABN]      PAP Smear         1
          C95-405     GYN      [NORM]     PAP Smear         2
          C95-406     GYN      [NA]       PAP Smear         2
          C95-407     GYN      [NA]       PAP Smear         2    X
          C95-408     GYN      [NA]       PAP Smear         2
          C95-409     GYN      [MAL]      PAP Smear         2
          C95-412     GYN      [NA]       PAP Smear         2
          C95-413     GYN      [NA]       PAP Smear         2
          C95-414     GYN      [NA]       PAP Smear         2
          C95-415     GYN      [NA]       PAP Smear         2
          C95-416     GYN      [ABN]      PAP Smear         2              X


                                   End of Report
```

Report Layout

Report Header

PAGE NUMBER
The page number of the report prints on the first line. This field is right justified.

DEPARTMENT NAME
The name of the laboratory department prints on the second line of the report. This field is centered.

DATE/TIME PRINTED
The date and time the report was printed is centered on the third line of the report. This field prints directly below the Department Name field.

REPORT TITLE
The title of this report is *Screener Workload Report*. *Summary*, *Specimen*, or *Case* also appears in the title, depending on the type of report you specified. This field prints below the Date/Time Printed field and is centered on the report.

DATE RANGE
The date range of the data included on the report prints on the fifth line of the report.

Report Body (Summary)

SCREENER
This field displays the name and ID of each screener.

GYN - nonGYN - TOTAL
These fields display the number of GYN cases and slide counts, the number of nonGYN cases and slide counts, and the total number of GYN and nonGYN cases and slide counts for the screener.

NOTE: The number in parenthesis indicates the number of exempt slides captured by the screener in the Repeat Queue, the Discrepancy Queue, or the Review Queue.

DIAGNOSIS CATEGORIES - GYN - nonGYN - TOTAL
These fields display the diagnosis categories for cases resulted within a specific period of time, the number of GYN cases for each diagnosis category, the number of nonGYN cases for each diagnosis category, and the total number of cases for each diagnosis category.

Report Body (Specimen)

SCREENER
This field displays the name and ID of each screener.

GYN - NONGYN - TOTAL
These fields display the number of GYN cases and slide counts, the number of nonGYN cases and slide counts, and the total number of GYN and nonGYN cases and slide counts for the screener.

NOTE: The number in parenthesis indicates the number of exempt slides captured by the screener in the Repeat Queue, the Discrepancy Queue, or the Review Queue.

DIAGNOSIS CATEGORIES - GYN - nonGYN - TOTAL
These fields display the diagnosis categories for cases resulted within a specific period of time, the number of GYN cases for each diagnosis category, the number of nonGYN cases for each diagnosis category, and the total number of cases for each diagnosis category.

SPECIMEN - DIAG CATEGORIES - TOTAL
These fields display the specimen types associated with cases resulted within a specific period of time, the diagnosis categories and counts for each specimen type, and the total count for each specimen type. Each specimen type includes a GYN or nonGYN indicator in parenthesis.

Report Body (Case)

SCREENER
This field displays the name and ID of each screener.

GYN - NONGYN - TOTAL
These fields display the number of GYN cases and slide counts, the number of nonGYN cases and slide counts, and the total number of GYN and nonGYN cases and slide counts for the screener.

NOTE: The number in parenthesis indicates the number of exempt slides captured by the screener in the Repeat Queue, the Discrepancy Queue, or the Review Queue.

DIAGNOSIS CATEGORIES - GYN - nonGYN - TOTAL
These fields display the diagnosis categories for cases resulted within a specific period of time, the number of GYN cases for each diagnosis category, the number of nonGYN cases for each diagnosis category, and the total number of cases for each diagnosis category.

CASE - TYPE - DIAG - SPECIMEN - SLD - HR - OVER MAX
These fields display the case number, the specimen type category (GYN or nonGYN), the associated diagnosis category, the specimen type, and the number of slide counts for each case. Exempt slides are not included in this section of the report. An indicator (*X*) defines the High Risk cases. The over max indicator (*X*) identifies those cases that were processed by the screener once the maximum number of slide counts had been reached or exceeded.

Report Footer

END OF REPORT
The report prints *End of Report* at the bottom of the last page of the Screener Workload Report.

GYN Comparison

The GYN Comparison processor enables you to compare test results between GYN cases that have a case number pool defined as either histology or cytology. You select the two cases or tests you want to compare and then review and compare the selected information on a split screen. Once you make your comparison, you can flag the comparison as clinically significant and document the comparison. Using Cytology QA Management Reports, you can access and track all of the comparisons you perform regardless of the status of cytology workload/QC.

This processor does not make any comparison to determine if there are result discrepancies between tests or components. The individual performing the comparison subjectively determines any correlation or results between the two selected cases/tests. You use the processor to make your comparison and to document any clinically significant discrepancies and corrective actions.

