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STAR 2000™

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Any comments or suggestions regarding this publication are welcomed and should be forwarded to the attention of

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Preface

This document explains how the STAR Patient Care, Medical Record Transcription Interface works. It describes the various components, functions, and uses of the Medical Record Transcription Interface.

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 the STAR system. (This key may also be referred to as 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--

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 Letters and Numerals 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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Introduction

The *STAR Patient Care, Medical Record Transcription Interface Guide* is written for all users of the STAR Patient Care system. This volume describes the various components, functions, and uses of the Medical Record Transcription Interface.

Chapter 1: Getting Started with the Interface

This chapter details several aspects of the interface including assumptions/cautions, facility and vendor requirements, pre-installation steps, installation considerations and troubleshooting tips.

Chapter 2: Interface Functionality

This chapter outlines how the benefits of utilizing the transcription interface are affected depending on the presence of STAR Chart Management and/or STAR Clinical Browser/Horizon*WP*® Physician Portal.

Chapter 3: Data Transmission

This chapter contains explanations of the formats and specifications for data transmission in the transcription interface, as well as the column heading definitions and field notes related to Health Level Seven® (HL7®) that are used in the transcription interface.

Chapter 4: Updating STAR Clinical Browser and Horizon*WP* Physician Portal with Transcription Data

This chapter describes several areas of STAR Clinical Browser/Horizon*WP* Physician Portal that are used with the transcription interface.

Chapter 5: Updating Chart Deficiency with Transcription Data

This chapter describes the various portions of the STAR system related to Chart Deficiency that are used with the transcription interface.

Chapter 6: Reports

This chapter includes descriptions and examples of reports related to the transcription interface.

Chapter 7: Transcription Interface Test Plan

This chapter includes a detailed test plan for the transcription interface.

MEDICAL RECORD TRANSCRIPTION

Medical transcription is the process of transforming dictated information into medical reports. Within a facility, transcription areas can be decentralized and located within various hospital departments (e.g., Medical Record Department, Radiology, Lab/Path, etc.) or centralized into a single transcription department.

The purpose of this interface is to provide the Medical Record Department with a generic interface based on HL7 standards and TCP/IP communication protocol. A standard HL7 interface solution enables the McKesson customer to choose the transcription vendor suited to their needs and does not require McKesson to maintain a vendor-specific interface.

In order to ensure the standard interface is operational with other transcription vendors, the *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface* has been developed and is provided as part of the STAR online library.

By providing a transcription interface in the STAR Medical Record Product line, STAR provides customers with the following benefits and value-added features:

- Availability of MPI and related patient information (transmitted from STAR) to the transcription system. This has a positive impact on the productivity of the transcriber and aids in positive identification of a patient's report.

- The ability to view, print, and/or electronically sign transcribed reports via STAR Clinical Browser and Horizon^{WP} Physician Portal.

- Ability to view and print transcribed reports via STAR Patient Care modules. This provides caregivers with vital information in a timely and efficient manner. This has a positive impact on the quality and efficiency of patient care.

- Availability of transcription information for the purpose of automatically updating STAR Chart Deficiency provides not only an added benefit to customers utilizing this product, but can result in a positive impact on the productivity of processing incomplete records.

With the combined use of online report review and electronic signature, a decrease in the turnaround time of incomplete medical records can be realized. This has a positive impact on the facility's cash flow and A/R days.

Chapter 1 - GETTING STARTED WITH THE INTERFACE

INTRODUCTION

This chapter details several aspects of the transcription interface to assist you in getting started. It includes assumptions/cautions of which you should be aware, facility and vendor requirements that must be met before continuing, pre-installation steps to be followed, installation considerations, and troubleshooting tips.

STAR Clinical Browser and Horizon^{WP} Physician Portal are integrated with the Medical Record Transcription Interface; therefore, transcribed reports (History & Physical, Operative Report, Discharge Summary, etc.) can be displayed quickly for the benefit of delivering care. And the reports can be electronically signed. The interface is written in HL7 programming language; thus, the communication protocol and the data sent are standard.

The interface can do one or all three things:

1. Send STAR admission, discharge, and transfer encounter data to the transcription vendor

2. Perform a real-time query to the transcription system to view and/or sign a report

3. Update the STAR Chart Deficiency information

REAL-TIME QUERY

The real-time query is useful because it enables physicians/clinicians to read transcribed reports on the computer instead of having to obtain a hard copy.

One-Step Query

If reports are transcribed when the interface is active, a report header is sent from the transcription system to the STAR database indicating the type of report, who needs to sign it, the account's admission date, and some other basic information about the report.

The report header does not contain the text of the report. The text of the report is always stored on the transcription system and must be retrieved by performing a query when needed. (A screen print of the actual report text is not in this book.) A real-time query is performed when a report is viewed or displayed for signature. The report header is the "key" to the specific textual report in the transcription system. This is called a one-step query and is most common.

STAR Clinical Browser

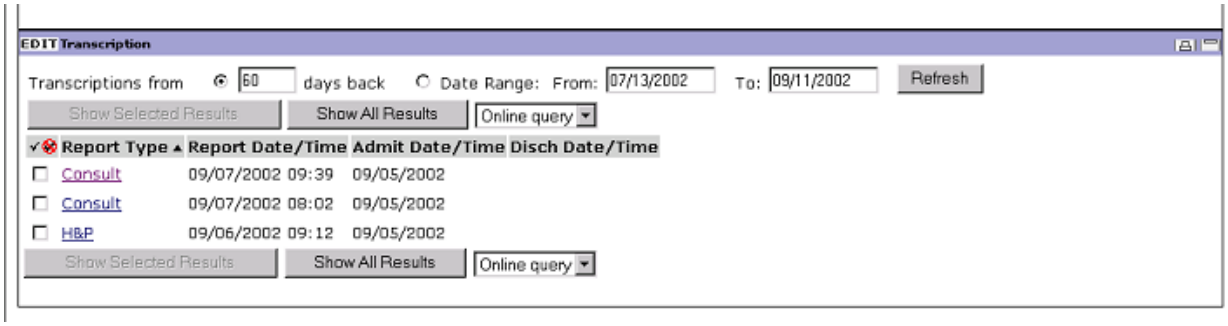
A STAR Clinical Browser one-step query sample is below.

Select	Report Type	Report Date/Time	Admit Date	Discharge Date
☐	HIS	05/23/2001 04:20	05/22/2001	
☑	CONS	05/24/2001 22:07	05/22/2001	
☑	PROC	06/05/2001 15:28	05/22/2001	

Get Selected Reports | Query Offline Reports

Horizon^{WP} Physician Portal

In Horizon^{WP} Physician Portal, this method is called *Online Query*. Following is a sample from Horizon^{WP} Physician Portal:



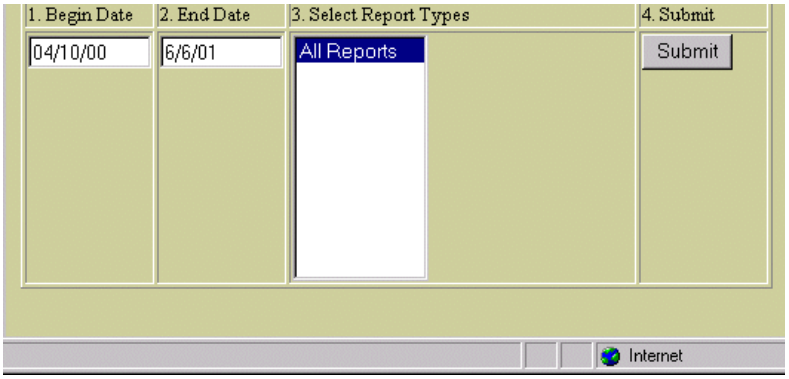
Two-Step Query

If reports are transcribed when the interface is not active (interface down, typed before interface live date, etc.), a report header is not sent for each report to STAR; thus, the STAR database does not have a key and is not aware of the particular report. In this situation, two queries to the transcription system must be performed. Choose the *Query Offline* feature in STAR Clinical Browser and Horizon^{WP} Physician Portal to invoke a two-step query.

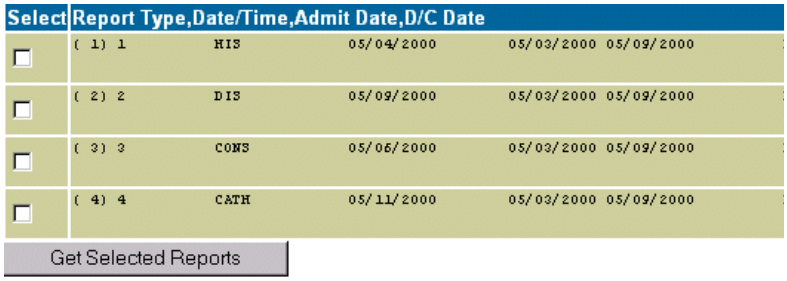
The first of two queries is performed, using the search criteria below, to narrow the search range.

STAR Clinical Browser

The samples below are from STAR Clinical Browser.



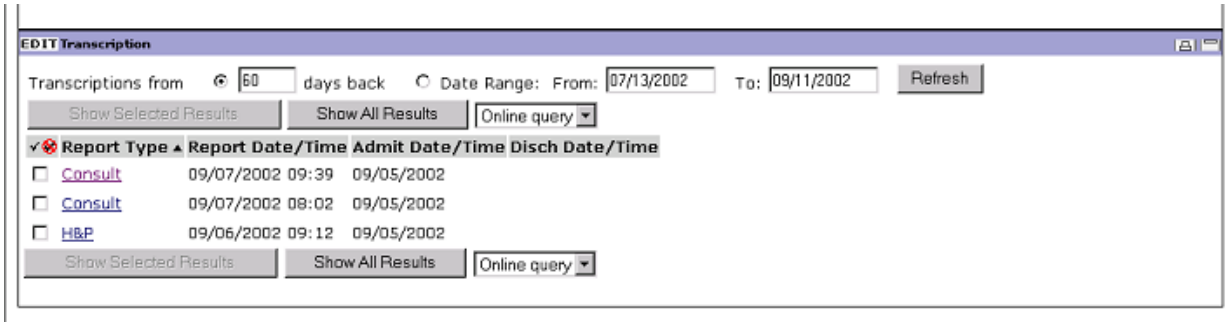
The transcription system sends a list of the matching reports:



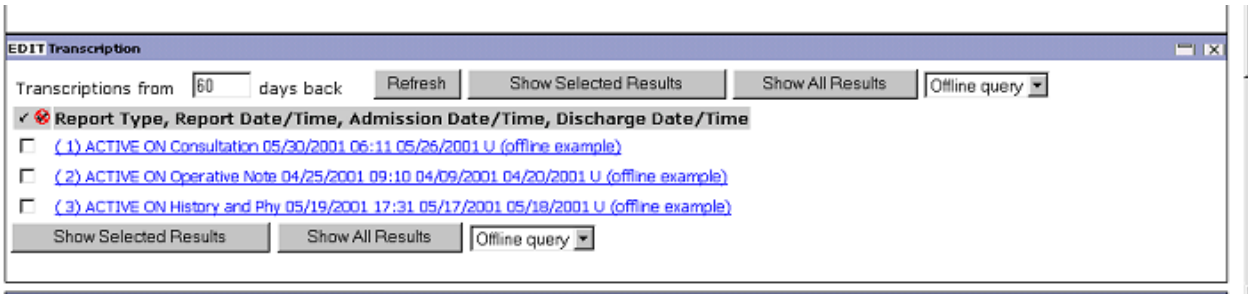
The particular report is selected from the list, and then the second query is performed. The transcription system finds the report and sends the text to display on the STAR screen. (An example screen is not displayed in this book.) This is called a two-step query.

HORIZON^{WP} PHYSICIAN PORTAL

In Horizon^{WP} Physician Portal, this method is called *Offline Query*. Following is a sample:



Following is a sample of what is returned from the transcription system:



ASSUMPTIONS/CAUTIONS/LIMITATIONS

- McKesson takes no ownership of the integrity of the data sent from the transcription system. The transcription vendor is solely responsible for the integrity of the transcription document information.

- Any table in STAR that is utilized in the transcription interface must have corresponding valid values in the transcription system. For example, the Physician Master must be kept in sync across the two systems.

- ADT information that has been transmitted to the transcription system and updated within that system is *not* transmitted back to STAR.

- Transcribed reports are *not* maintained by nor stored in STAR. All reports are maintained in the transcription system.

- A report is available for viewing and printing via STAR only for as long as that report is available in the transcription system.

- Updates or changes to transcribed reports (other than the attachment of an electronic signature) *cannot* be done via STAR.

- Reports that are viewed and/or printed via STAR are in ASCII format and *do not* appear in the same word processing format (i.e., WordPerfect®, Microsoft® Word, etc.) as found in the transcription system.

- McKesson does not maintain a transcription system at the corporate office; thus, beta testing is frequent.

- It is assumed that the customer's transcription vendor of choice follows the HL7 guidelines and format as outlined in the vendor specifications document. Failure to do so will result in a customized version of the transcription interface. McKesson will not change the base interface to be specific to any one vendor.

FACILITY REQUIREMENTS

In order for a facility to install the transcription interface they must meet the following requirements:

1. The facility must have STAR Patient Processing.

   Chart Management and STAR Clinical Browser/Horizon*WP* Physician Portal are desirable, but **not** required. The interface does **not** update a foreign (i.e., non-STAR) Chart Management or Physician product.

2. The facility must be able to accommodate the TCP/IP communication protocol.

3. The facility must have a designated network coordinator/manager who is involved in this interface and is familiar with PCs, networks, and TCP/IP.

4. The transcription product must be in place or in the process of being installed prior to proceeding with the installation of the interface.

5. If the transcription product is in place and the customer is ready to install the interface, the transcription system representative should be contacted to determine if their product meets the vendor specifications. Additional software may need to be purchased. The customer should use the *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface* to ensure their interface follows the HL7 standards and McKesson requirements.

   The HL7 segments that are transmitted from STAR Clinical Browser or Horizon*WP* Physician Portal to the transcription vendor (in the ADT outbound) are identified in *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface*. STAR does not filter out the segments (and elements within the segment) that are not utilized by the transcription vendor. It is the responsibility of the McKesson customer and the transcription vendor to determine which segments (and associated elements) are to be utilized within the transcription system.

6. The customer should be made aware of the fact that each vendor may have varying recommended hardware configuration and requirements. The number of interface PCs required for query is based on the following user access guidelines, and an increase in that access could require additional interface hardware: 10 users accessing the system at any given time for the purpose of query.

VENDOR NOTE: SoftMed® has indicated that their customers need two PCs – one for the inbound and outbound data exchange and the second for the query. Contact the vendor for specific hardware needs.

7. The facility should allot at least three virtual ports to the interface. The ports can be associated with the same IP address, but must be associated with **different** TCP/IP ports (i.e., sockets).

8. **Important Note Regarding the CPU IP Address**: IP addresses are formatted as xxx.xxx.xxx.xxx (for example, 123.456.789.123). The last set of digits is called the fourth octet. *If the fourth octet of the Patient Care CPU IP address is 0 or 255, the inbound port cannot be opened.* To correct the problem the CPU address must be changed, which entails changing the IP address for all users on the Patient Care CPU. Therefore, this address should be checked at the very start of the installation process to ensure this is not discovered too late in the process. The facility's network manager/coordinator should be able to check and verify the address.

9. The facility should review this reference guide in its entirety prior to making decisions with regard to printer needs, physician training needs, menu access, table setup, etc. The reference guide contains a considerable amount of information that may be helpful in making these decisions.

TRANSCRIPTION VENDOR REQUIREMENTS

In order for the transcription interface to operate with the transcription system, the vendor must do the following:

1. Accommodate the TCP/IP communication protocol.

2. Accept and send information using the 2.1 version (or higher) of the HL7 standards for both data and queries.

3. Accommodate at least three query communication lines.

4 Maintain both a test and live environment. This may require a minimum of two interface PCs.

5. Follow the *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface*.

INSTALLATION OVERVIEW

This chapter identifies the tables, screens, parameters, etc. that are affected when the Medical Record Transcription Interface is used in conjunction with other STAR applications. This is to be used as a guideline to ensure these areas are covered during the installation phase.

In all the scenarios, Patient Processing ADT events are sent to the transcription vendor.

To create an index on STAR, a report header file is transmitted from the transcription system to STAR containing information regarding the transcribed report. This header information creates a report index that is maintained on STAR until the time the user-defined purge parameter has been reached. This index is used when transmitting queries from STAR to the vendor.

Option A: Patient Processing Only

If you have only STAR Patient Processing (i.e., not Chart Management, STAR Clinical Browser, or Horizon*WP* Physician Portal), there are no other installation considerations or tasks (within STAR) to be completed outside of setting up the necessary information to support the information outbound from ADT and the information inbound from the transcription system. When these settings are complete, ADT information is transmitted to the transaction vendor automatically.

You have the option of *not* creating the HL7 inbound line for the transcription information. If the inbound line is not established, an index of report information is not received, maintained, or created in STAR. You still have the option to query the transcription system for reports.

If you opt to create the inbound line, you should also review and complete the following:

Screens:
- M/R Maintenance
  - Electronic Signature Parameters
  - Report Query Parameters

Option B: STAR Clinical Browser or Horizon*WP* Physician Portal without Chart Deficiency

If you have STAR Clinical Browser or Horizon*WP* Physician Portal, you have the option to utilize the transcription interface to automatically send a “sign” message to the physician when a report header is received on STAR.

Tables:
- Medical Records & UM Table Maintenance
  - Transcription Report Types
  - Unsigned Report Reason
- Physician Table Maintenance
  - Physician Message Types
  - Product Options (for Physician Access only)
  - Physician Parameters 2 screen (for Physician Access only)

Screens:
- M/R Maintenance
  - Assign Physician Electronic Signature Parameters
  - Electronic Signature Parameters
  - Report Query Parameters

Reports:
- Transcription Discrepancy Notice (ERDTDNX)
- Unsigned Electronic Report Notice (EPAUENX)
- Electronic Authentication Report (ERDEAUX)

STAR Clinical Browser Product Options:
- Transcription Implemented Y/N
- Allow Offline Transcription Y/N

Horizon*WP* Physician Portal Modules and Parameters:
- Transcription
- STAR Electronic Signature
- Global Preference Settings
  - Days Back Default Values

Option C: Chart Deficiency without STAR Clinical Browser or Horizon*WP* Physician Portal

If you utilize Chart Deficiency, the transcription interface can automatically update deficiency information to a “sign” type. This can be done without using STAR Clinical Browser or Horizon*WP* Physician Portal. Whether or not you choose to utilize the changes made to Chart Deficiency, there are table and screen changes that should be reviewed.

Tables:
- Medical Records & UM Table Maintenance
  - Chart Deficiencies Table

Screens:
- Chart Deficiency
  - Deficiency History Processor Screen
  - Add/Edit Deficiency Processor

M/R Maintenance
Electronic Signature Parameters
Report Query Parameters

Reports:
Transcription Discrepancy Notice (ERDTDNX)

Option D: Chart Deficiency with STAR Clinical Browser or Horizon^{WP} Physician Portal

The optimal benefits of the transcription interface are realized when both Chart Deficiency and STAR Clinical Browser or Horizon^{WP} Physician Portal are utilized. In this scenario:

- Report headers are sent automatically to STAR
- The actual text of the report on the transcription system can be queried real time
- The report can be signed electronically and prints on the Electronic Authentication Report (ERDEAUX)
- The deficiency can be updated to a "Sign" type

Whether or not you choose to utilize all these modules, there are tables, screens, parameters, and reports that should be reviewed. You should first review and update the Chart Deficiency table, then set up the Physician Message Types, then the Electronic Signature Parameters.

Tables:
Medical Records & UM Table Maintenance
Chart Deficiencies Table
Unsigned Report Reason
Transcription Report Types

Physician Table Maintenance
Physician Message Types
Product Options (for Physician Access only)
Physician Parameters 2 screen (for Physician Access only)

Screens:
Chart Deficiency
Deficiency History Processor Screen
Add/Edit Deficiency Processor

M/R Maintenance
Assign Physician Electronic Signature Parameters
Electronic Signature Parameters
Report Query Parameters

Reports:
- Transcription Discrepancy Notice (ERDTDNX)
- Unaccepted Electronic Report Notice (EPAUENX)
- Electronic Authentication Report (ERDEAUX)

STAR Clinical Browser Product Options:
- Transcription Implemented Y/N
- Allow Offline Transcription Y/N

TROUBLESHOOTING TIPS

Problem: The console log is indicating that the interface is attempting communication but cannot establish a connection.

Resolution: First, deactivate then reactivate the communication line on both sides of the interface. If the problem is still not resolved, ensure each side is calling the correct IP address and port. If there is still a problem, contact your McKesson representative to verify that the HL7 Pending Changes have been applied.

Problem: The transcription system has transmitted a report header, but the physician is not receiving a message nor a report to sign in his Sign queue.

Resolution: Check the following:

1. Verify a Transcription Discrepancy Notice (i.e., No Account Number Match) was not generated.

2. Verify the report header has been received (for this patient) by reviewing the HL7 Audit Queue.

3. Verify the Report Type code is associated with a Message Type that has a system event code of “Transcription.”

4. Verify the same Report Type code is associated with a report in the Medical Record Transcription Report Types table.

5. Verify the report header did not contain an electronic signature.

Problem: System is not generating a Transcription Discrepancy Notice.

Resolution: Verify the report ERDTDNX is set up properly and associated with an active printer.

Problem: You are attempting to query the transcription system for a report, but it is not responding, or is taking an unusually long period of time.

Resolution: Verify the query lines in STAR are active. Verify the query lines in the transcription system are active. If necessary, deactivate then reactivate the query lines on both sides. If there is still no response, reboot the interface PC used by the transcription system.

Problem: The transcriptionists state that patients in STAR are not available in the transcription system.

Resolution: Verify the TXO (ADT outbound) communication line is active. If it is, deactivate and reactivate the line.

Problem: All reports are returned from the transcription vendor when only a specific report type was requested.

Resolution: Verify that your facility is using the QRF-04 segment in the HL7 query message. If your facility is using the QRF-01 segment, all reports are returned from the transcription vendor instead of only the selected report type. Check with your transcription vendor to ensure that they can process the QRF-04 segment. If you need to change the segment, place a support call to the STAR Integration group or have your McKesson ESD controller notify the STAR Integration group that you want to use the QRF-04 segment.

Problem: The transcription system has transmitted a report header, but a deficiency is not being created.

Resolution: Check the following:

1. Verify a Transcription Discrepancy Notice (i.e., No Account Number Match) was not generated.

2. Verify the report header has been received (for this patient) by reviewing the HL7 Audit Queue.

3. Verify this deficiency is set to have a deficiency automatically created.

4. Make sure the patient type is set up to allow deficiencies (in Patient Type Parameters).

5. Verify the “Report Type” in the Chart Deficiencies table is the same as that found in the transcription system.

Chapter 2 - INTERFACE FUNCTIONALITY

STAR MODULE RELATIONSHIPS

This chapter outlines how the benefits of the transcription interface are affected depending on the presence of STAR Chart Management and STAR Clinical Browser or Horizon*WP* Physician Portal. Although the interface works most effectively when it is utilized along with Chart Management and STAR Clinical Browser or Horizon*WP* Physician Portal, the presence of both modules is not essential.

The following is a brief description of what occurs when one of the modules is used and not the other; or neither of the modules is available for use. In all circumstances, the Patient Processing portion of STAR Patient Care **must** be available.

Neither Chart Management nor STAR Clinical Browser or Horizon*WP* Physician Portal

If Chart Deficiency and STAR Clinical Browser or Horizon*WP* Physician Portal are not available, but the transcription interface is available and active, the transmission of ADT information to the transcription system occurs. The report header information transmitted to STAR is maintained and used for queries to the transcription system for report viewing from any Patient Care menu.

STAR Clinical Browser or Horizon*WP* Physician Portal without Chart Management

The STAR Clinical Browser or Horizon*WP* Physician Portal module is updated with the transmitted transcription header information; however, if Chart Deficiency is not available or being utilized, chart deficiency information is not automatically updated when a report is electronically signed. If the physician electronically signs the report, STAR can transmit an HL7 message to the transcription system, alerting the vendor of the signature. Some vendors can print the report indicating it has been signed. The HL7 message contains the electronic signature, date, and time, which are available for storage with the document within the transcription system. The signature event also logs to the STAR Electronic Authentication Report.

Chart Management without STAR Clinical Browser or Horizon*WP* Physician Portal

Data in the Chart Deficiency portion of the Chart Management module is automatically updated with transcription information. If the STAR Clinical Browser or Horizon*WP* Physician Portal module is not available or being utilized, the updating of the Chart Deficiency information occurs only when the report header is transmitted since the physician cannot electronically sign the report. If the transcription system contains an electronic signature function, the system transmits another HL7 message segment containing the electronic signature, date, and time. The Chart Management module is updated accordingly.

NOTE: Without STAR Clinical Browser or Horizon^{WP} Physician Portal, the transmission of the electronic signature, date and time from STAR to the transcription system does not occur.

Patient Care Menu Access

To obtain additional benefits of the transcription system interface, the View/Print Electronic Report option (library element CPRTXV) can be attached to a menu within another STAR product (that resides on the Patient Care CPU) to enable other hospital employees to view and/or print transcribed medical record reports. This option must be attached to a menu that displays *after* the patient selection has occurred.

Although the actual report is not transmitted to STAR, this function enables the user to query the transcription system for reports.

NOTE: Currently there is no audit trail to indicate who has queried reports. Security of this function should be determined by menu access and security level of the employee.

Chapter 3 - DATA TRANSMISSION

INTRODUCTION

This chapter contains explanations of the formats and specifications for data transmission in the transcription interface. It also describes the Column Heading Definitions and Field Notes specific to the TXA segment. The TXA segment contains the data elements transmitted in the report header information. Some of the data elements in the TXA segment are not used by STAR but have been included based on feedback from other vendors and users that participate in the HL7 Health Information Technical Committee. The *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface* should be used for more information.

HL7 STANDARD INTERFACE RECORD OVERVIEW

NOTE: The information in this section was obtained from Health Level Seven, Version 2.2 © 1994.

What Is HL7?

The term Health Level 7 (HL7) refers to the highest level of the Open System Interconnection (OSI) model. In the OSI model, the function of both communications software and hardware are separated into seven layers, or levels. The HL7 standard is primarily focused on the issues that occur within this seventh, or application level. At this application level are the definitions of the data to be exchanged, the timing of the exchanges, and the communication of certain application specific errors between the applications.

What Is an HL7 Event?

HL7 is written from the assumption that an event in the real world of healthcare creates the need for data to flow among systems. This real-world event is called the *trigger event.* STAR currently contains the trigger events that transmit ADT information to other systems. These triggers are utilized in the transcription interface for the ADT outbound to the transcription system. For the receipt of the inbound transcription information, the trigger event resides in the transcription system. The trigger event is the completion (or releasing) of a transcribed document and/or an electronic signature (occurring within the transcription system).

What Is an HL7 Message?

A message is the atomic unit of data transferred between systems. It is comprised of a group of segments in a defined sequence. Each message has a message type that defines its purpose. A three-character code contained within each message identifies its type. For ADT outbound, the message type is ADT. For the inbound transcription header, the message type is MRM (Medical Record Management, since it falls in this HL7 chapter).

What Is an HL7 Segment?

A segment is a logical grouping of data fields. Segments of a message may be required or optional. They may occur only once in a message or they may be allowed to repeat. Each segment is given a name, and is identified by a unique three character code known as the Segment ID. For example, the ADT message may contain the following segments: Message Header (MSH), Event Type (EVN), Patient ID (PID), and Patient Visit (PV1). The transcription segment is TXA.

What Is an HL7 Field?

A field is a string of characters and is sometimes called an element. HL7 does not care how systems actually store data within an application. When fields are transmitted, they are sent as character strings. In defining a segment, the following information is specified about each field: position, name, ID number, maximum length, optionality, repetition, table, and data type.

What Is TCP/IP?

TCP is the Transmission Control Protocol. IP is the Internet Protocol. TCP/IP Internet Protocol Suite is a communication protocol used to communicate with the destination system. The low level TCP/IP protocol, as defined by the HL7 standard, is followed within McKesson and utilized in the transcription interface. TCP/IP is a layered set of protocols that allows sharing of applications among PCs in a high-speed communications environment. Because TCP/IP protocols are standardized across all its layers, including those that provide terminal emulation and file transfer, different vendors computing devices can exist on the same cable and can communicate with each other. The standard was developed by the Department of Defense.

FORMATS AND SPECIFICATIONS

Listed below are the formats and specifications for data transmission to and from the transcription system.

MPI Data Transmission

MPI data is transmitted unsolicited from the transcription vendor. An unsolicited transmission is when the PV1 and PID message segments are transmitted from STAR to the transcription system as the HL7 triggers occur within STAR. For these messages, a HL7 trigger event is identified as an admission, discharge, transfer, etc. The transmission consists of all HL7 segments created as a result of the defined triggers that have occurred since the previous transmission. The data is stored on the PC/File Server where the transcription system is located, and is available for use by the transcriber.

Report Header Information Transmission

Information specific to a transcribed report is transmitted to STAR in the TXA message segment as a trigger event occurs in the transcription system. Within the transcription system, this *trigger* is most likely the completion of a report which could be defined as printing, releasing, etc. Within STAR, the report information is used to update STAR Chart Deficiency as well as Physician Access/View.

The TXA message segment is included in the latest version of HL7 standards. At the time the transcription interface was created, the message segment had not been approved; therefore, the vendor must follow the specifications for transmission of the report header as outlined in the vendor specification.

Some of the data elements in the TXA segment are not used by STAR but have been included based on feedback from other vendors and users that participate in the HL7 Health Information Technical Committee working group meetings.

NOTE: The information presented here is only an extraction of what must be included by the vendor when transmitting a TXA message segment. Please do not have your vendor rely on this documentation, but rather utilize the *STAR Patient Care, Vendor Specifications for the Medical Record Transcription Interface.*

Complete Report Information Transmission

Transcribed reports need to be available for viewing via the STAR system. The reports are transmitted on an as-requested basis using a standard HL7 query, and are in ASCII format. The ASCII format deletes any fonting or formatting in the report. Utilizing queries eliminates the need to continuously transmit reports on a regular basis. The report remains in STAR for as long as that record is being viewed by the requestor. This method requires much less use of disk space, and eliminates duplicate storage of

information between the transcription and STAR systems. Concerns regarding response time on report queries can be addressed with additional PCs and/or communication lines.

NOTE: Modifications to reports are *not* permitted within any STAR application. All editing of reports must be done via the transcription system.

Electronic Signature Data Transmission

Through STAR Clinical Browser or Horizon^{WP} Physician Portal, physicians have the ability to electronically sign reports. A byproduct of this process is an update to the outbound T01 message, TXA segment. The updated segment is transmitted to the transcription system and the electronic signature information is available for the original document.

When the report is printed from a STAR Medical Record menu, a statement prints at the bottom indicating this report was electronically signed.

If the transcription system provides a method of electronic signature, a TXA segment is sent to the STAR system when a report is electronically signed. This information is used to update STAR Chart Deficiency.

INBOUND TO STAR

TXA - Document Notification Information Segment

SEQ	LEN	DT	R/O	RP/#	TBL#	ITEM#	ELEMENT NAME	MCKESSON USE
1	4	SI	R				Set ID - Document	•
2	30	S	R				Report Type	•
3	2	ID	O		XXXX		Document Content Presentation	
4	8	DT	O				Activity Date	•
5	60	CN	C				Primary Activity Provider Code/Name	•
6	19	TS	O				Origination Date/Time	•
7	19	TS	C				Transcription Date/Time	•
8	19	TS	O	Y			Edit Date/Time	•
9	60	CN	O				Originator Code/Name	•
10	60	CN	O	Y			Document Authenticator	•
11	60	CN	O	Y			Document Authenticator	•
12	60	CN	O	Y			Document Authenticator	•
13	48	ST	O				Transcriptionist Code/ Name	•
14	30	ST	C				Unique Document Number	•
15	30	ST	C				Parent Document Number	
16	30	ST	O				Unique Document File Name	•
17	2	ID	R		XXXX		Document Status	
18	30	ST	C		XXXX		Document Change Reason	
19	60	CM	O				Authenticated By Code/ Name, Date/Time	•
20	60	CN	O	Y/15			Distributed Copies (Code & Name of Recipients)	

Selected Field Definitions:
LEN = Maximum field length (HL7)
DT = Data Type (HL7)
R/O = Required/Optional/Conditional (HL7)
TBL# = Table Number (HL7)
ITEM# = Item Number (HL7)
MCKESSON USE = • indicates the field is utilized by the McKesson interface; see details below

COLUMN HEADING DEFINITIONS

SEQ
This column contains a sequence ID which is used to identify the position of the data field within the segment. The identifier is a positive, non-zero integer.

LEN
This column indicates the maximum number of characters that one occurrence of the data field may occupy in any message.

DT
This column identifies the type of data inthis field, and indicates the restrictions on the contents of the data field. The following data types are found in the TXA segment:

ST - STRING	Any display characters are allowed. String data is left justified with trailing blanks optional.
DT - DATE	Contains the date of the event and always includes a 4-digit year.
TS - TIME STAMP	Contains the exact time of an event, including the date and time.
ID - CODED VALUE	The value of this field follow the formatting rules for an ST field, except that it is drawn from a table of legal values. Examples of ID fields include physician, religion, and sex.
CN - CODE & NAME	Contains the code and/or name that corresponds to this element.
CM - COMPOSITE	A field that is a combination of other meaningful data fields. Each portion is called a component.

R/O
This column indicates the options available in a data element. The designations are as follows:

- **R** indicates this data element is required and the message segment cannot be transmitted without the presence of this field.
- **O** indicates this data element is optional and the message segment can be transmitted with or without the presence of this field.

- **C** indicates this data element is conditional. The message segment can be transmitted with or without the presence of this field. This is dependent on the trigger event or the presence of another piece of data in the segment.

RP/#
This column indicates if this is a repeating field. The designations are as follows:

- **N** - No repetition

- **Y** - The field may redisplay an indefinite or site-determined number of times. The **#** indicates the number of times this field can repeat.

TBL#
This column contains the table number as assigned by the HL7 Executive Committee. As of this time, the transcription related messages and segments are still under review, therefore, table numbers have not been assigned. Instead, “xxxx” displays here.

ITEM #
This column contains the item number associated with the element. As of this time, the transcription related messages and segments are still under review, therefore item numbers have not been assigned.

ELEMENT NAME
This column contains the unique identifying name of the field.

MCKESSON USE
This column indicates whether or not McKesson utilizes this element in the interface. The field notes further explain the role of each element.

Field Explanations

1. SET ID DOCUMENT
This field distinguishes the transcription segment from others in the same message.

2. REPORT TYPE
This field contains a report identifier used in the transcription system. Examples of report types are: history & physical, operative report, discharge summary, etc. A report type code can be up to 30 alphanumeric characters. This element is required. When this information is transmitted to STAR, it is compared against the Report Type code found in the Chart Deficiencies table to determine which deficiency is updated by the receipt of this report header, as well as the Report Type codein the Physician Message Type table.

3. DOCUMENT CONTENT PRESENTATION
This field identifies the method by which this document was obtained. Refer to the table below for valid codes. This element is not used by McKesson in this interface.

Value	Description
FX	Facsimile
SC	Scanned
VO	Voice
TX	Text
MM	Multimedia
SO	Sound
DG	Digital
VI	Video

4. ACTIVITY DATE
This field contains the date identified in the document as the date a procedure or activity was performed. This date can identify the date of surgery, non-invasive procedure, consultation, examination, etc. When this information is transmitted to STAR, it is compared against the Activity Date which corresponds to the appropriate deficiency within the Add/Edit Deficiency screen to further aid in positive matching of report headers and deficiencies.