All case/test comparisons are patient specific and may include any eligible case or test from the patient's account(s).

Cases/tests that are eligible for comparison must meet the following criteria:

- The test must be an AP type test.

- The case number pool must be defined as either histology or cytology.

- The case must have a GYN specimen type (primary or additional).

- The test code must have comparison components defined.

- The test must be in a partial or higher status (done, backloaded, cardfile, or archived).

- In the event a search is performed, the test must have been collected within the comparison search window time frame.

NOTE: Cases/tests from *all* departments that meet these criteria are eligible for comparison. The selection of a specific comparison case/test can be limited to the current department in specific scenarios where multiple departments are involved.

You perform comparisons between two eligible tests assigned to one or more GYN case(s) for a single patient by entering a known case or accession number or through

a search by patient. A search produces all eligible cases/tests for the patient. Once selected, the two comparison tests are then available for your review.

The two comparison tests are referred to as the first and second case or test. The terms, first and second, refer to the order in which the tests for comparison are actually selected. These terms do not relate to any tracking date and time associated with the tests.

Case Selection Overview

The following is a general overview of the case selection process for GYN comparison. Actual screen flows vary with different comparison scenarios. Factors that can affect the flow include:

- Whether or not the case numbers or accession numbers are known or require a search by patient.

- The size of the search window defined in the Anatomic Path Parameters maintenance processor.

- The number of eligible cases produced with a search by patient.

- The number of eligible tests per eligible case.

- Whether or not a previous comparison was performed on the selected tests.

- Multi-department considerations.

The following four application screens are used to select the two tests for comparison:

- The First Entry screen

- The First Selection screen

- The Second Entry screen

- The Second Selection screen

The Selection Process

Whether or not all four screens are displayed depends on the actual selection process which proceeds as follows:

The First Entry and Selection screens are used to determine the first case/ test for comparison. The Second Entry and Selection screens are used to determine the second case/test for comparison.

The First and Second Entry screens allow you to search by a specific case or accession number. Only cases or accessions that meet the criteria outlined above are allowed. If the case or accession number is not known, you can perform a search by patient for all eligible cases/tests.

When more than one eligible test exists, the First and Second Selection screens are used to select a specific comparison case/test.

When the input of a valid case number, accession number, or patient identification yields only one eligible case/test, the system automatically selects that test for comparison. The corresponding selection screen is not displayed and the system continues to the next logical step in the process. Otherwise, the system displays all eligible cases and tests on the appropriate selection screen.

When an invalid case or accession is entered (for example: the case or test does not meet the appropriate criteria for GYN comparison), the system displays the appropriate error message and prompts you to make another entry.

When a search by patient finds that no eligible case/test exists, the system displays an error message and returns you to the First Entry screen to begin a new search.

Multi-Department Considerations

Certain multi-department considerations come into play during the GYN comparison search and selection process:

- Input of a valid case number at the First Entry screen is limited to eligible cases for the current department only.

- The Second Entry screen accepts any valid case from any department for the patient.

- Input of a valid accession number at the First or Second Entry screen may include GYN cases/tests from any department.

- A search by patient at the First or Second Entry screen includes all eligible GYN cases/tests from all departments.

Cancelled Tests

Once a test has been cancelled, it is no longer eligible for comparison.

If a comparison was performed prior to the test being cancelled, the comparison information is still available, by date range only, on the GYN Comparison report.

SELECTING A **GYN** COMPARISON OPTION

To access this option, on the Cytology QA Input Options menu, select GYN Comparison (option number six).

If the Comparison Search Window parameter in the Anatomic Pathology Parameters maintenance processor is set to None, the following message displays and the system returns you to the submenu for another selection:

No GYN comparison allowed with defined search window parameters!

If the Comparison Search Window parameter in the Anatomic Pathology Parameters maintenance processor is set to one or higher (this setting determines the number of days the system searches back from the current date), the GYN Comparison Processor menu displays:

```
                    General Hospital GYN Comparison Processor
                                            Wed Apr 20, 1995 07:46 am




   ( 1) Compare Histology to Cytology GYN case
   ( 2) Compare Cytology to Histology GYN case
   ( 3) Compare Cytology to Cytology GYN case
   ( 4) Compare Histology to Histology GYN case


  Enter option number for comparison--
```

Select one of the following GYN test comparison options:

1 Compare Histology to Cytology GYN case
The first test selected for comparison is a histology case and the second is a cytology case.

2 Compare Cytology to Histology GYN case
The first test selected for comparison is a cytology case and the second is a histology case.

3 Compare Cytology to Cytology GYN case
The first test selected for comparison is a cytology case and the second is a cytology case.

4 Compare Histology to Histology GYN case
The first test selected for comparison is a histology case and the second is a histology case.

Your selection determines the case number pool(s) that will be included in the case search and selection process and the screens, prompts, and messages that display throughout the case selection and comparison process.

Since actual screen flows vary with different comparison scenarios, only one example of a GYN test comparison screen flow is discussed. In this example, option one, the Histology to Cytology GYN case test comparison, is used.   The first test selected for comparison is a histology case, and the second is a cytology case. The patient has multiple eligible tests and a search by patient is performed. The four Entry and Selection screens are presented.   Where applicable, alternative scenarios are noted.

In this example, entering one selects the Histology to Cytology GYN comparison option and displays the first entry screen.

Selecting the First Entry

In this example, the first test selected for comparison is a histology case. The patient has multiple eligible tests and a search by patient is performed.

```
                        General Hospital GYN Comparison Processor
                                                        Tue Jan 16, 1996 03:38 pm




















   Enter `&`unit #,`*`account #,accession # or `[`case #--
         |        patient name (Last,First M), `-`SS# or `=` for current
```

At the First Entry screen prompt, enter the information to determine the first case to be used in the comparison. You can enter a unit number, account number, accession number, case number, patient name, social security number, or soundex search. The more specific the information, the less amount of search time required.

Case or Accession Number Entry

If the case/test meets the following comparison criteria, you can enter a specific histology case number or accession number:

• The test must be an AP type test.

- The case number pool must be defined as histology.

- The case must have a GYN specimen type (primary or additional).

- The test code must have comparison components defined.

- The test must be in a partial or higher status.

The format of the case number entry can be the entire case number or the case number pool character followed by the number. This is the short format of case number that defaults to the current year.

A search by case number includes cases only for the current department. If you enter a specific case or accession number, the system does not perform the date range check, but does check all other GYN comparison criteria.

If the case or accession number entered does not meet the stated criteria for GYN comparison, the following message displays:

   Invalid entry!

You may then try another entry.

If entry of a valid case or accession represents only one eligible test, that test is automatically selected for comparison and the Second Entry screen displays. The First Selection screen is bypassed.

If entry of a valid case or accession represents more than one eligible test, the First Selection screen displays.

Search by Patient

If a search by patient is initiated, the system uses the Comparison Search Window defined in the Anatomic Path Parameters maintenance processor to determine the number of days to search back from the current date. The date checked for all eligible cases/tests is the collection date/time.

Whenever a patient name or ID number is entered, the system searches for all tests for the patient that meet the stated GYN comparison criteria. The criteria for this scenario are as follows:

- The test must be an AP type test.

- The case number pool must be defined as histology.

- The case must have a GYN specimen type (primary or additional)

- The test code must have comparison components defined.

- • The test must be in a partial or higher status.

- • The test must have been collected within the comparison search window time frame.

The search includes all active results and history cardfile results for the patient throughout all departments and facilities for all of the patient's accounts.

The searching message for a defined number of days displays as follows:

<< Searching previous N day(s) . . . Enter 'S' to stop search >>

The searching message for all data being searched displays as follows:

<< Searching all previous patient data . . . Enter 'S' to stop search >>

At any time, enter **S** to halt the search. The system returns you to the First Entry screen to enter another patient, accession number, or case number. If the search is successful and there are multiple cases/tests that meet the GYN comparison criteria, these tests display on the First Selection screen.

If the patient entered does not have a resulted test that meets the stated criteria, the system displays the following message:

No eligible test resulted within search period for [insert patient name]!

The system returns you to the First Entry screen to enter another patient, accession number or case number.

NOTE: The time period required for the system to search all patient data (across all departments and facilities, including active results and history cardfile results) could be extensive. The more specific the patient information entered (for example: case number or accession number) the better system performance.

Selecting the First Eligible Case/Test to Compare

Once the search is complete a list of all eligible cases and tests for the patient displays. If a single case includes more than one eligible test, each eligible test will be listed separately.