5. PRIMARY ACTIVITY PROVIDER CODE/NAME
This field contains the person identified in the document as the person responsible for performing the procedure or activity. This field can include the code and name of the provider. The provider identified in this field is not automatically assumed to be the person responsible for authenticating the report. This field is stored in STAR; however, it is not utilized to update Chart Deficiency, STAR Clinical Browser, or Horizon*WP* Physician Portal.

6. ORIGINATION DATE/TIME
This field contains the date and time the report was originated (i.e. dictated). This information is stored in STAR, but is not utilized to update either Chart Deficiency, STAR Clinical Browser, or Horizon*WP* Physician Portal.

7. TRANSCRIPTION DATE/TIME
The Transaction Date/Time is the date and time the report was actually transcribed. This field is stored in STAR and is used as the report date and time in the report header index that is created and maintained in STAR.

8. EDIT DATE/TIME
This field contains the date and time the report was edited. The unique document number enables the receiving system to associate the edit date and time with a previously received report header. This information is stored in STAR, and displayed within the Add/Edit Deficiency option.

9. ORIGINATOR CODE/NAME
This field identifies the person who originated (i.e., dictated) the report. The document originator may differ from the person responsible for authenticating the report. This information is stored in STAR, but is not utilized to update either Chart Deficiency, STAR Clinical Browser, or Horizon*WP* Physician Portal.

10.-12. DOCUMENT AUTHENTICATOR
This field identifies all persons responsible for signing the report. The TXA segment accommodates multiple authenticators per report. When this information is transmitted to STAR, it is compared against the Responsible Physician in the Add/Edit Deficiency screen to determine which deficiency is updated by the receipt of this report header. It is also compared against the Assign Physician Electronic Signature parameters (in STAR) to determine if these physicians receive a message to sign this report.

13. TRANSCRIPTIONIST CODE/NAME
This field identifies the transcriber of the report. This information is stored in STAR, but is not utilized in updating Chart Deficiency, STAR Clinical Browser, or Horizon*WP* Physician Portal.

14. UNIQUE DOCUMENT NUMBER (UDN)
This field contains the unique document identification number assigned by the transcription system. The UDN is used in STAR as the basis for setting up the report header index which is used for report queries. The UDN is also used to match future updates to the document. If the transcription vendor does not provide a UDN, some type of unique document identifier must be entered here, such as the document file name. In order to ensure uniqueness and maintain a usable document index, this number should never be reused.

15. PARENT DOCUMENT NUMBER
This field contains the document number that identifies the parent document to which this document belongs. The parent document number can be used to assist the receiving system in matching future updates to this document. Not all documents have a parent document. This information is not used by nor stored in STAR.

16. UNIQUE DOCUMENT FILE NAME
This field contains the unique name assigned to a document by the transcription system. The file name is used to assist the receiving system in matching future updates to the document. In order to ensure uniqueness and maintain a usable document index, this name should not be reused. In the transcription interface, the document file name is stored, but not utilized.

17. DOCUMENT STATUS
This field identifies the current state of the document. This element is not utilized by nor stored in STAR. The transcription vendor may hardcode a status of *PR* for the purpose of completing this field.

Value	Description
AU	Authenticated

Value	Description
DI	Dictated
IN	Incomplete
PR	Preliminary
AR	Archived
PU	Purged

18. DOCUMENT CHANGE REASON

This field identifies the reason a document status has changed. This element is not utilized by, nor stored in, STAR.

19. AUTHENTICATED BY CODE/NAME, DATE/TIME

This field identifies the person who has electronically authenticated (i.e., signed) the document as well as the authentication date and time. This information may be obtained by the STAR system and transmitted to the transcription system or vice versa. This element updates the deficiency in STAR. If a report header contains this element, a corresponding message is **not** set up in STAR Clinical Browser or Horizon*WP* Physician Portal since the report is now signed.

20. DISTRIBUTED COPIES

This field identifies the persons who received a copy of this document. This element is not utilized by nor stored in STAR.

Chapter 4 - UPDATING STAR CLINICAL BROWSER AND HORIZON^{WP} PHYSICIAN PORTAL WITH TRANSCRIPTION DATA

OVERVIEW

The STAR Clinical Browser and Horizon^{WP} Physician Portal applications enable viewing and signing of transcribed reports. The actual transcribed report is not stored on STAR; however, STAR enables the transcription system to be queried in real time to display reports.

To create a key on STAR, a report header file is transmitted from the transcription system to STAR containing information regarding the transcribed report. This header information creates a report index that is maintained on STAR until the time the user-defined purge parameter has been reached. This index is used when transmitting queries from STAR to the vendor.

The STAR system must be set up to accommodate the transcription interface.

Tables
- Physician Table - Physician Message Types
- Abstracting, DRG, and Utilization Management Table - Unsigned Report Reason Table

M/R Maintenance Parameters
- Assign Physician Electronic Signature Parameters
- Electronic Signature Parameters
- Report Query Parameters

Reports
- Unaccepted Electronic Report Notice
- Electronic Authentication Report

STAR Clinical Browser Product Options
- Transcription Implemented Y/N
- Allow Offline Transcription Y/N

TABLES

The following STAR tables are used by the transcription interface and STAR Clinical Browser/Horizon*WP* Physician Portal.

Physician Message Types

The Physician Message Type table located in the Physician/NSCG table must be defined to accommodate messaging and signing processes upon receipt of report header records transmitted from the transcription system. When a report header record is transmitted from the transcription system, STAR checks the Assign Phys Electronic Signature Parameter to determine if the physician has been defined to electronically sign this particular report type.

In STAR Clinical Browser and Horizon*WP* Physician Portal, if the physician has been set up, STAR determines, upon report header receipt, whether a message associated with the report type was previously sent. If a message exists for the physician in STAR Clinical Browser or Horizon*WP* Physician Portal, another message is not sent. If the message does not exist for the physician, one is created.

Example:
Dr. Smith has a message to sign a H&P, and a report header for another H&P is also transmitted. A new H&P message is not generated since he has already been alerted.

Once a message is created for the physician, the message is displayed in STAR Clinical Browser and Horizon*WP* Physician Portal. After a message is viewed, it is removed from the message list. All viewed and unviewed messages are retained in STAR, based on parameters in this table. If the System Event associated with this Message Type is that of Transcription or Attestation, the message *cannot be manually deleted by the physician.*

The following is an example of the Physician Message Type table. An entry must be defined for each report so the report triggers a message and can be viewed and/or signed:

```
            General Hospital Physician Table Maintenance Processor
                                                  Wed Mar 29, 1995 09:59 am
Physician Message Types
 1 Code                   2 Description
   CON                      CONSULT
 3 System Event           4 Trans Report Type    5 Allow Phys Deletion
   Transcription            Con                  -> No
 6 Unviewed Msg Hold Days                        7 Viewed Msg Hold Days
   7 days                                          3 days
 8 Print Prim Ins?        9 Edit By & Date
   No                       Hanes, Jane A   08/23/94 09:23am
10 Message Text
   This CONSULTATION report requires your signature.  This report is
   available for electronic signature.









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

Selected Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the three-character alphanumeric physician message type code. A code must be defined for each type of report to be viewed and/or signed in STAR Clinical Browser and Horizon^{WP} Physician Portal.

2. DESCRIPTION (19-AN-R)
The physician message type description is entered in this field.

3. SYSTEM EVENT (TABLE LOOKUP)
This field allows the selection of the system event that generates this message type for physicians and their office staff employees. The System Event Codes are controlled by McKesson and are not user maintained. When this field is selected, the following prompt is displayed:

Enter the system event that sends this msg type or '-' to list system events --

Enter a hyphen (-) for the table lookup of system events. When the Transcription system event is entered in this field, you can access the Trans Report Type field.

If the STAR Medical Record Transcription Interface is not active, selection of the event *Transcription* is not permitted.

NOTE: Two other conditions must be met for a physician to receive the message regarding transcribed medical record reports:

a. The physician code in the report header for the report type (message type) transmitted from the transcription system matches a physician code in the STAR Physician table.

b. For signing, the physician must be defined for electronic signature for the transmitted report type via Electronic Signature Maintenance. The physician is set up for electronic signature by a personal secret code maintained in the M/R Maintenance, Assign Phys Electronic Signature Parameters option.

4. TRANS REPORT TYPE (4-C-C)
This field can only be accessed if the System Event field is set to Transcription and then it is required. The field **must** be completed in order for physicians to receive messages and view/sign reports. If this field is accessed and the System Event field is not set to Transcription the following error message displays:

System Event field not set to Transcription. Field cannot be edited!

WARNING: You must enter the report code here exactly as it is found in the transcription system. The field is case sensitive.

System Set-up Suggestion:
The report type code in STAR and the report type code in your transcription system should be the same. For each report type being transmitted to STAR, there must be a corresponding Trans Report Type code defined in the Physician Message Type table. You cannot have two report types calling the same message type. A field similar to the Trans Report Type Code exists in the Chart Deficiency table that links the report type from the transcription system to a corresponding deficiency code.

5. ALLOW PHYS DELETION (1-A-R)
This field is not honored by STAR Clinical Browser and Horizon*WP* Physician Portal.

6. UNVIEWED MSG HOLD DAYS (3-N-R)
This field allows the physician to determine the number of days that messages that have not been viewed can be retained in the system.

After this field is selected the following prompt displays:

Enter # days to hold messages that HAVE NOT been viewed before purging [7]--
Entry of `1` will purge the message during midnight processing the same night

You can enter from 1 to 999; the default is **7**. If one is entered, the message continues to display on the day the message is sent and is purged that night during midnight processing. If two is entered, the message remains through two midnight processing runs.

7. VIEWED MSG HOLD DAYS (3-N-R)
This field allows the physician to determine the number of days that messages that have been viewed can be retained in the system.

After this field is selected the following prompt displays:

Enter # days to hold messages that HAVE been viewed before purging [3]--
Entry of `1` will purge the message during midnight processing the same night

You can enter from 1 to 999; the default is **3**. If one is entered, the message continues to display on the day the message is sent and is purged that night during midnight processing. If two is entered, the message remains through two midnight processing runs.

9. EDIT BY & DATE (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry and the date that the table entry was last updated.

10. MESSAGE TEXT (TABLE LOOKUP)
This field contains the user defined message text (appropriate for the message type at their hospital). The predefined message text displays in this field. Predefined text can be modified in STAR Clinical Browser and Horizon^{WP} Physician Portal without disturbing the original setup in the table. The text consists of up to ten lines of 74 characters each.

When you enter this field and make updates to a message, the system displays the operations associated with the function keys at the bottom of this screen. From here the physician can delete a line (F1), insert a line (F2), center a line (F3), exit (F4), store the line (F5), restore the line (F6), pack (F7), and receive help (F10)

When the fields have been completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

Impact

The Edit By & Date field reflects the new date associated with the individual and date of the charge if they were signed on with security.

Upon acceptance of this screen, the following takes place:

- The table entry is added, deleted, or revised as appropriate.
- The table listing reflects any changes made.

Unsigned Report Reason

The Unsigned Report Reason table must be used by the physician to indicate the reasons why they are not accepting an electronically transmitted report. This table

should be set up to accommodate usage for all reports that can be signed electronically by the physician. Therefore, each facility should review this table to add, change, or edit any existing codes and descriptions to accommodate information that is pertinent to all reports. The physician can also enter freeform text to explain more.

After the Unsigned Report Reasons table is selected, the system prompts you to enter an Unsigned Report reason code. You can enter the code, or press hyphen (-) and ENTER to display a list of codes from which you can select. After you enter the code, the following screen displays:

```
      General Hospital Medical Records & UM Table Maintenance Processor
                                                  Wed Jun 20, 1995 03:53 pm
Unsigned Report Reasons
( 1)Code         : 3
( 2)Description  : SECONDARY DIAGNOSIS INCORRECT

( 3)Edit by      : LAGER,BENNY
( 4)Edit date    : 06/19/95 02:47pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the two-digit alphanumeric code for the Unsigned Report Reason.

2. DESCRIPTION (33-C-R)
Enter the description of the Unsigned Report Reason. Examples of descriptions include the following: Not my patient, Incorrect principal diagnosis, Incorrect secondary diagnosis, Other procedures performed, Report requires correction, etc.

3. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry.

4. EDIT DATE (DISPLAY ONLY)
The system displays the date and time that this table entry was last updated.

When these fields are completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

Impact

The Edit By and Edit Date fields change to reflect the date and the name of the individual signed on with security at the time of the edit. If the individual making the change is not signed on with security, only the Edit Date field is changed.

Upon acceptance of this screen, the following takes place:

- The table entry is added, deleted, or revised as appropriate.
- The table listing reflects any changes made.

Transcription Report Types

The Transcription Report Types table enables you to convert the report code from the transcription vendor into a description physicians and other caregivers can understand. When a report header is transmitted from the transcription system to STAR, it includes the report code. This code is stored in the report index maintained in STAR. STAR converts the report code from the transcription system into a description using the information in this table.

After you select the Transcription Report Types table, the system prompts you to enter a transcription report type code. You can enter a new code up to seven alphanumeric characters, an existing code, or press hyphen (-) and ENTER to display a list of codes from which you can select.

Transcription report type codes are case-sensitive. When you enter a new or existing code, pay attention to upper and lower case letter usage. If the code you enter does not match what is in the transcription system exactly, the code displays in the description column on the report listing for View/Print Elec Reports, instead of a description.

After you enter the code, the following screen displays:

```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                  Thu Mar 20, 1997 08:53 am

Transcription Report Types
( 1)Code          : HP1
( 2)Description   : Resident H&P


( 3)Edit by       : Raines,Lenore T
( 4)Edit date     : 03/05/97 10:50A









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code entered at the initial prompt. Once this screen displays, this code is view only and cannot be changed on this screen. You must either delete the code and/or add a new code.

2. DESCRIPTION (16-AN-R)
This field enables you to enter a description of the code. The description entered displays in the available View/Print Report listing. A description is required for all new code entries.

3. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last updated this table.

4. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table code was last edited.

NOTE: When you modify a table entry, the Edit By and Edit Date fields change to reflect the date and the name of the individual signed on with security at the time of the edit. If the individual making the change is not signed on with security, only the Edit Date field reflects the new revision.

SIGNING REPORTS IN STAR CLINICAL BROWSER AND HORIZON^{WP} PHYSICIAN PORTAL

STAR Clinical Browser and Horizon^{WP} Physician Portal enable you to view electronic reports per patient and also enable physicians to electronically sign reports through another function. The signature is a computer key event and is not an image of an actual handwritten signature.

The reports that need to be signed by the user who is logged on are displayed automatically in the Sign Reports function. All of the report text is displayed prior to the Sign button.

The report can be signed only by entering an additional electronic signature password defined in M/R Maintenance, Electronic Signature Parameters. The Electronic Authentication Report is updated with the signed information so the Medical Record Department knows which reports have been signed electronically. Or, the report can be rejected and the rejection reason prints on the M/R Unaccepted Electronic Report Notice for the Medical Record and Transcription Departments. The text of the reports cannot be edited in STAR Clinical Browser or Horizon^{WP} Physician Portal.

When a physician electronically signs a report, the electronic signature (via computer key), date, and time are placed in a file and transmitted to the transcription system. The electronic signature notification is available for attachment to the report; thus,when the report is printed (from the transcriptionsystem), the electronic signature, date, and time are included (dependent upon the transcription vendor). Also, after the transcription vendor attaches the signature “phrase” at the bottom of the report, the next time you view or print the report via STAR, the phrase will be there.

An indicator is sent to the Chart Deficiency module for the associated deficiency and is updated according to the parameter in the Chart Deficiency table that indicates if the deficiency is marked Complete upon receipt of a signature. Also, the patient name prints on the Electronic Authentication Report (ERDEAUX).

If a physician chooses not to electronically sign a report, he can indicate the reason(s) the report is not being electronically signed and enter freeform notes. He can select up to five (5) Unsigned Report Reasons. Once the reason(s) has been selected, the physician can attach a message to the medial record or transcription department.

The unaccepted reason(s) and/or message prints at the printer associated with the report, Unaccepted Electronic Report Notice. When the unaccepted report is later updated by the transcription department and then re-transmitted to STAR, the report is again available for electronic signature.

Messaging Integration

Transcribed report messages are not patient specific; therefore, a patient name does not display for these message types. These messages are automatically formatted and

sent. The date and time that displays with these messages indicates the date and time the first of this message type was received for this physician. When the physician selects the message to view, the screen displays additional information associated with this message.

NOTE: The physician does not receive a message for a report type unless he has been set-up in the Assign Phys Electronic Signature Parameter to electronically sign that report type.

Signing Reports in STAR Clinical Browser

The cbutils Product Options page must have the *Transcription Implemented* parameter set to Yes to enable viewing and signing reports in STAR Clinical Browser. Also, the physician logged on must have an additional password defined in M/R Maintenance, Electronic Signature Parameters, Assign Phys Electronic Signature Parameters. If a password is not defined, the signature option does not display in STAR Clinical Browser. See the STAR Clinical Browser Help file for more information.

Signing Reports in Horizon^{WP} Physician Portal

Two parameters control if the facility can be changed and if the dropdown defaults to a facility when in the Electronic Signature module of Horizon^{WP} Physician Portal. These parameters are set in Epicentric by the system administrator in the STAR Electronic Signature module via Details.

In addition, users can personalize, if the system administrator allows, the following:

- Auto select all reports
- Bypass patient selection
- Signature confirmation

See the Horizon^{WP} Physician Portal Help file for more information.

Associated STAR Reports

The Electronic Authentication Report (ERDEAUX) and Unaccepted Electronic Report Notice (EPAUENX) are created when using STAR Clinical Browser and Horizon^{WP} Physician Portal.

For more information regarding these reports, see “REPORTS” on page 6-1.

Chapter 5 - UPDATING CHART DEFICIENCY WITH TRANSCRIPTION DATA

OVERVIEW

The STAR Chart Management Module enables automatic adding and/or updating of deficiency information when a report has been transcribed and/or electronically signed. The actual transcribed report is not transmitted to STAR. Deficiencies can be automatically updated, and you can query the transcription system for report viewing.

To create an index on STAR, a report header file is transmitted from the transcription system to STAR containing information regarding the transcribed report. This header information creates a report index that is maintained on STAR until the time the user-defined purge parameter has been reached. This index is used when transmitting queries from STAR to the vendor.

Various portions of the STAR system must be defined to accommodate the transcription interface. These modifications are divided into the following sections and described in detail.

Tables

Medical Record & UM Table Maintenance

- Unsigned Report Reason Table
- Chart Deficiencies Table

Screens

Chart Deficiency

- Deficiency History Processor Screen
- Add/Edit Deficiency Processor Screen
- DRG & UM Table Processor Screen

M/R Maintenance Parameters

- Assign Physician Electronic Signature Parameters
- Electronic Signature Parameters
- Report Query Parameters

Reports

Transcription Discrepancy Notice
Electronic Authentication Report
Unaccepted Electronic Report Notice

TABLES

Medical Records & UM Table Maintenance

UNSIGNED REPORT REASON TABLE

The Unsigned Report Reason table must be used by the physician to indicate the reasons why they are not accepting an electronically transmitted report. This table should be set up to accommodate usage for all reports that can be signed electronically by the physician. Therefore, each facility should review this table to add, change, or edit any existing codes and descriptions to accommodate information that is pertinent to all reports. The physician can also enter freeform text to explain more.

After the Unsigned Report Reason table is selected, the system prompts you to enter an Unsigned Report reason code. You can enter the code, or press hyphen (-) and ENTER to display a list of codes from which you can select. After you enter the code, the following screen displays:

```
      General Hospital Medical Records & UM Table Maintenance Processor
                                                  Wed Jun 20, 1995 03:53 pm
Unsigned Report Reasons
( 1)Code         : 3
( 2)Description  : SECONDARY DIAGNOSIS INCORRECT

( 3)Edit by      : LAGER,BENNY
( 4)Edit date    : 06/19/95 02:47pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the two-digit alphanumeric code for the Unsigned Report Reason.