```
                    General Hospital GYN Comparison Processor
                                        Thu Jan 15, 2009 09:04 am
  Unit #      Name            Sex Birthdate  Room    Physician     Srv ICD Status
   A000000010 TESTWHITE,ONE    F  02/18/1967 2103-02 TONGEN,LYLE A MED 10  I/P 843

                            Histology Tests
                                                          Page:01
  Opt # Case#       Acc #    Test Name              Date/Time        Status
  ( 1)  S95-860     5045     GROSS & MICROSCOPIC    04/18/95 0720    Done
           Dept:    LAB      Spec Type: Uterus
  ( 2)  S95-860     5045     FROZEN SECTION         04/18/95 0720    Done
           Dept:    LAB      Spec Type: Uterus
  ( 3)  S95-42      2044     GROSS & MICROSCOPIC    01/18/95 0714    Done
           Dept:    LB2      Spec Type: Uterus




  Enter histology option--
```

The header information on the first selection screen includes patient demographic information. The title line displays Histology Tests or Cytology Tests depending on the comparison option originally selected.

The columns of the table selection include the Option Number (Opt #), Case Number (Case #), Accession Number (Acc #), ordered Test Name, collection Date/Time, and Status (of the test).

Eligible tests display in reverse chronological order by collection date/time. Active cases/accessions are listed first followed by History Cardfile cases. Each entry has a two line display. The first line includes the data described in the column headers. The second line of each entry includes the ordering department and the primary specimen type for the case. An asterisk displays in front of the specimen type when more than one specimen is attached to the case.

When more than one test on a case meets the criteria, the tests display in numeric order by test code. The following prompt displays:

   Enter histology option--

The prompt displays as histology or cytology depending on the comparison option originally selected. Select one.

When you accept this screen, the system displays the Second Entry screen.

Selecting the Second Entry

Once selection of the first case for comparison is complete, selection of the second case begins. This process is similar to the first although, in this example, the second search will be limited to eligible cytology cases for the patient. Eligible tests include all cytology cases that meet the stated GYN comparison criteria.

```
                         General Hospital GYN Comparison Processor
                                             Thu Jan 15, 2009 09:04 am
Unit #        Name          Sex Birthdate  Room    Physician     Srv ICD Status
A000000010 TESTWHITE,ONE     F  02/18/1945 2103-02 TONGEN,LYLE A MED 10  I/P 134
Histology Case # S95-860        Test Code - 5050   GROSS & MICROSCOPIC




















Enter cytology case #, accession # or search(S) for previous cases--
```

In this example, the second entry screen includes the patient demographic information in the screen header as well as the case number and test code and description for the previously selected histology test. The following prompt displays:

Enter cytology case #, accession # or search(S) for previous cases--

The above prompt displays cytology or histology depending on the comparison option originally selected.

To determine the second case for comparison, enter a valid case number, enter an accession number, or search by patient.

Any case number entered must meet the stated criteria for GYN comparison. The format of the case number entry can be the entire case number or the case number pool character followed by the number. This is the short format of case number that defaults to the current year. A valid accession number may also be entered.

Once the case number or accession number is entered, the system makes the following checks:

- • The test must be an AP type test.

- • The case number pool must be defined as cytology.

- • The case must have a GYN specimen type (primary or additional).

- The test code must have comparison components defined.

- The test must be in a partial or higher status.

If the case number or accession number entered does not meet the stated criteria, the system displays the following message:

Invalid entry!

You may then try another entry.

If you do not know the cytology case number or accession number for comparison, enter **S** to initiate a search of cytology cases that meet the GYN comparison criteria.

NOTE: The cytology test must have been collected within the comparison search window date/time frame.

The searching message for a defined number of days displays:

<< Searching previous X day(s) . . . Enter 'S' to stop search >>

The following searching message for all data being searched displays:

<< Searching all previous patient data . . . Enter 'S' to stop search >>

If the search is successful and there are multiple cases/tests that meet the GYN comparison criteria, the tests display on the Second Selection screen.

At any time, to stop the search and begin the selection process anew, enter **S**. You are returned to the First Entry screen.

If the patient does not have a resulted test that meets the stated criteria, the system displays the following message:

No eligible test resulted within search period for [insert patient name]!

The system returns you to the First Entry screen to begin the selection process anew.

Selecting the Second Case/Test for Comparison

In this example, the second selection screen lists all cytology tests for the patient that are eligible for comparison. If a single case includes more than one eligible test, each eligible test is listed separately.