2. DESCRIPTION (33-C-R)
Enter the description of the Unsigned Report Reason. Examples of descriptions include: Not my patient, Incorrect principal diagnosis, Incorrect secondary diagnosis, Other procedures performed, Report requires correction, etc.

3. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry.

4. EDIT DATE (DISPLAY ONLY)
The system displays the date and time that this table entry was last updated.

When these fields are completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

Impact

The Edit Date and Edit By fields reflect the new date associated with the individual and date of the change if they were signed on with security.

Upon acceptance of this screen, the following takes place:

- The table entry is added, deleted, or revised as appropriate.
- The table listing reflects any changes made.

CHART DEFICIENCIES TABLE

The Chart Deficiencies code table is grouped with the Medical Records & UM Table Maintenance. Deficiency codes are used to indicate to a physician or department what must be completed on a medical record. You may set up as many deficiency codes as necessary for your facility. The following screen indicates the information you must complete for each deficiency code.

Much of the control between the transcription interface and Chart Management occurs via the Chart Deficiencies table.

After the Chart Deficiencies code table is selected, the system prompts you to enter a deficiency code. You can enter a new code, an existing code, or press hyphen (-) followed by ENTER to display a list of codes for selection. There is one screen involved in this transaction. After you enter a code, the following screen displays:

```
     General Hospital Medical Records & UM Table Maintenance Processor
                                                  Thu Jul 02, 1998 01:48 pm
Chart Deficiencies
 1 Code        2 Short Description     3 Long Description      4 Assign Date
   HP            HIST & PHY              HISTORY & PHYSICAL      Admission
 5 Bill Delay  6 Major Def  7 Sig Only   8 Multi  9 Activity Date 10 Rep Type
   Yes           Yes          No          No       No               HP
11 Auto Assign    12 Report Recvd       13 Due Date Update 14 Comp on Elec Sign
   Yes               SIGNATURE             Add 10             Yes
15 Dict Date/Time 16 Auto Def Slip      17 Edit By         18 Edit Date
                     Yes                   LTK                06/16/98
19 Status Code Description                 Days
    ( 1)  1    INCOMPLETE                    3
    ( 2)  2    WARNING                       2
    ( 3)  3    DELINQUENT                    2
    ( 4)  4    SUSPENDED                     2



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

Selected Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the alphanumeric code that was entered.

2. SHORT DESCRIPTION (10-AN-R)
The system requires you to enter a short description of the Chart Deficiency entry. The short description is displayed on various screens in chart deficiency and on related reports. Therefore, the short description should be meaningful and easy to understand in its abbreviated form.

3. LONG DESCRIPTION (20-AN-R)
The system displays the long description entry. The long description is used to describe in greater detail, information regarding the deficiency code.

4. ASSIGN DATE (1-A-R)
The system displays the type of assignment date entry. The Assign Date indicates the default assignment date of this deficiency. You can enter **A** for admission, **D** for discharge, or **C** for current date (actual calendar date the deficiency is assigned). Thus whenever this deficiency is added to a chart, the default date appears in the field for Assign Date on the deficiency processor screen.

9. ACTIVITY DATE (1-A-O)
Completion of this field is optional, but should be reviewed for consideration whether you plan to use the STAR Transcription Interface or not.

This parameter indicates whether STAR should prompt for the entry of an activity date, when this deficiency is added to an account via the Add/Edit Deficiency function. An activity date is defined as, the date the activity associated with this deficiency occurred,

such as, the performance of a procedure or consultation. This date is not intended to be used to indicate when the deficiency was entered, or when the patient was admitted or discharged, etc.

The main purpose of associating an activity date with the deficiency is to assist in matching a transmitted report header from the transcription system, with an existing deficiency. If the transcription interface is not active, the Activity Date field in the Add/ Edit Deficiency Processor Screen can still be completed.

When an activity date is associated with a deficiency, it displays on the Add/Edit Deficiency Processor Screen and the Deficiency History Processor Screen. The activity date does not display on the screen listing all deficiencies on the account.

When this field is entered, the following prompt displays:

Enable entry of Activity Date for this deficiency? (Y/N)[N]--

The following entry options are available:

Enter **N** for No, or press ENTER to indicate that STAR should not prompt for, or permit entry of, an activity date when the deficiency is added to an account. The default is **N**.

Enter **Y** for Yes, to indicate that STAR should prompt for entry of an activity date when this deficiency is added to an account. If this field contains **Y**, and the deficiency is added to an account, you are prompted for entry of an activity date, but entry is optional.

System Set-up Suggestion:
If you are using the transcription interface, the parameter should be set to **N** for deficiencies that do not have an associated activity date, such as history & physical, discharge summary, nursing notes, etc. It is suggested the parameter be set to **Y** for deficiencies that have an activity date of which there could be multiple deficiencies of this type for an account, such as, operative report or consultation report.

10. REP TYPE (6-ANP-O)
If you are not using the STAR Transcription Interface, completion of this field is not permitted. When utilizing the STAR Transcription Interface, completion of this field is optional, but must be reviewed for consideration.

This field is used for entry of the transcription system report code. The code provides the link between the information in the transcription system and the STAR Chart Deficiency system. If, the transcription system report code is different from that in field *one* of the screen, this field should be updated with that code. For example, if HP is the deficiency code for history & physical in STAR, and in your transcription system, the report type for history & physical is 1, then 1 is entered here. When the report header is transmitted from the transcription system and contains a 1 as the report type, STAR matches it to the HP deficiency for that patient.

WARNING: You must enter the code here exactly as it is found in the Transcription System. Upper and lower case must match.

If the transcription interface is not active, the field cannot be edited. When you attempt to enter the field, this message displays:

Error: Field cannot be edited!

When the transcription interface is active, and the field is entered, the prompt displays:

Enter transcription system code for this deficiency--

Enter the report code that matches the code found in the transcription system. There is no edit on this entry, therefore you must ensure the entry matches the code found in the transcription system.

Press ENTER, and the system either deletes what has been entered in this field, or leaves the field blank. If the field is blank, STAR does not update this deficiency when a report header is received.

System Set-up Suggestion:
The deficiency code in STAR and the report type code in your transcription system should be the same. If the codes are not the same, be sure what is entered here is *exactly* as it is found in the transcription system. If you do *not* want this deficiency to be automatically updated, leave this field blank. For deficiencies that are not related to transcription, this field *should* remain blank, such as progress notes, doctors orders, etc.

11. AUTO ASSIGN (1-A-O)
When you are not utilizing the STAR Transcription Interface, completion of this field is not permitted. When you are utilizing the STAR Transcription Interface, completion of this field is optional, but should be reviewed for consideration.

This field indicates whether STAR should automatically add the deficiency for the patient when a report header is transmitted for the same patient, but a deficiency does not exist for that report type.

Example:
The patient's account number in STAR matches the patient account number on the transmitted report header for a history & physical (HP), but HP does not exist as a deficiency for that account number (in STAR). A HP deficiency is created if the Auto Assign field contains Yes. When the system creates a deficiency, the status, assign date and aging of the deficiency are established utilizing the status codes and days for the deficiency. The deficiency type is that which is defined in the Report Received field. If the Auto Assign field is left blank, STAR interprets it as if N was entered, and a deficiency is not automatically created. If this field is set to Y for yes, and this deficiency already exists on the account for the same responsible physician, another deficiency

may be automatically created, and a Transcription Discrepancy Notice is created for Possible Duplicate Report.

When the transcription interface is not active, the field cannot be edited. If you attempt to enter the field, the following message displays:

Error: Field cannot be edited!

When the transcription interface is active and this field is entered, the following prompt displays:

Auto add this deficiency when transcription file is received (Y/N) [N]--

Enter **N** for No to indicate the deficiency should not be auto added to an account when a report file is transmitted from the transcription system.

Enter **Y** for Yes to indicate the deficiency should be auto added to an account when a report file is transmitted from the transcription system.

NOTE: If the Multi field is set to **N**, and this field is set to **Y**, the Multi field is ignored when a report file is transmitted. If a manual addition of this deficiency via Add/Edit Deficiency is done, then the Multi flag is checked.

12. REPORT RECVD (4-AN-O OR TABLE LOOKUP)
When you are utilizing the STAR Transcription Interface, completion of this field is optional, but should be reviewed for consideration. If you are not utilizing the STAR Transcription Interface, completion of this field is not permitted.

This field is used for entry of the Chart Deficiency Type that is entered/updated for a deficiency when a report header record is transmitted for the deficiency. This field accesses the Chart Deficiency Type table for selection.

Example:
The patient's account number in STAR matches the patient account number on the transmitted report record for a history & physical (HP), and HP exists as a deficiency for the patient's account. This field indicates to STAR how the deficiency type for this deficiency should be updated. If this field contains a type of Sign, when the transcription header record is received for the patient for the deficiency, the deficiency type is updated to Sign. The updated type is entered for the deficiency regardless of what is contained in the type field for that deficiency when the report file is transmitted.

When this field is entered, the following prompt displays:

Enter chart deficiency code, or '-' to list--

When the transcription interface is not active, this field cannot be edited. When you attempt to enter this field, the following message displays:

Error: Field cannot be edited!

When the transcription interface is active, the following entry options are available:

Enter the Chart Deficiency Type code.

Enter a hyphen (-) to display the Chart Deficiency Type table for selection. You can select one Deficiency Type for this field.

Press ENTER to leave this field blank to indicate the deficiency type is not automatically updated when a report header is transmitted from the transcription system.

System Set-up Suggestion:
It is recommended that a Chart Deficiency Type such as sign be entered here. Any type is accepted by STAR as long as it has been defined in the Chart Deficiency Type table.

13. DUE DATE UPDATE (2-AN-O)
Completion of this field is optional, but should be reviewed for consideration, whether you plan to use the STAR Transcription Interface or not.

This field is used to indicate if the deficiency due date (not assign date) should be updated when either a report header is received for the deficiency *and* the deficiency type is updated, or when the deficiency type is manually updated. This does not apply when a report header automatically adds a new deficiency. When this field is entered, the following prompt displays:

Enter No Date Change(N), Recalculate Due Date(R), or Due Date plus days(D)--

Whether or not the transcription interface is active, the following entry options are available:

Enter **N** for no date change, to indicate that the existing deficiency due date for the patient's deficiency should not be changed when the deficiency type is changed. If **N** is entered, there is no change in the due date or deficiency status when the type is changed. When **N** is selected, No Change displays in this field in the Chart Deficiencies table.

Enter **R** to indicate that the existing deficiency due date should be recalculated when the deficiency type is changed. If a deficiency is recalculated, STAR ignores the information in the Assign Date field in the recalculation, and utilizes the current date. If this field contains **R**, and the deficiency type for a patient is changed, the due date and deficiency status are updated according to the Status and days established in the table. The Assign Date for the deficiency is not changed. When **R** is selected, Recalculate displays in this field in the Chart Deficiencies table.

Enter **D** to indicate the existing deficiency due date should remain, but should be updated by a specified number of days. When **D** is entered, the following prompt displays:

Enter number of days past existing due date [0]--

The following entry options are available:

- Press ENTER to accept the default of zero (0) for this field. This indicates to STAR that no additional days should be added to the existing deficiency due date. This performs the same as if *No Change* had been indicated.

- Enter the number of days (up to 999) that should be added to the existing deficiency due date.

Example:
If the existing due date is 04/01/02 and this field contains a 5, the due date for this deficiency is changed to 04/06/02. The change in the deficiency due date occurs when the deficiency type is automatically or manually updated. The system does not also add the days in the first status, but utilizes the calculation of existing due date plus X days.

When **D** is entered, the deficiency status is updated based on statuses set up in the table for the deficiency, and *Add X* displays in this field, where *X* is the number of days.

14. COMP ON ELEC SIGN (1-A-O)
Completion of this field is optional, but should be reviewed for consideration, whether you plan to use the STAR Transcription Interface or not. If you *did not* purchase the STAR Transcription Interface, completion of this field is not permitted.

This field is used to indicate whether the deficiency should be automatically completed when the report is electronically signed.

Example:
Dr. Smith signs onto STAR Clinical Browser or Horizon*WP* Physician Portal and sees that he has a message indicating a transcribed history and physical is available for signing. After viewing the report, Dr. Smith electronically signs the report and a message is generated back to the Chart Deficiency system. Based on the indicator in this field, the HP deficiency is either marked complete or remains the same. When this field is entered, the following prompt displays:

Complete this deficiency when report is electronically signed? (Y/N) [N]--

If the transcription interface is not active, this field cannot be edited. If you attempt to enter this field, the following message displays:

Error: Field cannot be edited!

If the transcription interface is active, the following entry options are available:

- Enter **Y** for Yes, to indicate the deficiency should be automatically completed when the electronic signature is received. This pertains to when the signature is received from STAR Clinical Browser or Horizon^{WP} Physician Portal and/or transmitted in the report header.

- Enter **N** for No, or press ENTER, to accept the default of **N**. This indicates the deficiency should not be automatically completed when the electronic signature is received.

15. DICT DATE/TIME (1-A-O)
This field applies to the GUI version of Chart Management and indicates whether the Dict Date and Dict Time fields on the Add/Edit Deficiency Entry form should be automatically completed with the Dictation Date and Time transmitted from the transcription vendor via the STAR Medical Record Transcription Interface. If the STAR Medical Record Transcription Interface is not active, you cannot enter this field. If the STAR Medical Record Transcription Interface is active, complete this field as appropriate for your facility.

When you access this field, the following prompt displays:

Automatically update the dictation date and time fields? (Y/N) [N]--

Use one of the following entry options:

- Enter **Y** for yes to indicate STAR should automatically enter the dictation date and time into the Dict Date/Time fields when the transcription system transmits a report header to STAR that corresponds to this deficiency code (for the selected patient).

- Enter **N** for no or leave this field blank to indicate STAR should not automatically enter the dictation date and time into the Dict Date/Time fields on the Add/Edit Deficiency Entry form.

16. AUTO DEF SLIP (1-A-O)
Completion of this field is optional, but should be reviewed for consideration whether you plan to use the STAR Transcription Interface or not.

This field is used to indicate whether a deficiency slip should be printed automatically when the deficiency's type is updated either manually or automatically. This does not apply when a report header automatically adds a new deficiency with a deficiency type. When this field is entered the following prompt displays:

Auto print a new deficiency slip when deficiency is updated? (Y/N) [N]--

Whether or not the transcription interface is active, the following entry options are available:

- Enter **N** for No, or press ENTER to accept the default of **N**, to indicate that a new deficiency slip should not automatically print when this deficiency's type is updated.

- Enter **Y** for Yes, to indicate the system automatically prints a new deficiency slip when the deficiency type associated with this deficiency is updated. If multiple deficiencies are updated, and more than one have the Auto Def Slip field set to Yes, only one updated deficiency slip prints. The deficiency slip prints as indicated in the System Parameters of Chart Management (i.e., one per chart or one per physician).

17. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry.

18. EDIT DATE (DISPLAY ONLY)
The system displays the date this table entry was last updated.

Impact

The Edit By and Edit Date fields reflect the new date associated with the individual and date of the change if they were signed on with security.

Upon acceptance of this screen, the following takes place:

- The table entry is added, deleted or revised as appropriate.

- The table listing reflects any changes made.

SCREENS

This chapter describes the screens in the character-based version of the Chart Deficiency Module that accommodate the transcription interface.

Chart Deficiency

ADD/EDIT DEFICIENCY SCREEN

The Add/Edit Deficiency option enables you to add and/or edit deficiencies for a patient. To assist in the automatic updating of deficiencies when a report header is transmitted from the transcription system, an Activity Date field (to indicated when a procedure or consultation was performed) is on this screen.

The Add/Edit Deficiency Processor screen has been updated as follows:

```
           General Hospital  Add/Edit Deficiencies Processor
                                                 Tue Mar 22, 1994 04:01 pm
Unit Number Acct Number Patient Name              Attending Physician
000000301   9327100001  DOBB, MARJORIE            ADAMS,HAROLD R
Chart Status  Location        Dis Date  Due Date  Fin Class      Tot Charges
IMCOMPLT      MED RECORD      10/01/93  04/24/94  BLUE CROSS         $585.00
 1 Phys/Dept.                   2 Color          3 Deficiency
->
 4 Type         5 Assign Date   6 Due Date      7 Activity Date   8 Reviewer
                                                                    ABC
 9 Transcription Document Number









Enter current phys(=), department(D) or physician[P]--
```

Selected Field Explanations

7. ACTIVITY DATE (DATE-O)

This date indicates when the activity associated with the deficiency occurred, such as the performance of a procedure or consultation. If the deficiency entered in the Activity Date field has a flag in the Chart Deficiencies table set to Y, then the system enables you to enter a date in the field. When this field is accessed, the following prompt is displayed:

Enter activity date for this deficiency--

Enter the date of the procedure, consultation or other activity. Press ENTER to bypass date entry. Do **not** enter a date that is not the date the activity occurred. This field can

be completed at a later date when the information becomes available. The Activity Date is displayed in this screen and the Deficiency History Screen. The date is used to match deficiency information with the report header transmitted from the transcription system. The entering of an incorrect date in this field can cause a mismatch between the two systems. The mismatch can cause the deficiency type update to occur on the incorrect deficiency, or another deficiency to be added.

NOTE: The date entered here *does not* display on the screen listing all deficiencies for the account.

9. TRANSCRIPTION DOCUMENT NUMBER (DISPLAY)
This field contains the Unique Document Number or Unique Document File Name that was transmitted from the transcription system and associated with this deficiency. A number is contained in this field when the report header information created and/or updated the deficiency. This field is display only and cannot be edited. The information in this field is valuable when there are multiples of the same deficiency for a physician. If the physician manually signs a report, the document number on the report and the document number in this field can be compared. If they match, then it is clear which deficiency should be updated or marked complete by the chart analyst. This in turn removes the report entry for the physician in STAR Clinical Browser or Horizon^{WP} Physician Portal (if applicable).

DEFICIENCY HISTORY PROCESSOR SCREEN

The Deficiency History Processor screen contains information regarding changes and updates made to the selected deficiency on a selected account. An update has been made to the screen to display additional information and details regarding the deficiency.

The following is an example of the updated Deficiency History Processor screen:

```
                General Hospital Deficiency History Processor
                                                 Tue Apr 11, 1995 12:31 pm
Unit Number Acct Number Patient Name              Attending Physician
000001184   9509400001  DOBB, MARJORIE            ADAMS,HAROLD R
Chart Status  Location        Dis Date  Due Date
INCOMPLETE                              05/06/93
 1 Phys/Dept.                       2 Color           3 Deficiency
   COLEMAN,MICHAEL G                  RED               CON CONSULT
 4 Report Originator ID             5 Activity Date
                                      04/07/95
 6 Deficiency Audit Detail
          Date & Time               Inits         Old Due Date      New Due Date
From Type           To Type              From Status          To Status
          04/10/95 1510             LTR                             04/13/95
                   DICTATE                                        INCOMPLETE
          04/10/95 1514             LTR           04/13/95          04/21/95
DICTATE             TRANSCRIBE           INCOMPLETE           INCOMPLETE
          04/10/95 1517             ***           04/21/95          04/29/95
TRANSCRIBE          SIGNATURE            INCOMPLETE           INCOMPLETE


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

The information in Deficiency History is view only and cannot be edited.

Selected Field Explanations

3. DEFICIENCY (DISPLAY ONLY)
This is the deficiency (code and description) for which the physician or department is responsible for completing.

4. REPORT ORIGINATOR ID
This field indicates the number and name of the person who originated (i.e., dictated) the deficiency. This field contains data only when the transcription interface is active and the report header information has been transmitted to STAR. The originator ID can differ from the entry in Phys/Dept field. This can happen when the person dictating the report is not the same as the person responsible for the deficiency.

5. ACTIVITY DATE
This date indicates when the activity associated with the deficiency was performed, such as, a procedure or consultation. The date that displays in the field can be entered in one of three ways: at the time the deficiency is created, entered at a later date via the Add/Edit Deficiency Processor screen, included in the report header transmitted from the transcription system.

6. DEFICIENCY AUDIT DETAIL
This field tracks updates made to the selected deficiency. The audit information displays in chronological order, based on the date and time the change occurs. This is a scrolling screen, with no limit to the number of changes that can be stored and displayed. To view more entries in the field, use the slash (/) key to enter the field. When the field is entered, the screen displays the scrolling screen function keys used to view additional information.

For each update made to the deficiency, STAR displays the following:

- The date and time the change was made.
- The initials of the person responsible for making the change. When STAR automatically makes a type change, three asterisks (***) are displayed.
- The from and to type associated with the deficiency to indicate the pre- and post change.
- The From and To status of the deficiency at the time the change was made.

Entries that display in the field can be created by any one of the following:

- The deficiency type is automatically updated by STAR when the report header has been transmitted to STAR. This occurs only when the transcription interface is active.

- The deficiency type is manually updated via the Add/Edit Deficiency Processor screen (original entry or updated).
- The deficiency status is automatically updated by STAR when a report is electronically signed by the physician. This occurs only when the transcription interface is active.
- The deficiency status is updated by a manual change to either the assign date or due date via the Add/Edit Deficiency Processor screen.

Chart Deficiency Processing

When the transcription interface is active and all parameters and tables have been set up, the report header information transmitted from the transcription system automatically updates the Chart Deficiency information. The following sample scenarios outline the processing that can occur when the transcription interface is active.

For illustrative purposes, the following deficiency code table information for an operative report is being utilized:

```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                 Thu Mar 16, 1998 07:00 am
Chart Deficiencies
 1 Code            2 Short Description    3 Long Description    4 Assign Date
   OP                OP NOTE                OPERATIVE REPORT      Discharge
 5 Bill Delay   6 Major Def   7 Sig Only   8 Multi  9 Activity Date  10 Rep Type
   Yes            Yes           No           Yes      Yes               OP
11 Auto Assign    12 Report Recvd        13 Date Update        14 Comp on Elec Sign
   Yes               SIGN & DATE            Recalculate           Yes
15 Dict Date/Time 16 Auto Def Slip  17 Edit By             18 Edit Date
                     Yes               LTK                   03/10/98
19 Status Code Description                Days
    ( 1)  1    INCOMPLETE                   3
    ( 2)  2    WARNING                      5
    ( 3)  3    DELINQUENT                   5
    ( 4)  4    SUSPENDED1234567890          5
```

NOTE: For each scenario identified, if the report header has been transmitted to STAR it is available for viewing and/or electronic signature in STAR Clinical Browser/Horizon^{WP} Physician Portal.

Scenario 1

The patient is in STAR and currently has a deficiency for an operative report (OP) as follows:

```
                                          Assign   Due
Physician         Color  Deficiency Type  Date     Date     Status
( 1)STEVES,RICHARD       OP NOTE    TRANS 01/10/94 01/13/94 INCOMPLET
```

The operative report is the responsibility of Dr. Steves and currently has a type of *TRANS* (which in this example indicates that it has been dictated by the physician and is awaiting transcription). When the operative report has been completed by the transcriber, a report header record is transmitted to STAR. When the transmitted report header is received, STAR checks the account number, report type, activity date and authenticator ID number in the report header against what is contained in the Add/Edit Deficiency screen. If there is a match (and the deficiency has not been marked *Complete*), STAR compares the current deficiency type to that which is found in the *Report Recvd* field in the Chart Deficiencies code table for this deficiency (OP). If the types are the same, a new deficiency is added. If the types are different, the deficiency is updated with the type found in the *Report Recvd* field. For *OP*, the deficiency is updated to a type of *Sign* when a report header is received. STAR automatically changes the Type field on the Add/Edit Deficiency screen and updates the *Type Change* field in the Deficiency History screen. The deficiency assign and due dates and the deficiency status are updated according to the entry in the *Date Update* field of the Chart Deficiencies table.

Scenario 2

The patient is in STAR, but currently does not have a deficiency for an operative report. The operative report was dictated by Dr. Steves. Since there is no deficiency for this patient for this report, STAR checks the Auto Assign flag in the Chart Deficiencies table to determine if an OP deficiency can be automatically added. In this case, the flag is set to Yes, therefore, STAR creates a deficiency for the patient that displays on the Add/Edit Deficiency screen as follows:

```
                                          Assign   Due
Physician          Color Deficiency Type  Date     Date     Status
( 1)STEVES,RICHARD       OP NOTE    SIGN  01/10/94 01/13/94 INCOMPLET
```

NOTE: The Color field is blank, due to the fact that STAR cannot assume what to enter here. Also, this is an optional field and may not be used by all facilities. However, if the physician already has a deficiency for this patient, and another is automatically or manually added, STAR completes the Color field with the color already assigned for the physician.

STAR uses the default parameters set up for OP in the Chart Deficiencies table to determine assign and due date, as well as the deficiency status.

Scenario 3

The patient is not in STAR; therefore, there is not a deficiency for an operative report. This type of scenario may occur when the physician has dictated a report, such as a history and physical, prior to the admission of the patient. The operative report was dictated by Dr. Steves. Since there is no match for the patient, STAR can not automatically create a deficiency even though the Auto Assign field for OP is Yes. In order to track this information, STAR creates a Transcription Discrepancy Notice that indicates No Account Number Match.

Scenario 4
The patient is in STAR, and has a deficiency for an operative report. In the Add/Edit Deficiency Screen, the physician responsible for the completion of the deficiency is Dr. Steves. When the report header is transmitted to STAR it contains an authenticator code for Dr. Smith. Dr. Steves does not appear to be the person responsible for signing the OP report. STAR checks the Auto Assign flag in the Chart Deficiencies table to determine if an OP deficiency can be automatically added. In this case, the flag is set to Yes, STAR creates another deficiency as follows:

```
                                          Assign   Due
Physician          Color Deficiency Type  Date     Date     Status
( 1)SMITH,DONALD         OP NOTE    SIGN  01/10/94 01/13/94 INCOMPLET
```

NOTE: The Color field is blank, due to the fact that STAR cannot assume what to enter here. Also, this is an optional field and may not be used by all facilities. However, if the physician already has a deficiency for the patient, and another is automatically or manually added, STAR completes the Color field with the color already assigned for the physician.

STAR utilizes the default parameters set up in the Chart Deficiencies table for this deficiency to determine assign and due date, as well as the deficiency status.

The deficiency for Dr. Steves remains, since STAR cannot assume the transmitted report header corresponds to the deficiency for Dr. Steves. The system does not automatically update it. It is necessary for the department to manually determine whether the deficiency for Dr. Steves should remain, be deleted, or be completed.

Scenario 5
The patient is in STAR, and has a deficiency for an operative report. In the Add/Edit Deficiency screen, the physician responsible for the completion of the deficiency is Dr. Steves, and the status of the deficiency is *complete*. A report header is transmitted for an operative report for this account with the authenticator ID number for Dr. Steves. In this case, STAR does not designate the deficiency incomplete. The system creates a new deficiency assigned to Dr. Steves.

Scenario 6
The patient is in STAR, and has two deficiencies for OP (operative report). In the Add/Edit Deficiency screen, the physician responsible for completion of both OP deficiencies is Dr. Steves. Both deficiencies have a type of *Transcribe* and an activity date of 1/14/95. A report file is transmitted for an operative report for this account and an authenticator ID, which corresponds to Dr. Steves and the activity date is 1/14/95. Since the same deficiency exists for the same physician and activity date, STAR changes the type associated with the first OP deficiency. This occurs as long as the current deficiency status is not complete.

Scenario 7
The patient is in STAR, however, in the Patient Type Parameters for Chart Deficiency the patient's type has the flag set to **N**, indicating deficiencies cannot be added for this

patient type. In this scenario, a deficiency is not created for the patient, and the patient is placed on the Transcription Discrepancy Notice indicating No Account Number Match.

ELECTRONIC SIGNATURE MAINTENANCE

This section describes the functions of Electronic Signature Maintenance Options. These functions are accessed by selecting Abstracting & DRG Assignment Functions > Maintenance Functions > Electronic Signature Maintenance.

When the option Electronic Signature Maintenance is selected from the Maintenance menu, this submenu displays:

```
          General Hospital Electronic Signature Maintenance Processor
                                                 Mon Sep 15, 2003 12:34 pm
Electronic Signature Maintenance Options

               Option No.   Options
              ------------------------------------------------------------
                  1         Electronic Signature Parameters
                  2         Assign Phys Electronic Signature Parameters
                  3         Report Query Parameters
                  4         Update Transcription Index
```

Electronic Signature Parameters

The Electronic Signature Parameter screen is located on the Electronic Signature Maintenance menu in the base product. You have the option to put the function on the menu of your choice. The screen contains parameters that are required for the interface but are not specific to either Chart Management or STAR Clinical Browser/ Horizon*WP* Physician Portal.

The following is an example of the screen:

```
        General Hospital Electronic Signature Parameters Processor
                                              Sat Aug 25, 2001 01:21 pm

 1 Electronic Signature            2 Last Edit Date/Time     3 Last Edit Initials
   Yes                               10/31/94 0935             LTR
 4 Transcription Index Retention   5 Last Edit Date/Time     6 Last Edit Initials
   20                                01/18/95 1229             VAH
 7 Transcription Interface Date    8 Last Edit Date/Time     9 Last Edit Initials
   08/22/94                          10/31/94 0935             LTR
10 Transcription Product          11 Last Edit Date/Time    12 Last Edit Initials
   SOFTMED TRANSCRIPTION             10/31/94                  VAH
13 Electronic Authentication Rpt  14 Last Edit Date/Time    15 Last Edit Initials
   Yes                               06/01/95 1539             VAH




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

Field Explanations

1. ELECTRONIC SIGNATURE (1-A-R)
This parameter indicates whether the prompt to electronically send attestations to physicians, appears in the M/R Abstracting and DRG Assignment functions. This does not require that physicians sign attestations electronically. When the field is entered, the following prompt is displayed:

Is electronic signature used for Attestation forms? (Y/N) [N]--

The following entry options are available:

Enter **N** for No, or press ENTER to indicate electronic signature is not used for Attestation Forms. If **N** is contained in the field, STAR does not display the prompt to send the attestation to the physician (in the M/R Abstracting and DRG Assignment functions).

Enter **Y** for Yes, to indicate that electronic signature can be used for Attestation Forms. If **Y** is contained in the field, STAR displays the prompt to send an attestation message to the selected physician via the M/R Abstracting and DRG Assignment functions. When selecting **Y** the staff in the Medical Record Department can generate an attestation message to the selected physician.

2. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Signature field, the system automatically completes this field with the current date and time.

3. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Signature field, the system automatically completes the field with the initials of the person performing the update.

4. TRANSCRIPTION INDEX RETENTION (4-N-R)
This parameter indicates the length of time the report header information is stored in STAR. The parameter does **not** control the length of time the complete report is stored in the transcription system. Information contained in the report header can be found in this document under the section, Technical Field Explanations. It is the report header information that enables the STAR Clinical Browser/ Horizon*WP* Physician Portal and Chart Management modules to be updated. When this field is entered, the following prompt is displayed:

How long is the transcription index retained?--

You can enter a number from 0 to 9999 to indicate the length of time the transcription index is retained. The purge clock begins the date the transcription report header is transmitted to STAR. When another report header is transmitted for this patient, the purge clock is reset. The index is retained by patient. When the index is purged, all report inquiries must be made to the transcription system to obtain a list of reports to view.

Suggested System Set-up:
The retention should coincide with the amount of time the full reports are maintained on the transcription system. Keep in mind that the longer the retention, the greater the utilization of CPU disk space.

5. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Index Retention field, the system automatically completes this field with the current date and time.

6. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Index Retention field, the system automatically completes this field with the initials of the person performing the update.

7. TRANSCRIPTION INTERFACE DATE (DATE ENTRY)
This field indicates the date the transcription interface went *live* at the facility. Although this field does not directly affect the processing of the interface, it is helpful for support of the interface. It enables McKesson to determine the date, report header information became available. When this field is entered, the following prompt is displayed:

Enter transcription interface live date--

8. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Interface Date field, the system automatically completes this field with the current date and time.

9. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Transcription Interface Date field, the system automatically completes this field with the initials of the person performing the update.

10. TRANSCRIPTION PRODUCT (30-AN-O)
This field indicates the transcription product being utilized with the interface. The field does not, in any way, affect the processing of the interface. It is helpful for support of the interface, as it enables McKesson to determine the transcription vendor.

This field allows the entry of 30 characters. The entry should be as clear as possible. For example, if you are utilizing the SoftMed Systems' ChartScript®, an entry would be *SoftMed/ChartScript*. The description should provide identification of both the vendor and product. When this field is entered, the following prompt is displayed:

Enter transcription product name--

11. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon completion of data entry in the Transcription Product field, STAR automatically completes this field with the current date and time.

12. LAST EDIT INITIALS (DISPLAY ONLY)
Upon completion of data entry in the Transcription Product field, STAR automatically completes this field with the initials of the person performing the update.

13. ELECTRONIC AUTHENTICATION RPT (1-A-R)
This field is used to indicate whether the system should maintain an index of those reports that have been electronically authenticated (i.e., signed) by the physician (via STAR Clinical Browser/ Horizon*WP* Physician Portal). This index is used to create the demand report, Electronic Authentication Report (found in the Chart Deficiency Reports submenu). The information in the index is retained until the Electronic Authentication Report is generated, at which time it is purged and starts over. If the Electronic Authentication Report is never generated, the index continues to grow and is never purged.

This report is helpful to the Transcription Department and the Deficiency Area as it indicates the reports (i.e., deficiencies) that have been electronically authenticated.

When this field is entered, the following prompt displays:

Enable the Electronic Authentication Report to be created? (Y/N) [N]--

Select one of the following entry options:

Enter **N** for No, or press ENTER to indicate the system should not maintain an index of electronically authenticated reports. If you are not utilizing electronic signature in STAR Clinical Browser/ Horizon*WP* Physician Portal, No should be entered here. This prevents the system from maintaining the index.

Enter **Y** for Yes to indicate the system should maintain an index. If **Y** is entered, it is important to note that the index is created and continues to grow until the report is generated.

14. LAST EDIT DATE/TIME (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Authentication Rpt field, STAR automatically completes this field with the current date and time.

15. LAST EDIT INITIALS (DISPLAY ONLY)
Upon the completion of data entry in the Electronic Authentication Rpt field, STAR automatically completes this field with the initials of the person performing the update.

Assign Physician Electronic Signature Parameters

If you are not utilizing STAR Clinical Browser or Horizon*WP* Physician Portal for electronic signature of transcribed reports, it is not necessary to complete this screen.

The Assign Phys Electronic Signature Parameters function is used to enter a personal secret code and expiration date (of that code) for physicians who sign attestations or reports electronically. It is also used to identify which transcribed reports the physician has permission to sign electronically.

NOTE: In order to complete this parameter screen you first have to make sure you have built the necessary reports in the Physician Message Type table. For additional information on the Physician Message Type table, please refer to the *STAR Patient Care Reference Guide, Tables Volume*.

When the option Assign Phys Electronic Signature Parameters is selected, this prompt displays:

Enter physician code-- Enter '@' for all currently assigned, '' for all not currently assigned*

Select one of the following entry options.

- Enter the physician code that is to be added or updated by entering the physician code if you know it or by pressing hyphen (-) and ENTER to display the Physician Code table for selection, or you can enter the first letter(s) of the physician's last name followed by a hyphen (-) to display physicians whose name begins with the selected letter(s). This narrows the table search and you can select from this display.

- Enter an ampersand (@) and press ENTER to display all physicians with a password on file. Select from this display.

- Enter an asterisk (*) and press ENTER to display all physicians who do not have a password on file. Select from this display.

The following is an example of the screen:

```
      General Hospital Assign Phys Electronic Signature Parameters Processor
                                                  Sat Aug 25, 2001 06:14 pm

32 - ADAIR,FRANK
 1 Personal Secret Code     2 Expiration Date
   321                        05/21/2004
 3 Reports
   ANS-ANST NOTE
   CON-CONSULT
   CONS-Consultation Report









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

Field Explanations

1. PERSONAL SECRET CODE (15-AN-R)
This field is used for entry of the personal secret code for the physician to be used in STAR Clinical Browser and Horizon*WP* Physician Portal. The physician is prompted to enter the personal secret code prior to electronic signing of a report or attestation. The physician's personal secret code can be any combination of 15 alphanumeric characters. The code entered here can not be the same as the Secret Code entered in the Physician Parameters screen of the Physician table. When you enter a duplicate of the Secret Code, an error message is displayed and you are not allowed to use the code. When you enter this field, this prompt is displayed:

Enter physician's personal secret code--

2. EXPIRATION DATE (8-N-R)
This field is used for entry of an expiration date for the Personal Secret Code, to indicate the date when the code becomes invalid. After the expiration date has been reached, it is no longer possible for the physician to electronically sign reports, including attestations, via STAR ClinicalBrowser or Horizon*WP* Physician Portal. When you enter this field, the following prompt is displayed:

Enter expiration date--

NOTE: If you are entering a year beyond 2010, you must enter all four digits.

3. REPORTS (TABLE LOOKUP)
This field is used for entry of the report type(s) the physician electronically signs. This field accesses the Physician Message Types table. For additional information on this

table, please refer to the *STAR Patient Care Reference Guide, Tables Volume.* You can select as many codes as necessary, or enter **A** to select all.

From this field, STAR determines whether to automatically send the physician a message when the report type is available for signing.

NOTE: If the physician is currently utilizing the electronic attestation option, that Message Type should not beassociated with the physician here. Attestations are not sent automatically but rather as determined per patient by the staff in the Medical Record Department; therefore, it does not require identification for automatic messaging.

If the report type is not identified, the physician does not have the option to electronically sign the report.

When this field is entered, this prompt displays:

Enter report codes separated by commas, or '-' for list, or All(A)--

You have the following entry options:

- Enter the report type codes separated by commas. You may enter up to 46 report types. The system only accepts message type codes that are associated with a System Event of Transcription.
- Enter a hyphen (-) to display the message types for selection. The only types to display for selection are those with a System Event of Transcription.
- Enter **A** to indicate that all Message Types should be added.

Report Query Parameters

The Report Query Parameters screen is part of Electronic Signature Maintenance located in M/R Maintenance. These parameters control various aspects of the query portion (viewing) of the transcription interface and are required to use the query portion.

```
            General Hospital Report Query Parameters Processor
                                                Wed Apr 19, 1995 04:10 pm

Transcription Report Query Definition
 1 Number of Report Query Lines  2 Report Query Lines
   3                               TQ1
 3 Default Date Range (Days)     4 Account number required?
   7                               No
```

Field Explanations

1. NUMBER OF REPORT QUERY LINES (2-N-R)
This parameter indicates the number of query lines that have been defined in the STAR Communications Control Parameters. It is to be used for all transcription report queries when viewing and/or electronically signing. A minimum of three lines are required. Query lines are defined by McKesson during installation. When this field is entered, the following prompt is displayed:

Enter number of query lines--

2. REPORT QUERY LINES (78-AN-R)
This parameter indicates the names of the query lines that have been defined in the communications definitions, to be used for transcription report queries. Query lines are defined by McKesson during installation and are typically named TQ1, TQ2, and TQ3. When this field is entered, the following prompt is displayed:

Enter report query line communication definition(s) (separated by ',')--

3. DEFAULT DATE RANGE (2-N-R)
This parameter indicates the number of days prior to the current date to default the *Start Date* to when executing a two-step query in Physician Access/Physician View. This date range displays when **M** for More is entered from the View/Print Electronic Report options. When this field is entered, the following prompt is displayed:

Enter new number of days for the default date range (i.e. 7 for T-7)--

NOTE: STAR Clinical Browser and Horizon^{WP} Physician Portal do not use this parameter. Instead, the admission date of the selected encounter is defaulted.

4. ACCOUNT NUMBER REQUIRED (1-A-R)
This parameter indicates whether the transcription vendor requires the account number to be sent when executing a query to that system. When this field is entered, the following prompt is displayed:

Does transcription vendor require account number for report query (Y,N) [N]--

If the account number is sent, STAR must obtain all the account numbers for the patient and send them in the outbound message. This is time consuming.

NOTE: If you are using SoftMed, you should enter No at this prompt.

Update Transcription Index

The Update Transcription Index function allows you to remove an entry (report header) from a patient's transcription index on STAR. If a report is inadvertently associated with the wrong patient at the time of transcription, this mismatch can be corrected using this function.

When this option is selected, the MPI Search function is displayed to allow you to select a patient and visit. When a patient and visit are selected, a screen similar to the following is displayed, which contains all transcription index entries for the selected account number:

```
            General Hospital Update Transcription Index Processor
                                                 Tue Apr 20, 1999 01:27 pm
  No          Name             Sex    BD    Room    Physician     SVC   Status
9732400001    KENNEDY,THOMAS    M  09/09/64 3301-01 FRANKLIN,TODD PSY   MH  517
Page:01                                                  ##=Current Choices
Choice# Report Type              Date   Time  Adm Date  Dis Date  Elec Signed
( 1)   EC                       04/20/99 1327  11/20/97                No
( 2)   PM                       04/20/99 1327  11/20/97                No









Enter choices (eg. 1,3,5-9) or `-` choices to remove--
                                 end select(NL)
```

Field Explanations

CHOICE #
This field is the sequential number assigned by STAR to the transcription entry on this screen. Enter the Choice Number(s) at the prompt to select the index entry(ies) for deletion.

REPORT TYPE
This is the report type associated with the transcription index entry.

DATE
This is the date the entry was created in the index (usually the date the report was transcribed).

TIME
This is the time the entry was created in the index (usually the time the report was transcribed).

ADM DATE
This is the date the patient was admitted for the selected visit.

DIS DATE
This is the date the patient was discharged for this visit. If the patient has not been discharged, this field is blank.

ELEC SIGNED
This field indicates if the report has been electronically signed by the physician. If it has, a **Y** is displayed; if not, an **N** is displayed.

NOTE: A **Y** in this field does not prevent the entry from being deleted from the index.

At the prompt,

Enter choices (eg. 1,3,5-9) or `-` choices to remove--
end select(NL)

Enter the Choice Number(s) corresponding to the index entry(ies) you want to delete and press ENTER twice.

The following prompt is displayed:

Delete selected report headers? (Y/N)-- |

NOTE: You cannot retrieve the entry (report) after it has been deleted from the index.

To delete the selected entry(ies) from the index, enter **Y**. To abort the process, enter **N**.

If you enter **Y**, the message *Deletion Completed!* is displayed, the selected report (report header) is deleted from the transcription index, and the entry is no longer displayed in STAR Clinical Browser or Horizon*WP* Physician Portal.

If you enter **N**, you are returned to the Transcription Index Processor to select a different entry.

Chapter 6 - REPORTS

Illustrations

OVERVIEW

This chapter contains brief explanations and examples of each of the reports related to the transcription interface.

TRANSCRIPTION DISCREPANCY NOTICE (ERDTDNX)

The Transcription Discrepancy Notice enables tracking of discrepancies between STAR and the transmitted report header information. This notice prints automatically to a designated STAR printer when a report header is transmitted and one of the discrepancy criteria is met. The following incidents generate a Transcription Discrepancy Notice:

- **No Account Number Match**
  A patient is included on the Transcription Discrepancy Notice when a report header is transmitted, but the patient does not have an account number in STAR to match the report. The same message displays on the report if a report header is transmitted, but the patient type is one that does not permit entry of deficiency information as defined in the Patient Type Parameters of System Maintenance. This is the *only* notice that prints if Chart Management is not active.

  There are circumstances that prevent a transmitted report record from displaying as a message. This can happen if the physician dictated a report on a patient that had not been admitted to the facility (i.e., a preadmission history & physical); thus, the patient's account number had not been generated and was not in STAR. Without the patient account number in STAR, a patient match between STAR and the transcription system cannot be made, and the report header is transmitted but not stored.

- **Possible Duplicate Reports**
  A patient is included on the Transcription Discrepancy Notice when a report header is transmitted and two or more of the same deficiencies exists with the same responsible physician. These deficiencies each have a different Deficiency Type associated with them. This type of notice only prints if Chart Management is active.

System Set-up Suggestion:
The Transcription Discrepancy Notice should be set up to print at a location near the chart analysis, transcription, or incomplete file room area. These notices should be acted upon within a reasonable time. The Transcription Discrepancy Notice that prints when there is *No Account Number Match* contains the transmitted transcription header information. In the case of *No Account Number Match*, deficiency information is not included, since this account does not exist in STAR. When this type of Discrepancy Notice is generated, it indicates either 1) that STAR cannot automatically create the deficiency, as the account does not exist in STAR or 2) the report header applies to a patient whose patient type is set to **N** for Deficiency Tracking, and a deficiency cannot be added. In either case, STAR does not add a deficiency. This notice serves as a tool to alert the Medical Record Department staff that this deficiency needs to be manually added.

Examples of Transcription Discrepancy Notices that print for the types of No Account Number Match and Possible Duplicate or Multiple Reports, appear on the following screens.

The Transcription Discrepancy Notice that prints for No Account Number Match contains only the transmitted transcription header information. There is no deficiency information since this patient's account number does not exist in STAR.

Figure 6.1 Transcription Discrepancy Notice - No Account Number Match (ERDTDNX)

```
Transcription Discrepancy Notice

Report Transmission Date:  05/05/94
Report Transmission Time:  15:43
Discrepancy Notice Type:  No Account Number Match
Transmitted Transcription Information:
        Patient Name                  Dobb, Marjorie
        Admission Date                       05/05/94
        Unit Number                   96-26-36
        Account Number                       94240-00032
        Date of Birth                        06/24/12
        Report Type                      HP
        Procedure Date
        Primary Surgeon
        Dictation Date                       05/05/94
        Transcription Date/Time       05/05/94  15:30
        Edit Date/Time
        Originator ID                        32
        Provider #1                   32
        Provider #2
        Provider #3
        Transcriber IDLTR
        Document Number5643
        Document File Name
        Electronic Signature ID
        Electronic Signed Date/Time

Deficiency Information:
No Deficiency information exists for this patient.
```

Figure 6.2 Transcription Discrepancy Notice - Possible Duplicate or Multiple Reports (ERDTDNX)

```
Transcription Discrepancy Notice
Report Transmission Date:     05/05/94
Report Transmission Time:      15:43
Discrepancy Notice Type:     Possible Duplicate Report
Transmitted Transcription Information:
     Patient Name               Diamond,Ann
     Admission Date            05/05/94
     Unit Number                96-36-36
     Account Number                  94240-00032
     Date of Birth                   06/24/12
     Report Type                     OP
     Procedure Date                  05/07/94
     Primary Surgeon                 100
     Dictation Date                  05/07/94
     Transcription Date/Time         05/09/94 12:30
     Edit Date/Time
     Originator ID                   100
     Provider #1                     32
     Provider #2
     Provider #3
     Transcriber ID                  LTR
     Document Number                 5643
     Document File Name
     Electronic Signature ID
     Electronic Signed Date/Time

     Deficiency Information:
     Physician                       32-Adair,Phillip P
     Color
     Deficiency                      Op Note
     Type                            Signature
     Activity Date                   05/07/94
     Assign Date                     05/07/94
     Due Date                        05/12/94
     Reviewer Initials               ABC
     Status                          Incomplete

     Deficiency Information:
     Physician                      32-Adair,Phillip P
     Color
     Deficiency                     Op Note
     Type                            Signature
     Activity Date                  05/07/94
     Assign Date                    05/07/94
     Due Date                       05/12/94
     Reviewer Initials              DEF
     Status                         Incomplete
```

The Transcription Discrepancy Notice for a Possible Duplicate Report contains the transmitted transcription header information and the associated deficiency information found in Add/Edit Deficiencies for this report type. A *Possible Duplicate Report* is created when the report type and deficiency code match; the procedure date and the activity date match; and the Provider number and the Responsible Physician number match. Note that the two deficiencies in question have a deficiency type that matches what is in the Report Recv'd field in the Chart Deficiencies table and the deficiency is *not* complete. STAR creates another deficiency and creates the discrepancy notice to notify the Medical Record Department staff to verify and/or update the deficiency information for this patient.

UNACCEPTED ELECTRONIC REPORT NOTICE (EPAUENX)

A notice automatically prints when a physician has decided **not** to electronically sign a report. When the physician has utilized the option to reject an electronic report, a notice is automatically generated and printed at the designated printer. Following is an example.

Figure 6.3 Unaccepted Electronic Report Notice (EPAUENX)

```
Wed Jan 04, 1995 07:49 am     General Hospital              Page 1

                            Unaccepted Electronic Report Notice

   Report Transmission Date/Time:        05/05/94  15:43
   Unaccepted Date/Time:                 05/08/94  09:25
   Physician Unaccepting Report:         ADAIR,FRANKLIN P.
   Report Type:                          HP-HIST & PHYS
   Patient Information:
   Patient Name                          Dobb, Marjorie
   Admission Date                        05/05/94
   Discharge Date
   Unit Number                           96-26-36
   Account Number                        94240-00032
   Date of Birth                         06/24/12
   Provider #1                           32
   Provider #2
   Provider #3
   Transcriber ID                        LTR
   Document Number                       5643
   Document File Name
               Unaccepted Reason Information:
   Unaccepted Reasons:                   NOT MY PATIENT
   INCORRECT DIAGNOSIS
   TOO MANY BLANKS
   TOO MANY ERRORS
   INCORRECT PROCEDURE

                Unaccepted Reason Message:
   THIS REPORT NEEDS TO BE CORRECTED AND UPDATED BEFORE SIGNATURE.  I WILL COME
   INTO THE DEPARTMENT TO TAKE CARE OF THIS.
```

ELECTRONIC AUTHENTICATION REPORT (ERDEAUX)

With the transcription interface, physicians have the ability to electronically authenticate (i.e., sign) reports via STAR Clinical Browser or Horizon*WP* Physician Portal. To accommodate the ability to track when a report has been electronically authenticated, the Electronic Authentication Report has been added to the Chart Deficiency Reports menu. The purpose of this report is to alert the Medical Record Department to the fact that a document has been electronically signed by the responsible caregiver. This report displays all reports, by physician, which this physician has electronically signed. The report only displays those reports that have been electronically authenticated since the last time the report was generated. Once the report is generated, the index from which the Electronic Authentication Report is generated is purged and it begins again.

NOTE: This report does not include electronically signed attestations.

The primary sort is always by physician, and prints in alphabetic order based on the physician's last name. You have two subsort options: terminal digit and unit number.

When the option, Electronic Authentication Report is selected, this screen displays:

```
          General Hospital Electronic Authentication Report Processor
                                                 Wed May 31, 1995 08:09 am

( 1) Physician/Dept    :
( 2) Sort Method       :









Sort by terminal digit(T) or unit number(U)? [U]--
```

Field Explanations

1. PHYSICIAN/DEPT
The Physician/Dept field is used to indicate those physicians that should be included on the report. When this field is entered, this prompt displays:

Enter physician codes separated by ',' 'A' for all, or partial name '-' --
'-' for list

You have the following entry options:

- Enter the physician code(s), separated by commas to select specific physicians.
- Enter **A** to indicate All physicians should be included on the report.
- Enter the first few letters of the physician's last name followed by a hyphen (-) to minimize the search. This allows selection of only one physician.
- Enter a hyphen (-) to display the Physician Code table from which multiple physicians can be selected for inclusion on this report.

2. SORT METHOD
This field is used to indicate the secondary sort for this report. You have the option to enter **T** to sort based on terminal digit, or **U** to sort based on the unit number (straight numeric).