```
                      General Hospital GYN Comparison Processor
                                      Thu Jan 15, 2009 09:04 am
Unit #       Name            Sex Birthdate  Room    Physician     Srv ICD Status
A000000010 TESTWHITE,ONE      F  02/18/1945 2103-02 TONGEN,LYLE A MED 10  I/P 134
Histology Case # S95-860          Test Code - 5050   GROSS & MICROSCOPIC


                                  Cytology Tests
                                                                      Page:01
Opt # Case#        Acc #    Test Name            Date/Time          Status
( 1)  C95-42       1050     CYTOLOGY, PAP SMEAR  05/10/95 0956      Done
          Dept:  LB2        Spec Type: Cervix
( 2)  C95-42       2044     MATURATION INDEX     05/10/95 0956      Done
          Dept:  LB2        Spec Type: Cervix





 Enter cytology option--
```

The header information for this screen includes patient demographic information, as well as the case number and test from the first selection. The title line displays "Histology Tests" or "Cytology Tests" depending on the comparison option originally selected.

Column headings are the same as the First Selection screen. Eligible tests display in reverse chronological order by collection date/time. Active cases/accessions are listed first followed by History Cardfile cases. When more than one test on a case meets the criteria, the tests display in numeric order by test code. The following prompt displays:

   Enter cytology option--

The prompt displays histology or cytology depending on the comparison option originally selected. Select one eligible case/test.

If the first and second cases/tests selected for comparison have been previously compared, the system displays the following message and prompt:

   Case has already been compared with [case number]! Continue? (Y/N) [N]--

To continue the comparison and proceed to the Result Viewing screen, enter **Y**. All previous case comparison information is retained.

To return to the First Entry screen to begin the selection process anew, enter **N** or period (.) ENTER.

Viewing the Two Selected Cases

Once you complete the search and selection process, the next step is to review and compare the selected results on the Result Viewing screen.

```
                        General Hospital GYN Comparison Processor
                                      Thu Jan 15, 2009 09:04 am
Unit #       Name           Sex Birthdate  Room    Physician    Srv ICD Status
A000000750 NALA,BLANCHE    F  03/02/1971 LD-04   CASPER,DAVID  OBS 10  I/P 14
Histo Case #:  S95-860/5050                   Cyto Case #:  C95-42/5014
 Component                 Histology Results
  Clinical Data          : Persistent bleeding
  Diagnosis              : No dysplasia present
  SNOMED Code 1          : Cervix, uterine - Normal Cytology, NOS
                         : (T-83000,M-00120)