After you select a sortoption, you are prompted to acceptthe screen. Once the screen is accepted, this message displays:

Electronic Authentication Report printing!

The message displays briefly, then you are returned to the menu from which this option was selected. The following is an example of an Electronic Authentication Report:

Figure 6.4 Electronic Authentication Report (ERDEAUX)

```
Tue May 30, 1995 03:47 pm              GENERAL HOSPITAL                    Page 1
Electronic Authentication Report
Sort: Terminal Digit

Authenticating Physician: 1 - ADAMS, JAMES M

Unit Number     Patient Name            Acct Number       Adm Date         Dis Date
       Unique Document Number      Signed Date & Time
    Deficiency      Type                  Due Date          Activity Date
--------------------------------------------------------------------------------

000000637       DIMARCO,THOMAS           9506900011       03/10/95         05/10/95
       84736273                     05/30/95 14:31
    CONSULT        SIGN & DATE           04/06/95
```

Field Explanations

UNIT NUMBER
This is the unit number of the patient.

PATIENT NAME
This is the name of the patient on whom this report was electronically authenticated.

ACCT NUMBER
This is the account number of this patient's episode.

ADM DATE
This is the date the patient was admitted for this episode.

DIS DATE
This is the date the patient was discharged for this episode. If the patient has not been discharged, this field is blank.

UNIQUE DOCUMENT NUMBER
This is the document number transmitted by the transcription system associated with the document that was electronically authenticated.

SIGNED DATE & TIME
This is the date and time the document was electronically authenticated by the physician.

NOTE: The following fields are blank if STAR Chart Management is not implemented or if the report is signed using STAR Clinical Browser or Horizon^{WP} Physician Portal and the report does not have an associated Chart Management deficiency.

DEFICIENCY
This is the deficiency that was associated with the report that was electronically authenticated.

TYPE
This is the deficiency type associated with the deficiency once the report is electronically authenticated. If the deficiency type is altered between the time the report is authenticated and the Electronic Authentication Report is generated, the altered type is not reflected in this report.

DUE DATE
This is the due date associated with the deficiency.

ACTIVITY DATE
This is the activity date associated with the deficiency.

Chapter 7 - TRANSCRIPTION INTERFACE TEST PLAN

GETTING STARTED

Prerequisite Knowledge

To complete this test plan, you should have a general working knowledge of the following:

- STAR tables
- Admission process
- STAR Clinical Browser or Horizon*WP* Physician Portal
- Chart Deficiency
- Basic understanding of HL7

You should also have read this book.

Pre-Testing Set-Up

The following set-up must occur before the test plan can be completed:

1. The transcription interface must be active.
2. Attestations can be electronically signed.
3. The outbound, inbound and query communication lines must be defined and activated.
4. The transcription system must be able to accommodate test patients.

To Complete the Test Plan

To perform the complete test plan, you need to have access to STAR Clinical Browser or Horizon*WP* Physician Portal, STAR Chart Deficiency, STAR M/R Abstracting & DRG Assignment, STAR tables, and the transcription system.

Sending HL7 Messages from the Transcription System

During the testing you will need to generate report header messages by creating reports on the transcription system. These headers update Chart Deficiency and STAR Clinical Browser or Horizon*WP* Physician Portal. You must ensure you have the same account number in both the STAR test ID and the transcription test system.

Signing On to STAR Clinical Browser or Horizon^{WP} Physician Portal

You need to be able to sign onto the Physician system in order to complete the test plan. You need to know the physician number, the physician secret code, and the personal secret code.

Determining If HL7 Messages Were Received by STAR

During testing you may need to verify that the report header was actually received by STAR. To do this, follow the steps outlined below:

1. Select the HL7 Audit Inquiry option from the following menu sequence:

   System Management
   Communications Control
   HL7 Interface Functions
   HL7 Audit Inquiry

   When then HL7 Audit Inquiry option is selected, this prompt displays:

   Enter date for audit inquiry or `-` to list available dates [Today]--

2. Press ENTER to accept the default of today, or enter a date. This is to display HL7 transactions that have occurred on the specified date. Once a date is selected, the following is an example of the screen that displays:

```
                    General Hospital HL7 Audit Inquiry Processor
                                                    Wed Mar 08, 1995 08:41 am

Page:01              HL7 Interfaces with audits on 03/08/95

 ( 1) TRANSCRIPTION - IN









Enter choice--
```

   This screen displays a listing of transactions that have occurred on the selected date. Select the option number associated with the transcription interface. When the option is selected, this prompt displays:

Display in (C)hronological or (R)everse chronological order? [C]--

3. Press ENTER to accept the display default of **C** for chronological (date) order, or enter **R** to display the transactions in reverse chronological order. Once a selection is made, this prompt displays:

   Enter start time [midnight]--

4. Press ENTER to accept the starting time default of midnight, or enter a start time. Once an entry is made, this prompt displays:

   Select (I)ndividual messages or (S)tatistics [I]--

5. Press ENTER to accept the default of **I** to display individual message information, or **S** for statistical information. For testing purposes, accept the default of **I**. Once you press ENTER, the following is an example of the screen that displays:

```
                General Hospital HL7 Audit Inquiry Processor
                                                 Wed Mar 08, 1995 08:41 am
Page:01            Messages for 03/08/95 since 0000 (`*` - Received)
( 1) *03/08 0808 TRANSCRIPTION (A-T01-01)                        [296]
( 2) *03/08 0808 TRANSCRIPTION (A-T01-01)                        [297]
( 3) *03/08 0808 TRANSCRIPTION (A-T01-01)                        [298]
( 4) *03/08 0827 TRANSCRIPTION (A-T01-01)                        [299]
( 5) *03/08 0827 TRANSCRIPTION (A-T01-01)                        [300]
( 6) *03/08 0829 TRANSCRIPTION (A-T01-01)                        [301]
( 7) *03/08 0830 TRANSCRIPTION (A-T01-01)                        [302]
( 8) *03/08 0837 TRANSCRIPTION (A-T01-01)                        [303]









Enter choice--
```

This screen displays a listing of the individual messages for the selected transaction type (in this case, Transcription-In). The asterisk (***)** preceding the date indicates the message was received by STAR.

6. Enter the option number associated with the message to view the segments associated with message. The following is an example of this screen:

```
               General Hospital HL7 Audit Inquiry Processor
                                                  Wed Mar 08, 1995 08:41 am
Message: A-T01-01 on 03/08 0900 [Sequence #305]
Page:01                                    Segments
( 1) MSH-01 MESSAGE HEADER
( 2) EVN-01 EVENT TYPE
( 3) PID-01 PATIENT IDENTIFICATION
( 4) PV1-01 PATIENT VISIT
( 5) TXA-01 DOCUMENT NOTIFICATION









Enter choice--
```

7. Enter the option number associated with the segment to view the elements associated with the segment. For example, when you select the TXA segment associated with this message, the following sample screen displays:

```
               General Hospital HL7 Audit Inquiry Processor
                                                  Wed Mar 08, 1995 08:41 am
Message: A-T01-01 on 03/08 0900 [Sequence #305]
Segment: TXA - DOCUMENT NOTIFICATION
 1 Z0359-01 SET ID - DOCUMENT NOTIFIC   *   1
 2 Z0323-01 REPORT TYPE                     HP
 3 Z0441-01 TRANSCRIPTION DOCUMENT TY   *
 4 Z0324-01 TRANSCRIPTION PROCEDURE D       ""
 5 Z0325-01 TRANS. PRIMARY PROVIDER
 6 Z0326-01 DICTATION DATE AND TIME         199503080900
 7 Z0327-01 TRANSCRIPTION DATE AND TI       199503080900
 8 Z0328-01 EDIT DATE AND TIME              199503080900
 9 Z0329-01 ORIGINATOR CODE                 2;2&""&""
10 Z0330-01 TRANSCRIPTION PROVIDER #1       0002;2&""&""
11 Z0331-01 TRANSCRIPTION PROVIDER #2       "";""&""&""
12 Z0332-01 TRANSCRIPTION PROVIDER #3       "";""&""&""
13 Z0333-01 TRANSCRIBER CODE/NAME           VAH
14 Z0334-01 TRANSCRIPTION UNIQUE DOCU       UDN03080859HP
15 Z0409-01 PARENT DOCUMENT NUMBER      *
16 Z0335-01 TRANSCRIPTION FILE NAME         ""
17 Z0336-01 TRANSCRIPTION DOCUMENT ST       ""
18 Z0337-01 TRANSCRIPTION DOCUMENT CH       ""

F1 Prev Page  F2 Next Page  F5 Select  F6 Reset  F7 Exit ?
```

This display identifies the actual data elements transmitted within the segment.

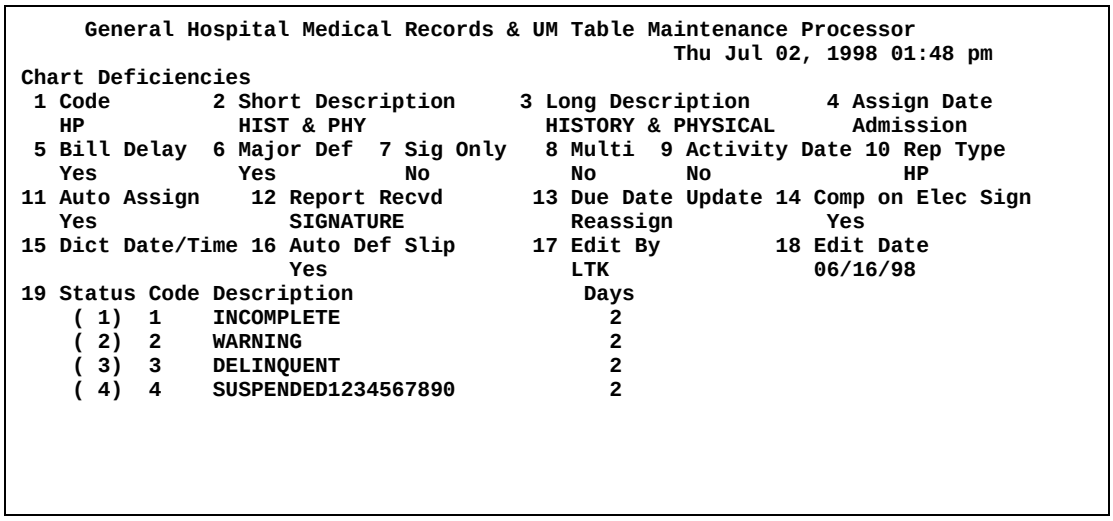
Setting Up Tables and Parameters for Testing

This test plan has been written under the assumption the following tables and associated table codes and parameters are set up as outlined below.

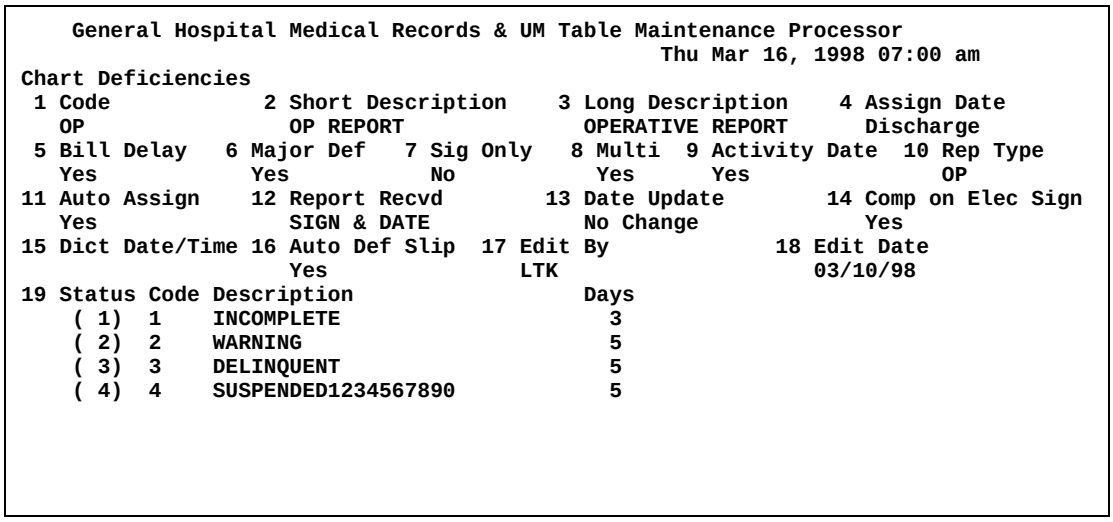
NOTE: The interface must be active to complete the table maintenance.

1. CHART DEFICIENCIES (Accessed via Medical Records & UM Table Maintenance)
Five deficiency codes need to be utilized. Verify deficiencies codes HP, OP, CON, DO and PRG are set up as follows, or set them up if necessary.

NOTE: If you use different codes, the complete test plan needs to be modified accordingly.



```
     General Hospital Medical Records & UM Table Maintenance Processor
                                                 Thu Jul 02, 1998 01:48 pm
Chart Deficiencies
 1 Code         2 Short Description     3 Long Description      4 Assign Date
   HP             HIST & PHY              HISTORY & PHYSICAL      Admission
 5 Bill Delay   6 Major Def  7 Sig Only   8 Multi  9 Activity Date 10 Rep Type
   Yes            Yes          No          No       No               HP
11 Auto Assign    12 Report Recvd       13 Due Date Update 14 Comp on Elec Sign
   Yes              SIGNATURE             Reassign            Yes
15 Dict Date/Time 16 Auto Def Slip      17 Edit By         18 Edit Date
                     Yes                   LTK                06/16/98
19 Status Code Description                 Days
    ( 1)  1    INCOMPLETE                    2
    ( 2)  2    WARNING                       2
    ( 3)  3    DELINQUENT                    2
    ( 4)  4    SUSPENDED1234567890           2
```



```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                 Thu Mar 16, 1998 07:00 am
Chart Deficiencies
 1 Code            2 Short Description    3 Long Description    4 Assign Date
   OP                OP REPORT              OPERATIVE REPORT      Discharge
 5 Bill Delay   6 Major Def   7 Sig Only   8 Multi  9 Activity Date  10 Rep Type
   Yes            Yes           No           Yes      Yes               OP
11 Auto Assign    12 Report Recvd        13 Date Update        14 Comp on Elec Sign
   Yes              SIGN & DATE           No Change             Yes
15 Dict Date/Time 16 Auto Def Slip  17 Edit By             18 Edit Date
                     Yes               LTK                   03/10/98
19 Status Code Description                 Days
    ( 1)  1    INCOMPLETE                    3
    ( 2)  2    WARNING                       5
    ( 3)  3    DELINQUENT                    5
    ( 4)  4    SUSPENDED1234567890           5
```

```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                Tue Apr 04, 1998 09:00 am
Chart Deficiencies
 1 Code        2 Short Description     3 Long Description      4 Assign Date
   CON           CONSULT                 CONSULTATION RECORD     Current
 5 Bill Delay  6 Major Def  7 Sig Only   8 Multi  9 Activity Date 10 Rep Type
   No            No           No           Yes      Yes              CON
11 Auto Assign    12 Report Recvd       13 Date Update   14 Comp on Elec Sign
   Yes              SIGN & DATE           Add 8             Yes
15 Dict Date/Time 16 Auto Def Slip  17 Edit By            18 Edit Date
                     Yes               LTR                  04/04/98
19 Status Code Description                 Days
    ( 1)  1    INCOMPLETE                    3
    ( 2)  2    WARNING                       3
    ( 3)  3    DELINQUENT                    3
    ( 4)  4    SUSPENDED1234567890           3
```

```
   General Hospital Medical Records & UM Table Maintenance Processor
                                                Tue Mar 21, 1998 10:48 am
Chart Deficiencies
 1 Code        2 Short Description     3 Long Description      4 Assign Date
   DO            DOC ORDERS              DOCTOR ORDERS           Current
 5 Bill Delay  6 Major Def  7 Sig Only   8 Multi  9 Activity Date 10 Rep Type
   No            No           No           Yes      Yes              DO
11 Auto Assign    12 Report Recvd       13 Date Update   14 Comp on Elec Sign
   Yes              SIGN & DATE           Add 2             Yes
15 Dict Date/Time 16 Auto Def Slip  17 Edit By            18 Edit Date
                     No                VAH                  03/20/98
19 Status Code Description                 Days
    ( 1)  1    INCOMPLETE                    7
    ( 2)  2    WARNING                       7
    ( 3)  3    DELINQUENT                    7
    ( 4)  4    SUSPENDED1234567890           7
```

```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                  Tue Apr 04, 1998 09:00 am
Chart Deficiencies
 1 Code        2 Short Description     3 Long Description      4 Assign Date
   PRG           PROG NOTE               PROGRESS NOTE           Current
 5 Bill Delay  6 Major Def  7 Sig Only   8 Multi  9 Activity Date 10 Rep Type
   No            No           No           Yes      No
11 Auto Assign    12 Report Recvd       13 Date Update   14 Comp on Elec Sign
   No               SIGN & DATE          No Change        No
15 Dict Date/Time 16 Auto Def Slip  17 Edit By            18 Edit Date
                     No               LTR                   04/04/98
19 Status Code Description                Days
    ( 1)  1    INCOMPLETE                   3
    ( 2)  2    WARNING                      3
    ( 3)  3    DELINQUENT                   3
    ( 4)  4    SUSPENDED1234567890          3
```

2. UNSIGNED REPORT REASON (Accessed via Medical Records & UM Table Maintenance)

Verify at least five reasons have been set up in the table. The following is an example of this table:

```
    General Hospital Medical Records & UM Table Maintenance Processor
                                                  Mon Mar 20, 1995 04:12 pm
Unsigned Report Reasons

Page:01                                 Unsigned Report Reasons
( 1) 1-INCORRECT PRINCIPAL DIAG
( 2) 4-INCORRECT PROCEDURES
( 3) 2-MISSING SECOND DIAG
( 4) 3-NEED CHART TO SIGN
( 5) 6-NEED TO UPDATE REPORT
( 6) 5-NOT MY PATIENT
( 7) 8-WRONG INFORMATION
( 8) 7-WRONG TRANSCRIPTION
```