F1=Prev Pg    F2=Next Pg    Cytology Results   F5=Change Window   F7=Exit
  Diagnosis                : Cellular change - human papilomavirus
  Categorization           : Unable to define classification
  Recommendations          :
      Follow-up with collection of genital specimen for routine
      aerobic culture.
   SNOMED Code 1           : Cervix, uterine - Normal Cytology, NOS
                            : (T-83000,M-00120)




```

Results for both tests display on one split screen. The header information for this screen includes patient demographic information, as well as the case number and test code for both comparison tests.

Results that display are determined by the Results for Comparison maintenance processor settings for each test. Only those result components defined as Display are presented for review.

The orientation of results on this screen is not dependent on the sequence in which the two tests for comparison were selected. The following screen presentation rules apply to all comparison options and scenarios:

- The case/test number that displays on the left side of the screen refers to test results in the top window and is the test with the oldest accession date.

- The case/test number that displays on the right side of the screen refers to test results in the bottom window and is the test with the most current accession date.

- The result components that display in the split screen are the names of the components based on the performing test and department.

- The result field for any component defined as Display that does not have a result is left blank.

The result components defined to display for one test may be totally different from the components defined for the other. The system makes no comparison to determine if there are any result discrepancies between tests or components.

The GYN Comparison processor provides the means for you to make the comparison and to document any decisions about the outcome of the comparison. Correlation or results between the two tests is purely subjective and is based on the conclusions of the individual performing the comparison.

To navigate within and between the two screens, use the following function keys:

Function Key	Description
F1=Prev Pg	Move back to the previous page.
F2=Next Pg	Move forward to the next page of information.
F5=Change Window	Move from one window to the other window on the split screen.
F7=Exit	Display the Comparison Information screen.

After the results have been reviewed, press **F7** to continue.

Entering the Results of Your Comparison

Upon leaving the Result Viewing screen the following Comparison Information screen displays.

```
                    General Hospital GYN Comparison Processor
                                              Thu Jan 15, 2009 09:04 am
Unit #      Name             Sex Birthdate  Room    Physician     Srv ICD Status
A000000010 TESTWHITE,ONE    F  02/18/1945 2103-01 TONGEN,LYLE A MED 10  I/P 134
Histo Case #:  S95-860                     Cyto Case #:  C95-42