3. PHYSICIANS (Accessed via Physicians Table Maintenance)

Select or create four physicians from the Physician table. Enter your selections here for use during the testing:

PHYSICIAN NUMBER	PHYSICIAN NAME
Physician A	
Physician B	
Physician C	

PHYSICIAN NUMBER	PHYSICIAN NAME
Physician D	

4. PHYSICIAN MESSAGE TYPE TABLE (Accessed via Physician Table Maintenance)
Verify or create four message types with a System Event of Transcription. The suggested message types are HP, OP, CON and DO and should be set up as follows:

NOTE: Selecting other message types alters the outcome of the test plan.

```
          General Hospital Physician Table Maintenance Processor
                                                Thu Mar 16, 1995 07:54 am
Physician Message Types
 1 Code                  2 Description
   HP                      HISTORY & PHYSICAL
 3 System Event          4 Trans Report Type    5 Allow Phys Deletion
   Transcription           HP                     No
 6 Unviewed Msg Hold Days                       7 Viewed Msg Hold Days
   7 days                                         3 days
 8 Print Prim Ins?       9 Edit By & Date
   No                      Booth,Linda T  07:54am
10 Message Text
   This History & Physical is available for your signature.
```

```
       General Hospital Physician Table Maintenance Processor
                                                Thu Mar 16, 1995 07:48 am
Physician Message Types
 1 Code                  2 Description
   OP                      Operative Report
 3 System Event          4 Trans Report Type    5 Allow Phys Deletion
   Transcription           OP                     No
 6 Unviewed Msg Hold Days                       7 Viewed Msg Hold Days
   7 days                                         3 days
 8 Print Prim Ins?       9 Edit By & Date
   No                      Dean,Sherry L  12:06pm
10 Message Text
   Please electronically sign this operative report.  Thank you.
```

```
       General Hospital Physician Table Maintenance Processor
                                                Thu Mar 16, 1995 07:55 am
Physician Message Types
 1 Code                  2 Description
   CON                     CONSULT
 3 System Event          4 Trans Report Type    5 Allow Phys Deletion
   Transcription           CON                    No
 6 Unviewed Msg Hold Days                       7 Viewed Msg Hold Days
   7 days                                         3 days
 8 Print Prim Ins?       9 Edit By & Date
   No                      Reynolds,Vicky A  04:24pm
10 Message Text
   This CONSULTATION report requires your signature.
```

```
      General Hospital Physician Table Maintenance Processor
                                                Thu Mar 16, 1995 03:05 pm
Physician Message Types
 1 Code                  2 Description
   DO                      DOCTORS ORDERS
 3 System Event          4 Trans Report Type    5 Allow Phys Deletion
   Transcription           DO                     No
 6 Unviewed Msg Hold Days                       7 Viewed Msg Hold Days
   7 days                                         3 days
 8 Print Prim Ins?       9 Edit By & Date
   No                      Reynolds,Vicky A  04:24pm
10 Message Text
   DOCTORS ORDERS
```

5. ASSIGN PHYSICIAN ELECTRONIC SIGNATURE PARAMETERS

This parameter is accessed by selecting the following menu options within the Medical Record CRT:

Abstracting & DRG Functions
Maintenance Functions
Electronic Signature Maintenance
Assign Phys Electronic Signature Parameters

Verify the four physicians (identified previously) are set up as follows or set them up if necessary. You need to refer to this information when completing Section Three of the test plan.

```
    General Hospital Assign Phys Electronic Signature Parameters Processor
                                                Thu Mar 16, 1995 08:00 am
XXXXXX - PHYSICIAN A
 1 Personal Secret Code     2 Expiration Date
   321                        01/01/96
 3 Reports
   CON-Consultation Report
   DO-DOCTORS ORDERS
   HP-HISTORY & PHYSICAL
   OP-Operative Report
```

```
     General Hospital Assign Phys Electronic Signature Parameters Processor
                                                Mon Mar 20, 1995 04:25 pm
XXXXXX - PHYSICIAN B
 1 Personal Secret Code     2 Expiration Date
   321                        12/31/96
 3 Reports
   All
```

```
    General Hospital Assign Phys Electronic Signature Parameters Processor
                                                Mon Mar 20, 1995 04:26 pm
XXXXXX - PHYSICIAN C
 1 Personal Secret Code     2 Expiration Date
   321                        01/01/96
 3 Reports
   OP-Operative Report
```

```
    General Hospital Assign Phys Electronic Signature Parameters Processor
                                                Mon Mar 20, 1995 04:27 pm
XX - PHYSICIAN D
1 Personal Secret Code     2 Expiration Date
   321                        12/31/96
3 Reports
   CON-CONSULT
   HP-HISTORY & PHYSICAL
   OP-Operative Report
```

TESTING CHART MANAGEMENT PROCESSING

Testing Chart Deficiency Update with Transcription Report Headers

Scenario 1: Verification of Auto Assigned Deficiencies.

TESTING STEPS

___a. Select a patient that has the same account number in *both* the STAR and the transcription system. This may require admitting patients to STAR and transmitting them to the transcription system. This is now Patient A (ensure the patient type enables chart deficiencies to be added).

___b. Verify the patient *does not* currently have any chart deficiencies for this account in STAR.

___c. Go to the transcription system and create a HP report for Patient A that creates a transmission to STAR. Record your data here (or make a screen print):

Patient Account #: _____
Report Type: HP
Provider #1: Physician B
Unique Document Number: _____

___d. Return to STAR and verify the patient now has a HP deficiency for Physician B. The Type for this deficiency should be Signature.

___e. Select the HP deficiency and enter **E** to edit. Add the color Black for Physician B for the HP deficiency.

___f. Go to the Chart Deficiency Reports option and create a Deficiency Pull List for Physician B.

___g. Verify the Deficiency Pull list for Physician B now contains a HP Deficiency for this patient.

Scenario 2: Verification of Auto Assigned Deficiencies with Color field auto completed.

TESTING STEPS

___a. Go to the transcription system and create a DO report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: DO
Provider #1: Physician B
Unique Document Number: _____

___b. Return to STAR and verify the patient now has a DO deficiency for Physician B. The Color associated with this deficiency should be the same as that entered for the HP.

___c. Go to the Chart Deficiency Reports option and create a Deficiency Worklist for Physician B.

___d. Verify the Deficiency Worklist for Physician B now contains a DO Deficiency for this patient.

Scenario 3: Verification of inability to manually add the same deficiency for the same physician multiple times if the Multi field in the Chart Deficiencies table is set to No.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option and select Patient A.

___b. Add a HP deficiency for Physician B.

___c. Verify the system displays this message:

Error: Deficiency already assigned for physician!

___d. Exit out of this screen *without* adding a deficiency.

Scenario 4: Verification the system will automatically add the same deficiency for the same physician multiple times even if the Multi field in the Chart Deficiencies table is set to No.

TESTING STEPS

___a. Go to the transcription system and create a HP report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: HP
Provider #1: Physician B
Unique Document Number: _____

___b. Return to STAR and verify the patient now has two HP deficiencies for Physician B. The Color associated with this deficiency should be the same as that entered for the original HP and DO deficiencies.

___c. Verify the system created a Transcription Discrepancy Notice (ERDTDNX) for the second HP. The notice type should be Possible Duplicate Report.

___d. Go to Chart Deficiency Reports and create a Deficiency Notice for Physician B.

___e. Verify the Deficiency Notice contains two HP deficiencies for this patient.

Scenario 5: Verification of inability to add an Activity Date via Add/Edit Deficiency if the Activity Date field in the Chart Deficiencies table is set to No.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option, and access Patient A.

___b. Select one of the HP deficiencies, and enter **E** to edit.

___c. Access field #7 (Activity Date) and verify the system does not allow entry into this field.

Scenario 6: Verification of ability to add an Activity Date via Add/Edit Deficiency if the Activity Date field in the Chart Deficiencies table is set to Yes, and verification that this date displays in the Deficiency History processor screen.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option, and select Patient A.

___b. Select the DO deficiency, and enter **E** to edit.

___c. The cursor should be on field #7 (Activity Date).

___d. Verify the system enables you to enter a date. Enter a date two days prior to the Assign Date associated with the deficiency and accept the screen.

___e. Go to the Deficiency History option and verify that the Activity Date entered in Add/Edit Deficiencies displays in field #5 (Activity Date) for the DO deficiency.

Scenario 7: Verification that a deficiency is not automatically created if the Auto Assign field in the Chart Deficiencies table is set to No.

TESTING STEPS

___a. Go to the transcription system and create a PRG report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: PRG
Provider #1: Physician B
Unique Document Number: _____

___b. Return to the Add/Edit Deficiency option (in STAR) and verify the patient does not have a Progress Note (PRG) deficiency.

Scenario 8: Verification that a manually added deficiency is updated correctly when a report header is transmitted.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option and select Patient A.

___b. Add the following deficiency information:

Phys/Dept.: Physician C
Color: BLUE
Deficiency: CON (CONSULT)
Type: DIC (DICTATE)
Activity Date: Two days prior to Assign Date

The system automatically calculates the Assign and Due Dates. Record those here:

Assign Date: _____
Due Date: _____

___c. Go to the Deficiency History screen and verify the entry of this deficiency has been added to the audit trail.

___d. Go to the Chart Deficiency Reports option and create a Deficiency Pull List for Physician C.

___e. Verify (on the Pull List) the type for the CON deficiency (for this patient) is Dic.

___f. Go to the transcription system and create a CON report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: CON
Procedure Date: Same date as entered in the Activity Date field in Step b.
Provider #1: Physician C
Unique Document Number: _____

___g. Return to STAR and verify the Consult deficiency has a type of Sign & Date and the Due Date has been updated according to what is found in field 13 (Due Date Update) of the Chart Deficiencies table for the CON deficiency.

___h. Verify the patient has the following deficiencies:

Physician	Color	Deficiency	Type
(1) PHYSICIAN C	BLUE	CONSULT	SIGN & D

Physician	Color	Deficiency	Type
(2) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR
(3) PHYSICIAN B	BLACK	DOC ORDERS	SIGN & D
(4) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR

___i. Verify the Deficiency History Processor screen displays a new entry in the audit trail that includes the automatic updating of the CON deficiency.

___j. Verify a Deficiency Slip (ERDSX) automatically printed when the Type was updated.

___k. Go to the Chart Deficiency Reports option and create a Deficiency Pull List for Physician C.

___l. Verify (on the Pull List) the type for the CON deficiency (for this patient) is now Sign & Date.

Scenario 9: Verification that an existing deficiency is updated and a Transcription Discrepancy Notice prints when the following conditions exist: Two of the same reports for the same physician with the same or no Activity Date.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option and select Patient A.

___b. Add the following deficiency information:

Phys/Dept.: Physician C
Color: BLUE (should be auto-added by system)
Deficiency: CON (CONSULT)
Type: DIC (DICTATE)
Activity Date: None

The system automatically calculates the Assign and Due Dates.

___c. Go to the transcription system and create a CON report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: CON
Procedure Date: None
Provider #1: Physician C
Unique Document Number: _____

___d. Return to STAR and verify there are two Consult deficiencies with a type of Sign & Date.

___e. Verify the patient has the following deficiencies:

Physician	Color	Deficiency	Type
(1) PHYSICIAN C	BLUE	CONSULT	SIGN & D
(2) PHYSICIAN C	BLUE	CONSULT	SIGN & D
(3) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR
(4) PHYSICIAN B	BLACK	DOC ORDERS	SIGN & D
(5) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR

___f. Verify the Deficiency History Processor screen displays the audit trail that includes the automatic updating of the CON deficiency.

___g. Verify the system printed a Transcription Discrepancy Notice (ERDTDNX) for Possible Duplicate Report.

Scenario 10: Verification that a new deficiency is automatically created when this condition exists: Two of the same deficiencies for different physicians.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option and select Patient A.

___b. Add the following deficiency information:

Phys/Dept.: Physician D
Color: RED
Deficiency: CON (CONSULT)
Type: DIC (DICTATE)
Activity Date: Three days prior to assign date

The system automatically calculates the Assign and Due Dates. Record those here:

Assign Date: _____
Due Date: _____

___c. Go to the transcription system and create a CON report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: CON
Procedure Date: None
Provider #1: Physician A
Unique Document Number: _____

___d. Return to STAR and verify a Consult deficiency has been added for Physician A with a type of Sign & Date and the Due Date is correct.

___e. Verify the patient has the following deficiencies:

Physician	Color	Deficiency	Type
(1) PHYSICIAN C	BLUE	CONSULT	SIGN & D
(2) PHYSICIAN C	BLUE	CONSULT	SIGN & D
(3) PHYSICIAN A		CONSULT	SIGN & D
(4) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR
(5) PHYSICIAN B	BLACK	DOC ORDERS	SIGN & D
(6) PHYSICIAN B	BLACK	HIST & PHY	SIGNATUR
(7) PHYSICIAN D	RED	CONSULT	DICTATE

___f. Go to View Spooled Reports and verify the system did*not* print a Transcription Discrepancy Notice (ERDTDNX) for Possible Duplicate Report.

Scenario 11: Verification that the Deficiency History Processor is updated properly when the Deficiency Type is changed.

TESTING STEPS

___a. Select the Deficiency History option and select Patient A.

___b. Verify the audit trail for the following deficiency is correct:

```
PHYSICIAN D        CONSULT     DICTATE
```

___c. Go to the Add/Edit Deficiency option and change the Type for this deficiency to TRS (Transcribe).

___d. Go to the Deficiency History option and select the patient again and verify the audit trail now contains three entries for this deficiency.

___e. Go to the transcription system and create a Con report for Patient A that creates a transmission to STAR. Record your entry information here (or make a screen print):

Patient Account #: _____
Report Type: CON
Procedure Date: Three days prior to assign date of the deficiency
Provider #1: Physician D
Unique Document Number: _____

___f. Go to the Deficiency History option and select the patient again and verify the audit trail now contains four entries for this deficiency.

Scenario 12: Verification that the Deficiency History Processor is updated properly when the Deficiency Assign and Due dates are changed.

TESTING STEPS

___a. Go to the Deficiency History Processor screen and select Patient A.

___b. Verify an entry for Doc Orders for Physician B.

___c. Go to the Add/Edit Deficiency option. Select the Doc Orders deficiency or Physician B.

___d. Update the Assign Date to two days prior to the current assign date.

___e. Verify the audit trail for the deficiency has a new entry with the updated due date.

Scenario 13: Verification that multiple deficiencies are added when the report header contains multiple providers.

TESTING STEPS

___a. Select a new patient that has an account number in both the STAR and transcription systems. This is Patient B (ensure deficiencies can be added for this patient type).

___b. Go to Add/Edit Deficiencies and verify the patient does not currently have any deficiencies.

___c. Go to the transcription system and create an OP report for Patient B that creates a transmission to STAR. Record your data here (or make a screen print):

Patient Account #: _____
Report Type: OP
Provider #1: Physician B
Provider #2: Physician A
Provider #3: Physician D
Unique Document Number: _____

___d. Return to the Add/Edit Deficiency screen for Patient B, and verify the following deficiencies have been created:

Physician	Color	Deficiency	Type
(1) PHYSICIAN A		OP REPORT	SIGN & D
(2) PHYSICIAN B		OP REPORT	SIGN & D
(3) PHYSICIAN D		OP REPORT	SIGN & D

Verifying the Transmission of an Electronic Signature from the Transcription System to Chart Deficiency

Scenario 1: Verification that the electronic signature updates the deficiency.

TESTING STEPS

___a. Go to the transcription system and resend the OP report created in the previous scenario to resend the transmission to STAR. Record your data here (or make a screen print):

Patient Account #: _____
Report Type: OP
Provider #1: Physician B
Unique Document Number: Enter SAME number as found in the previous scenario
Electronic Signature: Physician B
Electronic Signed Date/Time: Today/Now

___b. Return to the Add/Edit Deficiency screen for this patient and verify the OP Report for Physician B is now complete.

___c. Go to the Deficiency History and verify there is a new entry in the audit trail indicating the deficiency status is complete.

TESTING STAR CLINICAL BROWSER AND HORIZON^{WP} PHYSICIAN PORTAL

Verifying Physician Messaging

Scenario 1: Verification that a physician does not receive a message when a deficiency is manually added.

TESTING STEPS

___a. Go to the Add/Edit Deficiency option and access Patient A utilized in previous scenarios.

___b. Add the following deficiency information:

Phys/Dept.: Physician A
Color: No Color
Deficiency: DO (DOCTORS ORDER)
Type: SIG (SIGNATURE)
Activity Date: None

The system automatically calculates the Assign and Due Dates. Record those here:

Assign Date: _____
Due Date: _____

___c. Go to STAR Clinical Browser or Horizon^{WP} Physician Portal and sign on as Physician A.

___d. Select the View Messages option.

___e. Verify there is not a new message for Doctors Order.

Scenario 2: Verification that a physician does not receive a message when they are not set up for that report type in the Assign Physician Electronic Signature Parameters.

TESTING STEPS

___a. Go to STAR Clinical Browser or Horizon^{WP} Physician Portal and sign on as Physician C.

___b. Select the View Messages option.

___c. Verify there is not a Consult message.

Scenario 3: Verification that a physician receives only one new message even though there are multiples of the same report type.

TESTING STEPS

___a. Go to STAR Clinical Browser or Horizon^{WP} Physician Portal and sign on as Physician B.

___b. Select the View Messages option.

___c. Verify there is one History & Physical Message. Do not select the message.

Scenario 4: Verification that viewing the new message deletes the message.

TESTING STEPS

___a. Go to STAR Clinical Browser or Horizon^{WP} Physician Portal and sign on as Physician A.

___b. Select the View Messages option.

___c. Select the message for Consult Report.

___d. View the message.

___e. Select the View Messages option again.

___f. Verify the Consult message is not available for selection.

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *STAR Patient Care - Medical Record Transcription Interface 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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