 1 Clinical       2 Discrepancy Category                 3 View Results
->
 4 Comparison Comment




 Is this a clinically significant discrepancy? (Y/N)--
```

Use this screen to enter information related to the comparison of the two cases. The header information is the same as the Result Viewing screen.

Field Explanations

1. CLINICAL (1-A-R)
This field is used to indicate if there is a clinically significant discrepancy between the two selected cases. The following prompt displays:

Is this a clinically significant discrepancy? (Y/N)--

Enter **Y** to flag this comparison as having a clinically significant discrepancy. If **Y** is entered, you must assign a discrepancy category to this comparison.

Enter **N** to indicate that no clinically significant discrepancy exists. No displays in the field and no discrepancy category can be assigned. Field 2 displays as N/A.

2. DISCREPANCY CATEGORY (TABLE LOOKUP-C)
Whenever a clinically significant discrepancy is identified, this field is used to enter the discrepancy category. If Field 1 displays No, this field cannot be accessed and displays *N/A*. If Field 1 is Yes, a discrepancy code is required and the following prompt displays:

Enter discrepancy code or `-` for table--

Enter a discrepancy category code or enter a dash to display a table of active codes defined in the Discrepancy Category maintenance processor.

3. VIEW RESULTS (1-A-O)
This field gives you the option to return to the split screen display and review the results of the comparison. Any information entered on this screen is retained. Entering this field displays the following prompt:

View results? (Y/N)--

Enter **Y** to review the comparison again. Enter **N** or period (.) ENTER to skip.

4. COMPARISON COMMENT (220-C-O)
This field enables you to enter 220 characters of optional free text to document any corrective action needed when discrepancies are identified or to clarify the comparison when no discrepancy is found. Entering this field displays the following prompt:

Enter comment--

The information entered in this field will appear on the GYN Comparison Report.

Once all required fields are resulted, you must accept the screen to file documentation that a comparison has occurred. The system displays the following prompt:

Accept this screen? (Y/N) [Y]--

Enter **Y** to accept the results. The following message displays:

Filed!

Comparison information including comparison results are stored and are available for reporting.

To exit this screen and not save any comparison information, enter period (.) ENTER. You are returned to the First Entry screen to begin the selection process anew.

Appendix A - Reports

INTRODUCTION

This appendix provides a list of the reports, labels, and forms generated by the STAR Laboratory system. The reports, labels, and forms are presented in alphabetical sequence based on the system name of each and then in alphabetical sequence based on the description of the report, label, or form.

For the STAR Laboratory reports, forms, and labels, the first character of the report name is always the department identifier. The department identifier is an alpha character that is automatically assigned by the system when the department is defined. The department identifier is followed by a three-digit report code. The report code may be the section code if the report is defined to be section specific in Spooler Report Definition. The next three digits represent the report type codes as defined in Spooler Printer Direction in Chapter 11: Spooler/Printer Matrix in the *Maintenance Functions Volume II* of the *STAR Laboratory Reference Guide*. The last digit represents the printer. For example: *0* is always the default printer, whereas other digits (such as 2, 3) represent the alternate printers respectively as defined in printer direction. The number of each report that displays is dependent upon the number of alternate printers selected. If no alternate printers are selected for a report, the report displays only once with the report identifier ending in *0.*

An example form is ALALLAL0. The *A* represents department A. *LAL* stands for the Laboratory Accession Label report code. *LAL* is the Report Type Code, which in this case is the Laboratory Accession Label. *0* represents the default printer being used for this form. Using this example, if accession labels are defined to be section specific, the report name would look like, for example, AHEMLAL0 for the Hematology section.

You can use the STAR Audit Service to audit user requests for certain reports. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. The report requests that can be audited are marked with a plus sign (+). For more information, refer to the *STAR Audit Service Reference Guide*.

SYSTEM REPORTS, LABELS, AND FORMS

System Report Names by Report Name

Below is a list of reports as they display with only the default printer defined.

REPORT	DESCRIPTION	REFERENCE GUIDE BOOK
ALALLAL0	Accession Label	Gen Apps Vol - Part I
+ALARLAR0	Archive Patient Listing	Gen Apps Vol - Part II
ALBALBA0	Barcode Accession Label	Maint Func Vol - Part II
ALBBLBB0	Barcode Specimen Rejection	Maint Func Vol - Part II
ALBCLBC0	Barcode Collection Label	Maint Func Vol - Part II
ALBCLBCL	Default Barcode Label	Maint Func Vol - Part II
ALBELBE0	Barcode Spooler Error	Maint Func Vol - Part II
ALBFLBF0	CMS ABN Report	Maint Func Vol - Part II
ALBGLBG0	Barcode General Label	Maint Func Vol - Part II
ALBHLBH0	Barcode Histotech Label	Maint Func Vol - Part II
ALBILBI0	Instrument Accession Label	Gen Apps Vol - Part I
ALBMLBM0	Barcode Adv Micro Label	Maint Func Vol - Part II
ALBNLBN0	ABN Report	Maint Func Vol - Part II
ALBOLBO0	Barcode Sendout Label	Maint Func Vol - Part II
ALBSLBS0	Specimen Rejection Label	Gen Apps Vol - Part I
ALCILCI0	Client Report	Contract Billing Module
ALCLLCL0	Collection Label	Gen Apps Vol - Part I
ALCMLPR0	Primary Report	Gen Apps Vol - Part I
ALCNLCN0	Census Reports	Gen Apps Vol - Part II
+ALCULCU0	Cums Report	Gen Apps Vol - Part I
ALCWLCI0	Client Report - Wide	Contract Billing Module
ALDNLDN0	Downloaded Lab Report	Gen Apps Vol - Part II
+ALDRLGR0	General Reports	All Volumes
+ALGRLGR0	Cytology QA Reports	Anatomic Path Module
+ALGWLGR0	General Reports - Wide	All Volumes
ALHMLPR0	Primary Report	Gen Apps Vol - Part I
+ALHRLHR0	Histotech Process Report	Anatomic Path Module
ALHTLHT0	Histotech Process Label	Anatomic Path Module

REPORT	DESCRIPTION	REFERENCE GUIDE BOOK
ALMILMI0	Microbiology Internal Log	Advanced Micro Module
ALMLLBM0	Barcode Adv Micro Label	Advanced Micro Module
ALMMLMM0	Micro Work-up Labels	Advanced Micro Module
+ALMRLMI0	Microbiology Reports	Advanced Micro Module
ALMRLPR0	Primary Report	Gen Apps Vol - Part I
+ALMWLMI0	Microbiology-Wide Reports	Advanced Micro Module
ALNPLNP0	Lab Network Printer	Gen Apps Vol - Part I
ALPRLPR0	Primary Report	Gen Apps Vol - Part I
+ALRCLRC0	Recall Reminder Letters	Gen Apps Vol - Part I
ALRMLPR0	Primary Report	Gen Apps Vol - Part I
ALRPLRP0	Draft Long Report	Gen Apps Vol - Part I
ALS	Archive Lab Summary	Gen Apps Vol - Part II
ALSLLSL0	Call Stat Labels	Gen Apps Vol - Part I
ALSOLSO0	Sendout Labels	Gen Apps Vol - Part I
+ALSPLSP0	Long Report	Gen Apps Vol - Part I
+ALSRLSR0	Summary Reports	Gen Apps Vol - Part I
+ALTRLTR0	Specimen Transfer	Gen Apps Vol - Part I

System Report Names by Description

DESCRIPTION	REPORT	REFERENCE GUIDE BOOK
ABN Report	ALBNLBN0	Maint Func Vol - Part II
Accession Label	ALALLAL0	Gen Apps Vol - Part I
Archive Lab Summary	ALS	Gen Apps Vol - Part II
+Archive Patient Listing	ALARLAR0	Gen Apps Vol - Part II
Barcode Accession Label	ALBALBA0	Maint Func Vol - Part II
Barcode Adv Micro Label	ALBMLBM0	Maint Func Vol - Part II
Barcode Adv Micro Label	ALMLLBM0	Maint Func Vol - Part II
Barcode Collection Label	ALBCLBC0	Maint Func Vol - Part II
Barcode General Label	ALBGLBG0	Maint Func Vol - Part II
Barcode Histotech Label	ALBHLBH0	Maint Func Vol - Part II
Barcode Sendout Label	ALBOLBO0	Maint Func Vol - Part II
Barcode Specimen Rejection	ALBBLBB0	Maint Func Vol - Part II
Barcode Spooler Error	ALBELBE0	Maint Func Vol - Part II
Call Stat Labels	ALSLLSL0	Gen Apps Vol - Part I
Census Reports	ALCNLCN0	Gen Apps Vol - Part II
Client Report	ALCILCI0	Contract Billing Module
Client Report - Wide	ALCWLCI0	Contract Billing Module
CMS ABN Report	ALBFLBF0	Maint Func Vol - Part II
Collection Label	ALCLLCL0	Gen Apps Vol - Part I
+Cums Report	ALCULCU0	Gen Apps Vol - Part I
+Cytology QA Reports	ALGRLGR0	Anatomic Path Module
Default Barcode Label	ALBCLBCL	Maint Func Vol - Part II
Downloaded Lab Report	ALDNLDN0	Gen Apps Vol - Part II
Draft Long Report	ALRPLRP0	Gen Apps Vol - Part I
+General Reports	ALDRLGR0	All Volumes
+General Reports - Wide	ALGWLGR0	All Volumes
Histotech Process Label	ALHTLHT0	Anatomic Path Module
+Histotech Process Report	ALHRLHR0	Anatomic Path Module
Instrument Accession Label	ALBILBI0	Gen Apps Vol - Part I
Lab Network Printer	ALNPLNP0	Gen Apps Vol - Part I
+Long Report	ALSPLSP0	Gen Apps Vol - Part I

DESCRIPTION	REPORT	REFERENCE GUIDE BOOK
Micro Work-up Labels	ALMMLMM0	Advanced Micro Module
Microbiology Internal Log	ALMILMI0	Advanced Micro Module
+Microbiology Reports	ALMRLMI0	Advanced Micro Module
+Microbiology Wide Reports	ALMWLMI0	Advanced Micro Module
Primary Report	ALCMLPR0	Gen Apps Vol - Part I
Primary Report	ALHMLPR0	Gen Apps Vol - Part I
Primary Report	ALMRLPR0	Gen Apps Vol - Part I
Primary Report	ALPMLPR0	Gen Apps Vol - Part I
Primary Report	ALRMLPR0	Gen Apps Vol - Part I
+Recall Reminder Letters	ALRCLRC0	Gen Apps Vol - Part I
Sendout Labels	ALSOLSO0	Gen Apps Vol - Part I
Specimen Rejection Label	ALBSLBS0	Gen Apps Vol - Part I
+Specimen Transfer	ALTRLTR0	Gen Apps Vol - Part I
+Summary Reports	ALSRLSR0	Gen Apps Vol - Part I

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■ **R e a d e r   C o m m e n t   F o r m** ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Anatomic Pathology Module* of the *STAR Laboratory Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

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